C. PRACTICE GUIDELINES

Programs shall ensure that Substance Use Disorder (SUD) treatment and recovery services are provided to adults and adolescents with a SUD, including those with co-occurring disorders. Programs shall provide these services to a specific subset of this population (e.g., women, probationers) based on the nature of their program. Programs are advised to refer to their contract for detailed information regarding their program's target population. To serve the target population to the standards expected by the County of San Diego Behavioral Health Services (COSDBHS), the following admission protocols shall be developed by the Programs.

Admission Policies, Procedures and Protocols

Programs shall develop and maintain written program admission policies, procedures and protocols. The policies, procedures and protocols shall be developed to ensure services to the target population and shall comply with the non-discrimination and related clauses in Article 8, Compliance with Laws and Regulations, of the Service Template. Programs shall implement non-discriminatory admission policies, ensuring that members are admitted to treatment and recovery services regardless of anticipated treatment outcome that are in line with harm reduction principles. Policies shall also comply with the entry criteria and priority as defined by the contracts. Admission policies and procedures shall be submitted for review and approval by the COR within 60 days of Agreement execution. In the very rare occasions that providers should exclude members from their program (example: members become violent), providers are to use case managers to do a warm hand-off to appropriate services. Medi-Cal members are entitled to receive DMC services. Providers should consult with their legal entity when excluding DMC members from receiving services as this does not align with the SOW and SUDPOH requirements. Legal entities may discuss with CORs.

All programs: AB 2081 – Disclosure Requirements for SUD Programs: Beginning January 1, 2025, licensed alcoholism or drug abuse recovery facilities and certified alcohol or drug programs must disclose their licensing/certification status on their websites and admission forms. This includes a link to the DHCS webpage listing facilities on probation or with revoked/suspended.

Daily Admissions

Outpatient and Residential programs shall have capacity to conduct daily admissions and level of care determinations for the days they are open. Outpatient programs are expected to be open five (5) days a week at minimum, and to complete the Initial Level of Care Assessment upon admission. At residential programs, the LPHA initial level of care face-to-face determinations are expected to be completed within the same day of admission and no more than 24 hours after the member admission. Doing so ensures that members staying overnight receive an initial assessment. Each residential program shall have Daily Admission Policy & Procedure developed with, and approved by, Medical Director, regarding member safety.

Acclimation Periods

Programs are required to follow their policies and procedures as developed with the program's Medical Director in determining length of, and rules around, any type of acclimation (i.e. "blackout") period after members' admission to a residential program. (Please note programs are not required to have such a period). These policies and procedures shall ensure that members at residential facilities may correspond, have reasonable access to telephones, and have regularly scheduled opportunities to meet with visitors consistent with treatment needs. Program rules and restrictions must always be germane to treatment and consistent with trauma informed and DMC-ODS principles, and the policies and procedures for the acclimation period must allow for access to medically necessary and clinically indicated appointments, such as mental health appointments, medical appointments, child visitation (including phone calls with children), court and

probation meetings, etc. Additionally, member correspondence addressed to, or from, the County of San Diego, public officials, attorneys, and clergy shall be unrestricted and shall be forwarded promptly without being opened or read by provider staff. Best practice guidelines indicate that arbitrary, blanket rules tend to be disempowering and may negatively impact the treatment milieu, therefore any restrictions to access during the acclimation period should be based on individualized risk assessment factors that are clearly documented in the member's chart.

Screening Process

The screening process functions to:

- Determine an appropriate provisional level of care for an individual
- Connect with emergency services if at any point during the call or in-person screen, it is determined that emergency services are required. At such times, providers are to follow written program crisis policy and procedure
- Facilitate a "warm handoff" of the member to the identified provider capable of meeting the individualized need(s) of the individual, including programs that specialized in treatment of special populations or specific cultural groups
- Respect individual rights and choice/preference
- Offer service recommendations to include an appointment for a comprehensive assessment for possible admission into a SUD treatment program
- Obtain member personal demographic and identifying information to assist for the establishment of eligibility for SUD treatment services
- Collection required ASAM elements for DHCS reporting
- Document member contact for access time standards
- Identify priority population

Perinatal screening

- The most important domains to screen for when working with women include:
- Substance use, including the type, frequency, and impact of alcohol or drug consumption.
- Pregnancy considerations, including the stage of pregnancy, potential risks to maternal and fetal health, and the impact of any substance use or medical conditions on the pregnancy.
- Immediate risks related to serious intoxication or withdrawal.
- Immediate risks for self-harm, suicide, and violence.
- Past and present mental disorders, including Posttraumatic Stress Disorder and other anxiety disorders, mood disorders, and eating disorders.
- Past and present history of violence and trauma, including sexual victimization and interpersonal violence.
- Health screenings, including HIV/AIDS, hepatitis, tuberculosis, and sexually transmitted diseases.

Should a service/level of care recommendation not be agreed upon by the individual and/or SUD provider that matches the individual's needs and preferences as determined by the screen, or, should the individual not have a readily available appointment date, and/or the provisional recommended level of care provider not have openings, the screener will provide the individual with additional provider options and continue to work with the individual and provider to secure a "warm hand off" linkage of member to provider for a scheduled appointment. Programs have the option of using the SUDURM Brief Initial Screening tool or using another screening tool of your choice. If you choose to use a screening tool of your choice, the tool shall include required data elements needed for ASAM reporting.

Priority Population Policies & Procedures

Programs will have written policy and procedure to reflect adherence to Federal and State Health and Human Services priority and entry criteria:

- Pregnant Injection Drug Users (IDU)
- Pregnant Substance Users
- Parenting Injection Drug Users
- All other IDU
- Parenting Substance Users
- All other County Health and Human Services (HHSA) referrals

Intake/Admission Process

SUD providers within the County of San Diego system of care are required to include within their program policies, procedures, and practice, written admission and readmission criteria for determining member eligibility and medical necessity treatment per Federal, State, and County, and contractual regulations, obligations. Program admission and readmission policy and procedure will ensure services are offered to the target population to include special populations and comply with all non-discrimination and related clauses in Article 8, Compliance with Laws and Regulations.

An Intake/Admission appointment is considered the members first treatment episode and is a billable service. The member admission to treatment date is considered the date on which any face-to-face treatment service is provided to a member. An individual becomes a member of the program once intake, assessment process, and verification of eligibility Section 51341.1(b)(13), Title 22, CCR, Federal, State, County, and program regulations, policy and procedure, is completed. Programs will ensure via policy and procedure that anticipated treatment outcome will not impact admission of an eligible member. Services for covered services are reimbursable even when:

- The Services are provided prior to determination of a diagnosis or prior to determination of whether access criteria are met, as described above.
- The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan.
- Services were provided prior to determination of SUD diagnosis.
- Services provided did not meet SUD criteria for continued services.
- The DMC-ODS County shall ensure that members receiving NTP services and working in or traveling to another county (including a county that does not opt into the DMC-ODS program) do not experience a disruption of NTP services.
- In accordance with 42 CFR 438.206, if the DMC-ODS county's provider network is unable to provide necessary services to a particular member (e.g., when a member travels out of county and requires daily NTP dosing), the DMC-ODS county shall adequately and timely cover these services out-of-network for the member, for as long as the DMC-ODS county's provider network is unable to provide them. In these cases, the DMC-ODS county shall coordinate and cover the out-of-network NTP services for the member.

Initial Assessment

Initial assessment for all levels of care, except Narcotic Treatment Programs (NTP) may be conducted:

- Face-to-face
- By telephone (defined as synchronous audio-only)
- By telehealth (defined as synchronous audio and video)
- In the community
- In the home

Documentation to be completed at intake/admission may include:

- ASAM Criteria Assessment
- TB Screening Questionnaire
- Health Questionnaire
- Proof of Pregnancy and the last day of pregnancy (for Perinatal programs if applicable)
- Financial Responsibility and Information Form
- CalOMS Profile Form
- CalOMS Admission Form
- Consent for Treatment
- Notice of Privacy Practices
- Written Summary Outlining Federal Confidentiality Requirements (per 42 CFR)
- Your Personal Rights at an AOD Certified Program (required for all programs as part of compliance with the "Alcohol and/or Other Drug (AOD) Program Certification Standards" of DHCS)
- Acknowledgement of DMC-ODS Member Handbook and BHS Provider Directory Form
- Grievance and Appeal Process is explained, and brochure with envelope is offered
- Provider Directory by Provider (pdf) is explained and offered
- Language/interpretation service availability reviewed and offered, as applicable
- Voter Registration material is offered
- Consent for Release of Information, as applicable
- Release of Information to primary care physician (PCP), or to assist linkage with one if the member does not have a PCP
- Consent for Photo, TV, Video (if applicable)
- Risk Assessment and Safety Management Plan
- High Risk Assessment (optional)
- Community Resource List

Per https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-25-003.pdf (Section 7010(d)), member is to be provided an introduction and overview to describe the functions and requirements of the program within seventy-two (72) hours of admission.

Medical Necessity and SUD Diagnosis Requirements
Medical necessity refers to the applicable evidence-based standards applied to justify the level of services provided to a member for the services to be deemed reasonable, necessary and/or appropriate. It refers to those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury consistent with 42 CFR 438.201(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

It is imperative that medical necessity standards be consistently and universally applied to all members to ensure equal and appropriate access and service delivery. Medical necessity is also established to demonstrate and maintain eligibility for services delivered.

An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services.

Members aged 21 years of age or older, services up to 30 calendar days form first visit with LHPA or certified/registered counselors are clinically appropriate services when provided during the *initial or full* ASAM Criteria© assessment.

Members 21 years and older

- A service is considered "medically necessary" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- At least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.

OR

- At least one diagnosis from the Diagnostic and Statistical Manual of DSM for Substance- Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

Members under age 21 years, services up to 60 calendar days from date of first visit with LHPA or certified/registered counselor and considered clinically appropriate services when provided during the *initial or full* ASAM Criteria© assessment

Members under the age of 21 may receive covered services that are appropriate, and medically necessary to correct and ameliorate health conditions (pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) under the federal statutes and regulations). Services provided need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and substance use disorders (SUDs). Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

All members to receive covered and "medically necessary" services. Services are considered "medically necessary" if the service is necessary to correct or ameliorate screened health conditions (pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) under the federal statutes and regulations).

Services for covered services are reimbursable even when:

1. Services are provided prior to determination of a diagnosis or prior to determination of whether access criteria are met, as described above.
2. The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or
3. Perinatal:
4. Care plans to include mother/child services, transport, education, ancillary coordination and parenting skills. Parenting skills should be integrated into the plan of care.
5.
6. The member has a co-occurring mental health condition.
    a. Clinically appropriate and covered DMC services delivered by DMC providers are covered and reimbursable whether or not the member has a co- occurring mental health disorder.
    b. Reimbursement for covered DMC services provided to a member who meets DMC criteria and has a co-occurring mental health condition shall not be denied as long as DMC criteria and requirements are met.

Diagnosis

1. Diagnostic determination shall be made by an LPHA.

2. A provisional diagnosis:
    a. may be used prior to establishing diagnosis.
    b. may be used prior to the determination of a diagnosis. It is permissible to use "Other" and "Unspecified" disorder. For Outpatient Programs, Social Determinants of Health (SDOH)/z-codes can be used.
    c. shall be updated by an LPHA to accurately reflect member needs.
3. A provisional diagnosis may be used prior to establishing diagnosis.

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4a. *For Outpatient Programs*: Per BHIN 24-001 and BHIN 22-013, Z-codes/SDOH are permitted to be used during the assessment phase of a members s treatment when a diagnosis has yet to be established. Clinically appropriate services may be delivered before a Diagnostic and Statistical Manual (DSM) diagnosis for Substance-Related and Addictive Disorders is established. An assigned z-code can be used prior to DSM 5 diagnosis to begin services.

b. For *Residential Programs*: Per DHCS, ICD-10: Social Determinants of Health (SDOH) codes/z-codes are not available for use as an available primary diagnosis. A list of Covered Diagnosis is in Appendix 5 of DMC-ODS Billing Manual (dhcs.ca.gov).

A SUD diagnosis can only be determined by a Medical Director or an LPHA. The Medical Director or LPHA shall document separately from the treatment plan the basis for the diagnosis in the member's record within timelines specified for the respective treatment modality (i.e. Within 30 calendar days of admission to outpatient services or within 10 calendar days of admission to residential services.) The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each member's assessment and intake information, including their personal, medical, and substance use history. ii. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

Level of Care Determination/Assessment

1) Outpatient providers are no longer required to complete their assessments within 30 days (60 days for those under 18 or experiencing homelessness). Assessments should now be completed "as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice." It is recommended that providers develop their own policy and procedure to ensure this standard is met and define how they will internally monitor.

2) Residential providers are no longer required to complete their assessments within ten (10) days and should follow the same standard for completion of a full assessment as outpatient providers; however, a "Multidimensional Level of Care (LOC) assessment" must be completed within 72 hours of admission. o Providers will use Optum's SUD Residential Authorization Request as the "Multidimensional LOC assessment" and will now be required to send the request to Optum within 72 hours of member admission. All other authorization timelines and requirements will remain in effect.

3) Residential Withdrawal Management (WM) providers are exempt from the 72-hour timeline to complete a "multidimensional LOC assessment" if a "pre-assessment within 72 hours" occurs and there are "contingency plans to transfer the resident to a subsequent level of care where a full assessment would be conducted

a. A "Multidimensional Level of Care (LOC) assessment" must be completed within 72 hours of admission.
b. Outpatient and Residential providers must complete assessments "as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice."
c. Residential Withdrawal Management (WM) providers are exempt from the 72-hour timeline to complete a "Multidimensional LOC assessment" if a "pre-assessment within 72 hours" occurs and there are "contingency plans to transfer the resident to a subsequent level of care where a full assessment would be conducted.
d. Placement and level of care determination shall be in the least restrictive level of care that is clinically appropriate to treat the member's condition.
e. A full ASAM assessment should be updated when a member's condition changes.

Additional Clarification

Assessments and Timely assessments:

1. To ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.

2. Clinically appropriate and medically necessary services are covered and reimbursable when provided prior to the determination of a diagnosis, during the assessment, or prior to determination of whether SMHS, DMC, or DMC-ODS access criteria are met, even if the assessment ultimately indicates the member does not meet the access criteria for the delivery system in which they initially sought care.

3. Crisis assessments completed during the provision of SMH crisis intervention or crisis stabilization, or a SMH, DMC, or DMC-ODS Mobile Crisis Services encounter, need not meet the comprehensive assessment requirements outlined in this BHIN. However, crisis assessments are not a replacement for a comprehensive assessment. When a member who has received a crisis assessment subsequently receives other SMH, DMC, or DMC-ODS services, an assessment shall be completed in accordance with the requirements in this BHIN. For assessment and documentation requirements specific to Medi-Cal Mobile Crisis Services, please refer to BHIN 23-025.

   Timeliness - If a member withdraws from treatment prior to completing the ASAM assessment and later returns, the time period starts over as noted above.
   a. Clinically necessary services are permissible prior to completion of a full ASAM assessment.
   b. An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services. *Please note that no preliminary level of care recommendation or screening tool is a substitute for a comprehensive ASAM Criteria© assessment.*
   c. A full assessment using the ASAM Criteria© shall be completed within 60 calendar days of the member's first visit with an LPHA or a registered/certified counselor (For adult members 18 years of age and over experiencing homelessness)

To establish the ASAM level of care requirement for medical necessity, the Medical Director or LPHA shall review and evaluate the member's assessment and intake information, if completed by a SUD counselor, and have a face-to-face or telehealth or telephone interaction with the counselor to verify the

member meets medical necessity criteria (MHSUDS Information Notice 16-044). The initial medical necessity determination is documented using forms as described in the SMH & DMC-ODS Health Plans (click SUDURM Tab). Initial assessment for all levels of care, except NTP may be completed by:

- A Licensed Practitioner of the Healing Arts (LPHA), OR
- A Registered/certified alcohol and other drug counselor
- An LPHA shall evaluate the assessment in consultation with the registered/certified counselor.

Consultation between LPHA and registered/certified counselor may be performed:

- In person
- Via telephone
- Via telehealth

Documentation of the initial assessment shall reflect consultation between LPHA and registered/certified counselor.

Initial medical necessity determination must clearly demonstrate use of the ASAM Criteria to determine placement into the appropriate assessed level of care for services. Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the member. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, medical necessity encompasses all six ASAM dimensions for a more holistic concept of clinical necessity or clinical appropriateness for treatment.

For an individual to receive ongoing Narcotic Treatment Program (NTP) services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least annually through the reauthorization process to determine that the services are still clinically appropriate for that individual.

Clinical Documentation Guidelines

Clinical documentation refers to information within the member's health record that describes the treatment and its rationale, as provided to the member. Clinical documentation is often written in narrative form to capture treatment process and analysis of each member encounter. Clinical documentation is a critical component of quality treatment service delivery and serves multiple purposes to:

- Ensure comprehensive quality care.
- Ensure an efficient way to organize and communicate with other providers.
- Protect against risk and minimize liability.
- Comply with legal, regulatory and institutional requirements.
- Facilitate quality improvement and application of utilization management.

Member Record Documentation

County of San Diego SUD providers are required to establish, maintain, and update as needed, the individual member record for each member admitted to treatment and receiving services per Title 9, Chapter 11, and 42 CFR laws, regulations, guidelines, and professional standards. In addition, all providers must follow clinical documentation standards as outlined in BHIN-23-068. All clinical documentation must be credible and complete and is protected by HIPAA and 42 CFR Part 2. It encompasses every aspect of

clinical care to include initial assessments, progress notes, and all additional relevant encounters that occur outside of established appointments.

Upon the initial screen/intake and/or admission to treatment, the individual record shall contain member personal information to include the following:

- Information specifying member's name and/or identifier number
- Member date of birth
- Member gender
- Member race and/or ethnic background
- Member address
- Member contact number
- Member next of kin or emergency contact name and number

All clinical documentation must include the following characteristics:

- Member name and/or unique identifier
- Must be legible
- Must be completed within timelines per regulation guidelines
- Contain a "complete" signature which includes the providers
    - Legible signature
    - Appropriate credentials
    - Date

- Documentation and Co-Signature Requirements: Staff who provide direct services are required to adhere to certain documentation and co-signature requirements. In general, staff that hold the license of an M.D., D.O., N.P., R.N., Ph.D., , LCSW, LPCC, or MFT do not require a co-signature on any documentation in the medical record. This also holds true for registered associates with the Board of Behavioral Sciences (ASW, APCC or AMFT), or staff waivered according to State guidelines. These above-mentioned staff may also provide the co-signature that is required for other staff, excluding clinical trainees. For the most current information on co-signature requirements, please refer to the Substance Use Uniform Record Manual, located at the Optum Website> BHS Provider Resources> SMH & DMC-ODS Health Plans> SUDURM tab. This manual will instruct staff on form completion timeframes, licensure and co-signature requirements, and staff qualifications necessary for completion and documentation of certain forms.

<u>Treatment Episode Documentation</u>

Documentation of the treatment episode within the member record to include all activities, services, sessions, and assessment information not limited to:

- Intake and admission data/release and consent forms, and if applicable, physical examination
- Medical Necessity/Diagnosis determination
- Problem list
- Minimum Member Contact (e.g. one (1) contact per month for outpatient treatment)
- Progress Notes
- Referrals
- Lab test orders and results, clinician consultation (medical documentation that verifies member pregnancy and the last day of pregnancy)

- Discharge Plan
- Discharge Summary
- Correspondence with or regarding the member
- Authorizations for Residential Services
- Drug screening results
- Additional information relating to the treatment services rendered to the member

For more information about clinical documentation guidelines, see the following documentation guide:

- Clinical Documentation Guide

Documentation Correction Guidelines

The following Documentation Correction guidelines have been developed to help programs and the County of San Diego reduce fraud, waste, and abuse, provide clear guidelines on when and how changes can be made to documentation in member records, including paper records and electronic health records (EHR), and encourage improved member participation and collaboration in Treatment Plan/problem list development.

General guidelines:

- For paper records, corrections can only be made with a single line through the error, initials of the person making the correction and the date the correction was made. The original documentation must remain legible.
- The original author of a document should be the only person making corrections to the document. The person who signs a clinical document is attesting to the accuracy of the documentation. For documentation that is written by or countersigned by an LPHA (such as AACA assessments and treatment/peer support plans), only the LPHA can make changes to the document once the LPHA has signed.
- If that person is no longer available (i.e., medical leave, no longer with the program), a supervisory LPHA (i.e., program manager or designee, clinical supervisor, other supervisory staff member) or Medical Director may make the correction. This does not apply for instances such as the staff out sick or on vacation. The reason for the correction should be documented. This may be done in a separate informational note.
- Corrections should not change the clinical content of the documentation.
- Administrative corrections (i.e., spelling errors that do not affect the clinical content of the document) or non-clinical factual corrections can be made by direct service staff with a line through the error, initials, and date.
- Once any document is signed, it should be considered final and a should not be removed from the member's chart.

Continued Service and Discharge Criteria

After the admission criteria for a given level of care have been met, the criteria for continued service, discharge or transfer from that level of care are as follows:

Continued Service Criteria:

It is appropriate to retain the member at the present level of care if:

1. The member is making progress but has not yet achieved the goals articulated in the individualized treatment plan or making progress on identified problems on problem list. Continued treatment at the

present level of care is assessed as necessary to permit the member to continue to work toward treatment goals or problems;

Or

2. The member is not yet making progress but has the capacity to address his or her problems. They are actively working on the goals articulated in the individualized treatment plan or working on identified problems on problem list. Continued treatment at the present level of care is assessed as necessary to permit the member to continue to work toward his or her treatment goals or problems;

and/or

3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the member's new problems can be addressed effectively.

Discharge/Transfer Criteria:
It is appropriate to transfer or discharge the member from the present level of care if the following criteria are met:

1. The member has achieved the goals articulated in their individualized treatment plan or resolved problems identified on the problem list, thus resolving the need(s) that justified admission to the current level of care;

Or

2. The member has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan or problem list. Treatment at another level of care or type of service therefore is indicated;

Or

3. The member has demonstrated a lack of capacity to resolve their problem(s). Treatment at another level of care or type of service therefore is indicated;

Or

4. The member has experienced an intensification of their problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the member's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the member should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

Discharge Criteria for WM 1 and 2:

- Withdrawal signs and symptoms are sufficiently resolved so that the member can be safely managed at a less intensive level of care
- Signs and symptoms of withdrawal have not responded to treatment and have intensified such that a transfer to a more intensive level of withdrawal management services in indicated.
- Discharge For Perinatal
    - Recovery support post-discharge & discharge summary within 30 days

Other Service Guidelines

Self-Help and Program Structure
Support groups should always be voluntary. An individualized treatment plan related to support groups should be driven by members' preferences. Any event or support group meeting at a program should maintain the strict confidentiality requirements aligned with 42 CFR Part 2. Programs will be held to

minimum standards outlined on the Quick_Guide_-_Residential_Services 4-23-25.pdf (5 clinical (3.1)/ 10 Clinical (3.5) and minimum of 1 service per day). The 20 hours of program structure should be shaped to fit the members' individual needs and can be determined by programs. Programs can link members to existing support group programs (e.g., 12-step) in the community and/or if confidentiality is a concern and since some members may opt for not participating in support group programs, the program can choose to coordinate a support group program in a different location for members that choose to participate.

Evidence Based Practices

Research and innovations have yielded significant progress in the development, standardization, and empirical evaluation of psychosocial treatments for SUD. This has resulted in a wide range of effective programs for SUD that differ in both theoretical orientation and treatment technique. While a number of approaches and techniques are effective depending on the clinical situation, certain treatment approaches have a stronger evidence base and therefore must serve as the foundation of a high-quality system of SUD care.

Within the County of San Diego, although other psychosocial approaches may be used, SUD providers are expected to implement at least two of the following evidence-based practices (EBPs) based on the timeline of the county implementation plan. . . The two EBPs are per provider, per. service modality. The Contractor shall ensure the providers have implemented EBPs and are delivering the practices to fidelity. The State shall monitor the implementation of EBPs during reviews. The EBPs include

- Motivational interviewing (MI): A Member-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes

- Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use disorder treatment.
- Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

- Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.

Care Coordination

Programs should educate members about the continuum of care in the initial stage of services as part of orientation to the County of San Diego DMC-ODS. Likewise, programs should encourage the member to see any community provider engaged in the member's mental or physical healthcare as critical members of their care team. Programs should facilitate information sharing with team members such as primary care physicians and mental health practitioners whenever proper consent allows for this best clinical practice. In this way, programs establish themselves as collaborators, with the member as well as with other providers within the greater SUD system and beyond. Expectations are made clear that as a member's needs change, transitions occur either up or down within the continuum of care.

Provider-Member Communications

Adequate communication serves a key component in ensuring proper care coordination for members. Case managers have the responsibility of serving as an advocate for members in the SUD system of care and shall assist with communication between members and other service providers. Providers may have to

exchange communication through emails, letters, telephone calls, progress notes, or reports to the County, State, or other service providers on behalf of the member. Case managers shall also assist members in ensuring they are receiving adequate care from other service providers and inform members of their right to appropriate treatment.

Policies and Procedures
In order to engage members and ensure successful continuity of care, programs should create policies/procedures on care coordination focusing on seamless transitions without disruption to service for the member. Minimum considerations include the following:

- Each SUD member must be assigned a primary counselor at the initiation of services. The primary counselor will guarantee that the member is directed to appropriate resources within the program, including linkage to the program case manager. The primary counselor's contact information must be provided to the member as their designated contact for assistance with in-program needs.

- The program case manager will coordinate with any external resources as indicated by the member's needs, wishes and goals. The member must be provided with the program case manager's contact information for assistance with resources outside the program.

- Program policies, procedures, and practices must allow for members to have timely access to medically necessary and clinically indicated appointments, such as medical or mental health appointments, child visitation (including phone calls with children), and court/probation meetings. The program case manager will assist the member in scheduling and accessing appointments in the community. Routine program schedules or program rules, such as acclimation or "black-out" periods in residential programs, shall not be used as a rationale for arbitrarily delaying or restricting member access to medically necessary and clinically indicated appointments.

- In order to document coordination of care, programs shall obtain a signed authorization to release information for the member's primary care physician, mental health provider and/or other health providers and document all care coordination efforts in the progress notes.

- Programmatic, interdisciplinary team meetings are expected as a means for all staff providing member services to maintain clear communication regarding assessed needs and any indications of change to level of care recommendations.

- Programs shall follow the Missed Scheduled Appointments protocol as defined previously in this section, as a means of continued member engagement and care coordination. These standards apply to new referrals (contacting within one business day by a clinical staff when a member does not show for a scheduled first appointment) and current members (containing within one business day by clinical staff when missing a scheduled appointment without a call to reschedule). Members with recent elevated risk factors will be contacted by clinical staff on the same day as the missed scheduled appointment.

- When a member is discharging from SUD services and transition to another program is not indicated, programs must offer recovery services when determined to be medically necessary for the member. Recovery services include substance use assistance, recovery monitoring (including relapse prevention), group counseling, individual counseling, and case management/care coordination delivered by an experienced registered or certified SUD counselor who assists in meeting the goals contained in their treatment plan for recovery service. The Process for engaging

member in recovery services is as follows:

- The member should be contacted within two (2) business days of his/her last treatment service to ensure they are receiving necessary support and recovery services offered.
- At least three (3) documented attempts to engage member, when member consents to this, on three (3) separate days are required to demonstrate efforts to engage member into the recovery service benefit.
- If the counselor has neither heard from nor made contact with the member for thirty (30) calendar days after the last attempted contact, additional efforts are not required. All follow-up contacts and/or attempts should be documented.
- Members who reconnect more than three (3) months after treatment discharge requesting recovery services must be screened to determine if this level of care continues to be appropriate for the member's needs at that time.

- When a member is transitioning from one level of care to another (or to an ancillary service), care coordination will be based on warm handoff principles: carefully coordinated transfer or linkage of a member to another provider, entity, agency, or organization who will continue, add, or enhance services.

- This warm handoff process will:
  - Ensure communication between concurrent providers of service (for example, NTP and IOS providers treating a member at the same time).
  - Occur prior to the case closing at the current program.
  - Ensure the member is clear on the reason for referral or transfer to another level of care
  - Include a direct conversation between providers to ensure passing of critical information in a timely fashion.
  - Include all pertinent documents (including signed release of information when necessary and other relevant clinical information, including Level of Care Recommendation form) to ensure transfer in a timely manner.
  - Occur anytime a referral is provided to another service provider.

- The warm handoff will include:
  - Ideally, a joint session/meeting with the providers and the member via face-to-face, telephone, or telehealth.
  - Information is shared between providers about member treatment and engagement history.

- Members transitioning to another level of care, including Recovery Services, should begin services at the next indicated level of care within 10 business days of discharge. For coordination up or down the continuum of care, the handoff is considered complete after there is confirmation that the member has engaged, and initial appointment has occurred.

In all cases of care transitions (both when the transition occurs along the SUD care continuum and when the transition occurs between other health systems), the last treating SUD provider is responsible for and must coordinate transitions in care. All coordination of care activities must be documented within the member record.

Medications

Members on medications will seek services. Members shall not be denied services based solely on the fact that they are taking prescribed medication, regardless of the type of medication. Treatment services within

a harm reduction framework focus on supporting positive change, meeting individuals where they are, and working with people without judgment, coercion, discrimination, or a requirement for abstinence as a precondition for receiving care. Senate Bill No. 992 prohibits a licensee from denying admission to any individual based solely on the individual having a valid prescription from a licensed health care professional for a medication approved by the federal Food and Drug Administration for the purpose of narcotic replacement treatment or medication-assisted treatment of substance use disorders. Accordingly:

- Programs shall not deny services to a member with current, physician-prescribed medications. However, a program shall consider whether the nature and extent of the prescribed medications requires a higher level of care than offered at that program.
- With member consent, providers shall coordinate with the member's physician or health practitioner when she/he enters treatment with prescribed medications that have psychoactive characteristics. Services and support plans shall be reviewed with the prescribing physician or health practitioner.
- If while in treatment, a member exhibits behavior that is a cause for concern, the treatment provider may address this as a program issue with the member and the member's physician or health practitioner.
- Programs shall have a safety policy regarding the use of prescribed medications by a program member, including a provision for taking medications in private, if it must be taken on the premises.

Safeguarding Medications
When applicable, and to ensure appropriate access, program may store members' medication in the program facility. All medications must be in bottles with prescription labels and shall not be in envelopes. Program staff may assist with member's self-administration of medication in accordance with all relevant regulations and the Alcohol and/or Other Drug Program Certification Standards https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-25-003.pdf Medication may include over-the-counter (OTC) medicines or prescription medications for specific health conditions, inclusive of medications for substance use disorder, mental health, and physical health conditions. Programs shall maintain a central destruction log for medications, which includes two staff signatures verifying verification medications have been destroyed.

It is the responsibility of the Substance Use Disorder Program Medical Director to develop and implement medical policies and standards for the provider. At a minimum, Contractors shall ensure adherence to its own entity's policies and procedures, as developed by the Medical Director, to safeguard members' medication, and follow documentation standards for medication storage and destruction as specified in the Substance Use Disorder Uniform Record Manual (SUDURM). Policies and procedures may include but are not limited to process of observing members' self-administration of medication; security or storage/inventory system; procedure to address members' adverse reaction to medication (e.g., loss of consciousness, physical difficulties requiring hospitalization, etc.); members' and program staff's responsibility in reporting loss or theft.

Drug Testing
Providers shall develop, implement, and maintain a testing protocol to ensure against the falsification and/or contamination of any urine and/or oral fluid samples. Providers shall conduct observed, random drug testing of members when mandated by the referral source(s) and/or in adherence to the individual treatment plan. (For justice referrals expected to follow NADCP guidelines for drug testing, see Appendix C.1 for additional information). Any observed urinalysis shall be conducted by a staff member of the same gender during collection. All drug testing results shall be documented in the member record. Providers shall use the BHS designated urinalysis/oral fluid drug testing vendor unless prior written approval for another vendor is received from the COR.

Drug Testing Results Reporting
All positive drug tests shall be reported to the referring entity within two business days of testing date, if the member has provided appropriate prior consent.

Drug Testing Technologies
Drug testing may include any of the following technologies:

- Urinalysis
- Oral Fluid Testing
- Breathalyzer

Trauma Informed Services
Contractor's systems and services shall be "trauma-informed" and accommodate the vulnerabilities of trauma survivors. Services shall be delivered in a way that will avoid inadvertently re-traumatizing members and facilitate member participation in treatment. Contractor's trauma-informed systems and services shall include screening of trauma; consumer driven care and services; trauma-informed, educated and responsive workforce; provision of trauma-informed, evidence-based and emerging best practices; safe and secure environments; and ongoing performance improvement and evaluation regarding program's provision of trauma-informed services.

Information from the National Center for Trauma Informed Care & Alternatives to Seclusions and Restraint

Trauma-Informed Approach
According to SAMHSA's concept of a trauma-informed approach, "A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in members, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*."

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.

SAMHSA's Six Key Principles of a Trauma-Informed Approach
A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

From SAMHSA's perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA's definition of recovery, services

and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration. Additional information and resources: Trauma and Violence - What Is Trauma and Its Effects? | SAMHSA

Trauma Informed Care for those that have experienced Human Trafficking
Survivors of human trafficking have experienced high levels of trauma. These experiences can impact many aspects of their life, including their self-concept, behavior, and mood. Programs that work with survivors of human trafficking should be aware of the additional needs of these individuals. Below are several resources with tips and tools to assist programs in developing appropriate interventions.

- National Human Trafficking Hotline Resource Library
  - https://humantraffickinghotline.org/resources
- The National Child Traumatic Stress Network- Understanding and Addressing Trauma and Child Sex Trafficking
  - https://www.nctsn.org/resources/understanding-and-addressing-trauma-and-child-sex-trafficking-policy-brief

Residential Requirements

Required Relapse Plan for Licensed Residential SUD Treatment Facilities
Per SB992, a licensed residential treatment facility must develop and maintain a written plan to address resident relapses. A relapse plan is a written plan that addresses:

- Resident relapse including when a resident is on the licensed premises after consuming alcohol or using illicit drugs;
- How the treatment stay and treatment plan of the resident will be adjusted to address the relapse episode;
- How the resident will be treated and supervised while under the influence of alcohol or illicit drugs; and
- Resident discharge and continuing care plan, including when a residential facility determines that a resident requires services beyond the scope of their license.

Initial applicants for residential treatment facility licensure must submit a relapse plan with the Initial Treatment Provider Application (DHCS 6002). Applicants that submitted an application for licensure prior to January 1, 2019 but have not been approved for licensure will be required to submit a relapse plan prior to licensure. Existing licensees must submit a relapse plan to their assigned DHCS analyst no later than April 1, 2019. DHCS will review the submitted relapse plan to determine compliance with the statutory requirements. DHCS will notify the licensee within 30 working days whether the relapse plan is complete or incomplete. A copy of the relapse plan must be kept onsite, or at a central administrative location, provided that the plan is readily available to staff and DHCS upon request.

For more information, refer to DHCS Information Notice 19-003. If you have questions about the relapse plan or Information Notice 19-003, contact Nadalie Meadows-Martin by email at Nadalie.Meadows-Martin@dhcs.ca.gov or Pelumi Abimbola at Pelumi.Abimbola@dhcs.ca.gov.

Residential: Bed Holds and Weekend Passes
Providers may be reimbursed room and board for up to 7 days when a member is hospitalized, AWOL, incarcerated, or in crisis residential while in residential treatment. COR preapproval is required if a member is in need of a bed hold beyond 7 days (e.g., member at crisis residential). As soon as member returns to the program, the provider shall consider any revisions to the ASAM level of care determination, risk

assessments and/or medical information to incorporate into the chart and/or treatment plan. Provider would not need to discharge/readmit member.

Providers may allow a member a weekend pass when member is in 3.1 LOC with a planned discharge. Providers may be reimbursed for treatment as long as one hour of service is provided daily (e.g., 1 hour of structured daily activity on Saturday before they leave and also when they come back on Sunday evening.) Otherwise, the provider would be reimbursed for room and board only. As soon as member comes back to the program, the provider shall consider conducting a level of care assessment.

NTP Requirements

NTP Documentation Standards

NTPs shall follow all applicable federal and state laws and regulations regarding confidentiality of, procedures for, and content of patient records. For more information refer to the NTP **Behavioral Health Information Notice (BHIN) : 25-008**
https://www.dhcs.ca.gov/individuals/Documents/BHIN-25-008-NTP-Regulation-Changes-Webinar.pdf

DHCS has established the outlier threshold of nine (9) or more NTP counseling unit for a Medi-Cal member across all claims for a single date of service for services delivered within an NTP setting, inclusive of procedure codes H0004 (Individual Counseling), H0005 (Group Counseling), and T1006 (Family Counseling (DMC-ODS only) **For more information refer to NTP Behavioral Health Information Notice No: 26-022: NTP Counseling Unit Threshold and Manual Review**