Sonoma County
Department of Health Services
Substance Use Disorders DMC-ODS Practice Guidelines

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Introduction

Thank you for being a Sonoma County Department of Health Services Behavioral Health Division (DHS-BHD) Substance Use Disorders (SUD) services provider. As a provider, you play a very important role in the delivery of SUD services to beneficiaries in Sonoma County. This manual is intended to provide further guidance and instruction to SUD providers to support the many requirements of providing SUD services. It contains helpful information for day-to-day operations, and is also to be used in conjunction with provider contracts. Please defer to your DHS-BHD contract for all required activities. Please note that not all parts of this manual apply to all providers. Should you have questions about information contained in this manual, please feel free to contact our QA staff at BHQA@sonoma-county.org.

We look forward to working with you to provide quality healthcare services to members of Sonoma County.

Mission Statement

The mission of DHS-BHD is to promote recovery and wellness to Sonoma County residents.

Drug Medi-Cal Organized Delivery System (DMC-ODS)

The goal of Sonoma County's plan for Drug Medi-Cal Organized Delivery System (DMC-ODS) is to create a clear and comprehensive continuum of care for substance use treatment that is client-centered, culturally competent, quality driven, recovery focused, and easily accessible. The continuum of care is modeled after American Society of Addiction Medicine (ASAM) levels of care. ASAM usage enables evidence driven service planning, efficient resource allocation to treatment needs, better client outcomes, and reduced system costs.

Purpose of Practice Guidelines

Sonoma County DHS-BHD SUD programs aim to provide timely access to quality alcohol and other drug treatment services for members requesting services. Maintaining member records that are accurate, comprehensive, high-quality, and meeting all legal and ethical requirements

is our practice. This manual clarifies documentation standards for Drug Medi-Cal ODS services provided and managed by Sonoma County DHS-BHD. The guidelines will provide explanations of what is required at each step of the treatment process. Practice Guidelines content will be updated as needed to ensure current guidance and clinical information is accessible to service providers.

Utilization Management

Sonoma County DHS-BHD SUD Utilization Management Program (UM Program) is in place to ensure members have timely and appropriate access to SUD services, ASAM criteria are used to determine level of care placement, and that service interventions are appropriate for both diagnosis and level of care.

In order to ensure goals and requirements are met, contractors and Sonoma County direct service providers are required to participate in annual audits including self-audits, quality reviews, and utilization review audits.

Utilization Management for DMC-ODS services is overseen by the Quality Assurance Substance Use Disorders Manager and Clinical Specialist on the Utilization Review and Authorizations Team (UR) located within the Quality Assessment and Performance Improvement section of Sonoma County DHS-BHD.

The UR team meets on a monthly basis to review utilization data, including trends in over-utilization and under-utilization of services. This team meets with the SUD Billing and Claiming Committee every two weeks and is comprised of content experts from fiscal, contracting, service provision, and quality management. The UR team meets with the Audit and Monitoring Team (AMT) on a weekly basis to discuss service provision, monitoring, and support for providers.

The UR team provides training and support to SUD providers at monthly SUD provider meetings, by providing written documentation guides on specific topics, through program or agency specific focused trainings, and through on demand question and answer using Sonoma County DHS-BHD Quality Assurance email: bhqa@sonoma-county.org.

Accessibility to Care

Sonoma County DHS-BHD DMC services aim to make services accessible to all members according to their needs at the appropriate level of care, and to accomplish this as quickly as possible.

Timeliness and Waitlist

Timeliness data is recorded using the SUD Timeliness form and reports in SmartCare which are designed and updated in alignment with DHCS reporting requirements.

Once a member requests services and completes a screening they are referred to an appropriate SUD program and set to Requested status for that program in SmartCare. The

waitlist for each SUD program is comprised of members set to Requested status. Once the member begins treatment the status is changed to Enrolled and both dates are recorded permanently. While the member is in Requested status, the provider is required to offer interim services. If the member chooses to receive interim services, these are rendered and documented in SmartCare.

Capacity

Contracted partners and Sonoma County DHS-BHD ODS treatment providers are required to submit timely DATAR reports by the 10th of the month following the report activity month on an ongoing basis. Treatment providers and county SUD analysts work together to monitor treatment capacity. Perinatal programs above 90% capacity must report each instance of exceeding 90% capacity, but not each month when continuously above 90% to: DHCSPerinatal@dhcs.ca.gov. Monthly DATAR reporting updates are given at the monthly SUD provider meeting.

ASAM Usage for Placements

SUD treatment providers are required to complete ASAM training prior to rendering services and must complete a full ASAM for each placement in alignment with timeline requirements for each ASAM level of care. Sonoma County DHS-BHD provides assistance with training in ASAM modules using the Change Companies curriculum. Sonoma county UR team and representatives from treatment providers are required to participate in ASAM fidelity groups every two weeks. During these meetings ASAM ratings are calibrated to increase reliability, validity, allow for clinical consultation, and address systems issues related to client placement and flow throughout the SUD continuum and its levels of care.

ASAM Completion Timelines:

Outpatient

1.0 Outpatient Services: Less than 30 days for adults over 21. When member is under 21 or homeless the ASAM must be completed within 60 days.

2.1 Intensive Outpatient Services: Less than 30 days for adults over 21. When member is under 21 or homeless the ASAM must be completed within 60 days.

Narcotic Treatment Program: Less than 30 days for all.

Residential

3.1 Clinically Managed Low-Intensity Residential Services: within 72 hours following admission.

3.3 Clinically Managed Population-Specific High-Intensity Residential Services: within 72 hours following admission.

3.5 Clinical Managed High-Intensity Residential Services: within 72 hours following admission.

Withdrawal Management

3.2 Clinically Managed Residential Withdrawal Management (WM): within 72 hours following admission. This requirement may be waived if a pre-assessment is completed within 72 hours following admission and there are plans to transfer the resident to a subsequent level of care where a full assessment would be completed.

Appropriateness of Service Interventions:

Sonoma County DHS-BHD takes a multi-faceted approach to ensure the appropriateness of service delivery including: training, auditing, and fidelity groups.

Auditing:

Sonoma County DHS-BHD Audit and Monitoring Team (AMT) conducts annual auditing reviews for all DMC-ODS treatment programs and conducts pre-billing audits to mitigate risks for claims disallowance and ensure that services are provided meeting all regulatory requirements.

Training:

All SUD treatment providers are required to complete CalMHSA CalAIM trainings, SmartCare trainings, and Change Companies ASAM training modules prior to rendering services. Annual trainings for Motivational Interviewing and one or more program specific evidence-based practices are provided.

The Utilization Review and Authorizations Team for SUD provides support trainings at monthly SUD provider meetings, focused program and individual trainings, written documentation guidance, and dedicated question and answer support at the BHQA email: BHQA@sonoma-county.org.

Fidelity Groups:

Collaborative support and learning occurs in fidelity groups that are attended by representatives from contracted providers and Sonoma County DHS-BHD providers. Fidelity groups include ASAM, Motivational Interviewing, and other evidence-based programs based on need.

Service Delivery

Timely access to services is a critical element for positive SUD treatment outcomes. All providers must process new service requests using the SUD Timeliness form in SmartCare. This form tracks timeliness reporting elements required by the California Department of Health Care Services (DHCS). All providers are expected to meet DHCS Data and Alcohol Treatment Access Report (DATAR) requirements for collecting and reporting SUD treatment data on capacity and wait lists. DHS-BHD analysts review data to address systemic issues with capacity and wait time to ensure expedient member access to SUD services.

Access to Services

Entry Points

Screening and Referral: Points of entry into the continuum of care include multiple access points. Members seeking treatment may be referred by any staff trained in Sonoma County DHS-BHD approved screening tools at listed access points to DMC-ODS network providers.

- Behavioral Health Access Team – 24 /7 Access Line which provides SUD screening, SUD referral, and SUD care coordination resulting in a referral to an SUD program and the indicated level of care (LOC). Phone: (707) 565-6900
- DHS-BHD Crisis Programs - Withdrawal Management Program or Crisis Stabilization Unit (CSU)
- Contracted SUD treatment providers: Substance Use Disorder (SUD) Services (ca.gov)
- Mobile Crisis Services
- Interdepartmental Multidisciplinary Team (IMDT) programs
- Whole Person Care Program
- County case-management programs for treatment courts
- County-run programs working with in-custody clients in the jails: Treatment Alternatives for Safer Communities (TASC)
- County and community-based organizations (CBO) operating youth and mental health programs

Residential Authorization:

Residential Services Authorization: At the time that a screener within the Behavioral Health Access Team refers the member to a residential treatment program, the screener must contact the Authorization Team within DHS-BHD Quality Improvement Performance Improvement (QAPI) Section to request a 5-day residential authorization. The 5-day authorization period will enable the residential program, to which the client was referred, to conduct the full ASAM assessment. The residential provider will return the completed ASAM assessment and any additional paperwork to justify an ongoing residential authorization period for up to 30 days.

If a designated screener outside the Behavioral Health Access Team (e.g., IMDT, Mobile Crisis Team, Orenda Detox, Contracted SUD treatment provider, etc.) identifies a beneficiary need for residential treatment in accordance with the SUD screening tool, the designated screener will be required to contact the Authorizations Team to request a residential referral. In addition, for individuals who self-refer directly to a residential program seeking treatment, the residential program will be required to contact the Authorizations Team to initiate the authorization process prior to rendering treatment. The Authorizations Team will have up to 1 business day to render an authorization decision once the authorization request is made and must reply to the residential provider with that decision within the same time period.

All screenings completed will require sufficient documentation and correspondence with the authorizations team to determine that member needs for dimensions 1, 2, and 3 are sufficiently

stable to be placed into treatment for the initial 5-day residential authorization period at the ASAM 3.1 or 3.5 levels. A high-risk score in any of these dimensions indicates a need for withdrawal management, medical monitoring, or psychiatric stabilization at the ASAM 3.7 or 4.0 levels will be needed. Individuals presenting at this level of need will be assigned a Specialized Care Coordinator (SCC) to coordinate needs at the appropriate level of care with an aim to stabilize for subsequent 5-day residential authorization at the 3.1 or 3.5 ASAM levels.

Where there is concern to stability in Dimension 1, 2, or 3 but the individual does not clearly screen as a candidate for ASAM 3.7 or 4.0 the Authorizations Team will correspond and create a stabilization plan with the residential program prior to admission. This plan may include supportive measures such as assigning a Specialized Care Coordinator (SCC), requiring medical clearance, establishing a medical treatment plan to monitor acute or chronic conditions, increased monitoring of mental health conditions, or other measures and is co-approved by the Authorizations Team and the designated residential team member of the ASAM 3.1 or 3.5 facility.

The purpose of this enhanced screening is to protect members from medical and psychiatric complications and to ensure that the appropriate level of care is matched to the member needs. Training for screeners is developed in partnership with the Authorizations Team and service providers. Training materials are provided to screeners and trainings provided during ASAM fidelity meetings.

For subsequent residential authorization periods beyond 30 days, the residential provider must complete a re-assessment incorporating ASAM placement criteria and submit it to the QAPI Authorizations Team prior to the initial 30-day authorization period ending.

QAPI will conduct periodic quality reviews of LOC authorizations to ensure that authorization decisions are made in full fidelity to ASAM client placement criteria. These reviews will also include a review of determinations made for changes in LOC, and program discharge/treatment terminations.

Medi-Cal Eligiblity: Drug Medi-Cal services are healthcare services for Medicaid eligible individuals with substance use disorders. A client's Medi-Cal eligibility needs to be determined as soon as possible by the screening staff members and may be done in SmartCare. Medi-Cal eligibility must be monitored for each member monthly. Screening staff members will support members directly or by referral to apply for Medi-Cal or transferring residency to Sonoma County upon request.

Initial Assessment

ASAM: A full American Society of Addiction Medicine (ASAM) assessment will take place at the SUD program to which the member is referred. The ASAM assessment will be among the first services rendered at the initial appointment and will be completed within the ASAM Completion Timelines (see section in practice guidelines) by a Licensed Practitioner of the Healing Arts (LPHA), or a registered/certified SUD counselor with review and approval by an LPHA.

This review entails consultation with the LPHA and counselor, and may take place in person, by telehealth, or by telephone. The LPHA must document the consultation including rationale for diagnosis and any other identified treatment considerations. The LPHA completes the diagnosis form in SmartCare. The counselor must complete a service note for the ASAM. The ASAM form in SmartCare is signed by both LPHA and counselor.

The ASAM assessment, diagnosis, and supporting service note will provide confirmation that the beneficiary meets medical necessity for the SUD program to which the beneficiary was referred. The ASAM form alone is separate and distinct from medical necessity and must be taken into consideration with meeting these requirements:

DMC-ODS services must be medically necessary. Pursuant to W&I Code section 14059.5(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and 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. (Section 1396d(r)(5) of Title 42 of the United States Code; W&I Section 14059.5(b)(1)).

In the event that the SUD program's ASAM assessment determines that a different Level of Care is warranted, i.e., to a LOC not offered by the program, the SUD program will alert the Behavioral Health Access Team immediately and facilitate the beneficiary's transition to a SUD program within the indicated and appropriate Level of Care. This transition should occur within 10 business days.

NTP Medical Necessity:

NTPs conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to a NTP qualifies for the purpose of determining medical necessity under the DMC-ODS.

Access Criteria for Members After Assessment

Members 21 years and older: To qualify for DMC-ODS services after the initial assessment process, members 21 years of age and older must meet one of the following criteria:

i. Have at least one diagnosis from DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders
ii. ii. Have had at least one diagnosis from the 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 the age of 21: Members under age 21 qualify to receive all medically necessary DMC-ODS services as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and 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.

Not Qualifying for Services

Members or prospective members determined to not qualify for services for any reasons are given appropriate referrals by screening staff members to meet their needs. In cases where members do not meet medical necessity criteria a Notice of Adverse Benefit Determination (NOABD) denial notice letter is provided to the member in a packet including informing materials as to their rights. The NOABD letter includes information on the decision made and how to appeal if the member is in disagreement. Each NOABD is logged for tracking and review quarterly at the Quality Improvement Committee (QIC).

Service Planning

Structured Treatment Plan Required (NTP and Peer Support)

The only DMC-ODS services that are not permitted to use a problem list instead of a structured treatment plan are: NTP services, and Peer Support Services. NTPs are required by Federal law to create treatment plans and must comply with federal and state regulations requiring treatment plans. Peer Support Services require a plan of care documented in progress notes in the member's clinical record. This plan of care must be approved by a behavioral health professional or a peer support specialist supervisor. Contracted providers are expected to incorporate elements identified during assessment into their treatment plans.

The Problem List

While a structured treatment plan is not required for all other services treatment planning takes place using the problem list and documentation within the service notes contained in the clinical record. A required element of service notes is to include next steps for planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

The problem list helps facilitate continuity of care by providing a comprehensive and accessible list of problems to quickly identify the person's care needs, including current diagnoses and key health and social issues.

Problem List Includes

A list of **symptoms, conditions, diagnoses, and/or risk factors**

Required Elements: Code (eg ICD 10 Code), Description (corresponding to code), Date Added, Date Removed, identified by (name and title), provider type (eg AOD counselor)

The problem list includes clinician-identified diagnoses, identified concerns of the person in care, and issues identified by other service providers, including those by non-LPHA staff.

When a provider identifies a diagnosis within scope of practice it should be added along with any specifiers applicable and based on the current DSM. LPHAs are the only in scope providers qualified to complete this documentation.

Outside Scope of Practice Adds to Problem List

Providers may update problem list to include diagnoses outside of their scope of practice *IF* they are reported to the provider by the client or another qualified professional and documented as such.

Example: Collateral contact with MD reports client has Type 2 Diabetes

Example: Client reports they have Type 2 Diabetes

Both examples could be added to the problem list by a registered counselor, certified counselor or LPHA for example, but the client record should include information on when, by whom, and to whom the problem was reported.

Problem List Completion and Updates

Complete a full problem list no later than the end of the completion of the client initial assessment.

Example: I have completed intake paperwork, screening, and a full ASAM at this point a full problem list should be completed.

A problem list in progress may and should be started prior to the completion of the full assessment whenever possible.

Example: using "**Z-codes**" during 30 or 60 day "assessment period". These codes would be on problem list and claimable for billing during this period before a full assessment is completed.

ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a person's treatment when a diagnosis has yet to be established.

Please refer to the list of most common ICD-10 codes Z55-Z65 in the **back of the Clinical Documentation Guide** for AOD Counselors developed by CalMHSA. These are Social Determinants of Health items that can be added by any service providers independent of licensure and are **listed in Appendix IV DHCS Priority SDOH codes**

CalAIM Documentation Guides - California Mental Health Services Authority (calmhsa.org)

There is also a list for ICD-10 codes Z55-Z65 in the online SmartCare training materials from CalMHSA

How to Add a Problem to the Problem List - 2023 CalMHSA

Problems identified during a service encounter can be addressed within scope of practice and then subsequently added to the progress list.

The problem list is updated on an ongoing basis whenever a new problem is identified or an existing problem is resolved or changes.

As to the timeliness of Problem List updates, the best practice is to keep in alignment with clinical documentation requirements of 3 days for non-crisis and 24 hours for crisis progress notes.

Providers are expected to incorporate ASAM into their own assessments and problem lists and refer to appropriate LOC for clients with co-occurring substance use and mental health conditions. Generally speaking, any identified problem list item that cannot be resolved by the service provider necessitates a referral and service connection to an appropriate resource.

Treatment Services

ASAM Level of Care

Screening, Brief Intervention, Referral to Treatment, and Early Intervention Services (ASAM Level 0.5): Services provided to individuals who are at risk of developing a substance-related issue but may not have a diagnosed SUD. These early intervention services include motivational interventions, assessment, and educational services, screenings such as BQuIP, Driving Under the Influence (DUI) Program and Screening, Brief Intervention, and Referral to Treatment (SBIRT). Early intervention services are intended to identify positive protective factors that reduce the potential of developing an SUD and these services seek to identify substance-related risk factors to help individuals recognize the potentially harmful consequences of high-risk behaviors.

Outpatient Services (ASAM Level 1): Offer comprehensive, coordinated, and defined services that may vary in level of intensity. Outpatient programs may address a variety of needs, including, but not limited to, situational stressors, family relations, interpersonal relationships, mental health issues, life span issues, psychiatric illnesses, SUDs, and other addictive behaviors. These

services consist of intake, assessment, individual and group counseling, client education, collateral services, crisis intervention services, treatment, and discharge planning. Outpatient Services consist of two types of sessions:

- **Group counseling** sessions shall focus on short-term personal, family, job/school, and other problems and their relationship to substance use or a return to substance use. Services shall be provided by appointment. Each beneficiary shall receive at least two group counseling sessions per month unless waived by a physician. Group size is no less than two (2) and no more than twelve (12) clients at the same time.

- **Individual counseling** shall be limited to intake crisis intervention, collateral services, and treatment and discharge planning. Services occur in 15-minute increments.

The LPHA must determine medical necessity and this level of services must be documented in the client chart. Case Management will be provided to collaborate care and transfer clients between LOC.

Narcotic Treatment Program (ASAM OTP Level 1): Services are provided in facilities licensed by the California Department of Health Care Services (DHCS) and accredited by a federally approved accreditation provider. The medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or their licensed designee and approved and authorized according to Title 9 CCR Regulations. Services are directed at reducing or eliminating the use of illicit drugs, criminal activity, and/or the spread of infectious diseases while improving the quality of life and functioning of the beneficiaries served. The treatment services consist of intake, individual and family counseling, client education, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy, and discharge services. Beneficiaries can be concurrently enrolled in Outpatient, Intensive Outpatient (IOP), or Residential while receiving Narcotic Treatment Program Services (NTP). DHS-BHD contracted NTP programs use Methadone, Buprenorphine, Naltrexone, and Disulfiram as medications for addicted treatment (MATs). **See Narcotic Treatment Program section**.

Intensive Outpatient Services (ASAM Level 2.1): Consist primarily of counseling and education about SUD–related problems, with specific components including intake, individual counseling, group counseling, family therapy, client education, medication services, collateral services, crisis intervention services, treatment planning, and discharge services. The LPHA must determine medical necessity and this level of services must be documented in the client chart. Case Management will be provided to coordinate care and transfer clients between LOC. Intensive Outpatient may prevent or minimize the need for higher levels of treatment. It may also function as a step-down from inpatient care or partial hospitalization or as transitional care following an inpatient or partial hospitalization stay to facilitate a return to the community.

Intensive Outpatient Treatment services shall be provided in 15-minute increments to any DMC-eligible beneficiaries for at least 9 hours a week for adults, and 6-19 hours per week for adolescents. The treatment schedules can be flexible - for instance, adult treatment can be

provided in various combinations of 15-minute units that total 9 hours a week. Group size is limited to no less than two (2) and no more than twelve (12) clients at the same time.

Residential Treatment & Inpatient Services (ASAM Level 3.1 and 3.5): The County of Sonoma currently provides through contracted CBOs a non-institutional 24-hour non-medical, short-term (30 days or less) or long-term (31 days or more) program that provides rehabilitative services. Rehabilitative services consist of intake, individual and group counseling, client education, safeguarding medications, collateral sessions with non-professional significant people in the client's life, crisis intervention services, treatment planning, and transportation and discharge services. The program involves the family or other support in services whenever possible. Beneficiaries must receive a minimum of 20 hours of services (not counting transportation services per week). The required 20 hours of services per week will be structured to accommodate other needed services included in the client's treatment plan. Services, such as dental work, psychological evaluations, medical visits, and others are necessary for clients' success. A minimum of 5 of these hours must be counseling services.

The required twenty hours of rehabilitative services may be distributed differently each week, with some days having more or less hours per usual. The LPHA must determine the medical necessity for Residential Services. Additionally, courts/judges sentencing individuals to rehabilitative services must first rely on the County and the use of the ASAM to make placements because LOC should be solely based on medical and service necessity. Case Management must be provided to coordinate care and transfer clients between levels.

Perinatal residential substance use disorder services including intake, admission, physical examinations and laboratory tests, medical direction, treatment planning, individual and group counseling services, parenting education, body specimen screens, medication services, collateral services, and crisis intervention services, will be provided by staff that are lawfully authorized to provide and/or order these services within the scope of their practice, certification, and licensure.

The daily bundled rate for residential services does not include MAT, Care Coordination, and Recovery Services.

<u>Medications for Addiction Treatment (MAT):</u>

- Medications for addiction treatment include all medications and biological products Food and Drug Administration (FDA) approved to treat Alcohol Use Disorder (AUD), Opioid Use Disorder (OUD), and any SUD.
    - Methadone; Buprenorphine (transmucosal and long-acting injectable); Naltrexone (oral and long-acting injectable); Disulfiram; Naloxone
- Service components: Assessment; Care Coordination; Counseling (individual and group); Family Therapy; Medication Services; Patient Education; Recovery Services; SUD Crisis Intervention Services; Withdrawal Management Services
- MAT may be provided in clinical or non-clinical settings.
- MAT may be delivered as a standalone service.
- Additional clarification on MAT

  - DMC-ODS counties shall ensure all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanism to the most clinically appropriate MAT service for the beneficiary with SUD diagnoses that are treatable with medication or biological products.
  - Effective referral mechanism is defined as facilitating access to MAT off-site for beneficiaries if not provide on-site.
  - Providing a beneficiary, the contact information for a treatment program is not considered sufficient.
  - An appropriate facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary shall be made whether or not the provider seeks reimbursement through DMC-ODS.
  - Counties shall monitor the referral process or provision of MAT services.
- The required MAT medications were expanded to include all medications and biological products Food and Drug Administration (FDA)-approved to treat opioid use disorders (OUD) and Alcohol Use Disorders (AUD)
- DMC-ODS counties have the option to cover drug product costs for MAT when the medications are purchased and administered or dispensed outside of the pharmacy or NTP benefit.
  - This means county pays for cost for MAT medications purchased by providers and administered or dispensed on site or in the community and billed to the county DMC-ODS plan.
  - If the DMC-ODS county elect the above option could reimburse providers for the medications, such as naloxone, trans-mucosal buprenorphine, and/or long-acting injectable medications (such as buprenorphine or naltrexone), administered in DMC facilities and non-clinical or community settings.
- DMC-ODS counties who do not choose to cover the drug product costs for MAT outside of the pharmacy or NTP benefit, DMC-ODS counties are still required to cover the drug product costs for MAT services even when provided by DMC-ODS providers in non-clinical settings and when provided as a stand-alone service.
- All medications and biological produces utilized to treat SUDs, including long-acting injectables, continue to be available through the Medi-Cal pharmacy benefit without prior authorization and can be delivered to provider offices by pharmacies.
- Beneficiaries needing or using MAT must be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in the program.
- DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a beneficiary who declines counseling services.
- For beneficiaries with a lack of connection to psychosocial services, more rigorous attempts at engagement in care may be indicated, such as using different evidence-based practices, different modalities (e.g., telehealth), different staff, and/or different services (e.g., peer support services).

- If the DMC-ODS provider is not capable of continuing to treat the beneficiary, the DMC-ODS provider must assist the member in choosing another MAT provider, support continuity of care and facilitate a warm hand-off to ensure engagement.

Care Coordination:

- Coordinating with primary care and mental health care providers to monitor and support comorbid health conditions.
- 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/specialty medical providers.
- 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, and mutual aid support group.

Recovery Services:

- Recovery services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level with emphasis on the beneficiary as the central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management.
- Service components: Assessment; Care Coordination; Counseling (individual and group); Family Therapy; Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the beneficiary's SUD.; Relapse Prevention, which includes interventions designed to teach beneficiaries with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary's SUD.
- Services may be provided based on the beneficiary's self-assessment or provider assessment of relapse risk.
- Diagnosis of "remission" is not required to receive Recovery Services.
- Services may be provided concurrently with MAT services, including NTP services.
- Services may be provided immediately after incarceration with a prior diagnosis of SUD.
- Services may be provided in person, by telehealth, or by telephone
- Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care described.

Withdrawal Management (ASAM Level 3.2-WM): Habilitative and rehabilitative services when determined by the LPHA as medically necessary. The Withdrawal Management (WM) services are intake, observation, medication services, and discharge services. Medically supervised withdrawal management is available to clients that would benefit from additional oversight and coordinated on a case-by-case basis to Withdrawal Management ASAM 3.7 and Withdrawal Management 4.0 delivered through FFS and MCPs. Case management is provided for clients in

Withdrawal Management to coordinate care with ancillary services providers and facilitate transitions between levels of care. Recovery coaches embedded in WM programs assist members in accessing treatment services and addressing related barriers.

Recovery Services (ASAM Dimension 6 – Recovery Environment)

As part of the assessment and treatment needs of Dimension 6, Recovery/Living Environment, of the ASAM Criteria and during the transfer/transition planning process, beneficiaries will be linked to applicable medically necessary recovery services, including Sober Living Environments (SLEs). Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed, or as a preventative measure to prevent relapse. Recovery services include outpatient individual or group counseling; recovery monitoring/coaching; linkages to services to enhance education and job skills; linkages to support groups and ancillary services; and peer-to-peer screening and navigation, supported by a clinical specialist. The clinical specialist oversees a team of recovery coaches is a specialized behavioral health provider housed within DHS-BHD that works with high-utilizer clients.

Members can be placed in these SLEs for up to 6 months per episode. Services include supervised/monitored board and care provided by peer recovery providers as well as education services, individual and group treatment provided by contractor, aftercare services, as well as ancillary supporting services such as vocational training.

Care Coordination

I - Specialized Care Coordinators (SCC)

Specialized Care Coordinators (SCC), 2.0 FTE Senior Client Support Specialists, function as high level care coordinators for clients with complex behavioral health &/or medical needs. These are defined as beneficiaries with co-occurring substance use disorders and severe and persistent mental health disorders, and/or high utilizers of crisis services and Hospital Emergency Departments. Eligible beneficiaries are referred to specialized care coordination via a) specialty mental health programs, b) Mobile Crisis Services, c) Detox facilities, e) hospital Emergency Departments, or f) other referral sources designated by the County Substance Use Administrator.

1. The SCC performs ongoing case management to beneficiaries for as long as needed during the beneficiary's episode of treatment within the DMC-ODS.
2. Specialized care coordination services include initial screening to inform program referral and determine eligibility for specialized care coordination services; development and periodic revision of a problem list; communication, coordination, referral, and related activities; monitoring service delivery to ensure beneficiary's successful access to services; monitoring the beneficiary's progress; client advocacy; linkages to physical and mental health care; and transportation.
3. The SCC will maintain at least monthly contact (sometimes weekly) with the beneficiary during his/her course of treatment within the DMC-ODS; this contact will include regular communication with the treatment provider.
4. In addition, the SCC will be primarily responsible for care coordination responsibilities listed in Section II parts 2-9 below.

II - Care Coordination Duties of DMC-ODS Providers

DMC-ODS SUD treatment programs shall designate primary case managers for each beneficiary who implement the following procedures to deliver and coordinate care for as follows:

1. If a DMC-ODS treatment program chooses to provide care coordination to a beneficiary who already has an assigned Specialized Care Coordinator, the treatment program may render those services so long as the services are coordinated with the SCC and there is no service duplication with the SCC.
2. Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs. It is the primary case manager's responsibility to coordinate services accessed by the beneficiary, and to inform the beneficiary of their care coordination role and how to contact them.
3. Coordinates services provided to the beneficiary as follows:
    a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.
    b. With the services the beneficiary receives from any other managed care organization (e.g. Sonoma County Behavioral Health Mental Health Plan, Partnership Health Plan, Kaiser Health Plan).
    c. With the services the beneficiary receives in FFS Medicaid.
    d. With the services the beneficiary receives from community and social support providers.
4. Conduct initial screening within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if initial attempts to contact the beneficiary are unsuccessful.
5. Share with the Sonoma County Behavioral Health, DHCS, or other managed care organizations (e.g. Partnership Health Plan, Kaiser Health Plan) serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.
6. Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.
7. Ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

Transitions Between Levels of Care

8. At program exit, whether due to a change in Level of Care based on re-assessment, or treatment completion, the primary case manager from the existing program will coordinate with the "new" SUD treatment provider in order to help facilitate seamless transfer of care without disruption in service. It is expected that the treatment provider's case managers ensure "warm hand-offs" between Level of Care, which may

require collaboration from staff at both SUD programs. This collaboration may include, but is not limited to, communication though emails or phone calls, transportation, or other practical supports, and is contingent upon client's written consent to share the information.

9. For beneficiaries exiting the DMC-ODS, i.e. not transitioning to a new SUD program or level of care, to the extent appropriate and based on client consent, the treatment provider will coordinate and communicate with other care providers or care managers serving the beneficiary for the purpose of facilitating a "smooth landing" and to prevent negative outcomes such as victimization, crisis, or homelessness.

III. Monitoring Plan for Care Coordination

a. In order to monitor care coordination across the DMC-ODS, Sonoma County Behavioral Health will require all SUD service providers (with the exception of Opioid Treatment Programs, and certain out-of-county providers who serve small amounts of clients as needed) to enter beneficiary clinical service information into SmartCare, the county's centralized electronic health record system (EHR) for substance use and mental health services. The following elements within the EHR will be used to evaluate and monitor care coordination activities:
    a. Completion of Coordinated Care Consent
    b. Progress Notes review with evidence of providing the beneficiary with information on how to contact the person responsible for coordinating their care.
    c. Review Primary Care Provider Detail section for completion
    d. Progress Notes review with evidence of care coordination between settings of care (e.g. detox, residential, outpatient, intensive outpatient) in accordance with Section I and Section II procedures.
b. Language on Care Coordination requirements is included in the DMC-ODS provider contracts, and the DMC-ODS practice guidelines.
c. Sonoma County Quality Assessment Performance Improvement (QAPI) staff review progress on performance standards through review of Treatment Perception Survey, timely transitions in level of care, evidence of follow-up post-discharge from DMC-ODS levels of care.

Clinician Consultation

Services that are designed to assist physicians within the DMC-ODS network with seeking expert advice on designing treatment plans or problem lists and supporting DMC providers with complex cases. These cases may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or LOC considerations. When needed, physician consultation services is provided by the County’s Behavioral Health Medical Director or contracted psychiatrist and may occur when beneficiaries are placed into treatment.

Narcotic Treatment Program (NTP)

DMC-ODS Required Medication Assistance Treatment – Narcotic Treatment Program Services

Required Medication Assisted Treatment (MAT) services under DMC-ODS include Narcotic Treatment Program (NTP) services provided in NTP-licensed settings. NTP services use medication as a narcotic replacement drug to alleviate the symptoms of withdrawal and cravings from opioids. Narcotic Treatment Programs participating in DMC-ODS are required to offer and prescribe medication to clients covered under the DMC-ODS formulary, including methadone, buprenorphine (transmucosal and long-acting injectable, naloxone, naltrexone (oral and long-acting injectable) and disulfiram, and may opt to provide Expanded MAT services (see DHCS MHSUDS Information Notice No.: 18-004) and (Intergovernmental Agreement, Exhibit A, Attachment I).

Services are provided by an individualized treatment plan determined by a licensed prescriber and approved and authorized according to State requirements (Intergovernmental Agreement, Exhibit A, Attachment 1).

NTP services do not require prior authorization.

Covered Components of NTP Services The included components of NTP services are (Intergovernmental Agreement, Exhibit A, Attachment I).

1) Assessment
2) Care Coordination
3) Counseling
4) Family Therapy
5) Medical Psychotherapy
6) Medication Services
7) MAT for OUD
8) MAT for AUD and non-opioid SUDs
9) Patient Education
10) Recovery Services
11) SUD Crisis Intervention Services

Special Adolescent Client NTP Requirements
Detoxification treatment for individuals who are under 18 years of age requires written consent from their parent(s) or guardian before the administration of the first medication dose (CCR, Title 9 10270(c)(3)). Narcotic Treatment Programs may seek an exception to this requirement on an individual client basis by submitting a temporary exception request to DHCS (see MHSUDS Information Notice No.: 18-061).

State regulations do not allow maintenance treatment for individuals who are under 18 years of age (CCR, Title 9 10270(d)(3)). DHCS will review temporary exceptions to this rule with or without the written consent of their parent(s) or guardian.

Daily/Weekly Medication Services and Counseling for NTP Clients with Severe Opioid Disorder

Narcotic Treatment Programs must include daily or several times weekly opioid agonist medication and counseling available for those clients with severe opioid disorder (Intergovernmental Agreement, Exhibit A, Attachment 1).

NTP Intake: Assessment and Treatment Planning

ASAM Assessments

NTP Client Orientation Requirements

Programs must advise clients of the nature and purpose of treatment through an orientation. Client acknowledgment of the orientation must be documented in the client record.
Client orientations must include, but not be limited to, the following information (9 CCR §10280):

1. The addicting nature of medications used in replacement narcotic therapy.

2. The hazards and risks involved in replacement narcotic therapy.

3. The client's responsibility to the program.

4. The program's responsibility to the client.

5. The client's participation in the program is wholly voluntary and the client may terminate his/her participation in the program at any time without penalty.

6. The client will be tested for evidence of the use of opiates and other illicit drugs.

7. The client's medically determined dosage level may be adjusted without the client's knowledge, and at some later point, the client's dose may contain no medications used in replacement narcotic therapy.

8. Take-home medication which may be dispensed to the client is only for the client's personal use.

9. Misuse of medications will result in specified penalties within the program and may also result in criminal prosecution.

10. The client has a right to a humane procedure of withdrawal from medications used in replacement narcotic therapy and a procedure for gradual withdrawal is available.

11. Possible adverse effects of abrupt withdrawal from medications used in replacement narcotic therapy.

12. Protection under the confidentiality requirements.

NTP Perinatal Orientation Requirements

In addition to the client orientation requirements applicable to all clients (see above), each program must provide a perinatal orientation to female clients of childbearing age that includes the following components (9 CCR §10285). Client acknowledgment of orientation must be documented in the client record.

1. Knowledge of the effects of medications used in replacement narcotic therapy on pregnant women and their unborn children is presently inadequate to guarantee that these medications may not produce significant or serious side effects.

2. These medications are transmitted to the unborn child and may cause physical dependence.
3. Abrupt withdrawal from these medications may adversely affect the unborn child.

4. The use of other medications or illicit drugs in addition to medications used in replacement narcotic therapy may harm the client and/or unborn child.

5. The client should consult with a physician before nursing.

6. The child may show irritability or other ill effects from the client's use of these medications for a brief period following birth.

NTP Medical Evaluation

Before admitting an individual to maintenance treatment, the medical director must either conduct a medical evaluation or document their review and concurrence of a medical evaluation conducted by an LPHA acting within their scope of professional practice. At a minimum, documentation of **all** the following must be in the client record:

1. A medical history which includes the client's history of illicit drug use;

2. Laboratory tests for determination of narcotic drug use, tuberculosis, and syphilis (unless the medical director has determined the individual's subcutaneous veins are severely damaged to the extent that a blood specimen cannot be obtained); and

3. A physical examination which includes: a. An evaluation of the client's organ systems for the possibility of infectious diseases; pulmonary, liver, or cardiac abnormalities; and dermatologic sequelae of addiction;

b. A record of the client's vital signs (temperature, pulse, blood pressure, and respiratory rate);

c. An examination of the client's head, ears, eyes, nose, throat (thyroid), chest (including heart, lungs, and breasts), abdomen, extremities, skin, and general appearance;

d. An assessment of the client's neurological system; and

e. A record of an overall impression that identifies any medical condition or health problem for which treatment is warranted.

Before admitting a client to maintenance treatment, the medical director must:

1. Document the evidence, or review and concur with the LPHA's documentation of evidence, used from the medical evaluation to determine physical dependence and addiction to opiates; and

2. Document their final determination concerning physical dependence and addiction to opiates.

NTP Client Consent

Each client must attest to voluntary participation in a program by providing written documentation of their informed consent (9 CCR § 10290). The program must ensure that the client reads and understands the consent form, explain program rules, and supply the client with copies of the consent form and program rules.

If a client is admitted to a new treatment episode after a previous episode of treatment was terminated by the program physician and the discharge was noted in the client's record, the program client reissues rules and instructions to the client and requires that the client resign the consent form.

NTP Intake Screening Criteria

The program must determine which clients with an addiction to opiates are accepted for maintenance treatment subject to the following minimum criteria which must be documented in client records:

1. Confirmed documented history of at least one year of addiction to opiates. The program must maintain the client record documents, such as records of arrest or treatment failures, which are used to confirm one year of addiction to opiates. Statements of personal friends or family must not be sufficient to establish a history of addiction. With prior Department approval, the program may make an exception to this requirement only if the program physician determines, based on their medical training and expertise, that withholding treatment constitutes a life- or health-endangering situation. The program physician must document the reason for this determination in the client's record.

2. Confirmed history of two or more unsuccessful attempts in withdrawal treatment with subsequent relapse to illicit opiate use. The methods used to make confirmations and the types of documentation to be maintained in the client's record must be stated in the protocol. At least seven days must have elapsed since completion of the immediately preceding episode of withdrawal treatment if it is to be used to satisfy this subsection.

3. A minimum age of 18 years.5

4. Certification by a physician of fitness for replacement narcotic therapy based upon physical examination, medical history, and indicated laboratory findings. Plans for correction of existing medical problems should be indicated.

5 Methadone and buprenorphine are indicated for the treatment of patients who are aged 18 years and older. Federal code on opioid treatment offers an exception for youth, aged 16 and 17, who have a documented history of at least two prior unsuccessful withdrawal management attempts and have parental consent (42 CFR § 8.12). The client record must justify methadone and buprenorphine treatment along with parental consent.

5. Evidence of observed signs of physical dependence.

a. A client who has resided in a penal or chronic care institution for one month or longer may be admitted to maintenance treatment within six months of release without documented evidence to support findings of physical dependence, provided the person would have been eligible for admission before he or she was incarcerated or institutionalized and, in the clinical judgment of the medical director or program physician, treatment is medically justified.

b. Previously treated clients who voluntarily detoxified from maintenance treatment may be admitted to maintenance treatment without documentation of current physical dependence within two years after discharge, if the program can document prior maintenance treatment of six months or more and, in the clinical judgment of the medical director or program physician, treatment is medically justified. Clients admitted under this subsection may, at the discretion of the medical director or program physician, be granted the same take-home step level they were on at the time of discharge.

6. All information relied upon in the selection of clients must be documented in client records.

NTP Special Intake Criteria Consideration for Pregnant Women

Pregnant clients who are currently physically dependent on opiates and have had a documented history of addiction to opiates in the past may be admitted to maintenance treatment without documentation of a one-year addiction history or two prior treatment failures, provided the medical director or program physician, in his or her clinical judgment, finds treatment to be medically justified (9 CCR § 10270(d)(5)).

Pregnant clients admitted to treatment without documentation of a one-year addiction history or two prior treatment failures must be reevaluated by the program physician not later than 60 days following termination of the pregnancy to determine whether continued maintenance treatment is appropriate (9 CCR § 10270(e)).

NTP Needs Assessment

Before developing a client's initial maintenance treatment plan, the primary counselor must complete and document in the client's record a needs assessment which must include:

1. A summary of the client's psychological and sociological background, including his or her educational and vocational experience.

2. An assessment of the client's needs for:

a) Health care as recorded within the overall impression portion of the physical examination;
b) Employment;
c) Education;
d) Psychosocial, vocational rehabilitation, economic, and legal services.

Methadone Maintenance for MAT Client Assessments

1. SUD treatment provider medical staff must conduct an assessment according to federal and state regulations which includes: 1) a medical history, including the individual's history of substance use; 2) laboratory tests for determination of narcotic drug use, tuberculosis, and syphilis; and 3) physical examination.

2. Transition to levels of care within methadone maintenance shall follow federal and state regulations and include frequency of counseling, as well as the need for supervised dosing.

3. Physicians, social workers, clinical pharmacists, and nurse practitioners must determine when office-based MAT (primary care) can replace Opioid Treatment Program (OTP) MAT as they work with each patient

4. ASAM assessment shall be provided as part of OTP treatment planning, within 30 days of admission, and will aid in determining further or higher levels of care that might be needed.

5. For patients on buprenorphine who stabilize, transfer criteria shall be used to decide to move to a primary care/Office Based Opioid Treatment (OBOT) setting.

6. Administration of the ASAM assessment shall not delay treatment.

NTP Pregnant Client Special Considerations and Care Requirements

Within fourteen (14) calendar days from the date of the primary counselor's knowledge that the client may be pregnant, as documented in the client's record, the medical director must review, sign, and date a confirmation of pregnancy (9 CCR § 10360). In addition, within this timeframe, the medical director must document his or her:

1. Acceptance of medical responsibility for the client's prenatal care; or

2. Verification that the client is under the care of a physician licensed by the State of California and trained in obstetrics and/or gynecology.

Within fourteen (14) calendar days from the date the medical director confirmed the pregnancy, the primary counselor must update the client's treatment plan. The nature of prenatal support reflected in subsequent updated treatment plans must include at least the following services:

1. Periodic face-to-face consultation at least monthly with the medical director or physician assistant designated by the medical director;

2. Collection of patient body specimens at least once each calendar week in accordance with collection procedures.

3. Prenatal instruction.

The medical director or licensed health personnel designated by the medical director must document the completion of instruction on each of the following prenatal topics:

1. Risks to the client and unborn child from continued use of both illicit and legal drugs, including premature birth.

2. Benefits of replacement narcotic therapy and risks of abrupt withdrawal from opiates, including premature birth.

3. Importance of attending all prenatal care visits.

4. Need for evaluation for the opiate addiction-related care of both the client and the newborn following the birth.

5. Signs and symptoms of opiate withdrawal in the newborn child and warning that the client does not share take-home medication with the newborn child who appears to be in withdrawal.

6. Current understanding related to the risks and benefits of breast-feeding while on medications used in replacement narcotic therapy.

7. Phenomenon of postpartum depression.

8. Family planning and contraception.

9. Basic prenatal care for those patients not referred to another health care provider, which shall include instruction on at least the following:

a. Nutrition and prenatal vitamins.

b. Child pediatric care, immunization, handling, health, and safety.

10. Evidence-based practices for managing neonatal abstinence syndrome

If a client repeatedly refuses referrals offered by the program for prenatal care or refuses direct prenatal services offered by the program, the medical director must document in the client's record these repeated refusals and have the client acknowledge in writing that she has refused these treatment services.

Within fourteen (14) calendar days after the date of birth and/or termination of the pregnancy, the medical director must document in the client's record the following information:

1. The hospital's or attending physician's summary of the delivery and treatment outcome for the client and offspring; or

2. Evidence that a request for information as specified in paragraph (f)(1) of this section was made, but no response was received.

Within fourteen (14) calendar days from the date of the birth and/or termination of the pregnancy, the primary counselor must update the client's treatment plan. The nature of pediatric care and child immunization must be reflected in subsequent updated treatment plans until the child is at least three (3) years of age.

NTP Initial Client Treatment Plan

Programs must develop an individualized treatment plan for each client (9 CCR § 10305). The primary counselor must enter in the client's record his or her name and the date the client was assigned to the counselor.

Within 28 calendar days after initiation of maintenance treatment, the primary counselor must develop the client's initial maintenance treatment plan which must include:

1. Goals to be achieved by the client based on the needs identified in paragraph (d) of this section and with estimated target dates for attainment in accordance with the following:

a. Short-term goals are those which are estimated to require ninety (90) days or less for the client to achieve; and

b. Long-term goals are those that are estimated to require a specified time exceeding ninety (90) days for the client to achieve.

2. Specific behavioral tasks the client must accomplish to complete each short-term and long-term goal.

3. A description of the type and frequency of counseling services to be provided to the client.

4. An effective date based on the day the primary counselor signed the initial treatment plan.

The supervising counselor shall review the initial maintenance treatment plan, along with the corresponding needs assessment, and all updated maintenance treatment plans within fourteen (14) calendar days from the effective dates and shall countersign these documents to signify concurrence with the findings.

The medical director shall review the initial maintenance treatment plan, along with the corresponding needs assessment within fourteen (14) calendar days from the effective dates and must record the following in the client record:

1. Countersignature to signify concurrence with the findings; and

2. Amendments to the plan where medically deemed appropriate.

NTP Updated Client Treatment Plan

The primary counselor must evaluate and update the client's maintenance treatment plan whenever necessary or at least once every three (3) months from the date of admission (9 CCR § 10305). This updated treatment plan must include:

1. A summary of the client's progress or lack of progress toward each goal identified on the previous treatment plan.

2. New goals and behavioral tasks for any newly identified needs, and related changes in the type and frequency of counseling services as required.

3. An effective date based on the day the primary counselor signed the updated treatment plan.

The supervising counselor must review the initial maintenance treatment plan, along with the corresponding needs assessment, and all updated maintenance treatment plans within fourteen (14) calendar days from the effective dates and must countersign these documents to signify concurrence with the findings.

The medical director must review the initial maintenance treatment plan, along with the corresponding needs assessment, and all updated maintenance treatment plans within fourteen (14) calendar days from the effective dates and must record the following:

1. Countersignature to signify concurrence with the findings; and

2. Amendments to the plan where medically deemed appropriate.

NTP Ongoing Services Medical Necessity Reevaluation
For an individual to receive ongoing Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) services, the Medical Director or LPHA must re-evaluate that individual's medical necessity qualification annually through the reauthorization process and determine that services are still clinically appropriate for that individual. This requirement applies to existing and new clients.

NTP Client Record Documentation Requirements

Each program must document the following information in the individual client's record:

1. The client's birth date.

2. Physical examination data, including laboratory results for required tests and analyses.

3. Evidence of current use of heroin or other opiates.

4. Date of admission to the program, plan of treatment, and medication orders signed by the physician.

5. The program's response to a test or analysis for illicit drug use that discloses the absence of both methadone and its primary metabolite (when prescribed by the medical director and program physician), the presence of any illicit drugs, or abuse of other substances, including alcohol.

6. Incidence of arrest and conviction or any other signs of retrogression.

7. Any other client information that the program finds useful in treating the client.

In addition to the requirements above, client records must contain the following for maintenance treatment:

1. Documentation of prior addiction and prior treatment failure.

2. Documentation of services and treatment provided, as well as progress notes, signed by the physician, nurse, or counselor; test or analysis results for illicit drug use and periodic review or evaluation by the medical director. Such review shall be made not less than annually.

3. For any client who is to be continued on maintenance treatment beyond two years, the circumstances justifying such continued treatment.

4. Reasons for changes in dosage of levels and medications.

5. For clients who have terminated the program, a discharge summary and follow-up notations to allow determination of success or failure of treatment.

Medication Documentation
Each program furnishing maintenance treatment must outline in its protocol the medical director or program physician's procedures for medically determining a stable dosage level that:

1. Minimizes sedation.

2. Decreases withdrawal symptoms.

3. Reduces the potential for diversion of take-home medication.

Deviations from these planned procedures must be noted by the medical director or program physician with reason for such deviations, in the client's record.

The medical director or program physician must review the most recent approved product labeling for up-to-date information on important treatment parameters for each medication. Deviation from doses, frequencies, and conditions of usage described in the approved labeling shall be justified in the client's record.
The medical director or program physician must review each client's dosage level at least every three months.

Maintenance Dosage Levels Specific to Methadone

The medical director or program physician must ensure that the first-day dose of methadone shall not exceed 30 milligrams unless (9 CCR § 10355):

1. The dose is divided, and the initial portion of the dose is not above 30 milligrams; and

2. The subsequent portion is administered to the client separately after the observation period prescribed by the medical director or program physician.

The total dose of methadone for the first day shall not exceed 40 milligrams unless the medical director or program physician determines that 40 milligrams is not sufficient to suppress the client's opiate abstinence symptoms and documents in the client's record the basis for his/her determination.

A daily dose above 100 milligrams must be justified by the medical director or program physician in the client's record.

NTP Client Take-Home Medication Documentation
Where the medical director or program physician has granted permission for a client to take home medications, the medical director or program physician must document in the client's record the granting of any exception and the facts justifying the exception (9 CCR § 10385).

NTP Client Test or Analysis for Illicit Drug Use Documentation
Each program shall maintain test or analysis records for illicit drug use which contain the following information for each client (9 CCR § 10330):

1. The date the client's body specimen was collected;
2. The test or analysis results; and
3. The date the program received the results of the test or analysis.

When a client fails to provide a body specimen when required, the program must proceed as though the client's sample from his or her body specimen disclosed the presence of an illicit drug(s). Such failures must be noted in the client's records (9 CCR § 10335).

NTP Client Hospitalization Documentation
If the program is aware that a client has been hospitalized, the program physician must attempt to cooperate with the attending physician and the hospital staff for the hospital to continue a client's replacement narcotic therapy (9 CCR 10185). The client's record must contain documentation of:

1. The program physician's coordination efforts with the attending physician and the hospital staff; and

2. The date(s) of hospitalization, reason(s), and circumstances involved.

NTP Client Incarceration Documentation
If the program is aware that a client has been incarcerated, the program physician must attempt to cooperate with the jail's medical officer in order to ensure the necessary treatment for opiate withdrawal symptoms, whenever it is possible to do so (9 CCR § 10190). The client's record must contain documentation of:
1. The program physician's coordination efforts with the jail; and

2. The date(s) of incarceration, reason(s), and circumstances involved.

NTP Client Attendance Documentation
A client must report to the same program to which he or she was admitted unless prior approval is obtained from the client's medical director or program physician to receive services temporarily from another narcotic treatment program (9 CCR Section 10295 The approval shall be noted in the client's record and must include the following documentation:
1. The client's signed and dated consent for disclosing identifying information to the program which will provide services temporarily.

2. A medication change order by the referring medical director or program physician permitting the client to receive services temporarily from the other program for a length of time not to exceed 30 days; and

3. Evidence that the medical director or program physician for the program contacted to provide services temporarily has accepted the responsibility to treat the visiting client, concurs with his or her dosage schedule and supervises the administration of the medication, subject to Section 10210(d).

NTP Client Absence Documentation
If a client in maintenance treatment misses' appointments for two weeks or more without notifying the program, the client's episode of treatment must be terminated by the medical director or program physician and the discharge must be noted in the client's record ((9 CCR § 10300).

If the discharged client returns for care and is accepted into the program, the client must be readmitted as a new client, and documentation for the new readmission must be noted in the client's record (9 CCR § 10300).

Extended MAT Documentation
NTPs shall administer, dispense, or prescribe medications to beneficiaries covered under the DMC-ODS formulary including methadone, buprenorphine (transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), naloxone and disulfiram. (Intergovernmental Agreement, Exhibit A, Attachment I)

A new state statute (AB 395) allows a licensed NTP to provide non-controlled medications approved by the FDA for providing medication-assisted treatment to clients with a substance use disorder (Expanded MAT). Any new medications approved by the FDA in the future also would be allowed to be utilized by NTPs. Examples of non-controlled medications approved by the FDA for clients with a substance use disorder include Naltrexone and Acamprosate. Narcotic Treatment Programs dispensing Expanded MAT medications must document in the client record the medications used in Expanded MAT traceable to specific clients, showing dates and quantities dispensed, prescribed, and/or administered (DHCS MHSUDS Information Notice No.: 18-004).

NTP Counseling Services Documentation Requirements

Upon completion of the initial treatment plan, a client must receive at minimum 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity (9 CCR §10345). Counseling sessions must meet the following requirements:

1. The program staff member conducting the session meets minimum counselor qualifications.

2. The session is conducted in a private setting in accordance with all applicable federal and state regulations regarding confidentiality.

3. The format of the counseling session must be one of the following: a. Individual session, with face-to-face discussion with the client, on a one-on-one basis, on issues identified in the client's treatment plan.

b. Group session, with a minimum of two clients and no more than twelve clients and having a clear goal and/or purpose that is a common issue identified in the treatment plans of all participating clients.

c. Medical psychotherapy session, with face-to-face discussion conducted by the medical director on a one-on-one basis with the client, on issues identified in the client's treatment plan.

The following do not qualify as a counseling session:

1. Interactions conducted with program staff in conjunction with dosage administration.

2. Self-help meetings, including the 12-step programs of Narcotics Anonymous, Methadone Anonymous, Cocaine Anonymous, and Alcoholics Anonymous.

3. Educational sessions, including client orientation sessions.

4. Administrative intervention regarding payment of fees.

The counselor conducting the counseling session shall document in the client's record within 14 (fourteen) calendar days of the session the following information:

1. Date of the counseling session;

2. Type of counseling format (i.e., individual, group, or medical psychotherapy);

3. The duration of the counseling session in ten-minute intervals, excluding the time required to document the session as required in Subsection (d)(4) of this regulation; and

4. Summary of the session, including one or more of the following: a. Client's progress towards one or more goals in the client's treatment plan.

b. Response to a drug-screening specimen that is positive for illicit drugs or is negative for the replacement narcotic therapy medication dispensed by the program.

c. New issue or problem that affects the client's treatment.

d. Nature of prenatal support provided by the program or other appropriate health care provider.

e. Goal and/or purpose of the group session, the subjects discussed, and a brief summary of the client's participation.

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 client's treatment plan.

Client Treatment for Concurrent Health Conditions Documentation
For Medi-Cal clients not enrolled in a managed care plan, medically necessary treatment of concurrent health conditions may be provided through NTPs which also are Medi-Cal certified providers. This includes diagnosis and treatment of concurrent health conditions including:

1. Medical treatment visits;

2. Diagnostic blood, urine, and X-rays;

3. Psychological and psychiatric tests and services;

4. Quantitative blood and urine toxicology assays; and

5. Medical supplies.

Clinical documentation requirements for Medi-Cal must be met in addition to documentation requirements for DMC-ODS.

NTP Client Discharge Documentation

The medical director or program physician must discontinue a client's maintenance treatment within one year after such treatment is begun unless they complete the following (9 CCR § 10410):

1. Evaluate the client's progress or lack of progress in achieving treatment goals; and

2. Determines, in his or her clinical judgment, that the client's status indicates that such treatment should be continued for a longer period of time because discontinuance from treatment would lead to a return to opiate addiction.

Client status relative to continued maintenance must be re-evaluated annually.

The medical director or program physician must document in the client's record the facts justifying his or her decision to continue the client's maintenance treatment.

Voluntary and Involuntary Client Participation & Discharge Summary Documentation

A client may voluntarily terminate participation in a program even though termination may be against the advice of the medical director or program physician (9 CCR § 10415). If the medical director or program director determines that the client's continued participation in the program creates a physically threatening situation for staff or other clients, the client's participation may be terminated immediately.

A client's participation in a program may be involuntarily terminated by the medical director or program physician for cause. If a program utilizes disciplinary proceedings which include involuntary termination for cause, the program shall include in its protocol reasons and procedures for involuntarily terminating a client's participation in the program. The procedures shall provide for:

1. Explanation to the client of when participation may be terminated for cause.
2. Client notification of termination.
3. Client's right to hearing.
4. Client's right to representation.

Either voluntary or involuntary termination must be individualized, under the direction of the medical director or program physician, and take place over a period of time not less than 15 days, unless:

1. The medical director or program physician deems it clinically necessary to terminate participation sooner and documents why in the client's record;
2. The client requests in writing a shorter termination period; or
3. The client is currently within a 21-day detoxification treatment episode.

Discharge Summary Documentation
The program must complete a discharge summary for each client who is terminated from treatment, either voluntarily or involuntarily. The discharge summary must include at least the following:

1. The client's name and date of discharge;
2. The reason for the discharge; and
3. A summary of the client's progress during treatment.

Service Restart Documentation
Clients who previously received at least six months of maintenance treatment before voluntarily detoxifying may be readmitted within 6 months without documenting current physical dependence. However, previous treatment for maintenance treatment must be documented in the client record, in addition to justification by the medical director or program physician that treatment is medically justified (9 CCR § 10270(d)(4)(B))

Sonoma County SUD Programs

Drug Testing - PassPoint

Random pupil scanned drug screenings (PassPoint) services for individuals enrolled in Sonoma County case management programs. Urinalysis testing is done for community AOD contract providers, and other court referrals as well as individuals with positive PassPoint screens. Testing analysis is done through Redwood Toxicology.

Testing instructions: (707) 565-7470

AB 109 Program

Post release community supervision (PRCS) and Mandatory Supervision (MS) clients are referred by probation department to DHS AB109 embedded staff. Services may include AODS assessments and related case management functions. Services include in custody outreach and case management support when applicable. This program includes a transitional housing element.

Adolescent Treatment Program

Provides assessment, education, individual and group counseling services to juvenile (under age 18) detainees at Los Guilicos, Valley of the Moon, community-based referrals from mental health or CSEC services, and referrals to residential treatment programs when indicated.

Dependency Drug Court (DDC)

Dependency drug court is a court-supervised, comprehensive case-management and treatment program in coordination with the Youth and Children Division of the Human Services

Department. The program is designed for parents and guardians whose children have been removed or are in danger of being removed from their care because of child abuse or neglect partially stemming from the parent's alcohol or other drug use.

2255 Challenger Way, Suite 107
Santa Rosa, CA 95407
(707) 565-7464

SonomaWORKS

AODS Counselors work at the Human Services Employment and Training Services Division to provide screening, assessment, and case management as part of the welfare to work team process. We contract with specific treatment agencies to provide necessary services to eligible clients with alcohol and drug problems that are barriers to employment.

Treatment Accountability for Safer Communities (TASC)

Provides advocacy, case management, assessment and treatment placement and supervision services for adults currently involved in the criminal justice system and who are ready to participate in treatment.

Drug Court

A minimum nine-month program based on outpatient and residential community treatment services and frequent court supervision designed to support voluntary, positive behavioral change. The Drug Court Program provides the opportunity to form a unique partnership between the criminal justice system, the drug treatment community, and the offender. A minimum duration of 9 months for misdemeanor offenses and 12 months for Felonies. Program includes testing, treatment and a collaborative court system.

DUI Compliance Court

DUI Compliance Court is a program for multiple DUI offenders. Through collaboration between the courts and community treatment providers, clients are provided case management and compliance services and alcohol and other drug education in outpatient and residential settings. Program includes testing, treatment, and a collaborative court system.

Drug Free Babies

A collaborative case management program for pregnant and delivering women, designed to reduce the negative impact of prenatal tobacco, alcohol and other drug exposure.

2255 Challenger Way, Suite 107
Santa Rosa, CA 95407
(707) 565-7464

To be eligible you must be pregnant or have a baby under one year of age.

Call (707) 565-7463.

Driving Under the Influence Program

To enroll in the Driving Under the Influence program you must first attend a one-hour orientation meeting within 21 days of your DUI court conviction date. Program requirements are based on whether Juvenile or Adult offender and on history of convictions. Program fees are required for participation.

Driving Under the Influence Program (ca.gov)

Alcohol and Drug (AOD) Problem Assessment Program

Assessment program for persons dismissed from the Multiple Offender Driving Under the Influence (DUI) Program for the first time for a reason other than non-payment. The Court may also order any person convicted of a DUI to the program.

DHS-Behavioral Health SUD Outpatient Services DRC Program

A county run outpatient program ASAM level 1.0 done in partnership with Sonoma County Probation. Individuals must follow program requirements set forth by both DHS and Sonoma County Probation. Referrals are exclusively made by Sonoma County Probation. The curriculum used in Matrix Model involving both early recovery skills and relapse prevention.

Evidence-Based Practices

All service providers are required to implement a minimum of two Evidence-Based Practices (EBPs). Motivational Interviewing (MI) is required by all providers, and for any other EBPs providers may use one or more of the following:

- Trauma-Informed Treatment
- Cognitive Behavioral Therapy (CBT)
- Relapse Prevention
- Psychoeducation

Motivational Interviewing

A client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment by paying attention to the language of change. This approach frequently includes other problem solving or solution-focused strategies that build on patients' past successes. Motivational Interviewing is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.

Trauma-Informed Treatment

According to SAMHSA's concept of a trauma-informed approach, "a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization." Trauma informed treatment ensures members they will be safe while in treatment, have a voice in their care, have collaborative service providers, and that their treatment is positive not punitive. Seeking Safety is an example of an evidence-based trauma-informed practice.

Cognitive Behavioral Therapy

Members in Cognitive Behavioral Therapy (CBT) learn to identify and correct both unhelpful or faulty ways of thinking and problematic barriers by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur. Members learn more effective ways of coping with problems resulting in symptom relief and more effective living. The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.

Relapse Prevention

According to SAMHSA's National Registry of Evidence-Based Programs and Practices, relapse prevention is "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 treatment. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide patients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a client's overall coping capacity." The Matrix Model is an example of an integrated therapeutic approach that incorporates relapse prevention techniques.

Psychoeducation

Psychoeducation interventions educate clients about substance abuse and related behaviors and consequences. The information provided may be broad but are intended to lead to specific objectives. Psychoeducation about substance abuse is designed to have a direct application to clients, to instill self-awareness, suggest options for growth and change, identify community resources that can assist patients in recovery, develop an understanding of the process of recovery and prompt people using substances to take action on their own behalf.

Beneficiary Protections

Informing Materials

Service providers must inform members at initial contact of their right to request beneficiary in forming material and remind on an annual basis thereafter and upon request. Medi-Cal informing materials for DMC-ODS members are available here: https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/medi-cal-informing-materials.

Grievance and Appeals
Service providers shall post notices explaining grievance, appeal, and expedited appeal processes in all program sites, as well as make available forms and self-addressed envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone. The County will produce required beneficiary informing materials in English and Spanish. Contractor shall request materials from the County, as needed. Refer to 42 CFR 438.10(g)(2)(xi) for additional information about the grievance and appeal system. Grievance and Appeals materials are available here: https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/medi-cal-informing-materials

Notice of Adverse Benefits Determination (NOABD)
Service providers must follow NOABD requirements when taking any of the following actions:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;
5. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
6. The denial of a beneficiary's request to dispute financial liability.

Service providers must send a written NOABD for any of the above actions that: is timely, adequate, on an approved NOABD template, and includes required attachments. Templates are available in SmartCare and online: https://sonomacounty.ca.gov/health-and-human-services/health-services/divisions/behavioral-health/contractor-resources/medi-cal-informing-materials. Details are specified in DHCS MHSUDS IN: 18-010E.

Overview of Regulations

Service providers in Sonoma County DMC-ODS plan are required to maintain the following as applicable:

- Drug Medi-Cal Certification

- AOD License (NTP, Residential)
- Level of Care Designation (Residential and Residential Withdrawal Management)
- BHIN 23-001: DMC-ODS Requirements for 2022-2026

The majority of regulatory requirements for delivering services within the Sonoma County DMC-ODS plan include:

- CCR Title 9
- CCR Title 22
- BHIN 23-001
- BHIN 23-068
- 42 CFR Part 438 (Managed Care Regulations)

State and County Contracts:

- DMC-ODS Intergovernmental Agreement: requirements for County and sub-contractors
- Substance Abuse Prevention and Treatment Block Grant (SABG): requirements for County and sub-contractors

Required Standards and Guidelines:

- AOD Certification Standards: https://www.dhcs.ca.gov/provgovpart/Documents/DHCS-AOD-Certification-Standards.pdf. (For All AOD certified programs)
- Minimum Quality Drug Treatment Standards for SABG: https://www.dhcs.ca.gov/provgovpart/Documents/Substance%20Use%20Disorder-PPFD/SUD%20PPFD%20Contracts/Document_2Fb_Minimum_Quality_Drug_Treatment_Standards_for_SABG.pdf. (For all SUD treatment programs partially or fully funded by SABG)
- Perinatal Practice Guidelines: https://www.dhcs.ca.gov/Documents/CSD_KS/CSD%20Perinatal%20Services/Perinatal-Practice-Guidelines.pdf (DMC and SABG as specified in guidelines)
- Adolescent Best Practices Guide: https://www.dhcs.ca.gov/Documents/CSD_CMHCS/Adol%20Best%20Practices%20Guide/AdolBestPracGuideOCTOBER2020.pdf (ages 12 through 17)

Practice Guidelines Change Log

Draft Version 1.0 Completed on 12-06-23. Changes log will include date of changes made, participants involved in change discussion, and corresponding authority driving change (Example: BHIN XX-XXX, AODS Certification Standards 1.0, etc.)