A. THE COUNTY OF SAN DIEGO DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

In 2015, the California Department of Health Care Services (DHCS) received approval from the Center for Medicare & Medicaid Services (CMS) for an 1115 waiver amendment which is referred to as the Drug Medi-Cal Organized Delivery System (DMC-ODS). This allowed for improvements to provision of substance use disorder services by providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services. Additionally, it enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidence-based practices in substance use disorder treatment, and coordinates with other systems of care. This approach provides Drug Medi-Cal members with access to the care and system interaction needed in order to achieve sustainable recovery.

After a process of planning and collaboration with community partners and recipients of SUD services, the County of San Diego submitted their DMC-ODS Implementation Plan to DHCS in 2017. The plan was approved, and implementation began in 2018.

The DMC-ODS expands the standard Drug Medi-Cal (DMC) substance use disorder service benefits package in the following ways.

Covered DMC-ODS Services

- DMC-ODS services are provided by Drug Medi-Cal (DMC)-certified providers and are based on medical necessity.
- DMC-ODS services must be recommended by Licensed Practitioners of the Healing Arts (LPHAs), within the scope of their practice.
- DMC-ODS services include the following comprehensive continuum of outpatient, residential, and inpatient evidence-based SUD services.
    - Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5)
    - Outpatient Treatment Services (ASAM Level 1)
    - Intensive Outpatient Treatment Services (ASAM Level 2.1)
    - Partial Hospitalization Services (ASAM Level 2.5)
    - Residential Treatment and Inpatient Services (ASAM Levels 3.1 – 4.0)
    - Narcotic Treatment Program
    - Withdrawal Management Services (ASAM Levels 1-WM, 2-WM, 3.2-WM, 3.7-WM, and 4-WM)
    - Medication for Addiction Treatment (also known as Medication Assisted Treatment – MAT)
    - Peer Support Specialist Services (effective July 2022)
    - Recovery Services
    - Care Coordination
    - Clinician Consultation (not a direct service to the member)

DHCS remains responsible for administering SUD treatment in California, and the County of San Diego Behavioral Health Services (COSDBHS) contracts with DHCS to fund local SUD services. As a part of the contract with DHCS, COSDBHS ensures that state SUD treatment requirements and standards are met by maintaining fiscal management systems, monitoring provider billing, conducting compliance visits, processing claims for reimbursement, and offering training and technical assistance to SUD treatment providers.

Note: To provide DMC-ODS program requirements pursuant to the California Advancing & Innovating Medi-Cal (Medi-Cal Transformation), effective January 2022 through December 2026, which replaces the Section 1115 Standard Terms and Conditions used to describe the DMC-ODS program for the years 2015-2021. In accordance with W&I § 14184.102(d), until DMC-ODS counties shall adhere to the terms in the Behavioral Health Information Notice, BHIN-24-001 or subsequent revisions, where current contracts are silent or in conflict with the terms of BHIN 24-001 or subsequent revisions. The SUDPOH has been updated to reflect policy improvements under Medi-Cal Transformation. Any county, or consortium of counties in a regional model, or Tribal or Indian managed care entity that elects to opt-in to the DMC-ODS that does not already an approved implementation plan by the Department of Health Care Services (DHCS) shall refer to BHIN 24-001 or subsequent revisions for information on requirements for the implementation plan.

Mission of the County of San Diego Drug Medi-Cal Organized Delivery System Service Programs

The County of San Diego Behavioral Health Services (COSDBHS) Division provides a continuum of Behavioral Health Services (mental health and substance use disorder services) for children, youth, families, adults, and older adults. The Division embraces *Live Well San Diego:* The County's over-arching vision to promote healthy, safe and thriving communities throughout the County of San Diego. It promotes recovery and well-being through prevention, treatment, and intervention, as well as integrated services for clients experiencing co-occurring mental illness and substance use disorders. The Behavioral Health Services Division provides services under two systems of care: Adult/Older Adult Services and Children, Youth, and Family Services.

Substance use disorders are a major public health and safety problem impacting adults with diverse treatment needs, children, youth, families, and communities. Substance Use Disorder (SUD) programs provide an integrated system of community-based substance use prevention, intervention, treatment, and recovery services throughout San Diego County via contracts with local service providers. SUD program contractors should be relational and strength-based, trauma-informed, culturally competent and involve healing of the family unit in a safe and sober environment. It is the mission of the County of San Diego Behavioral Health Services to deliver these services at the highest level of quality, ensuring that clients are given the necessary tools and support to become productive citizens. Services are delivered under contracts managed by a BHS Contracting Officer's Representative (COR).

The Drug Medi-Cal Organized Delivery System Substance Use Disorder Provider Operations Handbook (DMC-ODS SUDPOH) is specifically designed to be used by all administrative and direct service staff to ensure understanding of core values and principles for the SUD system of care and adherence to the clinical and business expectations meant to ensure delivery of quality and outcome-based services.

The DMC-ODS SUDPOH, along with other federal, state and local regulations, governs delivery of SUD treatment services in the County of San Diego. A partial list is as follows (see the Resources section for a more comprehensive listing):

- 42 Code of Federal Regulations (C.F.R.) Part 2 Confidentiality of Substance Use Disorder Patient Records;
- Health Insurance Portability and Accountability Act (HIPAA);
- California Code of Regulations (CCR) Title 9 Counselor Certification the California Code of Regulations;
- CCR Title 22 Drug Medi-Cal;
- Drug Medi-Cal Organized Delivery System Special Terms and Conditions; (note, in the event of conflicts between Title 22 Drug Medi-Cal provisions and the DMC-ODS Special Terms and Conditions, the provisions of Title 22 shall control if they are more stringent);
- Department of Health Care Perinatal Practice Guidelines and Adolescent SUD Best Practice Guide
- County of San Diego DMC-ODS Implementation Plan and Finance and Rates Plan;
- The DHCS & County of San Diego Intergovernmental Agreement (IA);
- State Department of Health Care Services (DHCS) Letmediters and Information Notices
- State mandated Performance Improvement Projects (PIP) – the State has mandated that each county undertake one administrative and one clinical improvement plan yearly.
- The Contract Template and Statement of Work for each Program including but not limited to the Specific Services to be provided.

Additionally, The Federal Managed Care Regulations, specifically part 438 of title 42 Code of Federal Regulations applies to the provision of Medicaid Managed Care (MMC) programs and managed care organizations (MCOs), Pre-Paid Inpatient Health Plans (PIHPs), and Pre-Paid Ambulatory Health Plans (PAHPs). Counties opting-in to the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver are considered PIHPs. Key goals of the final rule are:

- To support State efforts to advance delivery system reform and improve the quality of care
- To strengthen the member experience of care and key member protections
- To strengthen program integrity by improving accountability and transparency
- To align key Medicaid and CHIP managed care requirements with other health coverage programs

All providers shall adhere to the rules and regulations as stipulated in the Medicaid and CHIP Managed Care Final Rules.

System of Care Principles

Substance Use Disorders as a Chronic Disease

Substance use disorders (SUD) are often chronic, relapsing conditions of the brain that cause compulsive drug seeking and use, despite harmful consequences. They are considered a brain disease because substances change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors. (National Institute on Drug Abuse).

A chronic disease is one that cannot be easily or simply cured, but instead must be treated, managed, and monitored over time. Like heart disease, diabetes and asthma, SUD exhibits a chronic course that requires treatment and management over a longer period, and at times over the course of a lifetime. While some individuals may develop a SUD and achieve recovery after minimal intervention and over a brief period of time, the majority of individuals will exhibit a more chronic and relapsing course.

With this in mind, the County of San Diego has chosen to participate in the Drug Medi-Cal Organized Delivery System (DMC-ODS) continuum of service model of SUD treatment. This perspective values the individualized needs of the person with a SUD, and tailors services to meet these unique needs. SUD services from this perspective are not "one size fits all," but based on an individual's needs at a specific point in time. As an individual advances along their recovery journey, the type and intensity of treatment services they receive should change and reflect the severity and nature of the client's SUD. This approach emphasizes care coordination and ensuring a full continuum of care that offers varying levels of care to best tailor service delivery to client need. As a result, a key goal of SUD treatment is to provide the right service, at the right time, for the right duration, in the right setting.

Harm Reduction

Despite longstanding commitments and efforts by leaders from across sectors including substance use disorder (SUD) treatment providers within San Diego County, high-risk behaviors and harms related to substance use remain at an all-time high. Overdose deaths in the region jumped from 616 in 2019 to 941 deaths in 2020, including a three-fold increase in fentanyl deaths. Overdose deaths are only one indicator of the impact of substance use in our region, as the harms of substance use extend to families, neighborhoods, the healthcare system, and to other intersecting systems.

To make a significant impact on this trend, a broader approach focusing specifically on reducing harms and high-risk behaviors is being integrated across health and social services—one that is cohesive and on a continuum with existing SUD services. Over thirty years of evidence around the world has shown that harm reduction approaches reduce the spread of the Hepatitis C virus (HCV) and the human immunodeficiency virus (HIV), lead to greater engagement with treatment, lead to reductions in crime, and reduce overdose deaths, among other positive outcomes, with no increase in usage rate of substances.

A Comprehensive Harm Reduction Strategy is being implemented to guide the County of San Diego, in collaboration with partners and stakeholders, in addressing the most pressing issues at the intersection of behavioral and public health. This strategy will initiate and effect data-driven decision-making and evidence-based solutions to improve outcomes for both the people who use drugs (PWUD) population—a high-need population—and the broader San Diego community.

The guiding principles of the harm reduction approach in San Diego County are as follows:

Human Rights and Dignity

Substance Use and Harm Reduction approaches in San Diego County respect all human beings, meeting them "where they're at" without judgment and aim to reduce the stigma of people who use drugs (PWUD).

Diversity and Social Inclusivity

The County of San Diego strives to respect all PWUD, as well as their families and communities, regardless of gender, race, age, sexual orientation, ethnicity, culture, spirituality, health, or socioeconomic status.

Health and Well-Being Promotion
The County of San Diego aligns with the *Live Well San Diego* vision of healthy, safe, and thriving communities. Harm reduction efforts are oriented toward improving the health, safety, and capacity to thrive for all PWUD.

Partnerships & Collaborations
Harm reduction approaches are informed by and carried out through partnerships and collaborations across all sectors in the community. Partnerships are built upon the foundation of shared goals and trust in the interest of serving our community.

Participation ("Nothing about us without us")
The County of San Diego recognizes the right of PWUD to be involved in the efforts to reduce the debilitating impact of drug use in their communities.

Accountability and Improvement
The County of San Diego is committed to continuous improvement in the quality of its harm reduction efforts and intends to use data, community feedback, and input to continually assess current and future individual and community needs.

Accessing Service: "No Wrong Door"
Consistent with the Health and Human Services Agency's "No Wrong Door" philosophy, clients may access SUD services through multiple points of entry. Clients who are residents of San Diego County may call the Access and Crisis Line (ACL), call or walk into a program directly, or be referred to a program by community partners.

Client-Centered Care
The County of San Diego Behavioral Health Services (COSDBHS) embraces a philosophy of client-centered care. In order to engage and retain a client in treatment, providers must work collaboratively with clients, respecting an individual's preferences, needs, well-being and values. Client-centered care is not the same thing as "always doing what the client wants," as there will be times when clinical judgment does not align with a client's desires but is deemed in the best interest of the client; however, client preferences and values need to be considered as part of that decision-making process.

Customer Service
The County of San Diego Behavioral Health Services (COSDBHS) recognizes that its greatest strength lies in the talent of its providers and expects them to always treat clients, families and other consumers with respect, dignity and courtesy. Clients/families shall be treated equally regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, as well as source of payment or any other non-treatment or non-service-related characteristic.

Clients and families deserve high-quality customer service, which includes:

- Treating customers with courtesy, respect, professionalism and a positive attitude
- Responding to customers in a timely manner whether in person, by phone, in writing or via e-mail
- Being aware of cultural diversity and focusing on understanding customer differences
- Providing complete, accurate and reliable information and feedback

SUD providers are expected to ensure that they have a customer-first attitude which is instilled throughout their operations. Systems should be in place to enable customers to voice any grievances or problems, and if needed, to do so anonymously. Review Section I: Quality Assurance for SUD program requirements regarding reporting grievances.

The following are the basic expectation that COSDBHS has for all County and contracted programs:

1. Establish Customer Service Standards. For example, the County of San Diego Customer Experience Initiative has set a standard of using a positive approach to provide customers with a positive experience. This commitment is summarized in the acronym HEART:
    - **H**elpfulness: going out of our way to find answers
    - **E**xpertise: being knowledgeable
    - **A**ttentiveness: being ready to meet customer needs
    - **R**espect: Treating customers with dignity and courtesy
    - **T**imeliness: being efficient with customer time
2. Ensure that all staff members are aware of these standards and are clear that adhering to Customer Service Standards is an expectation of the program.
3. Ensure clients and families that no form of retaliation will come from any grievances or suggestions for improvement made to the program.
4. Enhance program services based on input received from customers to demonstrate receiving and accepting feedback from customers.
5. Make Customer Service Standards training available to all staff.

Ensuring a Standard Quality of Service

The DMC-ODS is a core component of the larger healthcare system and, as such, needs to maintain minimum standards and expectations to ensure high quality services for the clients it serves. Similar to the management of other chronic conditions, these minimum standards for SUD ensure a reasonable degree of consistency across service providers, while also allowing sufficient flexibility to provide services that are tailored to the individual needs of clients. For example, an individual with diabetes may receive slightly different services depending on the provider (e.g., one doctor may suggest a different medication or dietary/lifestyle change than another), but the treatment and management approach should be guided by certain best practice and clinical standards.

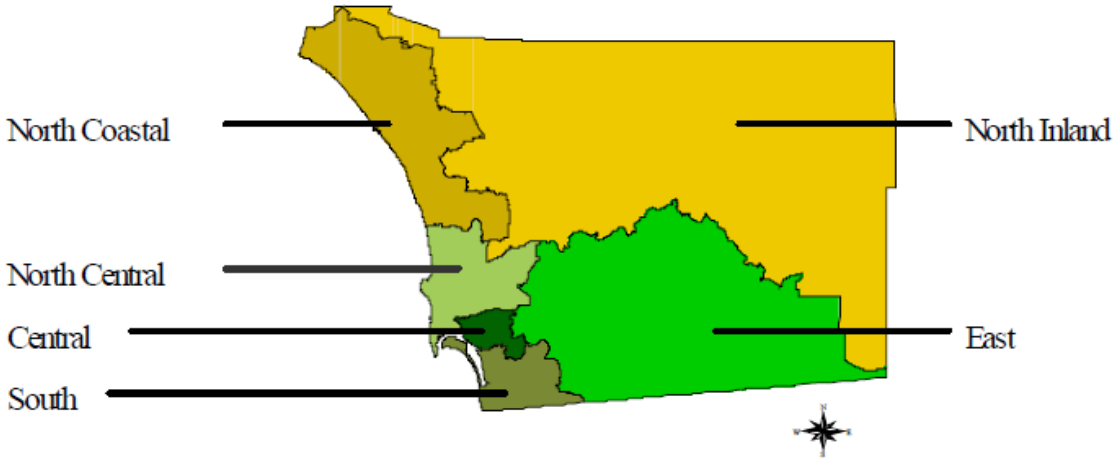
Similarly, SUD services need to be guided by best practice and clinical standards, which include the use of evidence-based practices (EBPs). Motivational Interviewing (MI) and Relapse Prevention are required EBPs in the County of San Diego DMC-ODS.

It is important to note that standards-based care and individualized care are not mutually exclusive. Service providers can offer individualized and client-centered care that also meets certain minimum best practices and clinical standards.

This provider manual describes a framework of standards that involve client services, clinical and business processes, and pertains to all providers within the County of San Diego Drug Medi-Cal Organized Delivery System. In outlining these minimum expectations, this provider manual establishes an infrastructure of qualify for SUD treatment throughout San Diego County.

County of San Diego Drug Medi-Cal Organized Delivery System Regions

The County of San Diego is divided into six Health and Human Services Agency regions by zip code. The following list presents the regions and the communities contained therein.



Service Area	Zip Codes
North Coastal	92007, 92008, 92009, 92010, 92011, 92014, 92024, 92054, 92055, 92056, 92057, 92058, 92067, 92075, 92081, 92083, 92084, 92091, 92672
North Inland	92003, 92004, 92025, 92026, 92027, 92028, 92029, 92036, 92059, 92060, 92061, 92064, 92065, 92066, 92069, 92070, 92082, 92086, 92096, 92127, 92128, 92129, 92259, 92536
North Central	92037, 92093, 92106, 92107, 92108, 92109, 92110, 92111, 92117, 92119, 92120, 92121, 92122, 92123, 92124, 92126, 92130, 92131, 92140, 92145, 92161
Central	92101, 92102, 92103, 92104, 92105, 92113, 92114, 92115, 92116, 92134, 92136, 92139, 92182
East	91901, 91905, 91906, 91916, 91917, 91931, 91934, 91935, 91941, 91942, 91945, 91948, 91962, 91963, 91977, 91978, 91980, 92019, 92020, 92021, 92040, 92071
South	91902, 91910, 91911, 91913, 91914, 91915, 91932, 91950, 92118, 92135, 92154, 92155, 92173

General Practice Guidelines
The County of San Diego Behavioral Health Services (COSDBHS) recognizes that clinical care needs to be an individualized process that balances client needs, established clinical standards, and available resources. Each clinical case is unique and there are many variables that impact care; however, care guidelines can be helpful to outline generally accepted clinical standards.

The guidelines outlined below are not intended to be a comprehensive overview of all aspects of clinically appropriate substance use care. It is strongly recommended that one refer to more detailed clinical guidelines provided through SAMHSA and other respected resources for additional information. (SAMHSA publications can be found here).

Medical Necessity and Assessment
Medical necessity refers to the applicable evidence-based standards applied to justify the level of services provided to a client, so the services can be deemed reasonable, necessary and/or appropriate. It refers to those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury consistent with 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

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

There are various types of assessments focusing on medical necessity and clinical care, including level of care determinations. Assessments, and the corresponding documentation, serve as the foundation of high-quality care. Assessment is also an important aspect of client engagement and treatment planning and is generally performed in the initial phases of treatment, though not necessarily during the initial visit.

In the treatment of persons with SUD, ongoing assessment is an expected process and is essential in order to identify client needs and help the provider focus their services to best meet those needs.

In certain situations, brief and focused assessments may be more appropriate than more extensive assessments. However, the comprehensive treatment of addictions requires a comprehensive assessment to be conducted in the initial phases of treatment. An important competency of counselors/clinicians is to discern when a brief assessment versus a comprehensive assessment is needed. Additionally, collaborative and coordinated care is a key characteristic of quality care and is based on the ability to perform appropriately comprehensive assessments in order to determine the most suitable referral or linkage.

Staff and professionals who possess the appropriate training perform assessments within their scope of practice. Comprehensive clinical assessments are performed by appropriately trained Licensed Practitioners of the Healing Arts (LPHAs) and SUD counselors.

Clinical assessments are based on the ASAM Criteria, which includes multidimensional assessments comprised of six dimensions:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications

3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery/living environment

The multidimensional ASAM assessment provides a common language to describe holistic, biopsychosocial assessment and treatment across addiction, physical health, and mental health services. At a minimum, comprehensive assessments include the following elements:

- History of the present episode
- Substance use and addictive behavior history
- Developmental history (as appropriate)
- Family history
- Medical history
- Psychiatric history
- Social history
- Spiritual history
- Physical and mental status examinations, as needed
- Comprehensive assessment of the diagnose(s) and pertinent details of the case
- Survey of assets, vulnerabilities, and supports
- Client strengths
- Treatment recommendations

Assessments based on the ASAM Criteria ensure that necessary clinical information is obtained in order to make appropriate level of care determinations. Assessments must be appropriately documented (see the Documentation section for specifics), reviewed, and updated on a regular basis, including at every care transition, in order to promote engagement and meet the client's needs and preferences. If during the course of assessment, the client and provider(s) determine that adequate progress toward treatment goals has been made, plans to build upon these achievements must be made, which may include transitions to other services and recovery-focused strategies. Similarly, reassessments of the diagnosis, treatment modalities/intensity/goals must be performed if progress toward agreed upon goals is not being made within a reasonable time. See Appendix A.1 for ASAM Criteria Dimensions at a Glance.

For more information about medical necessity or assessments, see Section D: Practice Guidelines for Medical Necessity.

Drug Testing

Drug testing is often a useful tool to monitor engagement and provide an objective measure of treatment efficacy and progress to inform treatment decisions. In general, the frequency of drug testing should be based on the client's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued drug use has been identified to be more common.

A punitive approach to drug testing does not facilitate a productive and therapeutic relationship with clients and should be avoided. Consequences to drug testing should be communicated in a therapeutic manner and the communication of these consequences does not need to adversely affect the therapeutic alliance. Decisions about appropriate responses to positive drug tests and relapses should consider the chronic nature of addiction, recognize that relapse is a manifestation of the condition for which people are seeking SUD treatment, and recognize instances in which medications or other factors may lead to false or appropriately positive drug test results.

Additional practice guidelines regarding drug testing can be found here.

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

In San Diego County, although other psychosocial approaches may be used, SUD providers are at a minimum expected to implement the two evidence-based psychosocial interventions of Motivational Interviewing (MI) and Relapse Prevention. Below are brief descriptions of these and other evidence-based psychosocial interventions:

- **Motivational Interviewing (MI) -** A client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment by paying particular attention to the language of change. This approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes. According to the Motivational Interviewing Network of Trainers, MI "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."

- **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 clients 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."

In addition to these two required EBPs, programs may choose to also include EBPs such as:

- **Cognitive-Behavioral Therapy (CBT) -** According to the National Institute of Drug Abuse's Principles of Drug Addiction Treatment: A Research-Based Guide, "Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance use, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors 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 with it. A central element of CBT is anticipating likely problems and enhancing clients' self-control by helping them develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use and developing strategies for coping with cravings and avoiding those high-risk situations." 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.

- **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." Seeking Safety is an example of an evidence-based trauma-informed practice.

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

- Harm Reduction - Harm reduction is a set of strategies aimed at reducing negative consequences associated with drug use and incorporates a spectrum of tactics to meet people who use drugs "where they are" and address conditions of use along with the use itself (National Coalition for Harm Reduction). Reflective of these principles, harms related to substance use are concerns of overall health and well-being, and stigma should not be allowed to impede access to services. Harm reduction strives to respect all people who use drugs, as well as their families and communities. It is built on a multidisciplinary evidence base and over a decade of foundational work of local and regional stakeholders.

Elements of these practices may be used in any type of service setting and must be performed by trained providers within their scope of practice. Of note, the descriptions of the evidence-based psychosocial interventions above are simply summaries and providers are encouraged to refer to other available resources and manuals for more detailed guidance as to the effective clinical application of these approaches. Implementation of Motivational Interviewing and Relapse Prevention is a contract requirement and is monitored through the contract compliance monitoring process.

Medication-Assisted Treatments (MAT)

The County of San Diego's dedication to harm reduction principles includes a commitment to accessible Medication Assisted Treatment (MAT) within the system of care as a best practice in the treatment of SUD. Research has shown that for the treatment of addiction, a combination of medications and behavioral therapies is more successful than either intervention alone. Subsequently, medication-assisted treatments (MAT) must be part of a comprehensive, whole-person approach to the treatment of SUD that includes psychosocial interventions like counseling, behavioral therapies, case management, and care coordination. The use of FDA approved addiction medications as part of this comprehensive, whole-person approach to

the treatment of SUD shall not be discouraged in any way. Similarly, clients shall not be denied services based solely on the fact that they are taking prescribed medication, regardless of the type of medication.

For those programs providing MAT services, required elements of service include obtaining informed consent, ordering, prescribing, administering, and monitoring of all medications for SUD. Given the biopsychosocial nature of addiction, all available clinically indicated psychosocial and pharmacological therapies must be discussed and offered as a concurrent treatment option for appropriate individuals with an alcohol and/or opioid related SUD condition at all levels of care. When MAT is part of the treatment plan, licensed prescribers operating within their scope of practice should assist the client to collaborate in clinical decision-making, ensuring that the client is aware of all appropriate therapeutic alternatives. Informed consent for all pharmacotherapies must be obtained, including discussion about the advantages and disadvantages of MAT, taking into consideration the benefits, side effects, alternatives, cost, availability, and potential for diversion, among other factors.

All medications and biological products utilized to treat SUDs, including long- acting injectables, continue to be available through the medical pharmacy benefit without prior authorization, and can be delivered to provider offices by pharmacies.

Members needing or utilizing 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 a program. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a member who declines counseling services.

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

For more information, see MAT in Section B: Providing DMC-ODS Services.

Clinician Consultation

Clinician Consultation replaces and expands the previous "Physician Consultation" service referred to during the years 2015-2021. Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. Clinician consultation includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific members. Consists of DMC-ODS LPHAs consulting with other LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care. Clinical consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems. Clinician consultation is *not* a direct service provided to a member.

For more information, see Clinical Consultation in Section B: Providing DMC-ODS Services.

Recovery Services

Recovery Services are aftercare support services designed to help individuals become and stay engaged in the recovery process and reduce the likelihood of relapse. Recovery Services emphasize the client's central role in managing their heath and recovery and promotes the use of effective self-management and coping

strategies, as well as internal and community resources to support ongoing self-management. For more information, see Recovery Services in Section B: Providing DMC-ODS Services.

Culturally Appropriate Services
Culturally competent care is critical in providing high quality SUD services. Research indicates that lack of cultural competency in the design and delivery of services can result in poor outcomes in areas such as access, engagement, receptivity to treatment, help-seeking behaviors, treatment goals, and family response.

Core practices that address cultural competency include:

- Attitudes, beliefs, values, and skills at the provider level.
- Policies and procedures that clearly state and outline the requirements for the quality and consistency of care.
- Readiness and availability of administrative structures and procedures to support such commitments.
- Practices that demonstrate respect for cultural differences in attitudes toward substance use, help-seeking, engagement of family (including diverse definitions of family) and significant others in the treatment process, and use of traditional healing approaches to recovery.

Providers are required to adhere to CLAS standards and are responsible for providing services that are developmentally, culturally, and linguistically appropriate, and must ensure that their policies, procedures, and practices are consistent with this requirement. Providers must also ensure that these principles are embedded in the organizational structure of their agency, as well as being upheld in day-to-day operations.

The COSD will promote cultural competency by coordinating trainings designed to educate providers and administrators about various aspects of cultural sensitivity, with the goal of better engaging clients of diverse backgrounds and needs.

For more information see Section H: Cultural Competence.

Care Coordination
Care coordination are collaborative and coordinated approaches to the delivery of health and social services, linking clients with appropriate services to address specific needs and achieve treatment goals. Care coordination are intended to complement and integrate with existing systems and community resources while avoiding duplication or replacement of existing services and supports. Care coordination services are available to all clients who enter the County's DMC-ODS treatment system, are available throughout the treatment episode, and may be continued during recovery services as allowed by COSD.

Care coordination is meant to provide seamless transitions of care for clients within the DMC-ODS, to ensure that clients successfully transition between levels of SUD care (i.e., withdrawal management, residential, outpatient, etc.) without disruption to services. This includes access to recovery services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.

In the DMC-ODS, care coordination is also meant to ensure that each client has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for

coordinating the services accessed by the client. The client shall be provided information on how to contact their designated person or entity.

The primary role of the staff providing care coordination services is to coordinate client services:

- Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.
- With the services the member receives from any other managed care organization.
- With the services the member receives in FFS Medicaid.
- With the services the member receives from community and social support providers.

Care coordination with other client-serving entities requires recognition and communication regarding potential differences in goals and expectations for client outcomes, particularly for clients who may have continued substance use while enrolled in treatment or recovery services. Staff providing care coordination services shall be knowledgeable regarding harm reduction principles and shall explain the use of a harm reduction approach to entities, such as Courts and Child Welfare Services, with whom the client is involved to ensure a clear understanding of the use of MAT as well as how client relapse, positive drug screens, or other behaviors associated with the client's SUD and/or co-occurring mental health conditions will be handled by the program.

Successful care coordination requires documentation to be maintained and shared, as appropriate. The County DMC-ODS has created the SUDURM which details the requirements for maintaining a client health record in accordance with DMC-ODS and other professional standards. Written records, and the sharing of written and other types of communications, must be done in a way that maintains client confidentiality and privacy; thus, programs are to ensure that in the process of coordinating care, each client's privacy is protected in accordance with the 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.

Finally, as part of care coordination, programs shall share with DHCS or other managed care organizations serving the client the results of any identification and assessment of that member's needs to prevent duplication of those activities.

Care Coordination for Populations with Special Needs

More intensive care coordination activities will be required for populations with special needs. These populations may include clients with HIV/AIDS; clients with mental illness; homeless; pregnant and parenting women; adolescents, and justice involved. Each population will require care coordination activities to help an individual effectively navigate, access, and participate in an appropriate level of care for SUD services; access health and mental health services; secure housing; and obtain other supportive services.

For more information about care coordination see Section B: Providing DMC-ODS Services and Section D: Practice Guidelines.

Field-Based Services

Care coordination activities may be appropriate for clients served in field-based settings that may include, but are not limited to homeless encampments, runaway shelters, interim housing, permanent supportive housing, probation camps or other facilities. When services are provided in the field, providers must ensure

confidentiality and document where in the community services were provided (as well as how confidentiality was maintained). See Section D: Service Delivery for more details on documentation.

Housing Referrals
Housing and an individual's living environment are oftentimes a critical component to the ability to achieve and maintain recovery from SUD. Before being admitted to treatment, all SUD clients must be assessed on all six (6) ASAM dimensions of care, including ASAM Dimension 6 – Recovery/Living Environment. This intake assessment should reveal potential concerns regarding housing and living situations that may warrant further follow-up.

Special Populations

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

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

- Binge and Underage Drinking initiative (1996)
- Methamphetamine Strike Force (1996)
- Marijuana Initiative (2005)
- Prescription Drug Abuse Task Force (2008)
- San Diego County Substance Use and Overdose Prevention Task Force (2022)

For more information on see Primary Prevention in Section C: Prevention Services and Specialty Programs.

Adult Services
Clients who are age 18 or older with substance use and/or co-occurring disorders receive services through Adult SUD programs. These services include:

- Outpatient and Residential Treatment
- Withdrawal Management
- Case Management
- Justice Programs
- Ancillary services (i.e., TB testing)
- Narcotic Treatment Programs (NTP)

Gender Responsive Treatment

Contractor's systems and services shall recognize the importance of the histories, life circumstances, and behaviors of women and men with substance use disorders and take these into account when providing SUD treatment with the goal of producing the best possible treatment outcomes. Contractor shall ensure that the program addresses gender-specific issues in determining individual treatment needs and therapeutic approaches.

As outlined in the SAMHSA TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, core principles for gender responsive treatment include:

- Acknowledging the importance as well as the role of the socioeconomic issues and differences among women.
- Promoting cultural competence specific to women.
- Recognizing the role as well as the significance of relationships in women's lives.
- Addressing women's unique health concerns.
- Endorsing a developmental perspective.
- Attending to the relevance and influence of various caregiver roles that women often assume throughout the course of their lives.
- Recognizing that ascribed roles and gender expectations across cultures affect societal attitudes toward women who abuse substances.
- Adopting a trauma-informed perspective.
- Using a strengths-based model for women's treatment.
- Incorporating an integrated and multidisciplinary approach to women's treatment.
- Maintaining a gender responsive treatment environment across settings.
- Supporting the development of gender competency specific to women's issues.

Additionally, in SAMHSA TIP 56: Addressing the Specific Behavioral Health Needs of Men, particular factors impacting men are addressed, such as barriers to engagement and ways to engage men in SUD treatment.

Deaf and Hard of Hearing (DHH) Clients

For persons who are deaf or hard of hearing, the principles of addiction are the same as they are for hearing people, yet these individuals are currently unable to fully access the resources available to hearing individuals. DHH individuals are at a severe disadvantage in receiving and realizing long-term benefits from treatment for substance use, since treatment efforts are typically not focused on culturally specific information. During treatment, the majority of the therapeutic benefit comes from being involved with the counselor on a 1:1 basis, with peers in group and the interactions that occur during non-structured periods of the day. Without the availability of communication during program hours, a deaf person does not benefit from substance use treatment in the same way and to the same extent as their hearing peers. Ideally, individuals who successfully complete an alcohol/drug treatment program should be able to return to the environment that they lived in prior to entering a treatment program. However, that environment must include a sober living option, family/friend support, professionals trained to work with clients on aftercare issues and accessible support group meetings. This kind of environment is unavailable for the majority of deaf and hard of hearing individuals. Currently, there are only a handful drug and alcohol recovery programs for DHH people in the United States and less who have a full continuum of treatment and recovery options such as residential treatment and sober living homes.

While the County of San Diego explores treatment options for this special population, the following practice guidelines are recommended:

- Client records should reflect the client's hearing status, use of personal hearing assistive technology, preferred method of communication (including language and hearing assistive technology needs), preferred language for care and for written materials, presence of interpreters/communication service providers during any service delivery, preferred method(s) of contact, and communication method used to secure informed consent;
- Intake and assessment should include gathering information about cultural identification and hearing acuity, age of onset of hearing loss, etiological components, and language proficiencies;
- Treatment plans for each DHH client shall include services necessary to meet the client's needs, including interpreters, technology support, other services to ensure full linguistic access, and culturally accessible services;
- For clients whose preferred communication method is sign language, access to sign-fluent staff and/or an interpreter shall be utilized for all services.

Children, Youth, and Family Services
These services focus on a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

- *Relapse Prevention.* Relapse Prevention education and activities shall be available to help the client maintain sobriety over time. Example activities include:
    - Use relapse prevention workbooks and journals
    - Develop skills to reinforce sobriety and relapse prevention
    - Organize physical activities (individuals or teams) on site or off-site
    - Conduct meditation and relaxation activities
    - Cooking classes, food preparation, and nutrition education
    - Music appreciation sessions and/or learning to play a musical instrument
    - Organize outings to demonstrate drug free lifestyle changes
    - Communication building sessions/activities
    - Parent training on relapse prevention
    - Youth Leadership Group development/activities

For more information see Programs Serving Children, Youth & Families in Section C: Prevention Services & Specialty Populations.

Adolescent Services
As documented in the DHCS Adolescent Best Practice Guide, substance use and dependence among youth is a complex problem, resulting from multiple factors including biological predisposition, psychological factors, adolescent development, and social factors. Adolescents have added social factors such as bullying, peer pressure, and low self- esteem that have led to gang activity, sexual exploitation, and depression on

top of their substance use. Therefore, the biopsychosocial approach will aid in understanding and treating these disorders.

In San Diego County, the primary substance for adolescents upon admission into substance use disorder programs is marijuana. With recent legalization of marijuana for adults, this will further add to the appeal of marijuana use.

For more information see Adolescent Services in Section C: Prevention Services & Specialty Populations.

Perinatal Services for Women and Girls

Perinatal services (from age 15+) are gender-specific, trauma informed SUD treatment and recovery services provided to pregnant and new mothers and their dependent minor children, from birth through 17 years of age. Childcare service is provided for participants while on-site receiving services. Issues specific to perinatal clients include substance use while pregnant, pre-natal care, parenting, and family violence. All Perinatal Programs, regardless of funding source, are required to comply with the Perinatal Practice Guidelines

For more information see Perinatal Services for Women & Girls in Section C: Prevention Services & Specialty Populations.

Clients Involved with the Justice System

The justice system includes accused or adjudicated clients who require various SUD services. Parole and probation status is not a barrier to SUD treatment services provided that the parolees and probationers meet the DMC eligibility verification and medical necessity criteria. For many people in need of alcohol and drug treatment, contact with the justice system is their first opportunity for treatment. Services can be provided through courts, probation or parole agencies, community-based or institutional settings, or in sex offender programs. In each of these situations, the individual is accountable to comply with a criminal justice sanction. Legal incentives to enter SUD treatment at times motivate individuals to pursue recovery, whereas for other offenders, arrest and incarceration are part of a recurring cycle of drug abuse and crime.

Ingrained patterns of maladaptive coping skills, criminal values and beliefs, and a lack of job skills may require a more intensive treatment approach for the justice population, particularly among offenders with a prolonged history of substance use and crime. However, strong empirical evidence over the past several decades has consistently shown that the justice population can be effectively treated, and that SUD treatment can reduce crime.

Best practice is that staff working with justice populations receive specific training in working with criminogenic risk, need, and responsivity (RNR), as well as SUD and CODs. Staff also must be capable of integrating identified treatment goals with the goals of the involved agencies. As a result, it is critical for treatment providers to have a strong working relationship with probation and parole officers, judges, the court, and other legal entities involved in the client's care.

The first step in providing SUD treatment to people under justice supervision is to identify offenders in need of treatment. Comprehensive assessments incorporate issues relevant to justice involved individuals, such as assessment of criminogenic RNR, anger management, impulse control, values and behaviors, family structure and functioning, criminal lifestyle, and antisocial peer relationships. Assessments also pay particular attention to CODs, developmental and cognitive disorders, and traumatic brain injury.

In general, clinical approaches and the use of medication-assisted treatments must parallel those used with individuals who are not involved with the justice system, and a qualified counselor/clinician should determine the appropriate level of placement and interventions rather than court/probation requirements. Treatment interventions must be based on a multidimensional assessment and individualized needs. However, working with the justice population does have unique requirements that necessitate modified treatment approaches in order to meet their specific needs. Additionally, it is essential to collaborate with correctional staff to ensure that the treatment goals align with correctional and supervision case planning and/or release conditions (particularly involving the prescription of certain MAT).

Clinical strategies for working with justice clients may include interventions to address criminal thinking and provide basic problem-solving skills. Providers must be capable of using evidence-based practices designed to address SUD, mental health, and criminogenic needs. For example, motivational interviewing, cognitive behavioral therapy that focuses on both substance use and antisocial behaviors that lead to recidivism, trauma-informed care, and contingency management therapies.

Due to court mandates, classification policies and procedures, various security issues, and differences in available programming, one of the challenges of working with the justice population is determining when the ASAM Criteria can be meaningfully applied. The ideal scenario is for the level of care setting to match the severity of illness and functional impairment, similar to the general population. However, there are instances in working with offenders that necessitate close collaboration with correctional staff to provide services that are clinically appropriate and that also align with correctional and supervision case planning and/or release conditions. When skillfully applied, the ASAM Criteria can be used to access the full continuum of care in a clinically appropriate manner for the justice population.

Similar to other groups, treatment of offenders needs to be regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue even after the legal issues for justice clients are resolved.

DMC-ODS for members in the criminal justice system

- County should recognize and educate staff and collaborate with Parole and Probation partners.
- Parole and Probation is not a barrier to DMC-ODS treatment.
- Members may receive recovery services immediately after incarceration regardless of whether they received SUD treatment during incarceration.

For more information see Justice-Involved SUD Services in Section C: Prevention Services & Specialty Populations.

Homeless Population

There is wide recognition that substance use in the homeless population cannot be treated apart from addressing the needs of the whole person in the context of his or her environment. A continuum of comprehensive services is needed to address the various safety, health, social and material needs of homeless clients. Common examples include assistance with accessing food, clothing, shelter/housing, identification papers, financial assistance and entitlements, legal aid, medical and mental health care, dental care, job training, and employment services. These services may be provided within the SUD program itself

or through linkages with existing community resources. Proactive outreach, addressing needs in a non-judgmental and non-threatening environment, and addressing the various identified needs early in treatment may help to better engage this population.

On the whole, research demonstrates that effective programs for homeless clients address their substance use as well as their tangible needs (e.g., housing, employment, food, clothing, finances); are flexible and non-demanding; target the specific needs of subpopulations, such as gender, age, or diagnoses (e.g., COD/TAY/older adult populations); and provide longer-term, continuous interventions. As a result of these diverse needs, effective treatment for homeless clients must involve various disciplines and collaboration across agencies and organizations.

Stable housing is often critical to attaining treatment goals and is an important component of necessary services. Services that link clients to secure housing early in treatment tend to produce better outcomes, emphasizing the importance of case management in order to meet the varied needs of homeless clients.

Psychosocial interventions and MAT for clients experiencing homelessness must mirror the approaches that are successfully used in other populations, with modifications to meet the unique needs of this population. Mobile outreach services are ideal, along with motivational enhancement interventions, in order to encourage continued treatment engagement. Counselors and clinicians also must be mindful of the physical and mental health needs of this population, given high rates of co-morbidity for many individuals experiencing homelessness. Medications should be used when clinically indicated, with prescribing practices that take into consideration the environment in which these medications will be used and stored (for example, care is to be taken to ensure that medications that require refrigeration are not prescribed when the client has no way to store such medications). Integrated interventions that concurrently address the multitude of medical, psychiatric, substance use, and psychosocial needs of homeless persons tend to produce improved outcomes compared to interventions that are provided sequentially or in parallel with other services.

In general, treatment for homeless clients with SUD is challenging, but successful outcomes can be achieved by prioritizing access to appropriate housing and providing comprehensive, well-integrated, client-centered services with uniquely qualified staff.

For these reasons, designated programs throughout the county will provide Homeless Outreach Worker (HOW) services to assist with outreach and engagement in the community. Potential clients will be screened and then provided short-term case management and referral services as needed.

Lesbian, Gay, Bisexual, Transgender, Questioning Population

Lesbian, gay, bisexual, transgender, questioning (LGBTQ) populations tend to experience higher rates of substance use than the general population. The stigma and discrimination of being a member of a marginalized community such as the LGBTQ community causes some individuals to cope with these additional stressors by using substances. Furthermore, research has also shown that once LGBTQ clients do meet the criteria for a diagnosable SUD, they are less likely to seek help. These findings may be due to the various barriers the LGBTQ population faces in seeking treatment, and unique needs LGBTQ clients have that may not be addressed by SUD programs.

In many ways, psychosocial and pharmacologic interventions (medication-assisted treatment) geared toward LGBTQ clients are similar to those for other groups. An integrated biopsychosocial approach

considers the various individualized needs of the client, including the societal effects on the client and his/her substance use. Unless SUD providers carefully explore each client's individual situation and experiences, they may miss important aspects of the client's life that may affect recovery (e.g., social scenes that may contribute to substance use, prior experiences being discriminated against, a history of antigay violence and hate crimes such as verbal and physical attacks, etc.).

As with any client, substance use providers must screen for physical and mental health conditions in LGBTQ persons due to the risk of co-morbid health conditions. As a result of previously discussed challenges confronted by the LGBTQ community, members of this group do have higher rates of certain mental health conditions and are also at greater risk for certain medical conditions. Comprehensive screening and assessments can assist LGBTQ clients in accessing appropriate care for their physical and mental health concerns.

The methods of best practice outlined in counseling competency literature apply to all populations, particularly in working with LGBTQ clients. From this perspective, a counselor respects the client's frame of reference; recognizes the importance of cooperation and collaboration with the client; maintains professional objectivity; recognizes the need for flexibility; is willing to adjust strategies in accordance with client characteristics; appreciates the role and power of a counselor; appreciates the appropriate use of content and process therapeutic interventions; and is non-judgmental, respectfully accepting of the client's cultural, behavioral, and value differences.

There are also some unique aspects of treating LGBTQ clients that providers must be aware of. For example, while group therapies should be as inclusive as possible and should encourage each member to discuss relevant treatment issues or concerns, some group members may have negative attitudes toward LGBTQ clients. Staff members must ensure that LGBTQ clients are treated in a therapeutic manner and group rules should make clear that homophobia is not to be tolerated. The LGBTQ client (and not the other group members) is solely responsible for deciding whether to discuss issues relating to his/her sexual orientation and/or gender identity in mixed groups. Although providing individual services decreases the likelihood that heterosexism/homophobia/transphobia will become an issue in the group setting, there is also an opportunity for powerful healing experiences in the group setting when LGBTQ clients experience acceptance and support from non- LGBTQ peers.

Elements of treatment that promote successful treatment experiences for the LGBTQ client include cultural sensitivity, an awareness of the impact of cultural victimization, and addressing issues of internalized shame and negative self-acceptance. Cognitive-behavioral therapies challenge internalized negative beliefs and promote emotional regulation, which can be helpful for relapse prevention. Motivational enhancement techniques may also encourage treatment engagement in this population.

Veterans

Although veterans share commonalities, their experiences are as varied and unique as their needs. Some veterans may have experienced combat in one or more wars, while others may have served in non-combat roles. Likewise, some veterans may have experienced injury, including traumatic brain injuries (TBI), loss of limb, or other physical injury, while others may have emotional scars. In particular, gender may also influence veteran experiences, as reports of women veterans who have experienced sexual harassment and/or physical and sexual trauma are becoming more common. As a result of the cumulative effects of these events and experiences, veterans and family members may develop SUD and present to treatment with a unique set of needs and circumstances that must be addressed.

Under certain circumstances, veterans may be ineligible for Veteran's Administration (VA) benefits due to a dishonorable discharge or discharge "under other than honorable conditions," among other circumstances. Additionally, some veterans and family members may attempt to secure services from SUD treatment programs due to the long wait times at the VA. Regardless of the situation, SUD treatment providers should work to ensure that the services provided address the varied and unique needs of individuals.

While substances of abuse vary, veterans may abuse sedating substances such as prescription drugs in efforts to address untreated/under-treated anxiety or other mental health conditions. Additionally, co-occurring physical health conditions and injury may increase rates of prescription drug and opioid abuse, including the use of heroin, and thus certain veterans may be at higher risk for fatal overdoses and may be appropriate candidates for medication-assisted treatments.

Given the higher likelihood of trauma, physical and behavioral health complications of the veteran population, SUD providers perform thorough assessments that encompass the full range of complications that may be present. For example, assessments may include questions concerning trauma, combat or war experiences, or injuries that may impact the client's participation in SUD treatment. If the client reports (or it is determined that) injuries exist that may impact treatment, the SUD treatment provider should work with other providers (e.g., medical, mental health) to coordinate care, which is often particularly critical in this population.

Veterans may also have different reasons for their substance use, such as untreated/under-treated physical injury or mental health issue. Stigma is often an additional complicating issue. Although stigma exists around substance use, within the military stigma often also exists for seeking help for any health condition. Anger or personality disorders may also be present, further making treatment engagement difficult. In these instances, effectively engaging veterans and utilizing evidence-based techniques, such as motivational interviewing, will be critical to treatment success.

In summary, treatment providers may need additional training to fully understand the nuances of the veteran population and how their experiences impact their behaviors in order to adequately treat veterans and their families.

Tribal Communities
SUD services, including outpatient treatment services, withdrawal management, and medication assisted treatment, are offered through collaboration and partnership with local tribal communities via Tribal Federally Qualified Health Centers. Services are provided in rural and urban settings with the focus on providing treatment and recovery services to American Indian/Alaskan Natives residing both on and off reservation communities. For more information, refer to the Tribal Delivery System (Attachment BB) of the Special Terms and Conditions.

For more information see Indian Health Care Providers in Section C: Prevention Services & Specialty Populations.

Medi-Cal Transformation
The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called Medi-Cal Transformation: California Advancing and Innovating Medi-Cal. Medi-Cal Transformation advances

several key priorities by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

The vision of Medi-Cal Transformation is that people should have longer, healthier and happier lives by utilizing a whole system, person centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing. This initiative will be an integrated wellness system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

Medi-Cal Transformation has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform

For more information on Medi-Cal Transformation, please visit: https://www.dhcs.ca.gov/Medi-Cal Transformation/Pages/Medi-Cal Transformation.aspx