SUD Support Newsletter

Authority & Quality Improvement Services

December 2019

SUD Support Team

Azahar Lopez, PsyD, CHC
John Crump, LMFT
Joey Pham, PhD, LMFT
Emi Tanaka, LCSW
Angela Lee, LMFT
Erica Spencer, MS, HCM
Olga Gutierrez, MHS
Marsi Hartwell, Secretary
Faith Morrison, Staff Assistant

CONTACT
aqissudsupport@ochca.com
(714) 834-8805

CalOMS Late Submission Rate	
Jan	17.7%
Feb	17.9%
Mar	9.5%
Apr	12.6%
May	9.6%
Jun	10.5%
Jul	9.2%
Aug	9.4%
Sep	11.3%
Oct	8.7%
Nov	13.3%
Dec	8.3%

WHAT'S NEW?

All SUD treatment providers that receive SUD treatment funding from DHCS are required to submit DATAR information to DHCS each month. In addition, certified Drug Medi-Cal providers and Licensed Narcotic Treatment Programs must report, whether or not they receive public funding. The system retains information on each SUD provider's capacity to provide different types of SUD treatment to clients, and how much of the capacity was utilized in a given month.

Federal regulations require that each state develop a Capacity Management Program to report alcohol and other drug programs treatment capacity, to ensure the maintenance of the reporting, and to make that information available to the programs. To meet these requirements, DHCS established a Waiting List Management Program (WLMP) that includes a unique client identifier to document applicants who are not immediately admitted to a program due to lack of capacity. The WLMP consists of two separate reports, the Wait List Record and DATAR.

Currently counties must submit their DATAR data to DHCS in accordance with the DATARWeb User Manual. After November 2019, counties are no longer able to submit to or access data from the DATARWeb system. The December 2019, submission will be to the https://portal.dhcs.ca.gov

Reference: https://www.dhcs.ca.gov/Documents/BH-Information-Notice-19-050-DATAR-Rewrite.pdf

Upcoming Documentation Trainings

- January 22nd (1 day)*
- February 26th (1day)*
- March 9th & 11th (2 day)
- March 25th (1 day)*

**Prerequisites: ASAM A and ASAM B*

For both county staff and contract staff: e-mail us at AQISSUDSupport@ochca.com

12-Step Facilitation Approach to Drug Abuse Counseling

A. OVERVIEW, DESCRIPTION, AND RATIONALE

1. General Description of Approach

Twelve-Step Facilitation (TSF) consists of a brief, structured, and manual-driven approach to facilitating early recovery from alcohol abuse/alcoholism and other drug abuse/addiction. It is intended to be implemented on an individual basis in 12 to 15 sessions and is based in behavioral, spiritual, and cognitive principles that form the core of 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). It is suitable for problem drinkers and other drug users and for those who are alcohol or other drug dependent.

2. Goals and Objectives of Approach

TSF seeks to facilitate two general goals in individuals with alcohol or other drug problems: acceptance (of the need for abstinence from alcohol or other drug use) and surrender, or the willingness to participate actively in 12-step fellowships as a means of sustaining sobriety. These goals are in turn broken down into a series of cognitive, emotional, relationship, behavioral, social, and spiritual objectives.

3. Theoretical Rationale/Mechanism of Action

The theoretical rationale is based in the 12-steps and 12 traditions of AA and includes the need to accept that willpower alone is not sufficient to achieve sustained sobriety, that self-centeredness must be replaced by surrender to the group conscience, and that long-term recovery consists of a process of spiritual renewal. The primary mechanism action is active participation and a willingness to accept a higher power as the locus of change in one's life.

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Documentation

The following is the most common findings in in treatment plan deficiencies:

- Completed outside of the timeframe
- Missing treatment plan updates
- Late signatures
- Missing signatures (with no explanation)
- Goals and/or action steps closed out as "completed" or achieved

Treatment plan requirements reminders:

- 4 required elements:
  - Statement of the Problem
  - Statement of the Goal
  - Action Steps
  - Target Dates
- All problems identified in the assessment need to be on the treatment plan
- Each action step needs a target date
- Primary counselor's name
- Diagnosis

Quality Assurance and Quality Improvement

Quality assurance and quality improvement are closely related concepts having to do with quality management. Quality assurance is related to overseeing of the existing quality control processes whereas quality improvement is about improving upon production process and results.

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Quality Assurance (QA):

One word that distinguishes quality assurance from other quality control concepts is "confidence." Quality assurance is about confirming that the provider's practices meet the currently accepted standards, e.g. complying with the DMC-ODS waiver standards. The process of ensuring QA encompasses but not limited to utilization review, risk management, credentialing, peer review, quality control, privacy, customer satisfaction, employee satisfaction, and accreditation. Measuring and monitoring performance can be seen as the primary purpose of QA.

Quality Improvement (QI), also known as Continuous Quality Improvement (CQI):

Quality improvement is more concerned with the actual effectiveness of quality controls and effective production processes. QI looks to improve on current practices by examining how the current QA process can be improved upon in addition to looking into service delivery improvements.

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4. Agent of Change

The facilitator in the TSF treatment model is more truly a facilitator of change than an agent of change. The true agent of change (i.e., sustained sobriety) lies in active participation in 12-step fellowships like AA and NA along with the principles set forth in the 12 steps and 12 traditions that guide these fellowships.

5. Conception of Drug Abuse/Addiction, Causative Factors

Alcoholism and other drug addiction are considered illnesses that affect individuals both mentally and physically in such a way that they are unable to control their use of alcohol or other drugs. Viewed from this perspective, the concept of controlled use of alcohol or other drugs amounts to denial of the primary problem, that is, loss of control. Specific causative factors are of less relevance in recovery than is acceptance of both the loss of control and the need for abstinence and a willingness to follow the pathway laid out in the 12 steps.

B. CLIENT-COUNSELOR RELATIONSHIP

1. What Is the Counselor's Role?

The facilitator's role in TSF is broadly defined as including education and advocacy, guidance and advice, and empathy and motivation. Each of these broad goals is broken down further into a series of specific guidelines or objectives. For example, guidance and support include monitoring client involvement in AA/NA, encouraging clients to volunteer for basic service work, identifying appropriate social events the client might participate in, locating appropriate meetings, and clarifying the role of a sponsor.

2. Who Talks More?

Clients and facilitators talk about equally in effective TSF sessions. Since TSF is an active intervention, facilitators who are passive may not succeed in maintaining focus or accomplishing basic goals. At the same time, success in TSF is dependent on monitoring client activity and reactions, which requires soliciting active client involvement in sessions.

3. How Directive Is the Counselor?

TSF is similar to many cognitive-behavioral therapies in that it is focused and requires the facilitator to be fairly directive while still maintaining good rapport. The TSF facilitator is directive in the following ways:

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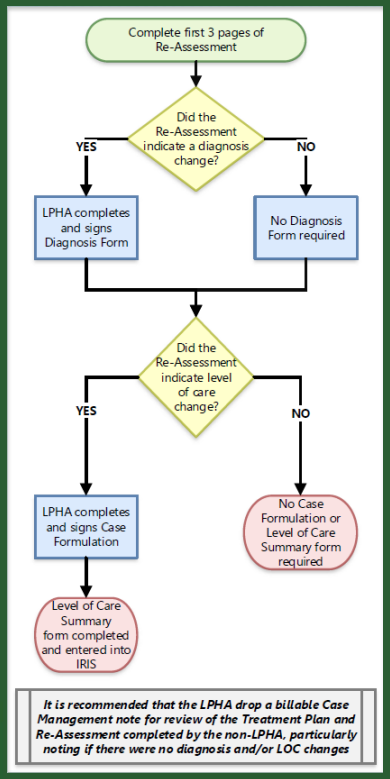
Re-assessment Workflow

1. If a diagnosis change was indicated by the 90/270 day Re-Assessment, the LPHA is to complete the Diagnosis form.

2. If a level of care change was indicated by the 90/270 day Re-Assessment, the LPHA is to complete the Case Formulation.

If the diagnosis changed, but the level of care did not change, the LPHA is *not* required to complete the Case Formulation



Self-care for Counselors

Self-care is vital for well-being, and no group knows that better than counselors. Not only do they help clients learn to take better care of themselves, but they also need to make self-care a priority, especially given the emotional strains inherent in their profession. Counselors can incorporate the following tips into their busy routines for better self-care.

- Identify what activities help you feel your best
- Take care of yourself physically
- Check in with yourself regularly
- Surround yourself with great people and good support network
- Remember that self-care is non-negotiable

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- The focus of therapy is on early recovery. The facilitator does not allow the focus to drift onto other issues (e.g., relationship or work problems) even if these are significant. The facilitator validates other concerns and helps the client develop an overall treatment plan to deal with them but maintains the focus of TSF.
- The client's reactions to assignments and meetings are considered very important. In TSF the facilitator needs to solicit specific feedback from the client.
- Each TSF session has a specific topic (core, elective, or conjoint) that includes a specific agenda to be covered. Although a given topic may require more than one session to cover, and while the facilitator needs to be somewhat flexible in his or her agenda, the facilitator must also take responsibility for controlling the content and flow of sessions.
- Each TSF session follows a set format that the facilitator is responsible for following. Again, there is some flexibility, but the facilitator does not simply follow the client's agenda.
- Every TSF session ends with the facilitator making specific suggestions to the client (recovery tasks). In addition, the facilitator is expected to make specific suggestions (e.g., which meetings to attend, how to ask for a sponsor) throughout treatment.

4. Therapeutic Alliance

In TSF, the facilitator is seen as an expert in interpersonal counseling techniques and as knowledgeable in the principles and practicalities of 12-step fellowships. However, in TSF the facilitator is not regarded as the primary agent of change; rather, it is the 12-step fellowship (AA or NA) that is seen as the agent of change. Accordingly, the TSF facilitator needs to conceptualize treatment as the product of a collaborative relationship and should assume responsibility for doing the best he or she can to establish that collaborative relationship. However, it is not the facilitator's goal to break down the client's denial, to provide all support needed to stay sober, to take the client to meetings, and so forth. Even in emergencies, the facilitator's role and responsibilities are limited in the TSF model. For this reason the word "facilitator" was chosen rather than therapist or counselor, as it seems to describe the role better than those labels.

Reference: retrieved from https://dualdiagnosis.org/resource/approaches-to-drug-abuse-counseling/twelve-step-facilitation/

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If an organization does not make an effort to improve its' processes, it will stagnate and fall behind the industry standards. Therefore, QI moves beyond the process of quality assurance and is utilized as a method to better a process or system by providing a set of proven, reliable steps to make improvement.

QA and QI Working Together

Assuring standards of production quality in the present is critical to remaining in contract with the Department of Health Care Services. Quality improvement processes are necessary in order to increase the effectiveness of quality assurance practices as well as raising the effectiveness of treatment services. If an organization does not look for new and better ways to produce products, it will become irrelevant over time in the marketplace. By combining both QA and QI, the DMC-ODS can create a Culture of Quality that ensures greater benefits to its customers (our DMC-ODS clients) and performance amongst its' workforce.