SUD Support Newsletter

Authority & Quality Improvement Services

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UPDATES

Effective 07/01/2020, **there will no longer be a requirement for Re-Assessments every 90 days.** This applies to the Intensive Outpatient Treatment (IOT) and Outpatient Drug Free (ODF) levels of care. The Continuing Services Justification (CSJ) will still be required between the 5th and 6th month from the date of the client's admission. Treatment plan updates are also still required every 90

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WHAT'S NEW?

Happy Birthday to the network! It has been a full 2 years since the implementation of the Drug Medi-Cal Organized Delivery System (DMC-ODS) and we are now going into our 3rd year. There have been many twists and turns along the way, but we are growing bigger and stronger. As we head into the new fiscal year, we wish to congratulate you on all the hard work that you have put into helping our beneficiaries. You are providing a vital service that is positively impacting the lives of those seeking a life of sobriety. Please continue to provide your feedback to the Authority and Quality Improvement Services (AQIS) Substance Use Disorder Support Team (SST) to help ensure that we continue to improve. You can reach out to us at AQISSUDSUPPORT@ochca.com.

You can also send inquiries to the above e-mail for the Quality Improvement and Compliance Consultants of the SST, who can help provide you with direct assistance on documentation and billing. If you send any sample documents for review, such as progress notes or treatment plans, please be sure to remove any patient identifying information.

Upcoming Documentation Trainings

- July 22nd (1 day)*
- August 26th (1 day)*

**Prerequisites: ASAM A and ASAM B*

Until further notice, all SST Documentation Trainings will be provided via online to ensure the health and safety of all.

To sign up, e-mail us at AQISSUDSupport@ochca.com. For county staff, Training Partner is no longer in use. Please send an e-mail.

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calendar days. Please remember that the timelines continue to be from the date of the client's admission to treatment. This results in no changes at the Residential level of care, where re-assessments will be required every 30 calendar days.

HOW WILL THIS IMPACT DOCUMENTATION?

Previously, at the IOT and ODF levels of care, the re-assessments and treatment plan updates coincided. Therefore, the emphasis was placed on using the information in the re-assessment to inform the treatment plan update. Now that there will be some treatment plan updates when no other formal documentation will be completed (aside from when the CSJ is completed), what do we do? Since the expectation is that there is collaboration with the client on his/her treatment plan, there should be documentation of a session where the topic of treatment plan update is discussed. In order to adequately update a client's treatment plan, there inevitably will be more involved in the discussion than just whether the client is or is not making progress. In addition to changes to the existing goals, there also needs to be consideration for what is currently happening in the client's life. It is an informal assessment of the client's current functioning so that we may take into consideration any new issues or areas of concern that should be incorporated into the client's treatment going forward. This helps to ensure that we are providing a tailored treatment that addresses the client's needs appropriately. For more info on things to consider, see page 3!

Documentation FAQ

1. As an LPHA, can I bill for reviewing the information in the SUD Assessment (completed by a non-LPHA) and writing the Case Formulation in the same note?

No. Reviewing documents and writing the Case Formulation are separate types of activities. Any time there is a review of a document that is pertinent to the client's treatment, such as the LPHA reviewing the SUD Assessment completed by a non-LPHA, the activity falls under "Case Management". The LPHA working on the determination of a diagnosis and documenting the medical necessity to establish the appropriate level of care, such as in the Case Formulation, is an assessment activity that falls under "Individual Counseling". If you would like to bill for these activities, there must be two separate progress notes written, even if they occur on the same day: one for *Case Management* and the other for Individual Counseling.

2. There is no option on the Placement Summary page of the SUD Assessment for a client who declines all services…what should I do?

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Welcome New Providers!

The following programs have recently joined the DMC-ODS network:

- **His House** (in Upland) & **New Creation** (in Colton) – serving adult males/females and designated for ASAM LOC 3.1 & 3.5
- **Wel-Mor Psychology Group (**added Fullerton and Laguna Hills) – serving adult & adolescent males/females and designated for ASAM LOC 1.0 & 2.1

Out of Network providers also partnering with us:

- **American Recovery Center** (in Pomona) & **Redgate Memorial** (in Long Beach) – serving adult males/females and designated for ASAM LOC 3.7 & 4.0
- 2 sites for Riverside County Latino Commission (**Bea's Youth Treatment Center** and **Michael's Youth Treatment Center**) – serving adolescents and designated for ASAM LOC 3.1

Documentation FAQ (continued)

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If you have assessed the client for a particular level of care and made the recommendation to the client, but the client refuses, a lower level of care than what is indicated can be offered to the client. If the client continues to refuse even the lower level of care and expresses that he or she does not want any services, there is currently no option specific to this on the form. Therefore, the counselor can write in on the "Level of Care/Service Accepted" section of the SUD Assessment or Re-Assessment that the client has declined all services. This information could also be written in the Case Formulation section. As long as there is documentation to clearly explain what the outcome was, it is acceptable. Additionally, it would be best practice to be sure that there is corresponding information in the progress note for the assessment session with the client where his or her options were discussed. It is also recommended that the provider document his or her efforts to inform the client of the benefits and risks to demonstrate our due diligence in the recommendation for SUD services. Please also check with the AQIS Managed Care Support Team as this situation requires issuing an NOABD.

3. The client I assessed two weeks ago to need IOT and agreed to IOT, is now saying that she wants to do ODF at our agency instead…Do I have to do a brand new assessment?

No. Although it would be good practice to complete a new assessment, the reality is that likely not much has changed with the client's presentation and functioning over the past two weeks. And another assessment may just indicate the same level of care recommendation, with the only change being the level of care accepted by the client. Therefore, it is clinically appropriate in such cases to add an addendum or information on the initial assessment (in the Case Formulation section) of the client's change in preference and noting that all of the aforementioned information is still applicable. It should also include information about how the client's needs can be accommodated at the lower level of care. Obviously, if you are aware that the client has had significant changes in the last two weeks or if there has been a longer span of time that could lead to significant changes, it is advised that a new assessment be completed. There should also be a corresponding progress note that documents the interaction you have with the client where his or her preferences are discussed. The documentation should also include the provider's efforts to educate the client about the differences in level of care, program expectations, and potential impact on current areas of need to help the client make the most informed decision.

Documentation for Treatment Plan Updates

Here are some things to think about and discuss with the client for treatment plan updates:

What progress has been made? What has helped the client achieve the goals that have been met? What are the barriers for the client being unable to achieve the goals set? Should the goals remain the same or be modified? If they should stay the same, what do we need to do differently in our sessions to promote progress? If they need to be modified, what should be changed? Should it be replaced with an entirely different goal or should the target be modified?

What has changed with the client's physical health? What is the status of the physical exam? What has changed in the client's mental health status? What is different in the client's living environment or circumstances that might be impacting his/her treatment or overall recovery?

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Documentation Reminders…

- Progress Notes: interventions need to tie back to substance use! We must be explicit and not assume that readers will know or understand that such topics as "healthy relationships" and "stress management" are relevant discussions for individuals in recovery. Be clear in documenting the effects on the client's treatment and sustaining sobriety. This also applies for case management notes!
- Don't forget to include the Documentation start and end times! We are allowed to bill for the time it takes to write the progress note, but we must include the start and end time. Be sure to also check that the start and end time matches the amount of documentation time being claimed.
- Is it case management or collateral? Remember that if an interaction involves an individual who has a professional relationship with the client, it is case management. An interaction with those who have a personal relationship with the client would be a collateral. Whether the

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Treatment Plan Updates & Progress Note Documentation

When it comes to writing the progress note for the session where all of the information about how the client is currently doing and what has changed, the key is to highlight those main points surrounding the treatment plan update. Identify what was discussed in general and for what purpose.

Include information on the following:

1. Client's progress towards treatment plan goals;
2. Status/changes in the client's areas of life identified in the initial assessment or CSJ (see also any problems identified in the previous treatment plan but not addressed as goals);
3. Consideration of any new information or changes that may impact the course of treatment;
4. Client's preferences/input

Remember we do not need to detail every discussion item. It is satisfactory to indicate broad areas that were focused on such as, "Reviewing client's progress toward treatment plan goals," but keep in mind that there should be enough information to justify the amount of time that is being claimed and the information should be specific to the client. Here are a few examples:

"Client's progress in treatment (specifically, client's reluctance to obtain a physical exam) was discussed in order to inform any necessary changes to the treatment plan."

"Counselor discussed with client about his recent transition to sober living and the option to include a goal on the treatment plan to address ways to manage the increased interpersonal issues that may negatively impact his progress in treatment."

"Counselor collaborated with client on what has and has not been working in regards to her goal to implement coping skills in order to modify the interventions needed."

This newsletter was established to help communicate any changes or updates as well as to reinforce our current understanding of requirements related to the provision of services under the DMC-ODS. You can access additional resources and previous issues of this newsletter (SUDsies) by visiting the "Providers" tab of the DMC-ODS website, here: http://www.ochealthinfo.com/bhs/about/aqis/dmc_ods/providers

Do you have suggestions for questions or information you would like to see addressed in a SUD Newsletter? E-mail us your thoughts at AQISSUDSUPPORT@ochca.com

Documentation for Treatment Plan Updates

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Are there new supports in place that were not there before? Are there more conflicts that the client is encountering now than before? Has anything changed with their legal issues or employment? What new stressors might compromise the client's recovery?

Look here for information on how to document these discussions in a progress note!

Documentation Reminders...

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interaction is billable or not depends on whether it is relevant to the client's treatment.

- Have you taken the Annual Provider Training (APT)? The Behavioral Health Services (BHS) DMC-ODS/SUD Annual Provider Training – 2019-2020 Update is a required annual training that should be taken as soon as possible if you have not yet done so. You can find it at: https://www.ochealthinfo.com/bhs/providers/trainings (Be sure to select the SUD version!)