# SUD Support Newsletter

## Authority & Quality Improvement Services

**August 2020**

# WHAT'S NEW?

Please welcome Annette Tran, LCSW who will be taking over for John Crump, LMFT on the Authority and Quality Improvement Services (AQIS) Substance Use Disorder Support Team (SST)! She has been with AQIS and the County for many years and is ready to dive in to the Drug Medi-Cal Organized Delivery System (DMC-ODS) world. Some of you have already met her through the work she has done with the Managed Care Unit in regards to the credentialing process. We are excited to have her join us!

We would like to give a warm farewell to John Crump, LMFT who has been a vital part of the SST. John has been involved with DMC-ODS in Orange County since its implementation and many of you have worked closely with him. We wish John the best of luck as he begins work leading the Certification and Designation Unit…you will likely still be interfacing with him on matters related to the certification requirements for DMC-ODS.


## Upcoming Documentation Trainings

- 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.

***Coming soon…***

We are working on posting the SST Documentation Training online for easier access!

## SUD Support Team

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## UPDATES

- The State is now allowing for us to utilize the **same assessment document for transitions between different providers**. This means that the SUD Re-Assessment form used to document the client's readiness for discharge from one level of care at Provider A can be used as the initial assessment to establish the medical necessity for services in

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## …UPDATES

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the new level of care at Provider B.

The receiving provider will be responsible for making sure that there is enough information contained in the assessment document to establish medical necessity for the level of care. The assessment document also needs to fulfill the requirements of an initial assessment, listed below.

- drug/alcohol use history
- medical history
- family history
- psychiatric/psychological history
- social/recreational history
- financial status/history
- educational history
- employment history
- criminal history
- legal status
- previous SUD treatment history

If the receiving provider finds that the assessment document does not have the necessary information, it is advised that a new assessment be completed for the client to ensure compliance with the requirements.

# Documentation FAQ

### 1. If only a Continuing Services Justification (CSJ) is required at Outpatient Drug Free (ODF) and Intensive Outpatient Treatment (IOT), why do we still have "Re-Assessment" on the form?

Although the CSJ is required by the State (between the 5th and 6th month) for IOT and ODF, there may be times when you may need to re-evaluate the client's functioning outside of the period when a CSJ is required. The "Re-Assessment" part of the form is for whenever it is clinically indicated. This means that if, at any point during treatment (when it is not yet time to do the CSJ), circumstances change and the counselor feels that perhaps the client needs a higher or lower level of care, the Re-Assessment can be done to determine what is most appropriate for the client. So, if for example the client has had a lapse/relapse 3 months into treatment and is showing a decompensation in functioning and there are concerns that perhaps the ODF level of care is not enough to assist this person, the Re-Assessment can be done to justify the need for the change in level of care.

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# Practice Guidelines

As discussed in the July Quality Improvement Coordinators' (QIC) Meeting, since we are a Managed Care Organization, federal law requires that we adopt Practice Guidelines (PG). A PG serves as a framework for clinical decisions and supports best practices in a specified clinical area. Although PG's are not a Policy & Procedure (P&P), they do need to be used to make decisions regarding utilization management, beneficiary education, coverage of services, and other areas where the PG's apply. It is important for you to know what PG's are available and pertinent to SUD as it relates to the work you do with our beneficiaries.

Currently there are three PG's specific to SUD:

- Perinatal Practice Guidelines (DHCS)
- Treatment for People with Physical and Cognitive Disabilities (SAMHSA)

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# Documentation FAQ (continued)

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## 2. Now that we are no longer required to do a Re-Assessment every 90 days at the ODF and IOT levels of care, do I need to do a Re-Assessment at the client's discharge?

Although it is not a requirement, it is advised to complete a Re-Assessment to document how you have determined that the client is ready for discharge from the current level of care. This means looking at where the client falls in terms of medical necessity for the current level of care. In most cases, our clients are not discharging from DMC services completely. Some may need to continue with their recovery journey and step down to a lower level of care. In other cases, clients may need to maintain what has been gained through participation in Recovery Services. In completing the Re-Assessment, you are also demonstrating how you intend to coordinate care for the client's current needs. Remember that the Re-Assessment for discharging the client at one level of care may also be used to open the client at the next indicated level of care. Even in those situations where the client is ready to discharge from any and all DMC services, it is in your best interest as a provider to have documentation to justify that the client truly has no other needs that should be addressed within the network.

## 3. Can I have my client sign their discharge plan in a group session if that is their "last face-to-face?"

No. It would not be clinically appropriate to review and sign the client's discharge plan in a group setting. The discharge plan is intended to be specific to the client's needs and should be discussed in an individual counseling session. If the plan is for the client to receive some services (such as group or case management) as their "last face-to-face," please review and sign the discharge plan in the last individual counseling session with the client. The progress note for this last individual counseling session should clearly document the plan for additional services that are needed prior to fully discharging the client. Perhaps the client is scheduled to attend one final "good-bye" group session. This can be justified as part of helping the client to prepare for transitioning to a new program, particularly if the client has any ambivalence or has established strong connections with peers. Perhaps there are a few case management activities that will still be required to assist the client with linkage to the new program. This can be justified as necessary to ensure coordination of care to prevent any lapse in treatment episodes.

# Practice Guidelines (cont.)

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- Youth Treatment Guidelines (State of California)

Other PG's that impact SUD providers:

- Clinical Supervision
- Suicide Assessment and Treatment Practice
- Trauma-Informed Care Workplace and Practice
- Treatment Interventions for Trauma
- More Practice Guidelines are in development and will be disseminated

You can access all current PG's here:

http://www.ochealthinfo.com/bhs/about/aqis/guidelines

# Making Corrections on Chart Documents

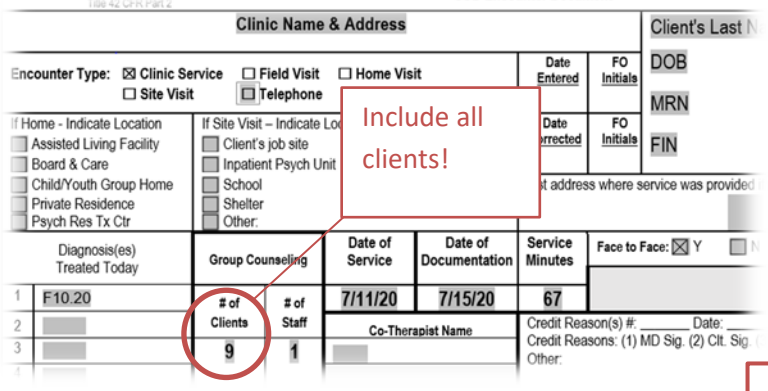
We all know that errors should be corrected with a single line strikethrough so that the error is still visible and that we are not allowed to use white out…but what else do we need to know?

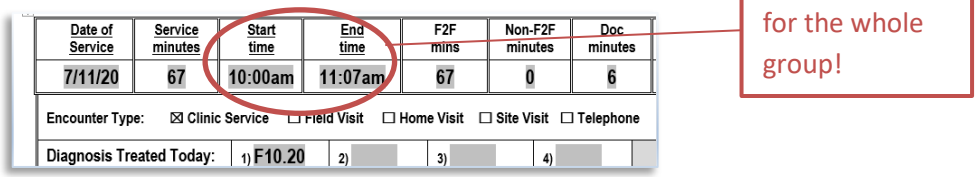
- Changes to Progress Note or Encounter Document content must be made by the rendering provider (unless he or she is no longer with the agency).
- Corrections must include the rendering provider's initials and the date of the correction.
- Information that is added to the document after its completion and signature and must be accompanied by the rendering provider's initials and the date of the addition (e.g., documentation start and end time added by hand after the progress note has been printed and signed).
- For late signatures, the date of the added signature must be included with the statement "Late entry" to demonstrate that the documentation was completed previously but not signed.

Not sure how to make a correction in IRIS? Contact the BHS Front Office Coordination Team for assistance!

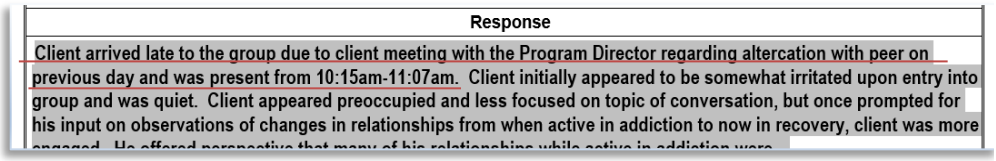
# Documentation for clients who attend part of a group session

**Documentation on progress notes should clearly indicate when a client has only attended part of a group, but we may include them in the total number of clients in attendance**. This means that for the Encounter Document (ED) and billing in IRIS, the total number of clients should include all clients that attended the group. If there were eight (8) clients who attended the entirety of the group and one (1) client who arrived late to the group, the total number of clients would be nine (9).




The progress note for the client who only attended part of the group should include the start and end time of that client's presence in the group within the body of the note.




Additionally, for the client who only attended part of the group, the group sign-in sheet will need to indicate the start and end time of that client's presence. So, for a group with a start time of 10:00am and end time of 11:07am, the client who arrived at 10:15am would show "10:15am-11:07am" next to his or her name.

| Client Name | Signature |
|---|---|
| Captain America 10:15am-11:07am | Captain America |

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

## What is SST's Technical Assistance?

Although the Quality Improvement and Compliance Consultants of the SST are most fondly remembered as those who conduct the clinical chart reviews to ensure documentation and billing compliance with DMC-ODS, they also provide Technical Assistance (TA). As you know, we can be reached at AQISSUDSUPPORT@ochca.com, but we will also be available to provide remote, one-on-one, live assistance for your site in the coming months. This is when a scheduled online meeting will be arranged with each agency or program in order to provide a dedicated time and space where you can to ask questions, gain clarification, discuss program-specific issues, request feedback on actual documentation, and trouble-shoot ways to ensure that your agency and staff are engaging in compliant billing and documentation practices. It is separate from a clinical chart review and no specific charts will be reviewed at that time.

Some helpful tips for preparing for your TA session:

- ✓ Submit any sample documentation (with PHI removed) prior to your scheduled meeting date and be sure to inform us of specific areas of concern or questions that you have about the documentation so we can be sure to address your needs adequately
- ✓ Consider common areas of concern or questions that are frequently asked by others on your team
- ✓ Is there any clarification needed from information presented at the SST Documentation Training that you attended or read about in the Documentation Manual?
- ✓ Is there any uncertainty about how you are currently billing or documenting an activity and need confirmation?