Alcohol & Drug Services
Drug Medi-Cal Organized Delivery System (DMC-ODS)
Practice Guidelines
# Table of Contents

1 WELCOME .......................................................................................................................... 9
   1.1 PHILOSOPHY OF CARE ................................................................................................. 9
      1.1.1 Purpose .................................................................................................................. 9
      1.1.2 Vision .................................................................................................................... 9
      1.1.3 Mission .................................................................................................................. 9
      1.1.4 Values .................................................................................................................... 9

2 INTRODUCTION .................................................................................................................. 9
   2.1 DRUG MEDICAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) ......................... 9
   2.2 PURPOSE OF PRACTICE GUIDELINES ..................................................................... 10
   2.3 SOURCES OF INFORMATION ..................................................................................... 10

3 OVERVIEW OF DMC-ODS ............................................................................................. 10
   3.1 ROLE OF MEDICAL DIRECTOR ................................................................................. 10
   3.2 DMC-ODS SERVICES ................................................................................................. 10
   3.3 EVIDENCE-BASED PRACTICES ................................................................................. 11
      3.3.1 Motivational Interviewing ..................................................................................... 11
      3.3.2 Cognitive Behavioral Therapy ............................................................................... 11
      3.3.3 Relapse Prevention ............................................................................................... 11
      3.3.4 Trauma-Informed Treatment ............................................................................... 12
      3.3.5 Psychoeducation .................................................................................................. 12
   3.4 CULTURAL COMPETENCY ......................................................................................... 12

4 GATEWAY TO DMC-ODS SERVICES .............................................................................. 12
   4.1 SUMMARY OF ENTRY POINTS .................................................................................... 12
      4.1.1 Phone .................................................................................................................... 12
      4.1.2 In Person ............................................................................................................... 12
      4.1.3 Referrals ................................................................................................................ 12
      4.1.4 Youth Referrals .................................................................................................... 13
   4.2 COORDINATION & CONTINUITY OF CARE ........................................................... 13
      4.2.1 Role of Primary Counselor (PC) .......................................................................... 13
      4.2.2 Role of the Licensed Practitioner of the Healing Arts (LPHA) ............................ 13
   4.3 CLIENT GATEWAY TO ASAM LEVEL OF CARE .................................................. 14
      4.3.1 Initial Request for Service ..................................................................................... 14
      4.3.2 Phone/Walk-in ..................................................................................................... 14
4.3.3 Referrals ......................................................................................................................... 14
4.3.4 Jail Referrals ..................................................................................................................... 14
4.4 INITIAL MEDI-CAL ELIGIBILITY CHECK ............................................................................. 15
4.4.1 Napa County Medi-Cal ......................................................................................................... 15
4.4.2 Out-of-County Medi-Cal ...................................................................................................... 15
4.4.3 No Insurance/Self-Pay ......................................................................................................... 15
4.4.4 Other Insurance .................................................................................................................. 15
4.4.5 Waiver from Payment ......................................................................................................... 15
5 ADMISSION CRITERIA & MEDICAL NECESSITY .................................................................... 15
5.1 MEDICAL NECESSITY CRITERIA........................................................................................ 15
5.2 DEFINITION OF ASAM CRITERIA OF MEDICAL NECESSITY ........................................... 16
5.3 PURPOSE OF MEDICAL NECESSITY .................................................................................... 16
5.4 ESTABLISHING MEDICAL NECESSITY .............................................................................. 16
5.5 OUT-OF-COUNTY MEDI-CAL ............................................................................................ 16
5.5.1 Access Line’s for Neighboring Counties ............................................................................. 17
5.6 NOT MEETING MEDICAL NECESSITY .................................................................................. 17
6 DMC-ODS BENEFICIARY HANDBOOK .................................................................................... 17
6.1 ADMISSION AGREEMENT AND INFORMED CONSENT ..................................................... 18
6.2 NOTICE OF PRIVACY PRACTICES ...................................................................................... 18
6.3 AUTHORIZATION TO USE, EXCHANGE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ............................................................................................................................................. 18
6.3.1 Revoking an Authorization .................................................................................................. 18
6.4 GRIEVANCE, APPEALS, NOTICE OF ADVERSE BENEFIT DETERMINATIONS (NOABD) & STATE FAIR HEARINGS ........................................................................................................ 18
7 CALOMS .................................................................................................................................... 19
8 GENERAL FLOW OF SERVICES & DOCUMENTATION ............................................................... 19
8.1 MEDICAL NECESSITY & APPROPRIATE LEVEL OF CARE (LOC) .......................................... 19
8.2 ASSIGNED PRIMARY COUNSELOR/LPHA ............................................................................ 20
9 AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) ASSESSMENT ............................. 20
9.1 ASAM CRITERIA .................................................................................................................... 21
9.2 ASAM LEVELS OF CARE (LOC) ........................................................................................... 21
9.2.1 ASAM Level 0.5 - Early Intervention .................................................................................. 21
9.2.2 ASAM Level 1.0 - Outpatient Treatment ............................................................................ 21
9.2.3 ASAM Level 2.1 - Intensive Outpatient Treatment ............................................................... 21
9.2.4 ASAM Level 3.1 & 3.5 - Residential Treatment .................................................................... 21
9.2.5 Withdrawal Management – Level 1-WM (not available). ................................................... 21
21 DOCUMENTING SERVICES ................................................................. 34

21.1 Service Time ........................................................................ 34
21.1.2 Documentation Time ...................................................... 34
21.1.3 Travel Time .................................................................... 34
21.2 DISALLOWED SERVICES ..................................................... 35

21.2.1 Prior to a Valid SUD Diagnosis ...................................... 35
21.2.2 After a Diagnosis Review Form has been Closed .......... 35
21.2.3 Prior to Completed Treatment Plan ......................... 35
21.3 SERVICE CODE DEFINITIONS ........................................ 35
21.4 THE GOLDEN THREAD ......................................................... 40
21.5 PROGRESS NOTE TIMELINES ........................................ 41

21.5.1 Documenting Late Progress Notes .................................. 41
21.6 PROGRESS NOTE COMPONENTS ..................................... 41
21.7 RECORDING DOCUMENTATION WITHOUT CONTACT ...... 41
21.8 DIRT FORMAT FOR PROGRESS NOTES ......................... 42
21.9 DOCUMENT GROUP COUNSELING .................................... 42
21.10 COMPLETING GROUP SIGN-IN SHEETS ...................... 43
21.11 DOCUMENT CASE MANAGEMENT .................................. 43

21.12 DOCUMENTING NO SHOWS, RESCHEDULES AND CANCELLATIONS ................................................. 44

21.12.1 Prior to Client Admission ............................................ 44
21.12.2 Individual Progress Notes .......................................... 44
21.12.3 Group Progress Notes ................................................. 44
21.12.4 One Client Shows up for Group ................................. 44
21.13 DOCUMENTING SPECIAL ISSUES .................................... 45

21.13.1 Crisis Intervention ....................................................... 45
21.13.2 Suicide Protocol .......................................................... 45
21.13.3 Threats of Violence ..................................................... 45
21.13.4 Child Abuse and Elder Abuse ...................................... 45
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.13.5</td>
<td>Incident Reports</td>
<td>45</td>
</tr>
<tr>
<td>21.13.6</td>
<td>Other Situations</td>
<td>45</td>
</tr>
<tr>
<td>21.13.7</td>
<td>Gathering Information for Court Reports</td>
<td>45</td>
</tr>
<tr>
<td>22</td>
<td>URINALYSIS</td>
<td>46</td>
</tr>
<tr>
<td>22.1</td>
<td>UA COVERAGE</td>
<td>46</td>
</tr>
<tr>
<td>22.2</td>
<td>BILLING FOR UA’S</td>
<td>46</td>
</tr>
<tr>
<td>22.3</td>
<td>UA TEST RESULTS</td>
<td>46</td>
</tr>
<tr>
<td>23</td>
<td>TREATMENT PLANS</td>
<td>47</td>
</tr>
<tr>
<td>23.1</td>
<td>ALLOWABLE SERVICE CODE/TYPE OF SERVICE PRIOR TO TREATMENT PLAN</td>
<td>47</td>
</tr>
<tr>
<td>23.2</td>
<td>ANASAZI TREATMENT PLAN DICTIONARY</td>
<td>47</td>
</tr>
<tr>
<td>23.3</td>
<td>COMPONENTS OF THE TREATMENT PLAN</td>
<td>47</td>
</tr>
<tr>
<td>23.3.1</td>
<td>Strengths</td>
<td>47</td>
</tr>
<tr>
<td>23.3.2</td>
<td>Problems</td>
<td>47</td>
</tr>
<tr>
<td>23.3.3</td>
<td>Goals</td>
<td>48</td>
</tr>
<tr>
<td>23.3.4</td>
<td>Obstacles</td>
<td>48</td>
</tr>
<tr>
<td>23.3.5</td>
<td>Objectives</td>
<td>48</td>
</tr>
<tr>
<td>23.3.6</td>
<td>Interventions</td>
<td>48</td>
</tr>
<tr>
<td>23.3.7</td>
<td>Review &amp; Final Steps</td>
<td>48</td>
</tr>
<tr>
<td>23.4</td>
<td>TREATMENT PLAN (PERINATAL)</td>
<td>48</td>
</tr>
<tr>
<td>23.5</td>
<td>TREATMENT PLAN TIMELINE &amp; SIGNATURE RULES</td>
<td>48</td>
</tr>
<tr>
<td>23.5.1</td>
<td>Client’s Signature</td>
<td>48</td>
</tr>
<tr>
<td>23.5.2</td>
<td>Initial Treatment Plan</td>
<td>49</td>
</tr>
<tr>
<td>23.5.3</td>
<td>Updated Treatment Plans</td>
<td>49</td>
</tr>
<tr>
<td>23.5.4</td>
<td>Ending Treatment Plans</td>
<td>49</td>
</tr>
<tr>
<td>23.6</td>
<td>TREATMENT PLAN ATTESTATION</td>
<td>49</td>
</tr>
<tr>
<td>23.7</td>
<td>DOCUMENTING TREATMENT PLANNING</td>
<td>49</td>
</tr>
<tr>
<td>24</td>
<td>REASSESSMENTS</td>
<td>49</td>
</tr>
<tr>
<td>24.1</td>
<td>JUSTIFICATION FOR CONTINUED SERVICES AT 6-MONTHS</td>
<td>50</td>
</tr>
<tr>
<td>24.1.1</td>
<td>Justification for Continuing Treatment Form</td>
<td>50</td>
</tr>
<tr>
<td>24.1.2</td>
<td>Justification Review Form</td>
<td>50</td>
</tr>
<tr>
<td>25</td>
<td>DISCHARGE DOCUMENTATION</td>
<td>50</td>
</tr>
<tr>
<td>25.1</td>
<td>DISCHARGE PLAN</td>
<td>50</td>
</tr>
<tr>
<td>25.2</td>
<td>DISCHARGE SUMMARY</td>
<td>51</td>
</tr>
<tr>
<td>25.3</td>
<td>CALOMS DISCHARGE</td>
<td>51</td>
</tr>
</tbody>
</table>
25.3.1 CalOMS Administrative Discharge: Discharge Summary ................................................................. 51
25.3.2 CalOMS Standard Discharge: Discharge Plan .............................................................................. 51
25.3.3 Discharge Status Definitions (Reasons for Discharge) ................................................................... 51
25.4 CLOSING THE CLIENT ASSIGNMENT IN ANASAZI ...................................................................... 53
25.5 CLOSING CLIENT ASSIGNMENT WHEN CLIENT ADMITTED TO RESIDENTIAL AND/OR DETOX .................................................................................. 53
26 TIMELINES AND TREATMENT REQUIREMENTS ............................................................................ 53
27 CORRECTING DOCUMENTATION & BILLING .................................................................................. 55
27.1 CORRECTIONS PRIOR TO FINAL APPROVAL OF A PROGRESS NOTE ......................................... 55
27.2 CORRECTIONS AFTER FINAL APPROVAL OF A PROGRESS NOTE .............................................. 55
27.3 CORRECTING DUPLICATE FINAL APPROVED PROGRESS NOTES ................................................. 56
27.4 USE OF A BILLING CHANGE FORM (BCF) ..................................................................................... 56
27.5 CORRECTIONS AFTER FINAL APPROVAL OF A GROUP PROGRESS NOTE .............................. 57
   27.5.1 Prior to 7-Days ....................................................................................................................... 57
   27.5.2 After 7-Days ......................................................................................................................... 57
27.6 DOCUMENTATION REVIEW (FEEDBACK FORM/EMAIL) ............................................................ 57
28 DOCUMENTATION EXAMPLES ......................................................................................................... 57
28.1 EXAMPLES OF STRENGTHS ........................................................................................................... 57
28.2 EXAMPLES OF INTERVENTION WORDS ....................................................................................... 58
28.3 EXAMPLES OF INTERVENTION PHRASES ................................................................................... 59
28.4 EXAMPLES OF PROGRESS NOTES ............................................................................................... 59
   28.4.1 Intake/Assessment Progress Note Example ............................................................................. 59
   28.4.2 Group Progress Note Example ............................................................................................. 59
   28.4.3 Case Management Progress Note Example ............................................................................. 60
28.5 DIAGNOSIS REVIEW FORM SUMMARY TEMPLATE ........................................................................ 60
28.6 COUNSELOR RESOURCES ........................................................................................................... 61
28.7 ACRONYMS GLOSSARY ............................................................................................................... 62
29 APPENDIX SECTION ....................................................................................................................... 63
29.1 APPENDIX A: MEDI-CAL EDIBILITY WORKFLOW ......................................................................... 63
29.2 APPENDIX B: REFERRAL CHECKLIST ........................................................................................... 64
29.3 APPENDIX C: SCREENING INTAKE CHECKLIST .......................................................................... 66
APPENDIX D: INTAKE ASSESSMENT CHECKLIST ............................................................................... 67
29.4 APPENDIX E: OFFSITE/JAIL INTAKE ASSESSMENT CHECKLIST ................................................. 69
29.5 APPENDIX F: TREATMENT PLAN WORKFLOW .............................................................................. 70
29.6 APPENDIX G: TREATMENT PLANNING CHECKLIST .................................................................. 72
<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.7</td>
<td>APPENDIX H: REASSESSMENT CHECKLIST (OUTSIDE OF THE 5-6 MONTH)</td>
<td>73</td>
</tr>
<tr>
<td>29.8</td>
<td>APPENDIX I: JUSTIFICATION FOR CONTINUED TREATMENT WORKFLOW</td>
<td>75</td>
</tr>
<tr>
<td>29.9</td>
<td>APPENDIX J: 6-MONTH JUSTIFICATION RE-ASSESSMENT CHECKLIST</td>
<td>76</td>
</tr>
<tr>
<td>29.10</td>
<td>APPENDIX K: DISCHARGE PLAN WORKFLOW</td>
<td>78</td>
</tr>
<tr>
<td>29.11</td>
<td>APPENDIX L: DISCHARGE SUMMARY WORKFLOW</td>
<td>79</td>
</tr>
<tr>
<td>29.12</td>
<td>APPENDIX M: CLOSING CHECKLIST</td>
<td>80</td>
</tr>
<tr>
<td>29.13</td>
<td>APPENDIX N: MAT WORKFLOW &amp; ATTESTATION</td>
<td>81</td>
</tr>
<tr>
<td>29.14</td>
<td>APPENDIX O: PHYSICAL EXAM WORKFLOW &amp; ATTESTATION</td>
<td>82</td>
</tr>
<tr>
<td>29.15</td>
<td>APPENDIX P: ADS PROGRAM UA PROTOCOL</td>
<td>84</td>
</tr>
<tr>
<td>29.16</td>
<td>APPENDIX Q: RESIDENTIAL MANAGED CARE ORGANIZATION (MCO) AUTHORIZATION PROCESS</td>
<td>85</td>
</tr>
<tr>
<td>29.17</td>
<td>APPENDIX R: RECOVERY SERVICES WORKFLOW</td>
<td>86</td>
</tr>
<tr>
<td>29.18</td>
<td>APPENDIX S: SCOPE OF PRACTICE-DETAIL</td>
<td>88</td>
</tr>
<tr>
<td>29.19</td>
<td>APPENDIX T: INTERAGENCY REFERRAL FORM</td>
<td>90</td>
</tr>
<tr>
<td>29.20</td>
<td>APPENDIX U: POPULATION SCREENER TOOL</td>
<td>91</td>
</tr>
<tr>
<td>29.21</td>
<td>APPENDIX V: SIX DIMENSIONS OF THE ASAM</td>
<td>92</td>
</tr>
<tr>
<td>29.22</td>
<td>APPENDIX W: SUICIDE RISK SCREENING TOOL</td>
<td>93</td>
</tr>
<tr>
<td>APPENDIX X: GROUP SIGN-IN SHEET TEMPLATE</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>APPENDIX Y: DOCUMENTATION FEEDBACK FORM</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>29.23</td>
<td>APPENDIX Z: BILLING CHANGE FORM (BCF)</td>
<td>96</td>
</tr>
<tr>
<td>30</td>
<td>AFTERWORD</td>
<td>97</td>
</tr>
</tbody>
</table>
1 Welcome

Welcome to Napa County Health and Human Services (HHSA) Alcohol & Drug Services (ADS) Division. The ADS Leadership Team and Quality Assurance Staff look forward to working with you to provide quality substance use treatment to our clients. The following core values are fundamental to our actions. Our commitment to these values will guide our work together and with our clients.

1.1 Philosophy of Care

Napa County Alcohol & Drug Services (ADS) Division provides an array of substance use prevention, treatment and intervention services to clients and loved ones. ADS embraces a recovery philosophy that promotes the ability of a person with substance use disorder to live a meaningful life in a community of his or her choosing, while striving to achieve his or her full potential. The principles of a recovery-focused system include: self-direction, individualized and person-centered care, empowerment and shared decision-making, and a holistic approach that encompasses physical and mental health wellness. ADS provides substance use disorder continuum of care services, from prevention, early intervention and treatment, case management to recovery services. Services are provided through County-operated programs and contracts with community-based organizations.

1.1.1 Purpose
To provide a welcoming and safe environment that offers hope, supports prevention and inspires recovery.

1.1.2 Vision
Create, promote and sustain communities free from problems of addictions of alcohol and drugs by empowering individuals and families.

1.1.3 Mission
Provide integrated, evidence-based education, prevention and treatment services that are accessible, affordable and culturally competent.

1.1.4 Values
- Compassion
- Integrity
- Professionalism
- Well-Being

2 Introduction

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

The goal of Napa County’s plan for Drug Medi-Cal Organized Delivery System (DMC-ODS) is to create a fully articulated continuum of care for substance use treatment that is client-centered, culturally competent, quality driven and recovery-focused. The Drug Medi-Cal Organized Delivery System (DMC-ODS) was implemented on December 15, 2017 and provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services. This change enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced-based practices and coordinates with other systems of care. This substance abuse treatment approach provides the beneficiary with access to the care and system interaction needed to achieve sustainable recovery. DMC-
ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs.

2.2 PURPOSE OF PRACTICE GUIDELINES

Napa County Alcohol & Drug Services Division aims to provide effective and quality alcohol & drug services to individuals entering our services. It is vitally important that as an agency we maintain comprehensive, well-written and uniform clinical records. Additionally, keeping accurate, high quality clinical documentation ensures that Napa County complies with all legal and ethical requirements. The purpose of the DMC-ODS Documentation Manual is to clarify clinical documentation standards for Drug Medi-Cal ODS services provided and managed by Napa County Alcohol & Drug Services. This manual reflects the best possible quality care standards and is designed to be used as a comprehensive reference source. It will provide guidance and explanations of what is required at each step of the treatment process and answers frequent questions regarding clinical documentation. Moving forward, this manual will be revised as needed to ensure it provides staff with the most up-to-date guidance and clinical information. It is recommended that staff refer to it frequently to ensure adherence to the guidelines set forth herein.

2.3 SOURCES OF INFORMATION

This DMC-ODS Documentation Manual is to be used as a reference and includes information from the following sources: Napa County Intergovernmental Agreement with the Department of Health Care Services (DHCS), 42 CFR Part 2, 42 CFR Part 438, California Medi-Cal 2020 Demonstration (DMC-ODS Waiver Special Terms and Conditions), California Code of Regulations (Title 22), California Code of Regulations (Title 9), Drug Medi-Cal Billing Manual (2017), DHCS Information Notices/Letters and Napa County ADS Division Policies & Procedures.

3 OVERVIEW OF DMC-ODS

3.1 ROLE OF MEDICAL DIRECTOR

The role of the Medical Director within a Drug Medi-Cal program is not only a requirement but also supports integration of substance use disorder services into the greater healthcare system. The Medical Director for Napa County Alcohol & Drug Services is certified in addiction medicine and available to the Division on a regularly scheduled basis. In addition to assisting/supporting professional staff with challenging cases (i.e. case conferences, SUD, co-occurring conditions, medication assisted treatment) the Medical Director has the following responsibilities for outpatient clients:

1. Establishing, reviewing and maintaining medical policies and standards
2. Ensuring the quality of medical services provided to all clients
3. Ensuring provider’s physicians and LPHA’s are adequately trained to perform diagnosis of substance use disorders for beneficiaries and determining the medical necessity of treatment for beneficiaries

3.2 DMC-ODS SERVICES

The following overview depicts Adult & Youth DMC-ODS Services provided in Napa County except for Narcotic Treatment Program (NTP) Services, which will be contracted and provided by MedMark Treatment Center in Solano County. Clients will move between various levels of care (LOC) as deemed medically necessary. Enhanced or adjunct services may be provided at each LOC and is dependent on the client’s individualized treatment plan.
3.3 Evidence-Based Practices

Evidence-based practices (EBPs) are interventions supported by Napa County Alcohol & Drug Services treatment programs. DMC-ODS treatment providers within the county are required to implement a minimum of two EBPs for SUD treatment modalities. Napa County Adult Outpatient program utilizes Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT) as well as Medication for Addiction Treatment as an evidence-based intervention when clinically appropriate.

3.3.1 Motivational Interviewing

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

3.3.2 Cognitive Behavioral Therapy

Individuals in Cognitive Behavioral Therapy (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. 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.

3.3.3 Relapse Prevention

According to SAMHSA’s National Registry of Evidence-Based Programs and Practices, relapse prevention is “a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide patients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of
lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a client’s overall coping capacity.”

3.3.4 **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.

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

3.4 **Cultural Competency**
Culturally competent care is an essential component to treatment. Napa County Health & Human Services and Napa County Alcohol & Drug Services promotes 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.

4 **Gateway to DMC-ODS Services**

4.1 **Summary of Entry Points**
The Napa County System of Care consists of different points of entry for Drug Medi-Cal Organized Delivery Services (MC-ODS) services:

4.1.1 **Phone**
Calls can be made to the Napa County Alcohol & Drug Services Division (ADS) 24/7 Main Access Line (707) 253-4063 or (855) 753-5247. A call may result in an Intake Assessment appointment scheduled with a Certified Drug & Alcohol Counselor or a Licensed Clinician (LPHA).

4.1.2 **In Person**
Individuals may request services in person at Napa County Alcohol & Services Division located at 2751 Napa Valley Corporate Drive, Building A, Napa, CA 94558. Walk-in days for intake appointments are offered throughout the week, call the ADS Main Access Line for more information.

4.1.3 **Referrals**
Referrals can be hand-delivered, mailed or faxed to ADS. The ADS confidential fax number is (707) 253-8039. Referrals come from other agencies such as the Mental Health Division, Probation Department, Child Welfare Services, Public Health and local primary care facilities. Other DMC-ODS levels of care such as Detox or Residential Treatment facilities may also submit referrals.
4.1.4 Youth Referrals
SUD services for adolescent/teens can come from schools, probation, families and the community. Service requests for youth outpatient treatment can be directly submitted to Aldea Behavioral Health Services at Wolfe Center located at 2310 1st Street, Napa, CA 94559. Phone (707) 255-1855.

4.2 Coordination & Continuity of Care
Napa County ADS Division has implemented procedures outlined in this handbook to ensure integrated care and coordinate services for all its clients. These procedures are organized to meet DMC-ODS requirements and to do the following:

1. Ensure each client has an ongoing source of care appropriate to their needs
2. Ensures seamless transition between the various SUD levels of care (i.e. withdrawal management, residential, outpatient) without a disruption of service or gaps in treatment
3. Ensures recovery support and services are offered immediately after discharge with the goal of sustained engagement and long-term retention in SUD treatment

4.2.1 Role of Primary Counselor (PC)
The Primary Counselor (PC) who is assigned to a client is either a Certified Drug & Alcohol Counselor or a Licensed Clinician (LPHA) and is responsible to support the coordination and continuity of care. A client is made aware of his/her PC and the range of SUD services at their initial treatment plan appointment. In Napa County, the PC also provides case management services and obtains Release of Information from the client to allow the exchange of information and facilitate collaboration of care with both physical and mental health. Examples of specific care coordination activities include: assessing client progress and goals, monitoring and follow-up of client needs, helping with transitions of care and linking to community resources.

4.2.2 Role of the Licensed Practitioner of the Healing Arts (LPHA)
For every client receiving DMC-ODS Services, a Licensed Practitioner of the Healing Arts (LPHA) is required to:
1. Establish medical necessity
2. Determine substance use diagnoses
3. Ensure appropriate LOC is completed

LPHA’s use the ASAM Placement Criteria to determine the best level of care (LOC) for the client. When an outside agency or individual recommends residential treatment, Napa County will provide authorization to determine if residential service is the appropriate level of care and client meets medical necessity.

LPHA includes Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage & Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

4.3 Client Gateway to ASAM Level of Care

Placement decisions will be made during the initial intake assessment, or at any time during treatment based on the client’s progress or lack of progress.

4.3.1 Initial Request for Service

An initial request for service can be made in person, over the phone, or by use of a referral form. At the time of receipt of request, the client information is entered Anasazi and an Interim Service Log (ISL) is opened that same day by an ADS Office Assistant (see Referral Checklist).

4.3.2 Phone/Walk-in

When someone calls or walks into ADS, they are greeted by an ADS Office Assistant (OA). The Population Screening Tool is used for several purposes. The first reason is to assess the urgency of the request for services and the second reason is to provide clients with the best possible match to a treatment track and primary counselor/LPHA (PC). The OA will ask the person requesting an intake assessment appointment a series of questions and will first determine the urgency of the request and make appropriate referrals if necessary. The OA will then schedule the intake assessment within the timeframe as indicated on the Population Screening Tool. Every effort is made to schedule an appointment with a counselor/LPHA that is most likely to be their PC. Scheduling conflicts may occur preventing a prospective client from being seen initially by the PC with whom they will begin treatment or new information may come to light during the assessment that indicates a different track or counselor may be more clinically appropriate for an individual (see Population Screener Tool).

4.3.3 Referrals

Interagency Referral forms can be found on the main HHSA website and they must be completed due to funding complexities and data tracking requirements. ADS Office Assistants in Office A will date stamp a referral upon receipt and log the information in the ADS Access Log. It is important to be timely and accurate when entering data into the ADS Access Log. OA’s are also required to submit monthly reports to the Division Manager. This data is used to report information to the Quality Improvement Committee (QIC) and State (see Interagency Referral).

4.3.4 Jail Referrals

Additional information is required for referrals received for individuals who are incarcerated. Since a completed intake assessment is valid for only 30-days, the timing of the intake session needs to be coordinated 1-2 weeks prior to an inmate being released from jail. Office A will communicate directly with the referring party on the day a referral is received to ensure the intake is scheduled appropriately. At times, a request for service is received prior to the referring party completing an Interagency Referral form however, it is especially important for the ADS Probation Clinician to review reason for referral prior to the intake assessment session. It is the responsibility of the ADS Office Assistant who received the initial request to ensure referrals are received prior to the intake session (see Off-Site Intake Assessments).
4.4 Initial Medi-Cal Eligibility Check

4.4.1 Napa County Medi-Cal
Drug Medi-Cal are healthcare services for Medicaid eligible individuals with Substance Use Disorders. A client’s Medi-Cal eligibility needs to be determined as soon as possible by the ADS Office Assistants. Supervisors will review the Medi-Cal Eligibility report monthly to identify individuals in treatment who are still in a pending status of Medi-Cal Eligibility and inform the clients Primary Counselor for follow up (see Medi-Cal Edibility Workflow).

4.4.2 Out-of-County Medi-Cal
When a client has Medi-Cal that is through a county other than Napa, the ADS staff must explain to the beneficiary seeking treatment and/or the referring party that in order to qualify for services, the client must transfer their residency to Napa County. Clients should be directed to contact their county of residency and Napa County Self-Sufficiency that is located at 2751 Napa Valley Corporate Drive, Building A, Napa, CA 94558. Phone (707) 253-4511. Notify the Program Supervisor and UR Coordinator if a client decides they want to start services prior to changing their Medi-Cal to Napa County. The assigned primary counselor/LPHA must also be notified in order to assist client with transferring residency.

4.4.3 No Insurance/Self-Pay
Clients who do not have Medi-Cal may choose to receive services and will be billed directly. By completing the CFR form, the client’s share of cost for treatment will be determined, based on amount of earnings each month.

4.4.4 Other Insurance
Clients who have another insurance carrier may choose to receive services and will be billed directly. By completing the CFR form, the client’s share of cost for treatment will be determined, based on amount of earnings each month.

4.4.5 Waiver from Payment
If a client believes he/she cannot meet his/her annual Alcohol & Drug Services Sliding Scale (ADSSS) liability, the Primary Counselor/LPHA (PC) may begin the process to request a waiver from payment. The PC will asks the client for the reasons the client believes he/she cannot pay, and the PC completes an Application for Waiver for Sliding Scale Liability form. The PC forwards this form to their Supervisor along with the ADSSS form that has been completed by the client. The Supervisor consults with Alcohol and Drug Services Leadership Team to review the request to ensure that any change to the client’s liability amount is made for therapeutic reasons. The Administrator of Alcohol and Drug Programs (“AOD Administrator”) signs the approved waiver and the AOD Fiscal Analyst brings a copy of the waiver back to the Fiscal Division to be entered into the Anasazi system to adjust the client’s percentage of costs. The original signed waiver is scanned into the client file.

Refer to the following Policy & Procedures:

- ADSSS (Alcohol and Drug Services Sliding Scale) Client Fee Determination and Billing Process
- Client Financial Review, Universal Method of Determining Eligibility to Pay (UMDAP) and Billing Processes

5 Admission Criteria & Medical Necessity

Napa County Alcohol & Drug Services provides substance use disorder services to persons who meet medical necessity as outlined below.

5.1 Medical Necessity Criteria
Drug Medi-Cal requires that medical necessity be established within 30 days of the client’s admission to treatment and is determined every six months through the justification for continuing treatment process for ongoing receipt of services except for NTP services which will require reauthorization annually. Napa County ADS establishes medical necessity
during the initial assessment, at 6 months and/or throughout the treatment process. To receive services through the DMC-ODS, the client must meet the following criteria:

1. Must be enrolled in Medi-Cal and reside in Napa County, or another participating DMC-ODS County.
2. Must have at least one diagnosis from the DSM-5 for Substance-Related and Addictive Disorders (except for Tobacco Use Disorder and non-substance addictive disorders such as Gambling), or at risk for developing substance use disorder (for youth under 21).
3. Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria or meet the ASAM adolescent treatment criteria.

5.2 Definition of ASAM Criteria of Medical Necessity
The six assessment dimensions identified in The ASAM Criteria is a more holistic concept and encompass all pertinent biopsychosocial aspects of addiction and mental health that determine the severity of the client’s illness and level of function. For these reasons, “medical necessity” should pertain to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the client.

5.3 Purpose of Medical Necessity
42 CFR 438.210(a)(4) outlines the purpose of establishing medical necessity at admission and throughout the treatment process.

- Place appropriate limits on a service on the basis of criteria applied under the State plan, i.e. The ASAM Criteria definition of medical necessity.
- For the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose.
- Must ensure that the services are sufficient in amount, duration or scope to reasonably achieve the purpose for which the service are furnished.

5.4 Establishing Medical Necessity
The Medical Director or LPHA will meet with the beneficiary face-to-face to establish medical necessity criteria. In lieu of the Medical Director or LPHA meeting directly with the beneficiary, the Medical Director or LPHA may evaluate each beneficiary’s assessment and intake information if gathered by a counselor through a face-to-face review or telehealth with the counselor to establish if the beneficiary meets medical necessity criteria. Only the Medical Director or LPHA will document the diagnosis. The interaction between the Medical Director or LPHA and counselor must be documented in the client’s chart. After the LPHA establishes a diagnosis, the ASAM Criteria will be applied to determine placement into the level of assessed services.

5.5 Out-of-County Medi-Cal
When a client has Medi-Cal that is through a county other than Napa, the ADS staff must explain to the beneficiary seeking treatment and/or the referring party that in order to qualify for services, the client must transfer their residency to Napa County. If the individual refuses to transfer residency, ADS staff will provide client with the SUD Treatment Access number in their county of residence. If client agrees to transferring their residency to Napa County they should be directed to contact Napa County Self-Sufficiency that is located at 2751 Napa Valley Corporate Drive, Building A, Napa, CA 94558. Phone (707) 253-4511. Notify the Program Supervisor and UR Coordinator if a client decides they want to start services prior to changing their Medi-Cal to Napa County. The client must show proof that they have applied and are in the process. The assigned primary counselor/LPHA must also be notified in order to assist and follow-up with the client to ensure change-of-residency is completed.
5.5.1 **Access Line’s for Neighboring Counties:**

- Sonoma County: (800) 870-8786 or (707) 565-7450
- Solano County: (707) 428-1131
- Contra Costa County: (800) 846-1652
- Marin County: (888)-818-1115
- San Francisco County: (888) 246-3333 or (415) 255-3737
- Alameda County: (800) 491-9099
- Santa Clara County: (800) 488-9919

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5.6 **Not Meeting Medical Necessity**

It is possible that some clients will not meet Medical Necessity criteria. When this is determined, the LPHA should provide the client with other referrals as appropriate. The LPHA will then instruct an Office Assistant to complete a Notice of Action Benefit Determination (NOABD)-Denial letter to be provided to the client. A Notice of Action is a written notice that gives Medi-Cal Beneficiaries an explanation of the Medi-Cal coverage or benefits. This NOABD includes decision made in the assessment and information about appeals and expedited appeals should the client not agree with the decision. All NOABD’s are then logged in the NOABD log report with the ADS Utilization Review Coordinator for Quality Improvement Committee (QIC) and state tracking purposes (see Billable Codes for the ICD-10 Code to use on the Diagnosis Review form).

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6 **DMC-ODS Beneficiary Handbook**

The DMC-ODS Beneficiary Handbook Table of Contents is reviewed during the ADS Intake Assessment process and prior to starting the interview/ASAM Assessment. This handbook outlines important information about Alcohol & Drug Services and the benefits covered by the Drug Medi-Cal Organized Deliver System (DMC-ODS). It is available in the ADS lobbies, ADS website and ADS Shared Drive. A hardcopy of the DMC-ODS Beneficiary Handbook must be offered to each client during the intake process. Several critical items need to be explained as outlined in this section.

6.1 Admission Agreement and Informed Consent

Treatment adherence and outcomes are enhanced by client collaboration and shared decision-making. The ASAM Criteria encourages engaging with the concept of “informed consent” and health care requires it. Informed consent indicates that the adult, adolescent, legal guardian and/or family member has been made aware of the propose modalities of treatment, the risks and benefits of such treatment, appropriate alternative treatment modalities, and the risks of treatment versus no treatment. Informed Consent must be obtained prior to providing services (first face-to-face contact) to a client. ADS obtains informed consent at the initial intake assessment and annually thereafter. Discussion about informed consent must be documented in the client’s medical record. If a client is unwilling or unable to provide informed consent, the reason and attempts to obtain informed consent must be documented in the client’s medical record.

6.2 Notice of Privacy Practices

The Notice of Privacy Practices should be reviewed with a client at intake. If a client has any questions about this notice, they are directed to the County Privacy Officer at (707) 259-8349. The Notice of Privacy Practices is outlined in the DMC-ODS Beneficiary Handbook and is also available online at http://www.countyofnapa.org/hhsa/ads/.

6.3 Authorization to Use, Exchange or Disclose Protected Health Information (PHI)

Alcohol and/or Drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be disclosed without any written consent. Napa County ADS updated its Authorization to Exchange Information form in 2017 to comply with changes made to the federal regulations governing the confidentiality of substance use disorder patient records (known as “42 CFR Part 2” or simply “Part 2”) by a Final Rule issued in January 2017. ADS staff is required to explain and obtain consent for the release of information from all clients upon entry into treatment and ensuring the completed form is entered into client records. The Authorization to Exchange Information forms must be completed correctly or they are invalid. ADS staff obtaining client consent must also print their name with credentials, sign and date form following client’s signature and date.

6.3.1 Revoking an Authorization

A client may withdraw consent or revoke a previously signed Authorization at any time during their course of treatment. In the event a client asks to revoke a release of information, staff must have the client complete the “Authorization for Revocation” form and send it to Medical Records for processing immediately and document change in Information Note in client record. Please refer to the HHSA Release of Protected Health Information Policy & Procedure for revoking authorizations.

6.4 Grievance, Appeals, Notice of Adverse Benefit Determinations (NOABD) & State Fair Hearings

Napa County DMC-ODS recipients have rights, including the right to report issues about the services they receive. ADS complies with the State Department of Healthcare Services and Federal Managed Care Regulations: Part 438 of Title 42 Code of Federal Regulations regarding the issuance of Notice of Adverse Benefit Determination (NOABD) to DMC-ODS beneficiaries. Beneficiaries are provided the opportunity to appeal a denial, modification or termination of services through the DMC-ODS provider appeal resolution process as well as to request a State Fair Hearing (SFH) if they are
dissatisfied with the DMC-ODS programs resolution to the appeal. These are tracked by the ADS UR Coordinator. Grievances on the other hand, are processed through the Quality Management (QM) Division and follows the DMC-ODS Plan Grievances: Filing, Processing and Resolving Grievances P&P. A grievance is an expression of dissatisfaction about any matter other than an NOABD.

7 CALOMS

CalOMS Treatment (CalOMS Tx) is California's data collection and reporting system for substance use disorder (SUD) treatment services. The Treatment data is due to DHCS by the 15th of each month, or approximately within 45 days of the report month. All clients who enter into Outpatient or Residential Tx services are required to have CalOMS entry for both an Admission and Discharge. The Primary Counselors must complete a CalOMS admission with the clients upon their first group service in the ADS Outpatient Division and open sub-unit 7099 in conjunction with the clients Level of Care subunit. The Primary Counselors must also complete a CalOMS Discharge form when a client completes or is discharged from Treatment services. NOTE: It is imperative that only the required Discharge Reason Codes specific to CalOMS Discharge are used in closing a CalOMS form. Please contact ADS Division Manager or ADS Division Analyst for questions concerning CalOMS Admission or Discharge entries.

8 GENERAL FLOW OF SERVICES & DOCUMENTATION

As each client begins services with Napa County Alcohol & Drug Services, there is a flow of information designed to support staff in providing services that help the individuals we serve meet their treatment goals. The treatment process begins with an initial assessment of needs, identification of substance use related functional impairments and qualifying diagnosis, and the development of a plan for delivery of services. Services provided should always relate to the person’s functional impairment, which was identified during the assessment process. A client’s record should depict an integrated record of treatment and have a “flow” often referred to as “The Golden Thread.”

8.1 MEDICAL NECESSITY & APPROPRIATE LEVEL OF CARE (LOC)

1. SUD Diagnosis and ASAM Assessment
2. Problems identified in each ASAM Dimensions listed on the Treatment Plan
3. Individualized Treatment Plan
4. Services are documented in Progress Notes focusing on Objectives/Goals on Treatment Plan
5. Continuous Reassessment

Medically Necessary services provided at the appropriate level of care (LOC)
Assessment & SUD Diagnosis:

- The ASAM Assessment tool can be completed by a Certified Counselor or LPHA and facilitates the development of a Diagnosis and Treatment Plan.
- An LPHA is required to establish medical necessity, determine substance use diagnoses and ensure appropriate LOC is completed.

Functional Impairments:

- The problems/functional impairments identified in each of the Six Dimension on the ASAM Assessment are listed on the Treatment Plan.
- Each problem is identified as active, referred or deferred.

Treatment Plan:

- The Treatment Plan creates a framework for the services ADS provides and is updated frequently.
- We collaborate with clients and other support persons/providers to develop goals, objectives and interventions that support their recovery.

Progress Notes:

- The services that we provide and document with progress notes must clearly note client’s progress or lack of progress toward his/her goals.

Reassessment:

- Reassessments may occur at any point during the treatment process. Typically, a client is reassessed every 3 months.
- The Justification for Continued Services Reassessment occurs between client’s 5th and 6th month of treatment.

8.2 Assigned Primary Counselor/LPHA

The Primary Counselor (PC) who is assigned to a client is responsible to support the coordination and continuity of care. A client is made aware of his/her PC and the range of SUD services at their initial treatment plan appointment. In Napa County, the PC also provides case management services and obtains Release of Information from the client to allow the exchange of information and facilitate collaboration of care with both physical and mental health. Examples of specific care coordination activities include: Assessing client progress and goals, monitoring and follow-up of client needs, helping with transitions of care and linking to community resources.

9 American Society of Addiction Medicine (ASAM) Assessment

Assessment is the process of gathering and analyzing history, observing behavior and obtaining information from a client and occasionally from significant others to formulate a comprehensive view of a client’s strengths and needs. The ASAM Assessment is the primary assessment tool used at intake and throughout the treatment process in order to establish medical necessity and ensure the appropriate level of care is recommended. A referring party may also be contacted with client approval when appropriate releases are in place. The assessment process leads to a diagnostic formulation, a medical necessity determination and a treatment recommendation. The process may be completed in one session, or if necessary, may be completed in up to 2 sessions beyond the initial intake assessment session. Assessments and its corresponding documentation service as the foundation of high-quality care. In the treatment of persons with SUDs,
assessments are an ongoing process and are essential in order to identify client needs and help the LPHA or Certified Counselor focus their services to best meet those needs.

9.1 ASAM Criteria

The ASAM treatment criterion provides outcome-oriented and results-based care in the treatment of addiction. It is a single, common standard for assessing client needs, optimizing placement, determining medical necessity, and documenting the appropriateness of reimbursement. ASAM criteria is used during the initial assessment and throughout the treatment episode to continually evaluate the client’s progress or regression to determine treatment level need. For both clinical and financial reasons, the preferable level of care is that which is the least restrictive while still meeting treatment objectives and providing safety and security for the client.

ASAM criteria uses six unique dimensions, which represent different life areas that together affect all assessment, service planning, and level of care placement decisions. The ASAM criteria structures multidimensional assessment around the six dimensions to provide a common language of holistic, biopsychosocial assessment and treatment across addiction services, physical health and mental health services. ASAM provides separate placement criteria for adults and adolescents to create comprehensive and individualized treatment plans (see ASAM Six Dimensions).

9.2 ASAM Levels of Care (LOC)

After establishing a substance use diagnosis, the ASAM Criteria will be applied to determine placement into the level of assessed services provided by Napa County or its contract providers.

9.2.1 ASAM Level 0.5 - Early Intervention

Service provided to client’s who are at risk of developing a substance use disorder (SUD). Includes Screening, Brief Intervention, and Referral to Treatment (SBIRT), which takes place in healthcare settings, such as physician’s offices or Emergency Rooms. SBIRT services are not paid for under the DMC-ODS system however, referrals for DMC-ODS services come from these community partners.

9.2.2 ASAM Level 1.0 - Outpatient Treatment

Less than 9 hours of medically necessary service hours per week offered for adults, and less than 6 hours per week offered for youth. Includes recovery or motivational enhancement therapies and strategies.

9.2.3 ASAM Level 2.1 - Intensive Outpatient Treatment

Minimum of 9 service hours per week and a maximum of 19 for adults, and a minimum of 6 service hours to a maximum of 19 for youth prescribed by a Medical Director or LPHA to be medically necessary. Multidimensional instability is treated.

9.2.4 ASAM Level 3.1 & 3.5 - Residential Treatment

Clinically managed population-specific low and high-intensity residential services with 24-hour care with trained counselors to help stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.

9.2.5 Withdrawal Management – Level 1-WM (not available)

1-WM is an organized outpatient service that is currently not available in Napa County. 1-WM is appropriate for mild withdrawal with daily, or less than daily outpatient supervision.

9.2.6 Clinically Managed Residential Withdrawal Management – Level 3.2-WM

Level 3.2-WM Clinically Managed Residential Withdrawal Management (detoxification) is an organized service for clients who are intoxicated or experiencing withdrawal. This service can be provided at DHCS Certified Outpatient Facilities with
Detox Certification, Physician or licensed prescriber, and at an NTP site for opioids. Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery. The components of WM services include:

- Intake
- Observation
- Medication Services
- Discharge Services

9.3 ASAM LEVEL OF CARE ATTESTATION

After completion of the initial and any subsequent ASAM assessment, the ASAM LOC Attestation must be completed by LPHA. The opening of a LOC subunit must correspond to the completed ASAM Assessment date. If LOC changes during treatment, a new LOC Attestation form must be completed (see ADS Workflow Checklists).

10 THE INITIAL INTAKE ASSESSMENT

Each assessment is an important aspect of the client engagement and individualized treatment planning. The intake is the process of admitted a client into a SUD treatment program and the first face-to-face service provided is the Admission or Admit date. Intake Assessment services include the following: evaluation or analysis of substance use disorders, the diagnosis of substance use disorders, and the assessment of treatment needs to provide medically necessary services. An intake may also include a physical examination laboratory testing necessary for substance use disorder treatment. The assessing LPHA or certified counselor will ensure all of the intake paperwork is explained to the client, completed thoroughly and required signatures obtained. If a certified counselor conducts assessment, the intake packet will be submitted to their Supervisor or reviewing LPHA for review and approval (see Intake Assessment Checklist).

10.1 PROBATION AND JAIL INTAKE ASSESSMENTS

Intakes facilitated at Napa County Probation Department and Napa County Jail follow a slightly different opening procedure (See Off-Site/Jail Intake Assessment Checklist).

10.2 INCOMPLETE INTAKE ASSESSMENTS

If a client decides not to engage in ADS service at the start of the session (or leaves within a few minutes), the Intake Counselor/LPHA will complete a Progress Note using the service code, “Intake/Assessment” and will follow the “No Show/Cancellation” procedure in this manual. Counselor/LPHA should be specific about what occurred in the narrative section of the note. This is not a billable service and by selecting “Cancellation” in the Service Type will ensure the session is not billed.

At times, an Intake session will end prior to establishing medical necessity criteria and/or a Substance Use Diagnosis. If the client does not return to complete the intake process within 30 days, then LPHA will complete a Diagnosis Review form to include the ICD-10 Code Z87.898 “Personal history of other specified conditions” in order to document not enough information was gathered to establish a Substance Use Disorder. This documentation allows the intake service to be billed.
11 Substance Use Disorder Diagnosis

Only an LPHA or Medical Director can document a SUD diagnosis. An LPHA or Medical Director may meet face-to-face with the counselor or via telehealth to establish medical necessity criteria. This case review is documented in the medical record. LPHA includes Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage & Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

11.1 DSM-5 Classification of Substances

The substance-related disorders in the DSM-5 encompass 10 separate classes of drugs. The essential feature of a substance use disorder is a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues using despite significant substance-related problems. Substance use disorders occur in a broad range of severity, from mild to severe, with severity based on the number of symptom criteria endorsed. Changing severity across time is also reflected by reductions or increases in the frequency and/or dose of substance, as assessed by the individuals own report, report of knowledgeable others, clinician’s observations, and/or biological testing. Course specifiers and descriptive features specifiers are also used when making a diagnosis. The diagnosing LPHA must document how severity rating was established in addition to the individual’s unique experience and/or report of symptoms.

The following is a list of substances that have associated diagnoses in the DSM-5:

1. Alcohol
2. Caffeine*
3. Cannabis
4. Hallucinogens (PCP, Other Hallucinogens LSD, DXM, Ketamine)
5. Inhalants (aerosols, gases, nitrites)
6. Opioids (heroin, opioid pain medications such as Dilaudid, OxyContin)
7. Sedatives, hypnotics, or anxiolytics (benzodiazepines, barbiturates)
8. Stimulants (amphetamine-type substances, cocaine, and other stimulants)
9. Tobacco**
10. Other (or unknown) substances

* For Caffeine Use Disorder: Refer client to their Primary Care Physician.

** For Tobacco Use Disorder: Refer client to their Primary Care Physician if this is the only substance use disorder. Tobacco Use Disorder is not on the list of included diagnoses for Drug Medi-Cal. However, if client presents with a Tobacco Use Disorder in conjunction with other substance use disorder(s), staff can treat client with Tobacco Cessation.

11.2 Diagnostic Criteria

A problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. The substance is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving, or a strong desire or urge to use the substance.
5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
7. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
8. Recurrent use of the substance in situations in which it is physically hazardous.
9. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
   b. A markedly diminished effect with continued use of the same amount of the substance.
11. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria set for alcohol or other substances withdrawal).
   b. The substance (or closely related substance, such as benzodiazepine for alcohol) is taken to relieve or avoid withdrawal symptoms.

11.2.1 Specifiers
Specify current severity of the substance use disorder:

- **Mild**: Presence of 2-3 symptoms.
- **Moderate**: Presence of 4-5 symptoms.
- **Severe**: Presence of 6 or more symptoms.

11.2.2 Additional descriptive features specifiers
Determine if there is a further specifier that should be noted:

- **In Early Remission**: After full criteria for the substance use disorder were previously met, none of the criteria for the substance use disorder were met for at least 3 months but for less than 12 months (with the exception that “craving, or a strong desire to use substance” may still be met).
- **In Sustained Remission**: After full criteria for the substance use disorder were previously met, none of the criteria for the substance use disorder have been met at any time during a period of 12 months or longer (with the exception that “craving, or a strong desire to use substance” may still be met).
- **In a Controlled Environment**: This additional specifier is used if the individual is in an environment where access to alcohol or substances of abuse is restricted.

11.3 Diagnostic Criteria for Youth
Youth under 21 years old who are assessed as being at risk for developing a substance use disorder must meet the ASAM adolescent treatment criteria and will have two or more of the following DSM 5 criteria:

1. Difficulties at school related to possession/use/sales of drugs or alcohol including poor school attendance/poor participation/poor grades.
2. Minor or newly emerging legal/school issues (e.g. a misdemeanor charge, a possession of tobacco ticket, school suspension or behavior contract) but no arrests or probation involvement.
3. Self-reported experimentation with drugs and alcohol.
4. Family history of substance use and/or legal involvement.
5. Lack of positive family involvement in client’s life.
7. Client reports having few friends or feeling bullied and/or socially isolated.
8. Recent death/loss of a significant person in client’s life.
9. Youth has recently experienced other major life stressors.

As a point of clarification, beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS Pilot overrides any EPSDT requirements.

**11.4 Included ICD-10 Billable Codes**

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Substance Use Disorder Code Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Z87.898</td>
<td>Personal history of other specified conditions *No SUD diagnosis established</td>
</tr>
<tr>
<td>F10.10</td>
<td>Alcohol use disorder, Mild</td>
</tr>
<tr>
<td>F10.20</td>
<td>Alcohol use disorder, Moderate</td>
</tr>
<tr>
<td>F10.20</td>
<td>Alcohol use disorder, Severe</td>
</tr>
<tr>
<td>F10.99</td>
<td>Unspecified Alcohol-related disorder</td>
</tr>
<tr>
<td>F10.229</td>
<td>Alcohol intoxication, With moderate or severe use disorder</td>
</tr>
<tr>
<td>F10.239</td>
<td>Alcohol withdrawal <em>(Must also have a Comorbid diagnosis of Moderate or Severe Alcohol Use Disorder)</em></td>
</tr>
<tr>
<td>F10.XX</td>
<td>Alcohol use disorder, In early or sustained remission (see Specifier List to code)</td>
</tr>
<tr>
<td>F15.10</td>
<td>Amphetamine-type use disorder, Mild</td>
</tr>
<tr>
<td>F15.20</td>
<td>Amphetamine-type Alcohol use disorder, Moderate</td>
</tr>
<tr>
<td>F15.20</td>
<td>Amphetamine-type Alcohol use disorder, Severe</td>
</tr>
<tr>
<td>F15.99</td>
<td>Unspecified amphetamine or other stimulant-related Disorder</td>
</tr>
<tr>
<td>F15.229</td>
<td>Stimulant intoxication, With moderate or severe amphetamine or other stimulant use disorder</td>
</tr>
<tr>
<td>F15.23</td>
<td>Amphetamine or other stimulant withdrawal <em>(Must also have a Comorbid diagnosis of Moderate or Severe Amphetamine-type stimulant-type Use Disorder)</em></td>
</tr>
<tr>
<td>F15.XX</td>
<td>Amphetamine-type use disorder, In early or sustained remission (see Specifier List to code)</td>
</tr>
<tr>
<td>F12.10</td>
<td>Cannabis use disorder, Mild</td>
</tr>
<tr>
<td>F12.20</td>
<td>Cannabis use disorder, Moderate</td>
</tr>
<tr>
<td>F12.20</td>
<td>Cannabis use disorder, Severe</td>
</tr>
<tr>
<td>F12.99</td>
<td>Unspecified cannabis-related disorder</td>
</tr>
<tr>
<td>F12.229</td>
<td>Cannabis intoxication, With moderate or severe use disorder</td>
</tr>
<tr>
<td>F12.288</td>
<td>Cannabis withdrawal <em>(Must also have a Comorbid diagnosis of Moderate or Severe Cannabis Use Disorder)</em></td>
</tr>
<tr>
<td>F12.XX</td>
<td>Cannabis use disorder, in early or sustained remission (see Specifier List to code)</td>
</tr>
<tr>
<td>F14.10</td>
<td>Cocaine use disorder, Mild</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F14.20</td>
<td>Cocaine use disorder, Moderate</td>
</tr>
<tr>
<td>F14.20</td>
<td>Cocaine use disorder, Severe</td>
</tr>
<tr>
<td>F14.99</td>
<td>Unspecified cocaine-related disorder</td>
</tr>
<tr>
<td>F14.229</td>
<td>Cocaine intoxication, with moderate or severe use disorder</td>
</tr>
<tr>
<td>F14.23</td>
<td>Cocaine withdrawal <em>(Must also have a Comorbid diagnosis of Moderate or Severe Cocaine Use Disorder)</em></td>
</tr>
<tr>
<td>F14.XX</td>
<td>Cocaine use disorder, in early or sustained remission <em>(see Specifier List to code)</em></td>
</tr>
<tr>
<td>F16.10</td>
<td>Hallucinogen use disorder, Mild</td>
</tr>
<tr>
<td>F16.20</td>
<td>Hallucinogen use disorder, Moderate</td>
</tr>
<tr>
<td>F16.20</td>
<td>Hallucinogen use disorder, Severe</td>
</tr>
<tr>
<td>F16.99</td>
<td>Unspecified hallucinogen-related Disorder</td>
</tr>
<tr>
<td>F16.229</td>
<td>Hallucinogen intoxication, With moderate or severe use disorder</td>
</tr>
<tr>
<td>F16.XX</td>
<td>Hallucinogen use disorder, In early or sustained remission <em>(see Specifier List to code)</em></td>
</tr>
<tr>
<td>F18.10</td>
<td>Inhalant use disorder, Mild</td>
</tr>
<tr>
<td>F18.20</td>
<td>Inhalant use disorder, Moderate</td>
</tr>
<tr>
<td>F18.20</td>
<td>Inhalant use disorder, Severe</td>
</tr>
<tr>
<td>F18.99</td>
<td>Unspecified inhalant-related disorder</td>
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<tr>
<td>F18.XX</td>
<td>Inhalant use disorder, In early or sustained remission <em>(see Specifier List to code)</em></td>
</tr>
<tr>
<td>F11.10</td>
<td>Opioid use disorder, Mild</td>
</tr>
<tr>
<td>F11.20</td>
<td>Opioid use disorder, Moderate</td>
</tr>
<tr>
<td>F11.20</td>
<td>Opioid use disorder, Severe</td>
</tr>
<tr>
<td>F11.99</td>
<td>Unspecified opioid-related disorder</td>
</tr>
<tr>
<td>F11.229</td>
<td>Opioid intoxication, With moderate or severe use disorder</td>
</tr>
<tr>
<td>F11.23</td>
<td>Opioid withdrawal <em>(Must also have a Comorbid diagnosis of Moderate or Severe Alcohol Use Disorder)</em></td>
</tr>
<tr>
<td>F11.XX</td>
<td>Opioid use disorder, In early or sustained remission <em>(see Specifier List to code)</em></td>
</tr>
<tr>
<td>F13.10</td>
<td>Sedative, hypnotic or anxiolytic use disorder, mild</td>
</tr>
<tr>
<td>F13.20</td>
<td>Sedative, hypnotic or anxiolytic use disorder, moderate</td>
</tr>
<tr>
<td>F13.20</td>
<td>Sedative, hypnotic or anxiolytic use disorder, severe</td>
</tr>
<tr>
<td>F13.99</td>
<td>Unspecified sedative, hypnotic or anxiolytic-related disorder</td>
</tr>
<tr>
<td>F13.239</td>
<td>Sedative, hypnotic or anxiolytic withdrawal <em>(Must also have a Comorbid diagnosis of Moderate or Severe Sedative, hypnotic or anxiolytic Use Disorder)</em></td>
</tr>
<tr>
<td>F13.229</td>
<td>Sedative, hypnotic or anxiolytic intoxication</td>
</tr>
<tr>
<td>F13.XX</td>
<td>Sedative, hypnotic or anxiolytic use disorder, In early or sustained remission <em>(see Specifier List to code)</em></td>
</tr>
<tr>
<td>FXX.XX</td>
<td>Stimulant use disorder <em>(see Amphetamine, Other Stimulants or Cocaine sections)</em></td>
</tr>
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</table>
**11.5 Recovery Services Billable Codes**

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>Substance Use Disorder Code Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>F10.11</td>
<td>Alcohol use disorder, In remission</td>
</tr>
<tr>
<td>F11.11</td>
<td>Opioid use disorder, In remission</td>
</tr>
<tr>
<td>F12.11</td>
<td>Cannabis use disorder, In remission</td>
</tr>
<tr>
<td>F13.11</td>
<td>Sedative, hypnotic, or anxiolytic use disorder, In remission</td>
</tr>
<tr>
<td>F14.11</td>
<td>Cocaine use disorder, In remission</td>
</tr>
<tr>
<td>F15.11</td>
<td>Other stimulant use disorder, In remission</td>
</tr>
<tr>
<td>F16.11</td>
<td>Hallucinogen use disorder, In remission</td>
</tr>
<tr>
<td>F18.11</td>
<td>Inhalant use disorder, In remission</td>
</tr>
<tr>
<td>F19.11</td>
<td>Other psychoactive substance use disorder, In remission</td>
</tr>
</tbody>
</table>

**11.6 Excluded ICD-10 Diagnosis Codes**

<table>
<thead>
<tr>
<th>Excluded ICD-10 Codes</th>
<th>Substance Use Disorder Code Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>F15.929</td>
<td>Caffeine Intoxication</td>
</tr>
<tr>
<td>F29.20</td>
<td>Caffeine Withdrawal</td>
</tr>
<tr>
<td>F15.99</td>
<td>Unspecified Caffeine-Related Disorder</td>
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<tr>
<td>Z72.0</td>
<td>Tobacco Use Disorder, Mild</td>
</tr>
<tr>
<td>F17.200</td>
<td>Tobacco Use Disorder, Moderate</td>
</tr>
<tr>
<td>F17.200</td>
<td>Tobacco Use Disorder, Severe</td>
</tr>
<tr>
<td>F17.203</td>
<td>Tobacco Withdrawal</td>
</tr>
<tr>
<td>F17.209</td>
<td>Unspecified Tobacco-Related Disorder</td>
</tr>
<tr>
<td>F63.0</td>
<td>Gambling Disorder</td>
</tr>
</tbody>
</table>

**12 Mental Health & Physical Health Considerations**

Substance use disorders impact all facets of life and treatment should be designed with the whole person in mind. The DMC-ODS demonstration encourages coordination and integration of SUD services with physical health and mental health care, potentially leading to improved clinical and fiscal outcomes. Therefore, the coordination of SUD care both within the SUD system and with medical and mental health services is especially important at intake and throughout the treatment process. When considering a substance use diagnosis, it is important to rule out other factors that may affect a client’s presentation of symptoms such as medical conditions and/or mental health conditions. Therefore, seek guidance/consultation from Program Supervisor and/or Medical Staff when clinically indicated.

**12.1 Co-occurring Services**

The Alcohol & Drug Services program understands that many people with substance use disorders suffer from co-occurring disorders (CODs) including mental health and medical problems, which complicate treatment and may contribute to poorer outcomes. To help alleviate a variety of barriers that can impede the integration of care for clients
with COD, ADS directly provides co-occurring treatment services under the care of a licensed clinician with in-depth understanding of both Substance Use and Mental Health conditions. Clients entering directly into co-occurring treatment must have both a MH and SUD diagnosis and be opened to the 7095 co-occurring subunit in conjunction with their appropriate level of care subunit (i.e. 7050, 7051). Refer to Subunit section of this manual.

SAMHSA’s Treatment Improvement Protocol (TIP) series titled “Substance Abuse Treatment for Persons with Co-Occurring Disorders,” recommends the following guiding principles in the treatment of clients with CODs:

- **Employ a recovery approach**: The recovery perspective essentially acknowledges that recovery is a long-term process of internal change that requires continuity of care over time, and recognizes that these internal changes proceed through various stages and that treatment approaches need to be specific to the goals and challenges of each stage of the COD recovery process.

- **Adopt a multi-problem viewpoint** – Treatment comprehensively addresses the immediate and long-term needs of the multidimensional problems typically presented by clients with COD. (e.g., housing, work, health care, a supportive network).

- **Develop a phased approach to treatment** – Treatment phases generally include engagement, stabilization, treatment, and continuing care, which are consistent with, and parallel to, the various stages of recovery. Treatment through these phases allows providers to develop and use effective, stage-appropriate treatment interventions.

- **Address specific real-life problems early in treatment** – Given that CODs often arise in the context of social and personal problems, addressing such problems is often an important first step toward achieving client engagement in continuing treatment.

- **Plan for the client’s cognitive and functional impairments** – Clients with a COD often display cognitive and functional impairments that affect their ability to comprehend information or complete tasks. As a result, services need to be tailored to and compatible with the need and functional level of COD clients.

- **Use support systems to maintain and extend treatment effectiveness** – Given that many clients with a COD have strained support systems, and the central importance of supportive people and environments in the recovery process, a vital element of effective treatment of the COD population is ensuring that clients are aware of available support systems and motivated to use them effectively.

### 12.2 Existing Mental Health Diagnosis

Napa County ADS shares electronic health records with the Mental Health Division. The Diagnosis Review form is frequently used and shared between both departments. When an ADS LPHA creates a new diagnosis review form, it is especially important to take certain steps if there is an existing mental health diagnosis. The end date for the following situations is one day prior to the beginning date of the current ADS diagnosis.

1. Never delete a MH diagnosis.
2. ADS LPHA may end-date a mental health diagnosis as long as the correct steps are taken to coordinate with the original diagnosing clinician. If clinician is not available, then refer to the ADS UR Coordinator or Supervisor who will follow-up with MH UR Coordinator.
3. If ADS opens a case and there is a Mental Health diagnosis, determine if the case is still open with the Mental Health Division.
   a. If it is open, keep the Mental Health diagnosis as priority 1.
   b. If the case is not open, priority 1 can be used by ADS if appropriate.
4. ADS LPHA can end-date a Mental Health “No Diagnosis,” which is “Z03.89 Encounter for observation for other suspected diseases and conditions ruled out.”
5. If MH added a SUD diagnosis and ADS believes it should be changed or modified, that is acceptable. End-date SUD diagnosis and add the appropriate SUD diagnosis.
6. ADS Staff, please notify ADS UR Coordinator or Supervisor if you notice an old DSM 4/ICD 9 code. ADS UR Coordinator or Supervisor will end-date the old DSM 4/ICD 9 code(s).

### 12.3 Existing Physical Health Conditions

Under the DMC-ODS waiver, identification of medical conditions on the Anasazi Diagnosis Review form is now required. Clients receiving DMC-ODS Services often have special healthcare needs. LPHA will identify and document special healthcare needs during the face-to-face intake assessment with the client or in review of the intake documents and case consultation with the Certified Counselor who gathered information for the intake. The LPHA should inquire about a client’s current medical condition(s) during the intake and/or during reassessments. It is important to note how the information was received for example, “per client report” or “as identified by doctor on physical exam.” MDT/Case Consultation with the Medical Director or other medical professional also provides an opportunity to discuss clients with special healthcare needs and included in a client’s treatment plan.

Clients may already have medical conditions listed on an existing Diagnosis Review form and/or may be added by LPHA. Once a special healthcare need is identified and documented, the Primary Counselor is required to follow through on the coordination of care. See Coordination of Care section of this manual and Medical Director Policy and Procedures on medical issues identified at intake assessment.

### 12.4 Perinatal

The state mandates that a pregnant or parenting woman with Substance Use Disorder obtain priority preference and receive urgent treatment services. Substance Use Dependence treatment must address treatment and recovery needs of pregnant and parenting women of up to 60 days postpartum. Priority must be given to pregnant women who are seeking or referred to treatment in the following order:

- Pregnant injecting drug users;
- Pregnant substance users;
- Injection drug users; and
- All others

In addition, there are specific capacity management and service delivery requirements for Perinatal clients. Those requirements can be found in the Perinatal Practice Guidelines by DHCS. Reference: [https://www.dhcs.ca.gov/individuals/Documents/Perinatal_Practice_Guidelines_FY1819.pdf](https://www.dhcs.ca.gov/individuals/Documents/Perinatal_Practice_Guidelines_FY1819.pdf).

### 12.5 Multidisciplinary Teams (MDT)/Case Consultation

ADS encourages a multidisciplinary approach to combine a variety of treatment specialists to create individualized treatment for every client. Ongoing case consultation with the Medical Director, Ole Health practitioners and/or other medical providers is encouraged. The Primary Counselor must document case consults in the client’s chart by use of a Progress Note (using applicable service code i.e. case management, treatment planning, etc.) or an Informational Note to include the specifics of the consultation. Only the client’s Primary Counselor/LPHA may bill for the consultation if a plan was developed specific to the client’s treatment plan.

### 13 Physical Examination (PE) Requirement

For Admission into DMC SUD Treatment, a Physical Exam (PE) is required in one of the following ways within 30 days from client’s admission date. This requirement is satisfied when client meets one of the following:
1. Client had a physical exam within the last 12 months. A copy has been reviewed by Medical Director or assigned medical personnel and placed into client electronic health record; or
2. Perform a new physical exam (by a physician, PA or LNP) or if neither (a) or (b) has been performed then,
3. Include the goal of obtaining a physical exam on the Treatment Plan.

13.1 Physical Exam Attestation Form
Ole Health County Campus is available for ADS clients to obtain a physical. A referral by the ADS Counselor to Ole Health is required. After Ole Health completes the client physical, HHSA Medical Records will scan both the physical exam and physical exam confirmation form from the Physician, Nurse Practitioner or Physician Assistant into the client chart. Medical Records will also complete the Physical Exam Attestation form in the client chart (see Physical Exam Workflow and Attestation).

13.2 Primary Counselor’s Responsibilities Regarding PE’s
It is the responsibility of the Primary Counselor to ensure that the physical exam requirement is completed and documented correctly, showing any attempts to obtain the completed physical. If the client has not obtained or completed his/her physical exam by 30 days of Admission, the ADS Primary Counselor must document the reason and/or attempts in a progress note. This will be an ongoing goal in the Treatment Plan until resolved and continuous attempts to resolve must be documented. There is a “Physical Exam” Informational Note template available to use for best practice. Physical Exams must also be conducted annually and scanned into the client’s medical record.

13.2.1 Physical Exam Review
The Primary Counselor/LPHA should review the client’s physical exam carefully and seek guidance from the ADS Medical Director, medical staff and/or Supervisor to ensure appropriate coordination of care occurs between ADS, Physical Health and Mental Health departments when appropriate.

13.2.2 Obtaining Kaiser Physical Exams
Follow the steps below to receive a copy of client’s physical exam from Kaiser.

1. Complete HHSA ROI and Kaiser ROI (see Addendum)
2. Complete Fax cover sheet requesting a fax or email response
3. Fax cover sheet and both Kaiser & ADS ROI to 707-651-2716
4. Kaiser will email the result in less than 10 minutes!

14 Medication Assisted Treatment (MAT)
Medication Assisted Treatment Includes the ordering, prescribing, administering and monitoring of all medications for substance use disorders. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber. Medication Assisted Treatment consists of buprenorphine, naloxone and disulfiram. For Napa County Alcohol & Drug Services, Medication Assisted Treatment is provided by Ole Health. Dr. Ninad Athale, Medical Director for ADS and Ole Health Primary Care Physician is certified in addiction medicine oversees the ordering, prescribing, administering and monitoring of all medications for ADS clients requiring MAT services. Medically necessary services are provided in accordance with and individualized treatment plan determined by the licensed physician or licensed prescriber.

14.1 MAT Referral Attestation Form
In ADS, the AOD counselor will identify the need for MAT services during the initial treatment planning session. If the client chooses to obtain, the Counselor shall complete an interagency referral form for Ole Health, attach an ROI and a
copy of the ASAM assessment and fax referral packet to Ole Health. After referral is completed, the AOD counselor will complete the **MAT Referral Attestation form** in Anasazi (see MAT Workflow).

### 14.2 Narcotic Treatment Program (NTP)

Opioid medication assisted treatment to those persons addicted to opiates including buprenorphine, naloxone, and disulfiram. NTPs also provide detoxification and/or maintenance treatment services, which include medical evaluations and rehabilitative services to help the client become and/or remain productive members in our community. (NOTE: NTP can also be referenced as Opioid (Narcotic) Treatment Program, OTP). Napa County contracts NTP services with MedMark Treatment Center in Solano County.

### 15 Residential Services

#### 15.1 Residential Assessments & Authorizations

Any client requesting or being referred to residential treatment must first complete an Intake Assessment to determine both medical necessity and level of care. Napa County ADS is the gateway for authorization to residential treatment, which is required to be authorized within 24 hours. Once medical necessity and level of care is determined by an LPHA, the LPHA will follow the procedures as outlined in the Residential Managed Care Organization (MCO) Authorization Process to refer client to residential treatment.

In the event the client is unable to be admitted to residential treatment immediately, the following options are to be considered:

1. Immediately offer and refer for Medication Assisted Treatment (MAT) services.
2. Offer 2.1 Intensive Outpatient treatment as an interim service, if client accepts 2.1 LOC, LPHA refers client case to their supervisor who will assign client to the Primary Counselor/LPHA Clinician.
3. A NOABD-Modification Letter must be given to client (within 3 days of intake).
4. The Primary Counselor/LPHA will complete a treatment plan and closely monitor client, documenting services provided until placed into a residential facility.
5. Primary Counselor/LPHA will work closely with client to connect to significant support persons or community resources.

Client will be informed to be ready to enter residential treatment immediately when called. The ADS Office Assistant will update the residential log and will conduct two outreach calls to the client. If the client does not respond or refuses the offered date, client may be removed from the residential log and must reassess for services in the future (see Residential Managed Care Organization (MCO) Authorization Process).

### 16 Ancillary Groups

In addition to the core Substance Use Dependence (SUD) groups, ADS offers clients ancillary groups for more intensive treatment requirements. Careful consideration was taken in identifying the needs for clients in recovery. The groups are identified by topic consideration and include Mental Health Wellness, Resiliency, Self (esteem, help, and efficacy), Criminal Thinking, Physical Wellness, Seeking Safety, and Relationships & Co-Dependency. As part of the individualized treatment focus, counselors are required to work with their client to help identify the appropriate ancillary group based on their assessment and level of care requirements. All offered groups must be indicated on the clients individualized treatment plan.
17 Case Management

Case Management is defined as a service to assist in accessing needed medical, educational, social, vocational, rehabilitative or other community services. Medical Necessity for Case Management Services must be determined and documented in the Treatment Plan. All ADS Primary Counselors (AOD Counselor or LPHA) are required to provide case management services to their clients. When Case Management services are provided, the service must be documented and billed as a separate service. Refer to the Service Code Definition section for components of case management. Case Management may be provided in treatment programs or alternative settings. They may be provided face-to-face, via telephone or telehealth, or in the community.

18 Court Services

18.1 Drug Court (DC)

This is court-ordered drug treatment program designed to give defendants the opportunity to enter into recovery rather than the prison system. Clients can be involved in Drug Court for at least 12 months and during their time in drug court, participants may receive a host of treatment services and progress (or lack of) is communicated weekly with the DC team. ADS assigns a dedicated AOD Counselor for DC who manages client’s participation in the program and provides weekly reporting to the DC team and judge. Clinical information from the ADS treatment program must be accurate and submitted timely to the Case Manager overseeing Drug Court (by Wednesday afternoon each week). The Drug Court team formally reviews the report every Friday morning before court.

Drug Court Case Manager may also enter client treatment status into the DOORS system which is a used for Drug Court Team reporting. The DOORS system is not considered the clients official medical record and all treatment services and client contacts must be entered into Anasazi.

18.2 Parent Recovery Court (PRC)

Parent Recovery Court (PRC) is conducted monthly for clients connected with HHSA Child Welfare Services Division. Preparation is required to gather information for reporting. PRC is held on the second Tuesday of each month. Primary Counselor is required to have the reports to the ADS Court Coordinator no later than 9 am on the Monday 8 days prior to court.

18.3 PC 1210 Court (Formerly Prop 36)

This court is conducted every Monday. The assigned AOD Counselor prepares the report, which includes: clients enrolled in or referred to ADS who are also PC1210 participants, client’s engagement and status in treatment, group attendance and UA results. The ADS assigned counselor provides the treatment report to the designated probation representative (currently Brenda Del Castillo) each Wednesday prior to the Monday court. The assigned AOD Counselor is required to attend court to support or clarify any treatment questions by the court or probation.

19 Recovery Services

Recovery Services address the recovery and wellness process following a primary treatment episode. It is intended that providers will assess the treatment needs in the recovery environment during the transfer/transition planning process. Recovery services shall be utilized when the client is triggered, has relapsed, or simply as a preventative measure to prevent relapse. Recovery services emphasize the client’s central role in managing their health and teaches them to use
effective self-management support strategies. Refer to Service Code Definition section for components of Recovery Services.

The offer of Recovery Services is indicated on a client’s Discharge Plan. If a client accepts Recovery Services, Primary Counselor must follow the steps outlined in the Recovery Services Workflow. It is required for the client to have an updated Diagnosis Review form completed by LPHA and a new Recovery Plan that addresses client’s needs in all of the ASAM Dimensions. The Recovery Plan (new treatment plan) may be completed by a Certified Counselor but must be approved by an LPHA (see Recovery Services Workflow).

20 Electronic Health Records System

Cerner-Anasazi is the Electronic Health Records (EHR) System for Napa County Health & Human Services Agency’s Mental Health and Alcohol & Drug Services Divisions. The next section outlines the Alcohol & Drug Sub-Units/Assignments and the Service Codes to utilize while writing progress notes. Service definitions in this manual provide descriptions of the kinds of activities associated with each Anasazi service code.

20.1 Opening Client in ADS Treatment Session

When opening a new client in Anasazi, you may notice the client has an active Treatment Session to Napa County. DO NOT USE this Treatment Session. Add a new Treatment Session, “3 – Alcohol and Drug Services” on the same date of Admission. The Alcohol & Drug Treatment Session is considered the overall umbrella of the Units/Subunits in Anasazi and remains open (active) while a client flows through different levels of care at the ADS Outpatient Division (i.e. Outpatient to Intensive Outpatient and vise-versa). A client’s Treatment Session will remain open until the client is fully discharged from their treatment episode. If the client returns after discharge, the client will have a new Treatment Session added for the new treatment episode.

20.2 Sub-Units/Assignments

The opening of a sub-unit/assignment must correspond with the approved date of a Diagnosis/ASAM or the date of a reassessment ASAM.

<table>
<thead>
<tr>
<th>Sub Unit/Assignment</th>
<th>Level of Care Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>7050</td>
<td>Outpatient 1.0</td>
<td>Minimum of 6 hours per week</td>
</tr>
<tr>
<td>7051</td>
<td>Intensive Outpatient 2.1</td>
<td>Minimum of 9 hours per week</td>
</tr>
<tr>
<td>7052</td>
<td>Outpatient Recovery 1.0</td>
<td>As clinically indicated</td>
</tr>
<tr>
<td>7075</td>
<td>Perinatal Outpatient 1.0</td>
<td>Minimum of 6 hours per week</td>
</tr>
<tr>
<td>7076</td>
<td>Perinatal Intensive Outpatient 2.1</td>
<td>Minimum of 9 hours per week</td>
</tr>
<tr>
<td>7077</td>
<td>Perinatal Recovery</td>
<td>Only in Outpatient 1.0</td>
</tr>
<tr>
<td>7095</td>
<td>Co-occurring</td>
<td>No services entered; for reporting &amp; tracking only</td>
</tr>
<tr>
<td>7099</td>
<td>CalOMS Reporting</td>
<td>No services entered; for reporting &amp; tracking only</td>
</tr>
<tr>
<td>7631</td>
<td>Residential 3.1</td>
<td>Utilization Review Purpose</td>
</tr>
<tr>
<td>7632</td>
<td>Residential Withdrawal Mgmt. 3.2</td>
<td>Utilization Review Purpose</td>
</tr>
</tbody>
</table>
21 Documenting Services

Electronic progress notes are completed for every service provided. Do not attempt to document an activity that you are not ‘credentialed’ for and would be considered outside your credential’s scope of practice. Credential information is contained in Scope of Practice-Detail in the Appendix Section of this manual. Service Codes listed as non-reimbursable (i.e. non-billable) must still be documented under the appropriate code in order that the activities can be identified, tracked, reviewed and measured.

The table below will provide guidance on how to document for each service type into a progress note. Attending to the service descriptions will assist you in determining the appropriate Service Code (SC) for the activity you are documenting. Each Service Code (SC) is listed along with the function of the service type and then outlines the billable activities associated with that service type. Remember, the clinical chart is a record of all activities and tell the story of clients’ progress and/or lack of progress on treatment goals and notes should be written objectively. The client can request his/her chart at any time, or a court may subpoena a chart both situations are outlined in HHSA policy and procedure. Technical support and information relating to accessing and completing required electronic record forms, including progress notes, is located on the Anasazi SharePoint Site.

21.1.1 Service Time

Service time is the total time it takes to provide the service, which can be in person, over the phone or in the community. There is a start and stop time in Anasazi and must be billed by the minute.

21.1.2 Documentation Time

Documentation time is the time it takes to complete the Progress Note or Group Progress Note in Anasazi. It also includes time spent to complete clinical documentation. When a service is provided, documentation time may be captured and billed when completed within 24 hours of the service. Documentation on its own is not a billable service. You may use an informational note to document completion of clinical form.

21.1.3 Travel Time

Travel time is the time it take to travel to an off-site location (other than satellite offices, such as probation). The total travel time should be added to the progress note.
21.2 Disallowed Services

21.2.1 Prior to a Valid SUD Diagnosis
Services other than “Intake/Assessment” that are provided before the approval of a SUD Diagnosis that determines medical necessity will be disallowed. There must first be an approved SUD diagnosis and a Diagnosis Review form completed in Anasazi by LPHA. See One-Shot Intake in the Appendix section for more information regarding the completion of a Diagnosis Review form when a client does not meet medical necessity for SUD services and/or when an intake is incomplete.

21.2.2 After a Diagnosis Review Form has been Closed
When a Diagnosis Review form is being closed, any and all progress notes must be entered before it is closed. Services will be disallowed if entered after the Diagnosis is closed. Documenting by Service Type.

21.2.3 Prior to Completed Treatment Plan
Please refer to the Treatment Plan Section of this Documentation Manual for more information about Treatment Plans. The only services that are billable prior to the finalization of the client’s Initial Treatment Plan are as follows:

- Intake/Assessment
- Treatment Planning
- Crisis Services

21.3 Service Code Definitions
DMC-ODS Services can be provided in-person, by telephone, or telehealth and can provided in the office, satellite or any appropriate setting in the community. Certified counselor or LPHA must document how confidentiality was ensured if the service was provided in the community. All progress notes will be final approved by the counselor/LPHA who provided the service, unless determined otherwise by a Supervisor.

<table>
<thead>
<tr>
<th>SC</th>
<th>Service Type</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>OUTPATIENT TREATMENT SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Patient Education</td>
<td>Individual services provided to client that provide research-based education on addiction, treatment, recovery, and associated health risks. Patient Education is similar to individual counseling however, the focus is on education.</td>
</tr>
<tr>
<td>53</td>
<td>Case Management</td>
<td>Focus on coordination of SUD care, integration with primary care (especially for clients with chronic substance use disorders) and interactions with criminal justice system, if applicable. Case Management assists clients with accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services including:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Assessment/reassessment of needs for Case Management (CM) services</td>
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<tr>
<td></td>
<td></td>
<td>- Assistance with transition to higher/lower Level of Care (LOC)</td>
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<tr>
<td></td>
<td></td>
<td>- Develop/update treatment plan that includes CM services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Communication and coordination of referral activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Monitoring service delivery to ensure access to services</td>
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<td></td>
<td></td>
<td>- Monitoring client’s progress</td>
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<tr>
<td></td>
<td></td>
<td>- Patient advocacy and linkage to physical and mental health</td>
</tr>
<tr>
<td>54</td>
<td>Family Counseling</td>
<td>In order to use this service code and include on the Treatment Plan, specific individuals need to be identified (i.e. mother, husband, etc.). Contacts between a client, family</td>
</tr>
</tbody>
</table>
member(s) and certified counselor or LPHA. Family members and loved ones can provide social support and help motivate client to remain in services. Family Counseling services includes:

- Family in the treatment process
- Education about factors important to client’s recovery
- Family recovery

**57 Intake/Assessment (and Re-assessments)**

Process of determining client meets medical necessity criteria and is admitted into a SUD treatment program. The first face-to-face service provided is the client’s Admit Date. Multiple assessment services may be provided in order to; collaborate with referring parties, provide clinical formulation and documentation, and/or make additional contacts with client and/or significant others to ensure accurate diagnosis and/or LOC placement. Verify ROI for each contact made and document in the progress note. Intake/Assessment includes:

- Intake, evaluation or analysis of substance use disorders, diagnosis, assessment of treatment needs, and determining appropriate LOC
- May also include physical examination and laboratory testing
- Reassessments occur at minimum, every 90 days

**58 Treatment Planning**

Process of preparing an individualized treatment plan, based upon the information obtained in the intake/assessment or reassessment process. Certified counselor or LPHA will engage client to meaningfully participate. Focus also on collaborative treatment planning and care coordination among providers within SUD continuum of care and broader health care systems (Mental Health & Primary Care). Multiple treatment planning services may be provided in order to; collaborate with care providers, provide clinical formulation and documentation, and/or make additional contacts with client and/or significant others to ensure individualized treatment.

- Verify ROI for each contact made and document in the progress note
- Treatment plans will be completed and signed by certified counselor or LPHA and the client within 30 days from client’s admission date
- Treatment plans must be updated every subsequent 90 days
- Updated sooner if there is a change in treatment modality, or significant event that would require a new treatment plan
- If client refuses to sign, counselor or therapist will document reason for refusal and strategy to engage.
- If Treatment Plan was completed by a certified counselor, a Physician or LPHA will review and sign within 15 days of date the counselor signed treatment plan.

**59 Discharge Summary (Non-Billable)**

Completed within 30 days of last face-to-face service provided. Service provided to document unexpected lapse in treatment services for 30+ days and includes the following:

- Duration of the treatment episode
- Reason for discharge
- Narrative summary of the treatment episode
- Prognosis
<table>
<thead>
<tr>
<th>Page</th>
<th>Individual Counseling</th>
<th>Contacts between a beneficiary and therapist or counselor focusing on client’s goals and objectives on the treatment plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>Group Counseling</td>
<td>Face-to-face contacts in which one or more counselors or therapists treat two or more clients at the same time with a maximum of 12, focusing on the needs of the individuals served. Document name of group and the topic of each group note.</td>
</tr>
<tr>
<td>62</td>
<td>Treatment Community Activity (Non-Billable)</td>
<td>Larger group activities providing clients with the opportunity for sober socialization and interaction. May include graduation celebrations, holiday events and community meetings.</td>
</tr>
<tr>
<td>63</td>
<td>Collateral Services</td>
<td>In order to use this service code and include on the Treatment Plan, specific individuals need to be identified (i.e. mother, husband, etc.). Sessions with certified counselor or LPHA and client’s significant persons in the life of a client, focused on the treatment needs of the client in terms of supporting the achievement of the client’s treatment goals. Significant persons is defined as individuals that have a personal, not official or professional, relationship with the beneficiary. Counselor or LPHA must verify ROI for collateral contact made and document in the progress note.</td>
</tr>
</tbody>
</table>
| 64   | Discharge Planning     | Completed within 30 days of last face-to-face service and signed by counselor or Therapist and client. Process to prepare client for referral into another LOC, post treatment return, reentry into community, and/or the linkage to essential community treatment, housing and human services. Includes the following elements;  
- List of relapse triggers  
- Plan for avoiding relapse when faced with triggers  
- Support plan  
- Must document a copy was provided to client |
| 65   | Perinatal Outreach (SAPT Perinatal) | Outreach services engages substance using perinatal women (including injection drugs) in need of treatment services making it more likely they will attend treatment, participate in activities, and complete treatment and recovery support services. Perinatal Outreach includes:  
- Contact, communication and follow-up  
- Promote awareness about the relationship between injection drug use and communicable diseases such as HIV  
- Recommend steps to ensure that HIV transmission does not occur  
- Encourage entry into treatment |
| 66   | Physician Consultation | Physician-to-Physician Consultation. DMC physician consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists.  
- This service is designed to assist DMC physician with seeking expert advice on designing treatment plans for a specific client.  
- Consultation for complex cases, which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. |
| 71   | Crisis Intervention    | All Crisis Services are unplanned and should not be included on a Treatment Plan. Contact between a counselor or therapist and a client in crisis. Services shall focus on alleviating crisis problem(s). Services shall be limited to stabilization of the client’s emergency. Crisis defined as an actual relapse or an unforeseen event or circumstance, which presents an imminent threat of relapse. |

37 | Page
<table>
<thead>
<tr>
<th>Page 73</th>
<th>Outside Provider (Non-Billable)</th>
<th>Outside Provider such as Ole Health, Public Health, CANV, or other provides clients education and resource information about a specific topic in a group setting. Counselor or therapist must document service provided by outside provider in a progress note for each client.</th>
</tr>
</thead>
</table>

| Page 210 | UA Testing | UA testing can be conducted by a counselor or LPHA. The Urine Drug Screen is conducted to (i) assists clients to recognize the nature and extent of their abuse or dependency; (ii) assists clients to sustain sobriety during and after treatment; and (iii) alerts treatment staff to clients who may be in need of more intensive or alternative treatment services. (See ADS Drug Testing P&P). |

<table>
<thead>
<tr>
<th>MAT Services</th>
<th>Physicians and Licensed prescribers in DMC programs will be reimbursed for:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Ordering, prescribing, administering and monitoring of all medication for substance use disorders.</td>
</tr>
<tr>
<td></td>
<td>• Medically necessary service are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.</td>
</tr>
<tr>
<td></td>
<td>• Buprenorphine, Naloxone and Disulfiram will be reimbursed for onsite administration and dispensing at NTP programs.</td>
</tr>
<tr>
<td></td>
<td>Long-acting injectable Naltrexone may be utilized and reimbursed for on-site administration. Counties that choose this option must cover the non-federal share cost.</td>
</tr>
</tbody>
</table>

| UTILIZATION REVIEW |

<table>
<thead>
<tr>
<th>Page 79</th>
<th>ADS Utilization Review/QA</th>
<th>Used only by staff performing UR activities – (assuring clients have appropriate access to SUD services; medical necessity has been established, beneficiary is at the appropriate level of care, interventions are at appropriate level of care, tracking number of days to first DMC-ODs services, evaluating accessibility to care and waiting list information). This code can include other pay sources.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 109</td>
<td>ADS 100% Utilization Review/QA</td>
<td>Utilization Review time for only Medi-Cal services, non-discounted (100%) activities.</td>
</tr>
</tbody>
</table>

| RECOVERY SERVICES: Clients may access Recovery Services after completing their course of treatment if triggered, have relapsed, or as a preventative measure to prevent relapse. |

<table>
<thead>
<tr>
<th>Page 103</th>
<th>Recovery Individual</th>
<th>Individual Recovery counseling sessions to help stabilize the client and reassess if further care is needed. Focus on building client’s self-management skills and link to community resources.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 104</td>
<td>Recovery Group</td>
<td>Group Recovery Counseling services to help stabilize the client and reassess if further care is needed. Focus on building client’s self-management skills and link to community resources.</td>
</tr>
<tr>
<td>Page 105</td>
<td>Recovery Case Management</td>
<td>Recovery Case Management Services focus on building beneficiary’s self-management skills and linking to community resources. Recovery Services includes:</td>
</tr>
<tr>
<td></td>
<td>• Education &amp; Job Skills: Linkages to life skills, employment services, job training, and education services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Family Support: Linkages to childcare, parent education, child development support services, family/relationship education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Support Groups: Linkage to self-help and support, spiritual and faith-based support</td>
<td></td>
</tr>
</tbody>
</table>
| Page | Ancillary Services: Linkage to housing assistance, transportation, case management, individual services coordination.  
| Case management can be delivered to a beneficiary in the following ways face-to-face, by telephone, by telehealth | Recovery Monitoring & Assistance | Recovery coaching and monitoring via telephone and internet. |
| RESIDENTIAL SERVICES: | The treatment plan will be consistent with the qualifying diagnosis and signed by the beneficiary and LPHA or the Medical Director. |
| Page 854 | Residential Case Management | A site/facility offering case management services must be a certified DMC provider. Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management services:  
| Transition to a higher or lower level of substance use disorder (SUD) care  
| Development & periodic revision of a client plan that includes service activities  
| Communication, coordination, referral, and related activities  
| Monitoring service delivery to ensure beneficiary access to service and the service delivery system  
| Monitoring the beneficiary’s progress  
| Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services; and,  
| Case management shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.  
| A Licensed Practitioner of the Healing Arts (LPHA) or an AOD counselor may provide case management services. The individual providing case management services must be linked, at a minimum, to a DMC certified site/facility.  
| Case Management services must be documented and billed as a separate service from Residential Day Treatment Services. |
| Page 906 | Residential 3.1 | 24-hour structure with available trained personnel; at least 5 hours of clinical service per week and preparation for outpatient treatment. The components of Residential Treatment Services include:  
| Intake  
| Individual and Group Counseling  
| Patient Education  
| Family Therapy  
| Safeguarding Medications  
| Collateral Services  
| Crisis Intervention Services  
| Treatment Planning  
| Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment.  
| Discharge Services |
| Page 908 | Residential 3.5 | 24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment. Able to tolerate and use the full milieu or therapeutic community. The components of Residential Treatment Services include:  
| Intake |
| 909 | Residential 3.2 WM (Detox) | Clinically Managed Residential Withdrawal Management, Level 3.2-WM: Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery. The components of 3.2-WM services include:  
- Intake  
- Observation  
- Medication Services  
- Discharge Services |

21.4 The Golden Thread

It is essential that clinical documentation reflect the individual client’s story, treatment needs and services provided to demonstrate medical and clinical necessity for care. The Golden Thread links the various stages and processes of treatment starting with client engagement during the assessment, formulating the treatment plan and documenting progress towards treatment goals in progress notes. The thread of documentation establishes a written and legal record of the course of treatment. It provides the information needed for both guiding the treatment process and for billing purposes.
21.5 **Progress Note Timelines**

Every service activity must have a separate corresponding note in Anasazi. If Counselor/LPHA provided two different services to the same client on the same day, each service requires a separate note. A progress note is recorded for each service provided on the same day or next business day as best practice. Progress notes entered after 7 calendar days will be disallowed. It is important for all ADS Staff to follow the guidelines outlined in the “Correcting Progress Notes” section of this manual.

There are situations that may affect the timeliness of a progress note:

- Counselor/LPHA is asked to make a correction to a progress note
- Supervisors/Reviewers must **NEVER** edit/change a progress note after a Counselor/LPHA completed it
- Supervisor/Reviewer must send an electronic “Feedback Form” to the Counselor/LPHA who completed the note requesting changes
- Upon correction by Counselor/LPHA, the Supervisor/Reviewer may final approve the progress note

21.5.1 **Documenting Late Progress Notes**

When completing a progress note after 7 days from the date service was provided, Counselor/LPHA must indicate reason for the late entry in the Progress Note. The date of service selected for the creation of the progress note is the actual date the service was provided. When documenting a late progress note, begin with “Late Entry” at the start of the narrative section of the Progress Note and include rationale for late entry, i.e. “Late entry due to (include reason). Service not billable.” It is important for ADS Staff to be mindful of when services are billable or not.

21.6 **Progress Note Components**

Anasazi creates default settings in the service indicator section for each service code. It is important to review these defaults thoroughly to ensure that each item or service indicator on the progress note corresponds with what occurred during the session. The narrative section in the note describes the purpose of the service, the client’s presentation in session and symptoms/behaviors, the provider’s interventions and the client’s responses to those interventions.

Progress notes must include a plan for subsequent services, progress toward goals and a description of significant changes in the client’s status. Progress notes should include any referrals to community resources and other agencies, follow-up care necessary and if changes are needed on the treatment plan, goals and/or interventions. The electronic signature of the person providing the service, including licensure or certification, is the provider’s legal signature. By following the DIRT format described in the next section, Counselor/LPHA will ensure that each of these elements are described in the note. DMC-ODS requires the following items at minimum:

- Date and location of service
- Type of service provided or service code
- Start time and end time of session using exact minutes
- Documentation and travel time listed separately
- Purpose of the session
- Description of the client’s progress, or lack thereof, toward treatment plan goals
- Signature of Counselor/LPHA who conducted the session shall provide their printed and signed name, along with their credentials (i.e. LMFT, LCSW, CCAPP, etc.)
- Date the note was completed and signed

21.7 **Recording Documentation without Contact**

Document without a service provided is not a billable service. Complete an Informational Note to record activity.
21.8 DIRT Format for Progress Notes

There are many acronyms to remind the counselor of what must be within the progress note. Napa County ADS Division has chosen the DIRT format to follow for consistency in documentation. The following format should be used for all Individual Services except Group Counseling & Case Management, which is outlined in the subsequent sections.

D (DESCRIBE):

- Describe the REASON for the service activity
- List TOPIC and/or presenting PROBLEM
- Describe session SPECIFICS (i.e. service code, phone, participants, etc.)
- Describe how client presents him/herself

I (INTERVENTION):

- List INTERVENTION(s) you provided during the session
- Select a OBJECTIVE/INTERVENTION from the Anasazi Treatment Plan

R (RESPONSE):

- Explain client’s RESPONSE to Counselor’s Intervention(s) used in session
- List client’s PROGRESS/LACK OF PROGRESS toward treatment plan goal(s)

T (TREATMENT PLAN):

- Outline NEXT STEPS for the recovery process
- What will client/other do as a result of this session?
- What are your next steps?

21.9 Document Group Counseling

Outpatient Treatment Groups must be between 2 and 12 participants. Groups larger than 12 participants must be broken into two separate groups with different counselors. A client that is 17 years of age or younger cannot participate in a group counseling with any participant who are 18 years of age or older unless counseling is at a provider certified school site. The group note must be completed for all groups conducted and includes an personalized narrative for each client within the Anasazi Group Progress Note template. The DIRT format should be used to document each clients’ interaction, response to intervention and any updates on Treatment Plan Goals and Action Steps. If a client no-shows to the group, counselor must document no-show in the group note for that client. The following DIRT format should be used for Group Counseling progress notes:

D (DESCRIBE):

- List NAME OF GROUP
- List TOPIC and/or presenting PROBLEM
- Describe session SPECIFICS (i.e. service code, phone, participants, etc.)
- Describe how client presents him/herself

I (INTERVENTION):

- List INTERVENTION(s) you provided during the session
- Select a OBJECTIVE/INTERVENTION from the Anasazi Treatment Plan

R (RESPONSE):

- Explain client’s RESPONSE to Counselor’s Intervention(s) used in session
- List client’s PROGRESS/LACK OF PROGRESS toward treatment plan goal(s)

T (TREATMENT PLAN):
- Outline NEXT STEPS for the recovery process
- What will client/other do as a result of this session?
- What are your next steps?

### 21.10 Completing Group Sign-in Sheets

Refer to Appendix U: Group Sign-in Sheet Template. ADS establishes and maintains a sign-in sheet for every group counseling session, which shall include all of the following:

1. The typed or legibly printed name, license/certification and signature of the counselor(s) and/or LPHA(s) conducting the counseling session. By signing the sign-in sheet, the counselor(s) and/or LPHA(s) attest that the sign-in sheet is accurate and complete. (All client names scheduled to be in the group must be on the sign-in sheet regardless if they do not show up. If they do not show up, counselors must write in “No Show”).
2. The date of the counseling session.
3. The topic of the counseling session (the name of the group is also required for the Group Progress Note).
4. The start and end time of the counseling session.
5. A typed or legibly printed list of the participants’ names and the signature of each participant that attended the counseling session. The participants’ shall sign the sign-in sheet at the start of or during the counseling session.
6. Any time changes that differ from the regular scheduled group session time, must be documented in the “Note” column on the sign-in sheet.
7. The counselor/LPHA is responsible for documenting and accounting for any time changes or “No Shows” in the Group Progress Note.

### 21.11 Document Case Management

The following DIRT format should be used for Case Management progress notes.

**D (DESCRIBE):**
- Describe the PURPOSE of the Case Management service
- **Describe how the service RELATES to the client’s treatment plan**
- List TOPIC and/or presenting PROBLEM
- Describe session SPECIFICS (i.e. service code, phone, participants, etc.)
- Describe how client presents him/herself

**I (INTERVENTION):**
- List INTERVENTION(s) you provided during the session
- Select OBJECTIVE/INTERVENTION from the Anasazi Treatment Plan

**R (RESPONSE):**
- Explain client’s RESPONSE to Counselor’s Intervention(s) used in session
- List client’s PROGRESS/LACK OF PROGRESS toward treatment plan goal(s)

**T (TREATMENT PLAN):**
- Outline NEXT STEPS for the recovery process
- What will client/other do as a result of this session?
21.12 Documenting No Shows, Reschedules and Cancellations

21.12.1 Prior to Client Admission
Office Assistants use Informational Notes in Anasazi to document when a client does not attend their scheduled Intake Assessment appointment. Client “No Shows,” or “Reschedules by the client,” and “Cancellation by the client” are clearly documented in the narrative section. Office Assistants also document “Rescheduled by ADS” or other situations that may arise such as “Client Incarcerated.” This information may be clinically relevant and so it is important to be specific about the reason for the appointment change.

21.12.2 Individual Progress Notes
When an individual session (i.e. Intake Assessment, Individual Counseling, Case Management, etc.) is cancelled for any reason, the Progress Note should be setup as if it occurred documenting the start and stop time of the session. Do not include documentation or travel time. Select “No Show” or “Cancellation” under Appointment Type in the service indicator section of the note. Keep in mind, this step keeps the service from billing and will not cause your time to overlap when you provide another service during the same time.

21.12.3 Group Progress Notes
Group Progress Notes are set-up differently than Individual Progress Notes. Counselors/LPHA’s may indicate the reason client(s) did not participating in the group in the narrative section of the note.

21.12.4 One Client Shows up for Group
In the event only one client shows up for group, then you will provide an individual session instead. Following the steps as outlined:

1. Group Sign-in Sheet:
   a. Document start and stop time you would have facilitated group.
   b. Lineout the name of the client that showed up and print “Individual session provided.”
   c. Initial and date next to the lineout/explanation.
   d. Indicate other clients “No Showed” on the group sign-in sheet.
2. Create a Group Progress Note template in Anasazi:
   a. Indicate start and stop time the group would have been facilitated.
   b. Do not add documentation time.
   c. Within the Group Progress Note template:
      i. Select “Cancelled by Center” under the “Appointment Type” for the client that did show up.
      ii. Write, “Individual session provided to client” in the narrative section of the client that showed up.
      iii. Select “No Show” or “Cancelled by Client” under the “Appointment Type” in the service indicator section for all clients that did not show up for group. “Cancelled by Client” may be used when a client gives advance notice and “No Show” may be used when no notice is provided.
      iv. Document specific information in each client’s narrative section to elaborate why client did not participate in group.
        Note: Due to selecting “No Show,” “Cancelled by Client,” or “Cancelled by Center” billing is NOT generated for this time and you may record an individual session during the time your group would have been held.
   3. Create an Individual Progress Note template:
      a. Use the service code that is most appropriate for the service provided (i.e. Individual Counseling, Patient Education, Case Management, etc.)
      b. Indicate actual start and stop time of your individual session.
c. Documentation time recorded for writing the individual progress note only.

**21.13 DOCUMENTING SPECIAL ISSUES**

**21.13.1 Crisis Intervention**
Crisis intervention is a face-to-face contact between the Counselor or LPHA and client in crisis. A crisis means an actual relapse or an unforeseen event or circumstance, which presents to the client an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the client’s emergency. Crisis Intervention should **not** be on the treatment plan as crisis by definition are unplanned events.

**21.13.2 Suicide Protocol**
A client who presents with risk of self-harm will be referred to Crisis Stabilization Services Program (CSSP). A Suicide Assessment/Risk Assessment must be done any time a client presents with a risk of self-harm (see Appendix S: Suicide Risk Screening Tool). The Counselor/LPHA must immediately contact Supervisor and/or accompany client to Exodus Napa County, Crisis Stabilization Services Program (CSSP) located at 2751 Napa Valley Corporate Drive, Building B and their 24/7 phone number is (707) 227-3900. Upon resolution of the crisis, Counselor/LPHA must clearly document incident in progress note using the Crisis Intervention Service Code. For Youth Services, the Counselor/LPHA must also notify and document the client’s guardian and/or emergency contact was notified.

**21.13.3 Threats of Violence**
Please refer to HHSA Threat Assessment Policy & Procedure for agency protocol, notify your Supervisor and complete Incident Report.

**21.13.4 Child Abuse and Elder Abuse**
As of January 1, 2018, Welfare and Institutions Code, Division 9, Part 3, Chapter 11, Section 15610.37 mandates certain individuals, including SUD counselors report known or suspected instances of elder or dependent adult abuse and failure to do so is a crime. As a result, a SUD counselor who has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult he or she has experienced these behaviors, is required to report the abuse immediately or as soon as practically possible. SUD Counselors and LPHA’s are also required to comply with all Federal and State Laws and Regulations pertaining to mandated child abuse reporting.

**21.13.5 Incident Reports**
Whenever there is an incident specific to a client, the situation must be documented in an Informational Note or a Progress Note. Indicate an incident report was made and submitted through HHSA Incident Reporting System (see HHSA Incident Report Policy & Procedure located on Chardonnay).

**21.13.6 Other Situations**
The medical record chart is a confidential and protected legal document. It can be subpoenaed by the court. There are legal and clinical standards in the documentation of the services. Only the client’s name should be in the client chart and no other clients name included in the chart. Initials only may be used. Names of family members should not be recorded except as required for Emergency Contact information, minor/parent involvement, etc. On the progress notes and other documentation, it is best to refer to the relationships as, “mother,” “father,” “etc. If names are to be used, then only first name or initials for clarification. In the unusual circumstances, such as a Tarasoff report, when another client’s name is used, DO NOT identify any individual as a substance use or mental health client.

**21.13.7 Gathering Information for Court Reports**
Gathering information and report writing is not a billable services and must be documented in an Informational Note. In the event Primary Counselor provides a service (in person or on the phone) on the same day and it’s related, then the
time may be bundled with the service/documentation time (i.e. talking with client and/or ADS Court Case Manager, probation officer).

22 Urinalysis

Counselors or LPHA’s shall conduct random drug testing to all clients as mandated by the referral source(s) and/or the individual treatment plan. ADS staff shall follow the ADS Program UA Protocol in the Appendix Section. ADS implemented new UA testing protocols as of 8/1/18 to protect against falsification and contamination of urine fluid specimens. As a reminder, staff conducting the UA must be gender appropriate. (NOTE: ADS will be updating UA Protocols based on Redwood Laboratory’s new laboratory requisition procedure.)

22.1 UA Coverage

If a counselor switches with another counselor for UA testing coverage, the change must be noted on individual calendars and posted on testing calendars. This will ensure clarification on who is responsible for testing and when. Counselors are required to put their name (or initials) on the UA test slips for easy identification. This also helps to identify who the “No Shows” need to be returned to.

22.2 Billing for UA’s

UA testing services may be bundled into another service provided on the same day by the same counselor who conducted the UA test. For example, if a counselor meets with a client for a treatment planning session and immediately following the session, the same counselor conducts a UA, then the service time shall include the UA test. In this example, the counselor would complete a progress note using the service code, “Treatment Planning.” In addition to documenting details of the session, counselor shall also indicate a UA test was facilitated in the “Intervention” section of the progress note and add UA details as outlined below.

If a UA testing service cannot be bundled into another service provided by the same counselor, then the counselor will complete a progress note using service code #210 “UA Testing.” The documentation for the UA testing time must be the actual time it took to facilitate the UA test (i.e. 8:04-8:09).

**Documenting Details of UA:**

- Time to complete test
- Substance tested
- Results of test
- If test was sent out to the LAB

22.3 UA Test Results

All positive drug tests shall be reported to the referring entity if the client has provided appropriate prior consent. When results from the Lab test are returned, Primary Counselor must document the following in an Information Note under using the template “UA Results:”

- Date of UA test
- Lab results
23 Treatment Plans

Counselors/LPHA are required to prepare individualized treatment plans based upon the information obtained during the intake and assessment process to establish treatment goals. Information is gathered from the client, family member(s), treatment providers and/or referring party. The client’s participation and understanding of all elements of the plan is essential for successful outcomes and is required by state regulations. The counselor/LPHA must document client’s participation in the development of the treatment plan in the progress note (see Appendix F: Treatment Plan).

23.1 Allowable Service Code/Type of Service Prior to Treatment Plan

Only the following services are billable prior the final approval of a client’s treatment plan:

- Intake/Assessment
- Treatment Planning
- Crisis Service

23.2 Anasazi Treatment Plan Dictionary

Interim Service Log (ISL): The Interim Service Logs (ISL) is opened on the date a client or referring party requests service. The ISL is a “place-holder” or container in Anasazi that is used until an initial treatment plan is completed.

New: A client’s initial treatment plan is developed at the start of treatment and is considered a new treatment plan. A new treatment plan must be completed for each new treatment episode. This allows for appropriate timeline tracking, although there may be circumstances using a prior treatment plan is acceptable. Seek guidance from a Supervisor or UR Coordinator.

Revised: A revised treatment plan does not change the time frame or due date for the updated treatment plan. Whenever a treatment plan is revised, the client signature must be obtained within 30 days from the counselors or LPHA’s signature.

Updated: An updated treatment plan will change the time frames.

23.3 Components of the Treatment Plan

The following elements and processes facilitate sound clinical practice, which also fulfill regulatory requirements. When creating a Treatment Plan the counselor/LPHA will include:

23.3.1 Strengths

- Explore what strengths the client and/or family brings to treatment that could help achieve the goals.
- Include information from referring party and/or other agencies involved in client’s treatment.

23.3.2 Problems

- The first problem statement for each client receiving ADS Services should be “Substance Dependence.” In the narrative section of this problem statement, include the following:
  - List the client’s Substance Use Diagnosis(es)
  - Current Level of Care
  - Number of treatment hours offered each week
  - Outline the specific services the client will be offered each week
  - If Counselor/LPHA who is completing the Treatment Plan is not the Primary Counselor, then the name of the Primary Counselor must be identified on the plan itself.
- List all of the problems identified in the six dimensions on the ASAM as Current, Referred or Deferred.
• Don’t forget to list “Physical Health” as a problem and select, “Obtain Physical/Dental Exam” as an Objective if the client doesn’t have an updated physical exam (PE) in their medical record.

23.3.3 Goals
• Explore and identify goals for each of the problems identified.

23.3.4 Obstacles
• Discuss any potential obstacles that could prevent his/her achievement of these goals.

23.3.5 Objectives
• A statement in specific and measurable terms that describes what the client will accomplish as a result of treatment and interventions.

23.3.6 Interventions
• Interventions are actions of the clinician designed to help the client complete the objectives. Discuss what you do, as the clinician/counselor, to help the client complete their objective in a measurable way. (List the treatment modalities, frequency and duration for each intervention).

23.3.7 Review & Final Steps
• Review final Treatment Plan with client and obtain signature.
• Client must be offered a copy of the Treatment Plan and acknowledge this by signing the plan which states, “Client helped develop, understands, agrees with the goals and has been offered a copy of this client plan.”
• Obtain final approval by Licensed Supervisor, LPHA or Physician as appropriate.
• Sign the Treatment Plan Attestation form in Anasazi (only LPHA may sign Treatment Plan Attestation).

23.4 Treatment Plan (Perinatal)
Perinatal services must address treatment issues specific to the pregnant and parenting women. Perinatal-specific services shall include the following:

• Mother/child habitable and rehabilitative services, such as parenting skills and training in child development.
• Access to services, such as arrangement for transportation.
• Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant.
• Coordination of ancillary services, such as medical/dental, education, social services and community services.

23.5 Treatment Plan Timeline & Signature Rules
23.5.1 Client’s Signature
The “Signatures” section on the Treatment Plan indicates the client’s participation and agreement with the Treatment Plan (CCR Title 9 Division 1, §1810.440). If client refuses to sign or is unavailable for a signature, the Treatment Plan must include a written explanation of the refusal or unavailability to sign. The written explanation should be on the plan itself and in a progress note. Document additional attempts to obtain the client’s signature.
23.5.2 Initial Treatment Plan
- Counselor/LPHA shall complete initial treatment plan within 30 calendar days of the admission to treatment date, indicating client’s participation in treatment.
- Client shall review, approve and sign within 30 calendar days of admission to treatment date.
- LPHA shall review to determine whether services are medically necessary and sign within 15 calendar days of signature by the counselor.

23.5.3 Updated Treatment Plans
- Counselor/LPHA shall update Treatment Plan every subsequent 90 days from date of counselor’s signature, unless there is a change in modality, LOC or significant event that would require a new treatment plan.
- Client must review and sign updated treatment plan within 30 days of the signature of counselor (or document client’s refusal plus strategies to obtain signature in the future).
- LPHA shall review updated treatment plan to determine whether services are medically necessary within 15 days from the date the counselor signed the treatment plan.

23.5.4 Ending Treatment Plans
- Upon client’s discharge to ADS Treatment, the Treatment Plan must be ended.
- If client returns to treatment, a new Treatment Plan must be completed.

23.6 Treatment Plan Attestation
An LPHA will sign the Treatment Plan Attestation form in Anasazi (only LPHA may sign Treatment Plan Attestation).

23.7 Documenting Treatment Planning
- Each treatment planning session shall be documented in a progress note using service code #58.
- Document a copy of the Treatment Plan was provided to the client.
- The progress note shall identify the Level of Care (LOC) to be provided.
- If Intensive Outpatient Treatment LOC 2.1 is recommended, list the specific services to be offered in the body of the progress note to total 9 to 19 hours per week.
- Primary Counselor (PC) is identified by the development and signature of the Treatment Plan.
- If it is not developed by the PC, then staff shall identify PC in the progress note and on the Treatment Plan itself in the narrative section of the first problem statement (Substance Use Dependence).
- Progress notes are final approved by the counselor/LPHA who completed the service.

24 Reassessments

Medical necessity qualification for ongoing DMC-ODS service will be determined on a continual basis but no later than every six months using the ASAM criteria and based on individual beneficiary need. The Counselor/LPHA will follow the ADS Reassessment Checklist.

- If updating a diagnosis, the LPHA or Medical Director may end date the current SUD diagnosis and start new SUD diagnosis with the new date. If the LPHA determines the diagnosis remains the same, the date remains as the same of the original diagnosis date.
- All reassessments must clearly document the reason for change in level of care (LOC) or reason for no change. If a reassessment results in no change in the LOC, the Treatment plan can be Revised (see Appendix G: 3-Month Reassessment Checklist). A reassessment resulting in a change in LOC requires a New/Updated Treatment Plan final approved by an LPHA.
24.1 Justification for Continued Services at 6-Months
For an individual to receive ongoing DMC-ODS services, the LPHA or Medical Director must re-evaluate client’s medical necessity determination at least every six months through the reauthorization process. In addition, Counselors/LPHA must review the progress and eligibility of the beneficiary and make recommendations for the client to continue receiving services or not. The final determination to extend treatment services every six months must be reviewed and approved by either an LPHA or physician. There are two Justification forms that need to be completed:

24.1.1 Justification for Continuing Treatment Form
The “Justification for Continued Treatment” form is required to be completed no sooner than five (5) months and no later than six (6) months after the client’s admission to treatment date or the date of completion of the most recent justification for continuing services. The Counselor/LPHA must update and complete a new ASAM reassessment and then complete this form, which will include documentation that all of the following have been considered:

- Client’s personal, medical and substance use history
- Documentation of the client’s most recent physical examination
- Client’s progress notes and treatment plan goals
- Counselor/LPHA recommendation
- Client’s prognosis

24.1.2 Justification Review Form
After a Certified Counselor completes a Justification for Continuing Treatment form, an LPHA or Physician will review and complete a “Justification Review” form, which serves as an attestation for the “Justification for Continuing Treatment” form. If LPHA completes the ASAM Reassessment and the first “Justification for Continued Treatment” form, then they must also complete the second “Justification Review” form. Supervisor review is not required for the LPHA Justification Review.

25 Discharge Documentation
Discharge planning begins at intake and should be discussed throughout the treatment process. Discharging the client is only required when the client is no longer in treatment. When a client is being transferred to a higher or lower level of care based on the ASAM Criteria within the ADS program, they are not required to be discharged unless there has been more than a 30-calender day lapse in treatment services. Two discharge processes/Anasazi “assessment/forms” are available to the Primary Counselor/LPHA.

1. Discharge Plan: Completed in conjunction with the client and is a billable service.
2. Discharge Summary: Completed when Primary Counselor lost contact with client and is not a billable service.

25.1 Discharge Plan
Discharge planning services should be part of the client’s initial treatment plan and updated throughout the episode. Counselor/LPHA must plan for continuing care of clients and it is important to develop a discharge plan in conjunction with the client. The Discharge Plan must be prepared within 30 calendar days prior to the last face-to-face session with the client and shall include the following:

1. Planned discharge date
2. Reason for discharge (see “Reason for Discharge” section)
3. Type of discharge
4. A description of the client’s relapse triggers
5. A plan to assist the client to avoid relapse when confronted with each relapse trigger
6. A support plan with copy provided to client will include:
   a. 12-Step or other self-help supports
   b. Other support services, as needed
   c. Recovery Services (offered and/or accepted)
   d. Permission for follow-up contact

25.2 Discharge Summary
A Discharge Summary service does not need to be on the client’s treatment plan and in the event this service code is used, you can select “yes” for “unplanned service.” A Discharge Summary should be completed in lieu of the Discharge Plan when the Primary Counselor is unable to make contact with the client and/or referring party. The Discharge Summary must be completed by the Primary Counselor within 30 calendar days from the last face-to-face service and should include:

1. Duration of the client’s treatment (admit and treatment end)
2. Date of discharge from treatment (assignment close date)
3. NOABD-Termination letter, if applicable
4. A narrative summary of the treatment episode
5. Client’s response to treatment
6. Reason for discharge (see “Reason for Discharge” section)
7. Client’s prognosis

25.3 CalOMS Discharge
Discharge information must be collected for all clients regardless of the discharge status. There are several types of discharges to report in CalOMS Tx. In order to report discharge data, a matching admission for the participant for which discharge data is being collected must be in the CalOMS Tx database. Discharges submitted without a matching admission will be rejected.

25.3.1 CalOMS Administrative Discharge: Discharge Summary
Administrative discharges should only be reported in the event the client cannot be located, either in person or by telephone, to answer the CalOMS Tx questions. Such attempts to contact a client for a CalOMS Tx discharge interview must be documented in the client’s file. Providers should never guess or complete responses on behalf of an absent client for the required CalOMS Tx discharge questions.

25.3.2 CalOMS Standard Discharge: Discharge Plan
A standard discharge is used to measure treatment outcomes for reporting purposes at the county, state and federal levels. It is very important to ask the client every CalOMS Tx standard discharge question and report the client’s response in the discharge record. This is because the outcome measures collected for a client’s admission and standard discharge for CalOMS Tx are used to measure whether the client reduced or abstained from drug use, obtained employment, remained out of the criminal justice system, etc. It is critical that counties and treatment providers collect accurate and complete client outcome data at discharge so client outcomes can be measured and reported to public funding agencies to demonstrate the benefits and efficacy of treatment services.

For standard discharges, providers are required to complete a full CalOMS Tx discharge record by interviewing the client and asking all of the required CalOMS Tx discharge questions. The date for a standard discharge is the date of the exit interview or the date of the last treatment service, whichever is later. It is also acceptable to use the last telephone conversation with the client as the discharge date.

25.3.3 Discharge Status Definitions (Reasons for Discharge)
The definitions of the CalOMS Tx discharge status codes and sample scenarios for their use are provided below.
1. **Comp Tx Goals/Referred/STD/ALL**: “Completed Treatment/Recovery Plan Goals - Referred/Standard (all questions) (status 1):” This is a standard discharge status and is considered a treatment completion status. This status should be used for a client who completed a SUD treatment service and is being referred to another SUD treatment service (this includes clients referred to further SUD treatment that do not accept the referral). The client is available to complete the discharge interview either in person as planned, or by contacting the client by telephone. This occurs when a program participant completes his/her treatment/recovery plan and is being referred to another treatment/recovery program. For example, the individual is moving from one modality or type of service to another within a treatment.

2. **Comp Tx Goals/Non-Referred/STD/ALL**: “Completed Treatment/Recovery Plan Goals – Not Referred/Standard (all questions) (status 2):” This is a standard discharge status and is considered a treatment completion status. This status should be used for a client who completed a SUD treatment service, who is not being referred to another SUD treatment service and for a client who is finishing the last treatment service program in a treatment episode (a series of planned consecutive admissions and discharges from various treatment programs). The client is available to complete the discharge interview either in person as planned, or by contacting the client by telephone. This occurs when a program participant completes his/her treatment/recovery plan and is not referred. For example, the participant has successfully completed an entire treatment episode and therefore is not referred for further services.

3. **Left/Satisfactory Progress/STD/ALL**: “Left Before Completion with Satisfactory Progress – Standard (all questions) (status 3):” This is a standard discharge status and a full data set should be collected. This status should be used for a client who is referred to another treatment program to complete either the service they have been receiving or to begin a different level of treatment. The client is available to complete the discharge interview either in person as planned, or by contacting the client by phone. This occurs when a participant has made satisfactory progress in a program and was referred to a different program to continue with the services or to receive different services in a different program. For example, when a client is referred to and enters Residential Treatment, Counselor/LPHA will select this reason for discharge.

4. **Left/Satisfactory Progress/ ADM/Min**: “Left Before Completion with Satisfactory Progress – Administrative (minimum questions) (status 4):” This is an administrative discharge status and only the minimum data set should be collected. This should be used for a client who made satisfactory progress in the treatment service, who did not complete the treatment service as planned, and could not be located to receive a referral for further SUD treatment or to conduct a discharge interview.

5. **Left/Unsatisfactory Progress/STD/ALL**: “Left Before Completion with Unsatisfactory Progress – Standard (all questions) (status 5):” This is a standard discharge status and the full data set should be collected. This status should be used for a client who is referred to another treatment program to complete either the service they have been receiving or to begin a different level of treatment. The client is available to complete the discharge interview either in person as planned or by contacting the client by phone. This occurs when a participant is referred to another program or service modality because they are not making satisfactory progress in the service/program in which they are participating.

6. **Left/Unsatisfactory Progress/ADM/Min**: “Left Before Completion with Unsatisfactory Progress – Administrative (minimum questions) (status 6):” This is an administrative discharge status and only the minimum data set should be collected. This should be used for a client who made unsatisfactory progress in the treatment service in which they were enrolled and who did not complete the treatment service as planned. The client is unavailable to be referred for other SUD treatment or to complete the discharge interview in person or by telephone.

7. **Deceased**: “*Death (status 7):*” This is an administrative discharge status. This should be used for a client who dies while enrolled in a treatment program. Because the client cannot be asked the CalOMS Tx standard discharge questions, the treatment counselor follows the same procedures used to complete an administrative discharge for clients who leave the program prior to finishing their treatment.
8. **Incarcerated**: This is an administrative discharge status. This should be used for a client who becomes incarcerated while enrolled in a treatment program. Because the client cannot be asked the CalOMS Tx standard discharge questions, the treatment counselor follows the same procedures used to complete an administrative discharge for clients who leave the program prior to finishing their treatment.

### 25.4 Closing the Client Assignment in Anasazi

The Client Assignment should be closed on the date Counselor/LPHA processed the final closing documents. Follow the “Closing Checklist” in Appendix I. In addition to the eight CalOMS Reasons for Discharge, other reason codes are available in order to best capture and document specifics of the discharge including, but not limited to:

1. **Administrative**
2. **Client Withdrew**
3. **Comp Intake Ref to Low Int Res**: “Completed Intake and/or Assessment and referred to low intensity Residential Treatment LOC 3.1.”
4. **Comp Intake Ref to High Int Res**: “Completed Intake and/or Assessment and referred to high intensity Residential Treatment LOC 3.5.”
5. **Comp Intake Ref to Intensive Outpatient**: “Completed Intake and/or Assessment and referred to Intensive Outpatient Treatment LOC 2.1.”
6. **Comp Intake Ref to Outpatient**: “Completed Intake and/or Assessment and referred to Outpatient Treatment LOC 1.0.”

### 25.5 Closing Client Assignment When Client Admitted to Residential and/or Detox

Until Center Point begins to provide Detox and Residential services in Napa County, McAllister Institute will continue to provide these services. There’s been some confusion about when to close the client assignment following an Intake Assessment that indicates Residential placement (with or without detox) and client agrees. We currently keep clients open if client will continue to get interim services in outpatient and/or hold them until placement. Brenda Montanez, ADS Senior OA, will send an email to PC, Supervisor and UR Coordinator with the date of client placement into detox and/or residential. Two options:

1. Client admitted into Residential Treatment 3.1 or 3.5: PC/LPHA will follow closing checklist, of course and close Client Assignment using the date of placement.
2. Client is admitted into detox: Determine if there is a plan for client to move directly to residential upon completion of detox and complete one of the two options:
   a. Client is admitted to detox with the plan to move into a residential bed immediately following. Closing client the day they enter detox.
   b. Or client doesn’t have a plan in place, then a PC would hold client on caseload.

### 26 Timelines and Treatment Requirements

Timelines refers to all Outpatient Level of Care.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Timelines</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission to Treatment</td>
<td>Starts clock for all documentation</td>
<td>Date of Intake Assessment session. Must be a face-to-face contact.</td>
</tr>
</tbody>
</table>
| Diagnosis Review form in Anasazi | Within 30 days of Admission  
Every 6 Months | Each client must have at least one SUD DSM-5/ICD-10 diagnosis with written description and should be included on the treatment plan.  
Medical Necessity must be reviewed and documented by LPHA or MD within 30 calendar days. |
| ASAM (Level of Care) | Within 30 days of Admission  
When Reassessing level of care  
At Discharge Plan/Recovery Services | Must complete an individualized history for each client that evaluates and scores on all six ASAM Dimensions. |
| Initial Treatment Plan | Within 30 days of Admission | Must be completed, signed and dated within 30 calendar days of a client’s admission to treatment by the Primary Counselor/LPHA and the client.  
Must be reviewed for medical necessity by LPHA or MD, signed and dated within 15 days of the initial signature of the Counselor.  
If Counselor/LPHA is unable to obtain client’s signature within 30 days, this must be documented in the progress note including reason for not obtaining the signature and the plan to obtain it.  
All Treatment Plans must be developed with the client. |
| Updated Treatment Plan | 90 calendar days of Initial Treatment Plan.  
Every 90 days thereafter, or when a change in problem or focus of treatment occurs. | Must be reviewed, approved, signed and dated by the Counselor/LPHA and client no later than 90 calendar days after signing the Initial Treatment Plan.  
Must be reviewed for medical necessity by LPHA or MD, signed and dated 15 days from the signature of the Counselor/LPHA.  
Treatment Plan must be signed by client and Primary Counselor. If the client is unavailable to sign the plan, the notes must reflect efforts to meet with the client to review the plan and sign it. |
| Physical Examination | Within 30 days from Admission or within 12 months prior admission | Must refer and document with each client whether he/she had physical examination within last 12 months; if none, then refer client to Ole Health for a physical within 30 calendar days of the client’s Admission to treatment date. Initial Treatment Plan must include a goal to obtain a physical examination and the goal continually updated on the Treatment Plan until the exam is completed. Updated annually. |
| CalOMS Data Collection | Admission | Registration & Admission: Is done by the first session of Outpatient Treatment and between the second and ninth day of Residential Treatment. |
| CalOMS Data Collection | Discharge | Regular Discharge: Must be completed by the Primary Counselor during the last face-to-face.  
Administrative Discharge: Must be completed within 30 days of the last face-to-face contact for each client with whom the provider has lost contact and for all involuntary discharges. |
Discharge Plan | Must be prepared (discussed and signed with client) within 30 days prior to last face-to-face treatment | The Discharge Plan addresses triggers for relapse and how to avoid them, along with a support plan, which includes referrals for ongoing care and resources. Must be signed and dated by the Primary Counselor and the client with a copy offered to the client. Plan may not be completed if client has left treatment; instead, the Discharge Summary will be used.

Discharge Summary | Completed within 30 days of last face-to-face with client | Includes the duration of treatment, reason for discharge, summary of the treatment episode and prognosis. If the client is to be discharged involuntarily, a 10-day notice of action (NOABD) must be issued. Client must be given notice of fair hearing rights.

### 27 Correcting Documentation & Billing

In order to ensure the accuracy of service documentation and claiming, Alcohol & Drug Services Division staff routinely require the ability to make corrections to service documentation in the EHR. Corrections may be triggered at a number of separate stages: prior to final approval of a progress note, after final approval upon staff or supervisor discovery of an error in service coding or duplication, after final approval for errors discovered through the concurrent review process, or after services have been claimed, billed out. With the implementation of the DMC-ODS Waiver on December 15, 2017, ADS has been working closely with the Fiscal Division and Anasazi Team to update processes and procedures to ensure accuracy of documentation and billing. The following situations outline the current procedures to make a correction to a progress note.

#### 27.1 Corrections Prior to Final Approval of a Progress Note

1. Changes to service indicators or to the progress note narrative may be made by deleting or changing those components of the Anasazi progress note prior to final approval.
2. For changes to the activity code only, changes must be made by:
   a. Opening up a new note.
   b. Coding the new note with the correct service code.
   c. Cutting the note narrative from the incorrect note and pasting the narrative into the corrected service.
   d. Deleting the (incorrect/non-final approved) progress note.
   e. Electronically signing and final approving the note with the correct information. The date the service was provided is the date of the progress note. The date of the staff signature is the date the note is signed and final approved.
3. If the narrative in the progress note is not yet completed and the activity code must be changed, staff may delete the entire note and start a new one.

#### 27.2 Corrections After Final Approval of a Progress note

All corrections to a progress note that has been final approved must be made through the use of the void functionality of Anasazi or by completing a Billing Change Form (BCF). See BCF section to determine if the form may be used prior to voiding a progress note. The ‘void’ functionality will only allow for the removal of the entire note (narrative and header).
UR Coordinator or Supervisors must be consulted in all situations involving use of the “void” functionality and are the only staff members who can void the note.

1. Prior to correcting a final approved progress note, staff will inform their supervisor who will complete the following.
2. Corrections are made in the following manner:
   a. Staff add a new progress note and input the correct(ed) service information.
   b. Staff copy the narrative of the [incorrect] progress note into the new [corrected] note.
   c. Staff electronically sign and final approve the corrected progress note. The date the service was provided is the date of the progress note. The date of the staff signature is the date the note is signed and final approved.
   d. Staff inform their supervisor that the incorrect note needs to be voided.
   e. Program Supervisor highlights the incorrect note and uses the “void” functionality of Anasazi to void the note. NOTE: Program supervisors will use select text to indicate the reason the note was voided.

### 27.3 Correcting Duplicate Final Approved Progress Notes
1. Fiscal staff will issue suspense reports identifying duplicate services.
2. UR Coordinator and/or Supervisors who determine, and can attest that a duplicate is due to the same service entered for the same client on the same day for the same may delete the service with the higher form number.
3. On the progress note look-up, right-click the true duplicate service and select “Void” to delete the note.

### 27.4 Use of a Billing Change Form (BCF)

When an error in billing and documentation (other than what is indicated below) is discovered after claims have been submitted to the fiscal department, a Billing Change Form (BCF) is required. BCF’s as used for individual services and make corrections without affecting the timeliness of entry. Group Progress Note changes follow a different procedure for corrections.

**BCF's Unable to Correct the following:**

1. Group Progress Notes
2. Service Date
3. Server
4. Client

**Instructions for Anasazi Billing Change Form (BCF):**

1. The staff member who provided the service will complete the BCF.
2. Complete the service information at the top of form, labeled “As originally submitted.” Please include all fields and service information, which will provide the necessary information to identify the service uniquely within the Anasazi system.
3. In the second box, labeled “Corrected Information,” enter only the service information that is changing and leave the remaining fields blank.
4. In the “Reason for Change” box, please simply describe the request and the reason the change should be made. This information will assist HHSA Fiscal Division in the processing of your request.
5. The BCF must be signed by both the person requesting the change and the authorized approver(s). The authorized approvers may be different between departments and divisions, so please check with your supervisor or manager. For ADS Division, Supervisors and the Utilization Review Coordinator are authorized approvers.
6. Put this form in the authorized approver’s mailbox.
7. The authorized approver will review BCF, sign and forward to the Fiscal Division’s Billing Specialist who will make the change.

27.5 CORRECTIONS AFTER FINAL APPROVAL OF A GROUP PROGRESS NOTE

27.5.1 Prior to 7-Days
If an error on a Group Progress Note has been identified prior to the 7-day timeframe, a new Group Progress Note may be completed and the incorrect Group Progress Note may be voided. Staff member will send an email to the UR Coordinator or Supervisor with the date and form # after you have completed a new Group Note.

27.5.2 After 7-Days
If an error is identified after the 7-day timeframe, there are a few situations, which a correction will not affect the timeframe. Seek guidance from the UR Coordinator or Supervisor when making changes.

- **Content Error**: If there is an error in the documentation content, you may complete an Informational Note on the date of the original group and explain what information should be corrected, added, deleted, etc. You must complete one Info Note per client that attended the group.
- **Minor Billing Error**: If there is an error with the service time, travel time and/or documentation time, but the total minutes billed remains the same, then you may complete an Informational Note as explained above. For example, travel 16 minutes was entered instead of 16 minutes as documentation time. The total time for the Group Progress Note is the same, but travel and documentation time needs to switch.
- **Voiding Group Note**: If none of the situations above applies, then the Group Progress Note must be voided, which will affect the timeliness of entry. Staff member will send an email to the UR Coordinator or Supervisor with the date and form # after you have completed a new Group Note.

27.6 DOCUMENTATION REVIEW (FEEDBACK FORM/EMAIL)
To ensure and uphold compliance with State and Federal regulations and identify any additional training needs, the ADS Division developed a “General Documentation Review/Feedback” template. The purpose of this form is to provide staff clear instructions on areas needing additional information and/or corrections in their client service documentation. Completing the information requested on this Review Feedback form/email in a timely manner and returning it to the Supervisor is mandatory to ensure that a client’s treatment is documented and meets regulatory and agency requirements (see Appendix T: Documentation Feedback Form/Email).

28 DOCUMENTATION EXAMPLES

28.1 EXAMPLES OF STRENGTHS
Strengths refer to individual and environmental factors that increase the likelihood of success. Therefore, it is not only important to recognize individual and family strengths, but to use these strengths to help them reach their full potential and life goals. These strengths may not be listed in Anasazi, but can be added in the narrative section of a similar word/phrase.

- Has maintained abstinence
- Working toward achieving abstinence and living a AOD-free lifestyle
- Working toward living a healthier lifestyle
- Actively reducing negative consequences associated with AOD use
- Motivated to change
- Has knowledge of his/her disease
• Has a support system (i.e. friends, family, etc.)
• Employed/does volunteer work
• Has skills/competencies (i.e. vocational, relational, transportation savvy, activities of daily living, etc.)
• Intelligent, artistic, musical, athletic
• Sees value in taking medications
• Has a spiritual program/connected to church
• Good physical health
• Adaptive coping skills
• Capable of independent living
• Interested in restoring relationships

28.2 EXAMPLES OF INTERVENTION WORDS
Interventions not included in the treatment plan are subject to disallowance; i.e., group therapy being provided without listing it as an intervention. Also interventions that are addressed in the treatment plan and then never utilized may also be reviewed and should be addressed in a progress note as to why the intervention is not being provided, if this continues it may indicate needing to update the treatment plan.

| Acknowledged                     | Honoring          |
| Actively Listened               | Identified        |
| Addressed                       | Information Giving/Gathering |
| Advised                         | Informed          |
| Advocated                       | Interacted        |
| Asked                           | Interpreted       |
| Assisted                        | Joined            |
| Challenging                     | Modeled           |
| Checked In                      | Observed          |
| Clarified                       | Physical Activity |
| Collaborated                    | Played            |
| Commended                       | Praised           |
| Confronted                      | Presented         |
| Conducted                       | Probed            |
| Conveyed                        | Problem Solving   |
| Crisis Intervention             | Prompted          |
| Developed                       | Rapport-building  |
| Educated                        | Recapped          |
| Empathized                      | Recommended       |
| Empowered                       | Redirected        |
| Encouraged                      | Reflected         |
| Ensured                         | Reflective Listening |
| Established                     | Reframed          |
| Explained                       | Reinforced        |
| Explored                        | Reiterated        |
| Expressed                       | Reminded          |
| Facilitated                     | Reviewed          |
| Focusing/Refocusing             | Role-played       |
| Framing/Reframing               | Social Skills Practice |
| Goal (setting)                  | Suggested         |
| Development/Goal Setting        | Supported         |
| Guided                          | Teaching/Lecturing |
| Highlighted                      | Urge              |
28.3 Examples of Intervention Phrases

- Explore drug/alcohol history
- Refer for physical exam to primary care physician
- Encourage follow up with physician
- Support and encourage evaluation for medication assisted treatment
- Discuss benefits/effectiveness of medication
- Encourage participation in appointments with mental health clinician
- Encourage participation in appointments with psychiatrists
- List/identify negative consequences of substance use/abuse
- Educate on consequences of substance use on mental health
- Encourage to remain open to discussion around denial acceptance
- Support participation in AA/NA
- Facilitate/ explore understanding of risk factors
- List positive aspects of sobriety
- Reinforce development of substance free relationships
- Review effects of negative peer influences
- Encourage exercise and social activities that do not include substances
- Encourage positive change in living situation
- Identify positive aspects of sobriety on family unit/social support system
- Explore effective self-talk
- Reframe negative self-talk

28.4 Examples of Progress Notes

28.4.1 Intake/Assessment Progress Note Example

D (Describe): Met with client for Intake appointment. Client was referred from (referral source or self-referred) due to (explain problem/reason for referral). (Describe client’s presentation or other situations relevant to the session).


R (Response): (Triage question outcome and list SAPT Questions, if applicable). Client was (describe client’s response to assessment questions during the session and/or interventions used in session). Client indicated he/she has not received a physical exam within the last year and was willing to go to Ole Health next week.

T (Treatment Plan/Recommendation): (Add next steps such as return visit, beginning of treatment services, meet primary counselor) i.e. Plan to meet with client tomorrow at 10 am to start the treatment planning process. (Add any referrals made MAT, Clinic Ole, Mental Health, Self- Sufficiency, etc.)

28.4.2 Group Progress Note Example

D (Describe): Facilitated the Early Recovery Group and the topic was “Internal Triggers.” The objective of the Topic was to help clients to differentiate between External Triggers, Internal Triggers, as well as to explore how the two interact with each other and can promote relapse. The discussion was facilitated through a curriculum handout, white board presentation, and interactive discussion.
I (Intervention): This writer began the group with client check-in, which was followed by a quick recap from a previous discussion on External Triggers, what they are, and how to manage them. The participants were then asked for examples of Internal Triggers to which the responses included Anger, Frustration and Discouragement. This writer demonstrated on the white board how External Triggers will usually cause Internal Triggers and those Internal Triggers left unaddressed can fester like an infected wound and lead to seemingly quick and repetitive relapse. The participants concluded the group with a discussion regarding healthy ways to address and manage the emotions that act as Internal Triggers and decrease the potential for relapse.

R (Response): Client was engaged and active in the discussion today. When checking in client stated, "I am at the Winter Shelter now. I have court coming up and I am worried that if they put me in jail, probation will make me start my whole program over when I am getting close to finishing." When discussing the topic client stated that his Internal Triggers were frustration, and discouragement because he would do everything that probation told him to, but he would still get arrested anyway.

T (Treatment Plan/Recommendation): Counselor to continue providing substance use education and skill building opportunities. Client to cooperate with probation and all law enforcement. Client agreed to write in journal to identify specific triggers relating to court and will identify ways to manage.

28.4.3 Case Management Progress Note Example

D (Describe): Met with client to review and discuss his case management needs. Client appeared alert and fully engaged while describing his situation. Client reported that he needs to get a physical exam per program requirements, but does not have any medical insurance. Client does not think that he will qualify for Medi-Cal due to his part-time employment.

I: (Intervention): Provided education and linkage services to assist client with obtaining medical coverage and discussed services available at the Self Sufficiency Department. Provided coordination assistance and took the client downstairs to show him where to check in to get the process started. Completed ROI for Self Sufficiency staff per client’s request.

R: Client appeared encouraged when he discovered that there was more than one option for medical coverage. Client appeared confused about the location of Self Sufficiency and agreeable to assistance. Client successfully checked in with the Self Sufficiency Dept.

T: Client agreed to contact this Case Manager if he ran into any difficulties and this writer will follow-up and assist client if needed. Client will meet with this Case Manager in one week to continue working on case management needs as identified on the treatment plan.

28.5 Diagnosis Review Form Summary Template

*LPHA please indicate if Intake, 3-month reassessment or 6-month Justification for Continued Treatment Reassessment at the start of the Diagnosis Review Summary Section.

Client is a (ethnicity) (age) (male/female) (other identifying information) who was referred to ADS by (enter referring party or self-referred) due to (add reason for referral). Client has participated in ADS (Outpatient/Intensive Outpatient Treatment/etc.) (number of times) in the last (number of months/months) with (some success). Client states, “(add what client hopes to get out of treatment).” Client demonstrates a problematic pattern of drug and/or alcohol use since (age of first use/drink), which has led to significant functional impairment and distress within the last 12-months. Client meets the DSM-5 criteria for the following Substance Use Disorder(s):

**Primary Drug:** (Name drug, severity and/or other specifiers (i.e. Controlled Environment, Early Remission, etc.). Client demonstrates a problematic pattern of (drug) use for (enter # years) with last reported use on (enter date). Identify and describe the criterion that supports the diagnosis.
Secondary Drug: (Name drug, severity and/or other specifiers (i.e. Controlled Environment, Early Remission, etc.). Client demonstrates a problematic pattern of (drug) use for (enter # years) with last reported use on (enter date). Identify and describe the criterion that supports the diagnosis.

Tertiary Drug: (Name drug, severity and/or other specifiers (i.e. Controlled Environment, Early Remission, etc.). Client demonstrates a problematic pattern of (drug) use for (enter # years) with last reported use on (enter date). Identify and describe the criterion that supports the diagnosis.

Mental Health Dx:

Client has an existing mental health diagnosis of (list each diagnosis separately) that was diagnosed by (name of clinician/doctor) from Napa County Mental Health. Client is current receiving services (describe client’s level of involvement with MH).

Medical Conditions:

Client identified the medical conditions listed on this diagnosis review (select medical conditions under General Medical Conditions section and indicate source of information).

ASAM Placement Summary and Recommendation:

Based on the ASAM Level of Care Determination Tool, used to determine the most appropriate level of care based on client’s risk factors, functioning and service needs, client meets medical necessity for (note Level of Care and code) as evidenced by the severity/functioning in each of the six dimensions on the ASAM Assessment (see Full ASAM Assessment).

28.6 Counselor Resources

4. ASAM Criteria Resources: [http://www.asam.org/resources](http://www.asam.org/resources)
5. DHCS Federal, State and DHCS Laws and Regulations: [https://www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx](https://www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx)
7. California Code of Regulations (CCR), Title 22 (51341.1, 51490.1 and 51516.1): [https://www.dhcs.ca.gov/services/adp/Pages/CA_Code_Regulations.shtml.aspx](https://www.dhcs.ca.gov/services/adp/Pages/CA_Code_Regulations.shtml.aspx)
8. CCR Title 9, Division 4, Department of Alcohol and Drug Programs: [https://govt.westlaw.com/calregs/CaliforniaCodeofRegulations](https://govt.westlaw.com/calregs/CaliforniaCodeofRegulations)
9. Counselor Certification Regulations, Title 9, Division 4, Chapter 8: [https://www.dhcs.ca.gov/provgovpart/Pages/CounselorCertification.aspx](https://www.dhcs.ca.gov/provgovpart/Pages/CounselorCertification.aspx)
28.7 Acronyms Glossary

AOD: Alcohol or Drug
ASAM: American Society of Addiction Medicine
ASOC: Adult System of Care
Batch: Monthly process preparing Services for billing
BHSD: Behavioral Health Services Division
BBS: Board of Behavioral Science
CalOMS: California Outcome Measures System
CAP: Corrective Action Plan
CBO: Community Based Organization
CJS: Criminal Justice System
COC: Continuum of Care
CSR: Client Status Report
CPM: Clinical Performance Measures
DHCS: Department of Health Care Services
DMC: Drug Medi-Cal
DSM: Diagnostic and Statistical Manual
EHR: Electronic Health Record
HIPAA: Health Insurance Portability Accountability Act
ICD: International Classification of Disorders
IOT: Intensive Outpatient Treatment
LNP: Licensed Nurse Practitioner
LOC: Level of Care
LOS: Length of Stay
LPHA: Licensed Practitioner of the Healing Arts
MAT: Medically Assisted Treatment (Includes Methadone, Buprenorphine and Vivitrol)
MH: Mental Health
MRN: Medical Record Number
NPI: National Provider Identifier
MMT: Methadone Maintenance Treatment
NTP: Narcotic Treatment Program
NIMH: National Institute of Mental Health
ODS: Organized Delivery Services
OP: Outpatient
PA: Physician’s Assistant
PC: Primary Counselor
PHI: Protected Health Information
P&P: Policy and Procedures
PSAP: Perinatal Substance Abuse Program
QA: Quality Assurance
QI: Quality Improvement
QIC: Quality Improvement Committee
RES: Residential Treatment
SAMHSA: Substance Abuse Mental Health Services Agency
SUD: Substance Use Disorder
TB: Tuberculosis (test)
TP: Treatment Plan
TSR: Treatment Status Report
TX: Treatment
UA: Urinalysis Screening for Drug Use
UM: Utilization Management
URF: Universal Referral Form
WM: Withdrawal Management (ASAM)
WX: Withdrawal (Detox)
YRS: Youth Referral for Services
YSOC: Youth System of Care
29 APPENDIX SECTION

29.1 APPENDIX A: MEDI-CAL EDITABILITY WORKFLOW

Client calls for an appointment

OFFICE A
Asks client if they have Medi-Cal.

YES
Obtain copy of Medi-Cal card or instructs client to bring in card to intake appointment or proof of eligibility.

NO
Instructs client that they will need to apply at Self Sufficiency (SS) immediately and bring proof of application to intake appointment. Provide client with SS contact number and location.

UNSURE
Collect client information to run MedsLite: Social Security and DOB.

OTHER TYPE OF INSURANCE
If client has Private insurance, obtain copy of insurance card.

KAISER INSURANCE
If client has Kaiser Medi-Cal, ok to enter ADS Treatment. If client has Kaiser non Medi-Cal, they need to be referred back to Kaiser.

OFFICE B
At intake, OA checks where client is in the eligibility process.

OFFICE B
If client has not applied for Medi-Cal, OA completes SS packet w/client and delivers to SS, and documents status in an Info Note.

OFFICE B
Runs Out-of-County Medi-Cal eligibility report and gives to Supervisor each month.

Supervisors follow up with counselor to make sure client is taking steps to obtain Medi-Cal.

OFFICE A
OA includes Medi-Cal status in the same Info Note of intake appointment made.

OFFICE B
Maintains a pending Medi-Cal list and removes them from the list once enrolled in Medi-Cal or discharged from ADS.

OFFICE B
If the client is out-of-county OA will provide fiscal the information monthly.

Counselor doing assessments offsite (i.e. Probation) will obtain proof insurance (copy of Medi-Cal, proof of application or Private insurance card) Call Office B OA to obtain Medi-Cal eligibility information.

July, 2018
### 29.2 Appendix B: Referral Checklist

**ADS WORKFLOW: Referral Tracking Checklist (10-10-18)**

<table>
<thead>
<tr>
<th>Referral Source:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Referred</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
</tr>
<tr>
<td>CVS</td>
<td></td>
</tr>
<tr>
<td>Other Medical</td>
<td></td>
</tr>
<tr>
<td>Residential</td>
<td></td>
</tr>
<tr>
<td>Detox</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

- In Custody/Approx Release Date: ___
- PO: ___

**Client Name:** __________________________   **Client DOB:** ____________

**Chart #:** ______________   **Phone:** __________________________   **Okay to leave detailed voicemail:** ____________

**Name of OA:** __________________________

(Enter the DATE requested)

**Establish Insurance Coverage:**

- 1. Follow "Medi-Cal Eligibility Workflow" and check one of the following:

- 2. Napa County Medi-Cal Verified or

- 3. Self-pay or Private Insurance: __________________________

**Track referrals and timeframes:**

- 4. Date on Interagency/Self-Referral Form

- 5. **Initial Request for Service Date** (date stamp on referral form or date of self-referral)

- 6. Complete "Population Screener" if urgent request, check box at top of form

- 7. Add Client and initial dates to the ADS Access Log

**Complete 'Soft Opening' (Steps 5-8):**

- 8. Look up client by name and/or DOB

  * **If client is in EHR, go to #5**

    - **If client is not in EHR, complete next steps to request chart #:**
      - a. Add client to Demographics form in ERH
      - b. Complete "Add Staff Signature" section
      - c. Add MR OA's at the bottom of demo (Diana Lessley & Heather Ernest)

- 9. Create Interim Service Log (ISL) using date #5 with no end date

- 10. Update information in existing Demographics form in ERH

- 11. Document receipt of referral in EHR with Info Note

**Connect referred client to ADS Services & document attempts/contacts:** (skip section if self-referred)

- 12. Complete one EHR Info Note per contact attempt or successful contact made w/details

- 13. First contact attempt (should be made on the same date as #5)

  * **If no response, also contact referring party**

- 14. Second contact attempt (within 3 business days from 1st attempt)

  * **If no response, complete next step**

- 15. Mail 10-Day Referral Closing Letter to client with a copy to Referring party

  **CLOSE on ____________ (enter 10 business days from date of #15)**

- 16. Enter date if contact made within 10-days of Referral Closing Letter & go to next section

- 17. If no contact made, close the referral, notify referring party

- 18. End-date ISL and complete ADS Access Log with above information

**Resolve the referral & track results of contact/attempted contact:**

- 19. Date of Initial Request for Service (enter the date from #5)
65 | P a g e

EHR Informational Note Example:

"1st Contact: (Name) contacted client and scheduled initial assessment on 8/12/18 at 10 am with (Counselor)."
## 29.3 APPENDIX C: SCREENING INTAKE CHECKLIST

### (Screening) Intake Tracking Checklist [11-1-18]

URGENT YES ☐ NO ☐

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Medical Record #:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of OA:</th>
<th>Orientation Lead:</th>
</tr>
</thead>
</table>

### Initial/Date each line upon completion:

1. Include Interagency Referral and Self-referral for ALL incoming clients
2. Include "Referral Tracking Checklist", "Intake Tracking Checklist" and "Population Screener" in packet
3. Prepare Blue Intake Folder (to include all necessary documents for Office A and LPHA)
4. Print Demo for client to review
5. Referral source/Name:
6. Prepare clipboards to include Welcome letter, Demo, SUD questionnaire and Elec Sig. Agreement
7. **Give client clipboard to begin working on forms when they arrive**
8. **Office A:** Make Copies of ID & all Insurance Cards (front & back) and add client # to each page

### During Orientation of Screening Clinic (if Walk-In LPHA will do this part as well)

9. Reviewed Beneficiary Handbook and other forms in ADS Admission Agreement (offer copies)
10. *****Orientation Leader is responsible for entering info note for each client attending

### Office B Meeting with Client for Intake documents

11. BHR - Open New "ADS Treatment Session" on date of Intake Assessment
12. BHR - Open client to 7050 as "Admit" status
13. Collect Demographics and confirm accuracy/Update in Medical record if necessary
14. BHR - Complete "Assignment of Benefits" form and print copy of "ADS Program Cost" for client
15. BHR - Add/New "Client Financial Review" (CFR) & add one if none on file or if previous has lapsed

- **If existing CFR is valid then confirm with client it is correct and then complete an Informational note in client chart indicating it was confirmed accurate (Do not edit as a means to confirm).**

16. BHR - Enter all of Payor Sources (i.e., CWS, Drug Court, Perinatal, CalWORKS)
17. **Office B:** Follow "Med-Cal Eligibility Workflow" and check one of the following:
   - Napa County Medi-Cal Verified
   - Pending Napa County Medi-Cal Application
   - Completed referral for Self-Sufficiency to get client application process started
   - Self-pay or Private Insurance: _____________

- **If client doesn’t have NC MC, email Counselor, Sup & UR Coord details (intake date, app status, self-pay, etc.)**

18. BHR - Complete the "ADS Admission Agreement" in Anasazi (offer copy & print if requested)

- **(**skip #18 if walk-in since LPHA has not yet reviewed admission docs)

19. Complete ROI for Self-Sufficiency (w/name) and CalWORKS Payor Sources
20. **Office B:** Notify identified available LPHA client is complete with intake paperwork

### UPHA with client during Apt:

21. **If Walk-in appt complete "Orientation" items above (#9)**
22. **If Walk-in appt have client sign the Admission Agreement in Anasazi**
23. Conduct ASAM Assessment Screener version and Complete Medical Necessity
   - (If immediate needs identified stop assessment and take clinically appropriate action)
24. Female clients, ask SAPT Questions (see handout)
25. Using SUD questionnaire/DSM5 as guide, determine dx
26. Complete with client ROI for "My Treatment Providers" as well as any other identified parties
27. At end of apt: Ask client to complete "Continuum review/client survey" questions
## APPENDIX D: INTAKE ASSESSMENT CHECKLIST

**ADS WORKFLOW: Intake Assessment Tracking Checklist** (10-10-18)

| Client Name: | ______________________________ |
| Name of OA: | ___________________________ | Counselor: __________________________ |

**Initial date each line upon completion:**

### Office Assistant Tasks and/or items to include in packet:

1. Include “Referral Tracking Checklist” and “Population Screener” in packet
2. Referral source/Name:
   - Include Intergency Referral and Self-referral for ALL incoming clients
3. Follow “Medi-Cal Eligibility Workflow” and check one of the following:
   - Napa County Medi-Cal Verified
   - Pending Napa County Medi-Cal Application
   - Completed referral for Self-Sufficiency to get client application process started
   - Self-pay or Private Insurance:
     - If client doesn’t have NC MC, email Counselor, Sup & UR Coord details (intake date, app status, self-pay, etc.)
4. Make Copies of ID & all Insurance Cards (front & back) and add client # to each page
5. Client Electronic Signature Agreement Signed & Dated (hard copy)
6. Client given “Demographics” to complete 1st and return to OA for entry
7. Client given “SUD Questionnaire” to complete 2nd while waiting for Counselor
8. EHR - Open New “ADS Treatment Session” on date of Intake Assessment
9. EHR - Open client to 7050 as “Admit” status
10. EHR - Complete “Assignment of Benefits” form and print copy of “ADS Program Cost” for client
11. EHR - Add/New ”Client Financial Review” (CFR) & add if none on file or if previous has lapsed
   - If existing CFR is valid then confirm with client it is correct and then complete an informational note in client chart indicating it was confirmed accurate (Do not edit as a means to confirm).
12. EHR - Enter all of Payor Sources (i.e. CWS, Drug Court, Perinatal, CalWORKS)
13. Complete ROI for Self-Sufficiency (w/name) and CalWORKS Payor Sources

### LPHA during APT:

14. TRIAGE Questions (see handout) - STOP session if necessary! Complete Diagnosis w/ Z Code
15. Reviewed Beneficiary Handbook and other forms w/ ADS Admission Agreement (offered copies)
16. EHR - Complete the “ADS Admission Agreement” in Anasazi (offer copy & print if requested)
17. Conduct ASAM Assessment and Complete Medical Necessity
18. Female clients, ask SAFT Questions (see handout)
19. Schedule follow-up call w/ the client
20. At end of apt: Ask client to complete “Continuum review/client survey” questions
21. Determine Primary Counselor based on weekly caseload chart
22. Follow up w/ a Tx Plan appointment w/ OA or Counselor

### LPHA after Apt:

21. Complete ASAM Assessment (must be typed)
22. EHR - Complete Progress Note [Include dx, recommended LOC, plan/next steps
23. MAT referral completed, sent to Ole Health and included to be scanned into EHR (or N/A)
24. Complete all other referrals (i.e. Mental Health, Housing..)
25. EHR - Complete MAT Attestation form (or N/A)
26. Recommended Track: ______________________________
| 27 | EHR - Complete Diagnosis Review Pg (to incl medical necessity statement in narrative) |
| 28 | EHR - Complete LOC Attestation form |
| **Review Procedure:** |  |
| **a) LPHA's conducted intake complete the following:** |  |
| 29 | LPHA: Email your supervisor to request clt placement in treatment track or if residential, email your supervisor and OA managing residential beds (Brenda) or if no Tx needed, email supervisor |
| 30 | LPHA: Complete checklist, incl documents should be sent to referring party (complete #41) |
| 31 | LPHA: Separate documents and place what needs to go to med rec for scanning in Med Rec folder |
| 32 | LPHA: Turn folder with completed checklists in to Office B |
| 33 | LPHA: If Residential, explain to clt options avail if no immediate bed (telehealth, IOS, wkly group) |
|   | If clt doesn't meet medical necessity, email Office A to complete NOABD-Denial (follow P&P) |
| 34 | **OA enter into ADS Access Log and write an info note/Supervisor to close out episode** |
|   | **Supervisor complete one of the following:** |
|   | □ If OP and new Counselor assigned, add counselor to 7050 assignment |
|   | □ If IOT close 7050 & open 7051 assignment is being made & ___ change Counselor in assignment using date the assessment was approved/assignment |
|   | □ If Co-Occurring open to 7095 using the intake assessment date & |
|   | □ If Residential email Brenda, Noelle & Brooke for tracking, include name of referral source & |
|   | ___ assign to *Counselor who facilitates the "weekly res. group" and they will hold and follow the case until bed available |
| 35 | Supervisor complete info note |
| **OA Completes the following:** |  |
| 36 | OA Submit HHS Facilities Request Medical Records for Intake Assessment note form #_______ & dated __________ to be released to referring party __________________________ |
| 37 | OA Update ADS Access Log |
|   | **Office B will run a report in Anasazi on a weekly basis in order to gather above info and enter** |
| 38 | OA Final completed CHECKLIST(s) turned into UR Coordinator |
### 29.4 Appendix E: Offsite/Jail Intake Assessment Checklist

**ADS Admit Workflow - Working Draft 11.15.18**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
</table>
| 1    | In client chart in Anasazi, print the following hard copy documents to take with you to jail:  
   - Demographic  
   - Assignment of Benefits (right click on signature and select "Document signature on hard copy")  
   - Print "ADS Program Cost" printout for client  
   - ADS Admission Agreement (right click on signature and select "Document signature on hard copy")  
   - Financial Review Form (You will need to have OA complete first)  
|    | Also bring:  
    - Electronic Signature Agreement (because if/when they come to program we need it)  
    - ROI (complete for My Treatment Providers and specific probation officer(s) and include David Guerrero in case residential is needed)  
    - Copies of Admission Agreement info, Privacy Practices, High Risk Substance Use Info sheet (remove all staples)  
    - SUD Questionnaire to use as guide during interview  
    - Triage Questions  
    - Continuum Review Questions to ask client at end of appointment  
    - Full ASAM assessment |
| 2    |   - Call Office B to let them know you have a jail assessment so they can check Medi-Cal, open session and assignment and complete Financial Review Form (which you will print after you take with you)  
   - Office Assistant Completes Highlighted Items Only  
   - Referral Source Name & Dept.  
   - Include "Referral Tracking Checklist" in packet that was completed by office A Office Assistant  
   - Include Interagency or Self Referral form for ALL incoming clients |
| 3    |   - Call OA Office B (X8708 or X4771) to check Medi-Cal Eligibility using the MEDS system;  
   - Name OA: ______________ verified;  
   - Napa County Medi-Cal  
   - Out-of-County Medi-Cal (County Name): ______________  
   - Does not have NC MC  
   - If CTC doesn’t have Napa County Medi-Cal, email Supervisor w/date of intake and do the following:  
   - Complete Self-Sufficiency packet, refer to S. Campus and document that this was done. |
| 4    |   - Make copies of ID & all insurance cards (front & back)  
   - EHR - Open New Treatment Session using "ADS" and date of intake assessment  
   - EHR - Open client to 7050 as "Admit" status  
   - EHR - Add/Update "Client Financial Review" (CFR) Add one if none on file or if previous has lapsed  
   - "If existing CFR is valid then confirm with client it is correct and then complete info note in EHR indicating it is accurate (Do not edit as a means to confirm)."  
   - EHR - Enter all of Payor Sources (i.e. CWS, Drug Court, Perinatal, CalWORKS)  
   - LPHA at Appointment with Client  
   - **DO FIRST** Triage Questions Asked  
   - Review Admission agreement, privacy policy, high risk substance use information, program cost info  
   - Review Demo with client and check for accuracy – note any changes needed so record can be updated  
   - Review Assignment of Benefits and have client sign hard copy  
   - Have client sign Admission Agreement |
29.5 Appendix F: Treatment Plan Workflow

Referral Received-OA creates Interim Service Log (ISL)

Intake/Assessment — first face-to-face service (Up to two meetings to complete)
   a. OA Opens Subunit 7050 at Intake Assessment
   b. Assigned LPHA completes ASAM and Diagnosis
   c. LPHA submits ASAM Summary and Narrative in PDF form to Medical Records to upload to client chart (ASAM PDF file will be named with initial date of ASAM)  i.e  M.Mouse 3.1.18

If LOC 7050 is determined by LPHA, 7050 remains open. If LOC is not 7050, LPHA closes 7050 effective the date of the ASAM and Dx. LPHA then opens the new appropriate LOC (i.e. 7051, 7075, 7076, 7077)

The closing of an LOC and opening of new LOC date needs to be the same date

If the client will be entering into the ADS Co-occurring groups, the LPHA will also open Sub Unit 7095. 7095 is not a Level of Care subunit but used to identify that a person is in the co-occurring program.

(Services will not be entered into Sub Unit 7095 but will be for Fiscal purposes only.)

Initial Treatment Plan — Counselor completes Tx Plan and client signs within 30 calendar days of admission.
   a. ISL will automatically end date when Tx Plan is created
   b. LPHA reviews and signs Tx Plan within 15 days of the date of counselor’s signature

Treatment Plan Attestation Form - Counselor completes this form indicating if client signed Treatment Plan or not. Non-signature form client requires explanation by counselor prior to completing this form.
   a. Enter Client Signature (if applicable)
   b. Counselor Signs
   c. LPHA Signs
Treatment Plan – Review/Revision (counselor updates 90 days from Intake date or earlier than 90 days if ASAM determines a change in LOC)
   a. Counselor completes an ASAM re-assessment (and Opens new LOC subunit and Closes previous subunit effective the same date if applicable)
   b. LPHA reviews and signs revised Tx Plan within 15 days of the date of counselor’s signature

Treatment Plan Attestation Form - Counselor completes this form indicating if client sign Treatment Plan or not. Non-signature from client requires explanation by counselor prior to completing this form.
   a. Enter Client Signature (if applicable)
   b. Counselor Signs
   c. LPHA Signs

LOC= Level-of-Care
F2F= Face-to-Face
LPHA= Licensed Practitioner of Healing Arts (LCSW, MFT, MFTI, PsyD)
7050- Outpatient 1.0
7051- Intensive Outpatient 2.0
7075- Perinatal Outpatient 1.0
7076- Perinatal Intensive Outpatient 2.1
7077-Perinatal Recovery (only in O/P 1.0 LOC)
7095- NEW Co-Occurring SubUnit for Fiscal Purpose (Services will not be entered here)
# Appendix G: Treatment Planning Checklist

**ADS ADMIT WORKFLOW - updated 11/13/18**

### Treatment Plan Tracking Checklist

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Treatment Plan Type: Initial or Review (circle one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of OA:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial/Date each line upon completion:</td>
<td></td>
</tr>
<tr>
<td><strong>Supervisor Initial/Date Completed</strong></td>
<td></td>
</tr>
<tr>
<td>1. Tx Planning Session</td>
<td>Date:</td>
</tr>
</tbody>
</table>

### If Initial Treatment Plan

1. 2 EHR - End ISL one day prior to Treatment Planning session with client
2. 3 EHR - Create a new ADS Treatment Plan (start: Tx Planning date & end: 89 days from start date)
3. 4 Ensure all contents are included in Treatment Plan:
   a. For each PROBLEM, list one strength, goal and objective with multiple interventions (service codes)
      i. First Problem (Substance Use D/O) has these interventions, treatment planning, and discharge planning.
      ii. If physical exam hasn’t been completed within prior 12 months (or if a copy cannot be obtained), then add goal to obtain a physical exam if goals have been met.
      iii. If client is perinatal, include objective to get a TB screening.
      iv. Every problem that was identified on the ASAM Assessment MUST be included on Tx Plan as; active goals, referred goals or deferred goals.
4. 5 Schedule CaiOMS Admission given to first group (Assign after Tx Planning Apt, or if known prior)
   - Date: | Time: |
   - Name of Counselor: (Notify & track CaiOMS)
5. 7 Completed and signed Client Plan
6. 8 Copy of Note if no Signature on Cit Plan

### If Treatment Plan is a Review

1. 2 Date previous treatment plan ends
2. 3 Each Objective has a narrative review of progress toward action steps during reporting/plan period
3. 4 Each Objective is either “resolved” or updated with action steps to be taken during next report/plan period
4. 5 If Physical Exam and/or TB Screening Objective is resolved, counselor confirms it is scanned into record under attachment
5. 6 Counselor confirmed with client and in BHR that all ROI’s are current
6. 7 Counselor signed on ________ (date)
7. 8 Client signed on ________ (date)
   - or
7. 9 Documented non-client signature
8. 10 Treatment Planning Progress Note entered into Anasazi for date of client signature or non-signature
9. 11 Date turned in to Supervisor
29.7 APPENDIX H: REASSESSMENT CHECKLIST (OUTSIDE OF THE 5-6 MONTH)

ADS ADMIT WORKFLOW - WORKING DRAFT 10.10.18
Reassessment (outside of the 5-6 month) Tracking Checklist

*ODS requires reassessment at least every 90 days.

Client Name: ___________________________ Date of Reassessment: ___________________
Counselor: ___________________________ Office Assistant: _______________________

Initial/date each line upon completion:

**Confirm Client has Napa County Medi-Cal with Office Assistant**

- 1. Send Office B an email requesting Medi-Cal status
- 2. If Out-of-County Medi-Cal, discuss plan for transfer with Supervisor

**Counselor during Appointment:**

- 3. Determine if additional Releases of Information are needed
- 4. Ensure copies of ID & all Insurance Cards are in the record (OA may assist)
- 5. Conduct the ASAM Update Assessment

**Counselor after Apt: Complete the following and make/print copies to submit to Supervisor for revisions.**

- 6. Complete ASAM Update Assessment (make copy and submit to MR)
- 7. EHR - Complete Updated Diagnosis Review Page (if SUD diagnosis changes)
- 8. EHR - Complete Progress Note

**If Counselor after Apt: Complete the following and make/print copies to submit to Supervisor for revisions.**

- 4. Case Consult with Supervisor
- 5. Supervisor - EHR Completes Updated Diagnosis Review form
- 6. Supervisor - Document Case Consultation with Counselor & completion of Diagnosis Review form
- 7. Supervisor-Complete LOC Attestation form

**Office Assistant Tasks and/or items to include in packet:**

- 9. Check client's MediCal (email UR Coordinator & Supervisor if out-of-county)
  
  *Until MEDS is available to ADS, please contact Sustainability or Billing for information.*

- 10. Check that all Payor Sources have been entered (i.e. CWS, Drug Court, Perinatal, CalWORKS)

- 11. Give to Supervisor. Name: ___________________________
Review Procedure:

12 Supervisor Received

13 Recommended Changes for Counselor/Therapist (complete within 24 hours)

14 Corrected Packet to Supervisor for Final Approval

15 If residential is recommended, McAlister referral included and email sent to Brenda for WL

16 Turned into Office Assistant (submit to Medical Records and scan documents)

17 OA Send client documents to Medical Records

18 Final completed CHECKLIST(s) turned into UR Coordinator

Use checklist if:
- Suspect LOC Change
- At 3 months
- At 9 months
29.8 Appendix I: Justification for continued Treatment Workflow

Justification for Continued Treatment
(After 5 months - before 6 months)

Anasazi Action Scheduler will alert ADS Primary Counselor that a Justification for Continued Treatment is due. ADS Counselor will schedule an appointment with his/her client to gather information for a complete re-assessment after 5 months and before 6 months of treatment.

An LPHA will review the information gathered with the AOD counselor to update the Diagnosis and Level of Care.

Once re-assessment is completed, AOD Counselor will complete and submit the Justification for Continued Treatment Form to Supervisor or reviewing LPHA to final approve (FA).

ADS Counselor will update client Tx Plan and send to Supervisor or designated LPHA for F/A.

Reviewing LPHA will review and final approve the Justification for Continued Treatment form and sign the Justification Review form with the same date in Anasazi.

If the 6 month Justification for Continued Treatment is not approved by the Reviewing LPHA, the counselor will follow ADS Client Discharge process.

LPHA: Licensed Practitioner of Healing Arts
FA = Final Approval

Revised 8/8/18
29.9 APPENDIX J: 6-MONTH JUSTIFICATION RE-ASSESSMENT CHECKLIST

Complete between 5 and 6 months from Admit Date or date of last Justification:

PHASE ONE:

1. PC will do the following:
   a. Conduct the FULL ASAM
   b. Ensure there is a recent Physical Exam in the medical record (if not, send client to the doctor)

2. An LPHA must meet with the client to:
   a. Review ASAM
   b. Verify medical necessity and LOC
   c. Update the Diagnosis Review Page (even if it’s the same diagnosis)
   d. Complete the LOC Attestation form

PHASE TWO:

3. PC completes the Justification for Continued Treatment Form and
4. LPHA will complete the following:
   a. Review Justification for Continued Treatment form
   b. Review the client’s chart and most recent physical exam
   c. Completes the Justification Review form

PHASE THREE:

5. PC will Update the Treatment Plan (Update, not revise – because the timeframe needs to change) – within 30 days of the ASAM
6. LPHA Reviews, signs and final approves Treatment Plan
7. LPHA Competes the Treatment Plan Attestation form
### ADS ADMIT WORKFLOW - 10.10.18

**Justification for Continued Treatment Tracking**
(After 5 months and before 6 months)

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**LPHA Process**

Client Name: ___________________________ Date of Assessment: ________________

Counselor: ___________________________ Office Assistant: ___________________________

Initial/date each line upon completion:

**Confirm Client has Napa County Medi-Cal with Office Assistant**

1. Send Office B an email requesting Medi-Cal status

2. If Out-of-County Medi-Cal, discuss plan for transfer with Supervisor

**LPHA Primary Counselor during Appointment:**

3. Determine if additional Releases of Information are needed

4. Ensure copies of ID & all Insurance Cards are in the record (as may assist)

5. Ensure physical exam (PE) reviewed and in chart (date ________________)
   
   Refer client for an updated PE if client’s physical is approaching 12 month annual date. Update PE in Tx Plan

6. Conduct the ASAM Full Assessment

**LPHA after Apt: Complete the following and make/print copies to submit to Supervisor for revisions.**

7. Complete ASAM Assessment (print a copy)
   
   Follow process of referring client to appropriate Level of Care
   
   If residential is recommended, McAlistar referral and ROI included and email sent to Brenda for WL

8. EHR - Complete Diagnosis Review Form
   
   Open new Diagnosis Assessment date being done, do not end date previous or current diagnosis if still active

9. Complete ASAM LOC Attestation Form

10. Complete Justification for Continued Treatment Form

11. Complete Justification for Review Form

12. EHR - Complete Progress Note
   
   If able to complete all above forms w/in 24 hours of service time, it must be included your prog note

13. Submit Documents to Medical Records

14. Complete CHECKLIST & turn into UR Coordinator

**LPHA completes Treatment Plan Review (update)**

15. Follow standard Tx Plan workflow process

---

**If Counselor after Apt: Complete the following and make/print copies to submit to Supervisor for revisions.**
AOD Counselor must complete the Discharge Plan form in Anasazi within 30 calendar days prior to the scheduled date of the last face-to-face treatment session with client.

AOD Counselor signs and dates the Discharge Plan. A copy of the plan must be offered to the client. The completed Discharge Plan must be signed by the client, counselor and LPHA.

AOD Counselor will complete or schedule an appointment for a new assessment and gather information to update the client’s ASAM and diagnosis.

(Follow procedures in Recovery Services workflow)
29.11 APPENDIX L: DISCHARGE SUMMARY WORKFLOW

Discharge Summary

AOD Counselor must complete a 10-day letter informing client of pending termination of treatment due to no-contact prior to completing a Discharge Summary. The ADS Office Assistant will log the 10-day letter and Office Assistant will send an official NOABD Termination letter to client if client does not return to treatment.

AOD Counselor will complete the Discharge Summary form in Anasazi within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary.

AOD Counselor must:

- Sign the completed Discharge Summary
- Follow ADS internal Documentation Closing checklist and turn completed checklist to Supervisor

NOTE: If a client is transferring to a higher or lower level of care based on ASAM and they are staying within the ADS program, client is not required to be discharged unless there has been more than a 30 calendar day lapse in treatment services.
## APPENDIX M: CLOSING CHECKLIST

**ADS WORKFLOW: Closing Checklist (10.10.18)**

| Client Name: |  | Chart #: |  |
| Primary Counselor (PC): |  | Date: |  |

| Initial/date each line upon completion or write "N/A": |
|---|---|---|---|
| **Discharge Plan:** |
| 1. Date of most recent ASAM |
| 2. Date of MDT, if not, please explain: |
| 3. Date of Discharge Planning Session |
| 4. Were Recovery Services accepted? Yes ___ No ___ |
| 5. CalOMS STANDARD Discharge Date |
| 6. Close CalOMS Sub-unit 7099 |
| *Select one of the 8 "Reason Codes" for CalOMS Discharges |
| 7. Last Face-to-Face Date |
| 8. Discharge Planning Note |
| 9. On discharge is processed, complete info note |
| *This treatment episode was completed and closed. |
| 10. End-date Treatment Plan or ISL |
| 11. Close Client Assignment in Anasazi (using date you are processing closing docs) |
| *You were prompted to "do you want to close the current treatment session?" |
| If client is moving into Recovery Services, select "No" |
| If client declines Recovery Services, select "Yes" and close Tx Session |
| 12. If LPHA End-date Diagnosis Review |
| *The date of the form is the date you are processing the closing documentation |
| *The end-date of the SUD diagnosis (the box where you end-date diagnosis), should be the date of the last face-to-face. |
| 13. Turn in Closing Checklist to Supervisor/Reviewer |

| **Discharge Summary:** |
|---|---|---|---|
| Use these Dates for the Anasazi Discharge Summary form: |
| 14. 1) Date of "Last Face-to-Face" and date of "End of Treatment" should be the same |
| 2) Date of "Closing" is the same date you are processing closing |
| 15. 3 Attempts to Contact for D/C Summary/Admin D/C (2 phone outreach & 10-day letter) |
| 1) |
| 2) |
| 3) 10-Day Letter Sent on: |
| *Mailed no later than 10 days after the last face-to-face contact |
| *Put Day 11 on your calendar to prompt you to close |
| *If Day 11 falls on a weekend or Holiday or your scheduled day off, then you must wait to close |
| 16. Date Eligible to Close (Day 11): |
| 17. Supervisor notified ahead of time if Administrative Discharge |
| 18. Referring Party notified of intent to close when 10-day letter sent |
| 1) Name of Referring Party:  |
| 2) Date(s) of Contact/Attempt:  |
| 3) Referring party notified of final closing on:  |
| 4) Complete a Progress Note for every contact made with Referring Party (bill) |
| *Write an Info Note if no contact made |
| 19. Documentation completed to support dates of contact(s) for client and referring party |
| 20. CalOMS ADMINISTRATIVE Discharge Date |
Medication Assisted Treatment
Work Flow with OLE Health

After client initial Treatment Plan appointment, ADS Counselor faxes client referral, release of information and copy of ASAM summary report to Ole Health County Campus.

Any client on a waitlist for Residential will be referred to OLE Health for MAT services immediately

AOD Counselor signs and dates
MAT Treatment Referral form in Anasazi

Ole Health contacts client directly and follows their own internal MAT process of Induction, Stabilization, Maintenance or Termination

Ole Health to contact both ADS Primary Counselor (from referral form) and Jeremy (MAT Liaison) when client is contacted and has entered into MAT services/or/ have not been able to contact

ADS MAT Liaison will print out a list monthly of all clients referred to MAT services and meet with OLE Health MAT liaison to conduct formal review of clients each month

Formal review will identify clients still in treatment, discharged, receiving MAT services, Treatment progress

*Ole Health Fax (707) 254-1779
29.14  **APPENDIX O: PHYSICAL EXAM WORKFLOW & ATTESTATION**

**ADS Physical Exam (PE) Process**

Client **DOES NOT** have physical exam - Seen by Ole Health County Campus

*Release of Information required at intake to initiate process*

May, 2018

**OLE HEALTH**: Physicals can be requested, reviewed or completed by Physician Assistant, Medical Doctor or Registered Nurse
**ADS Physical Exam (PE) Process**

Client **ALREADY HAS** physical exam *(within 12 months)*

**Release of Information required at intake to initiate process**

**ADS Primary Counselor initiates SRMS to Medical Records to request PE from other healthcare facility**

**Medical Records requests PE from other healthcare facility**

**Medical Records receives and scans PE into client chart and sends hard copy to Ole Health for review and PE Confirmation form completion**

**PE Confirmation Form is returned from Ole Health to Medical Records, scanned into the client chart & Med Records completes attestation form in Anasazi.**

**Ole Health Reviews Physical Examination of last 12 months & completes PE Confirmation Form**

**Medical Records notifies ADS OA through SRMS that the PE Confirmation form is in client chart**

**FINAL STEP**

ADS OA notifies ADS Counselor to Resolve Treatment Plan Goal

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May, 2018

*Ole Health Fax (707) 265-6995*

***OLE HEALTH: Physicals can be requested, reviewed or completed by Physician Assistant, Medical Doctor or Registered Nurse***
Appendix P: ADS Program UA Protocol

ADS Specimen Collection and Labeling Instructions

1. Write down the time that you are starting with a particular client.
2. Counselor put on gloves for dealing with bodily fluids.
3. Provide client a specimen cup that is labeled as “Sterile” and is unopened.
4. Instruct client to place sample in cup.
5. Counselor observes client putting sample in cup. Urine flow should be visible directly from body part (urethral area). If counselor is not observing, they must use the Mid-stream Method by instructing the client to begin urinating in the commode, stop the stream, and then begin urinating in the container provided.
6. Counselor collects cup from client and visually checks color and checks temperature on the cup to ensure proper body temperature. If tampering is suspected, due to either questionable color or temperature) specimen should be sent to lab. Client may not put lid on cup.
7. If counselor suspects diversion (client trying to cheat the test) in the moment, counselor should not accept specimen and should direct client to follow up with primary counselor.
8. Counselor then uses multi-substance panel and/or ETG test.
9. 5 panel requires counselor to place 3 drops of urine on the panel test. Dropper is provided with panel test.
10. ETG is a dipstick that counselor holds in urine sample for 15 seconds being very careful to not submerge strip past designated line on strip.
11. Both tests require 5 minutes to chemically process.
12. If specimen is negative, specimen should be dumped in toilet and cup disposed in hazmat bin located in bathroom.
13. If the test indicates a need for verification or clarification (such as if line is faint or if client adamantly denies using despite positive readi-test result) by lab the following labeling instructions should be used:
14. Counselor puts lid securely on specimen bottle. Please be very careful during this process and be sure the threads are lined up properly and tightened sufficiently.
15. On provided “Security Seal” sticker, client dates and writes their initials in indicated space and counselor places the seal over the top of the cup so that either end of the seal is affixed to opposite sides of the cup.
16. Counselor completes provided identification label to include Specimen date, client ID (ADS chart number), collector (counselor who observed the test).
17. Do not write anything under the “Chain of Custody”
18. Under the word “Request” in the top right corner of the label, complete the options based on what you would like tested (see examples).
19. Peel label from paper and wrap around circumference of specimen cup.
20. Place specimen cup in plastic bag provided by lab.
22. Double check and ensure that the appropriate label is placed on the correct specimen
23. Place specimen in a box provided by lab (up to two specimens may be placed in the same box).
24. Place box in designated mail bin.
**29.16 APPENDIX Q: RESIDENTIAL MANAGED CARE ORGANIZATION (MCO) AUTHORIZATION PROCESS**

- New Client Entry to ADS (Referral Types: Walk-in, Community, Self, Probation, Primary Care, Detox, Other)
  - Referral Received- OA creates Interim Service Log (ISL)
  - Intake/Assessment—first face-to-face service
    1. OA Opens Subunit 7050 and Tx Session at Intake Assessment
    2. Ensures ROI/MH received
    3. Determines Medi-Cal eligibility
  - ADS staff completes Diagnosis & ASAM and intake process
  - If Residential LOC is determined, LPHA closes Tx Session and 7050 effective the date the DX was F/A by the LPHA
    - Use Reason Code 9 or 10 for closing
  - Residential referral is sent immediately to URC to evaluate past residential admission (365 day look back 2x90 day TX Max in one year) and provides authorization within 24 hours
  - If no ROI from client, URC will look up client information in EHR to determine paclitazation and manually enter Residential assignment into client record
  - If Outpatient LOC is determined by LPHA, 7050 remains open and Client follows process for entering Outpatient TX
  - If client refuses to sign the ROI, staff will immediately document client refusal in EHR, inform Supervisor and URC, and send refusal with intake documents to Medical Records for scanning into client records
  - If client no-shows to residential treatment within 7 days, Center Point informs ADS and MCO deletes unused authorization
  - Center Point will generate bills and send to Fiscal staff
  - Fiscal Staff will enter services against Authorization monthly
  - If client is not in MCO system, Fiscal informs URC; URC reviews fiscal report and contacts Center Point if client is not found in MCO system.

- URC enters Authorization into Managed Care System (MCO) and service lines for 90-day residential treatment and services for Case Management
  - URC prints authorization with designated length of stay dates and fax to Center Point the same day of staff referral

**Level of Care (LOC)**
- 7050 – Outpatient
- 7631 – Residential 3.1
- 7635 – Residential 3.5
- 7571 – Residential 3.1 Perinatal
- 7575 – Residential 3.5 Perinatal
- 7632 – Residential W/O Mgmt. 3.2
- 7672 – Residential W/O Mgmt. 3.2 Perinatal

**Legend:**
- F/A= Final Approved
- OA= Office Assistant
- ROI= Release of Information
- URC= Utilization Review Coordinator
- LPHA= License Practitioner of Healing Arts

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*Page 85*
Recovery Services

Clients may access Recovery Services after completing their course of treatment if triggered, have relapsed or as a preventative measure to prevent relapse.

Plan for client to enter Recovery Services after completing ADS Outpatient Treatment.

Counselor complete DC Plan with client to include transition to Recovery Services upon completion from treatment. Update Release of Information. Schedule Recovery Services Tx Planning session prior to discharge (to gather information for Recovery Plan to open day after discharge).

Treatment Sub-Unit will be closed and the Recovery Services Sub-Unit is open: 7052 Outpatient Recovery /or/ 7077 Perinatal Recovery.

At Discharge, LPHA will revise Diagnosis Review form. A valid ICD-10 Diagnosis for remission is required.

AOD Counselor ends current Tx Plan and completes new Treatment plan and use Recovery Services as interventions. Client must sign new Tx Plan within 30 days of discharge date from Outpatient Tx.

Entering Recovery Services at initial intake & assessment (i.e. client completed SUD Treatment at another location).

If it is determined at intake that client meets medical necessity criteria for Recovery Services LOC, a valid ICD-10 Diagnosis for remission is required and client must still follow standard ADS Intake process.


Initial 7050 Sub-Unit must be closed and Recovery Services Sub-Unit opened on the same day: 7052 Outpatient Recovery /or/ 7077 Perinatal Recovery. Counselor creates a Recovery Plan with the client on the same day.

The Recovery Plan must be based on the ASAM 6 dimensions.

- Create “new” Treatment Plan and choose Strengths, Problems and Objectives appropriate for Plan
- Include Intake/Assessment intervention to allow Re-assessment during Recovery
- Choose the appropriate Recovery Services Interventions (Individual, Group, Monitoring or Case Management)
- LPHA must final approve Recovery Plans and a copy shall be provided to the client

All client contact (in person, telephone or internet) during Recovery Services must be documented using a Progress Note with the appropriate Recovery Service Codes.
Recovery Services

Clients may access Recovery Services after completing their course of treatment if triggered, have relapsed or as a preventative measure to prevent relapse.

CLOSING OUT RECOVERY SERVICES

If the counselor has not had any contact with the client in 30 days (either in person or via telephone) during the opening of Recovery Services, counselor shall follow Discharge Summary process, complete Discharge Summary form and close Recovery Service sub unit.

If the client is no longer in need or wants Recovery Services after 6 months, Counselor shall document in Progress Note reason for closing and close Recovery Services subunit.
# APPENDIX S: SCOPE OF PRACTICE-DETAIL

## DMC-ODS Staff Service Categories

*Revised March 2018*

### PHYSICIAN ONLY

<table>
<thead>
<tr>
<th>Service Description</th>
<th>LPHA Physician</th>
<th>LPHA Non-Physician</th>
<th>Counselor</th>
<th>Peer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician-to-Physician Consultation</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>• DMC physician consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists (Note: Counties may contract with one or more physicians or pharmacists to provide consultation services)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NTP Medication Psychotherapy:</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>• Face-to-face discussion conducted by the Medical Director of the NTP/OTP on a one-on-one basis with the patient</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### LPHA (PHYSICIAN AND NON-PHYSICIAN) ONLY

<table>
<thead>
<tr>
<th>Service Description</th>
<th>LPHA Physician</th>
<th>LPHA Non-Physician</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake and Assessment:</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>• Determination of Medical Necessity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Services</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>• Prescribe and Dispense Medication by staff authorized to provide services within their scope of practice or licensure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Buprenorphine, naloxone and disulfiram reimbursed for onsite administration and dispensing at NTP programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Long-acting injectable naltrexone reimbursed for onsite administration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ordering, prescribing, administering, and monitoring of medication assisted treatment reimbursed</td>
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<td></td>
</tr>
</tbody>
</table>

### LPHA + COUNSELOR

<table>
<thead>
<tr>
<th>Service Description</th>
<th>LPHA Physician</th>
<th>LPHA Non-Physician</th>
<th>Counselor</th>
<th>Peer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake</td>
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<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>• Assessment of Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Development of Client Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prepare individualized treatment plan</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Counseling</td>
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<td></td>
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<td>x</td>
</tr>
<tr>
<td>• Individual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Group (min 2, max 12)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Family Therapy</td>
<td></td>
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<td>x</td>
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<tr>
<td>• Incorporating family into treatment process</td>
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<tr>
<td>Patient Education</td>
<td></td>
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<tr>
<td>• Research based education</td>
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<tr>
<td>Collateral Services</td>
<td></td>
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<tr>
<td>• Sessions with therapists to support treatment goals</td>
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<tr>
<td>Crisis Intervention Services</td>
<td></td>
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<tr>
<td>• Stabilization of beneficiary emergency situation</td>
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<tr>
<td>Discharge / Referral Services</td>
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<tr>
<td>• Prepare beneficiary for referral</td>
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<tr>
<td>• Prepare beneficiary to return to community</td>
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<tr>
<td>• Link to community treatment</td>
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<tr>
<td>Withdrawal Management Services</td>
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<tr>
<td>• Monitoring course of withdrawal</td>
<td></td>
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<tr>
<td>Case Management Services</td>
<td>X</td>
<td>X</td>
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<tr>
<td>• Transferring patient to a higher or lower level of care</td>
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<tr>
<td>• Development and periodic revision of a client plan that includes service activities</td>
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<tr>
<td>• Monitoring service delivery to ensure beneficiary access to service and the service delivery system</td>
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<tr>
<td>• Monitoring the beneficiary's progress</td>
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<tr>
<td>• Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services</td>
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<tr>
<td>Recovery Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>• Recovery coaching, monitoring via telephone and internet</td>
<td></td>
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<tr>
<td>• Providing linkages to life skills, employment services, job training, and education services</td>
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<tr>
<td>• Providing linkages to childcare, parent education, child development support services, family/marriage education;</td>
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<tr>
<td>• Providing linkages to self-help and support, spiritual and faith-based support</td>
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<tr>
<td>• Providing linkages to housing assistance, transportation, case management, individual services coordination</td>
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<tr>
<td>LPHA + COUNSELOR + PEER</td>
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<tr>
<td>Substance Abuse Assistance</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Peer-to-peer services and relapse prevention</td>
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</tbody>
</table>

DMC-ODS Staff Definitions

**Licensed Practitioner of the Healing Arts (LPHA) Non-Physician:** Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Non-Physician LPHAs include: Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

**LPHA Physician:** Physicians are a sub-category of the LPHA definition and must be licensed, registered, certified, or recognized under California State scope of practice statutes. Physicians shall provide services within their individual scope of practice.

**Counselors:** As defined in Section 13005(a)(2) or 13005(a)(8) of Title 9 of the California Code of Regulations.

**Peers:** Peer-to-peer services are eligible for reimbursement under the DMC-ODS Pilot Program when provided as substance abuse assistance services, as a component of recovery services. The county must submit a training plan to DHCS for approval prior to providing covered peer support services. See Information Notice 17-008 for more information.
APPENDIX T: INTERAGENCY REFERRAL FORM

NAPA COUNTY INTERAGENCY REFERRAL FORM
2751 NAPA VALLEY CORPORATE DRIVE
NAPA, CA 94558

Please send referral to:
County Campus Ole Health – ph: 707-265-8785 fx: 707-254-1779

DATE: CLIENT: DOB:

PARENT / GUARDIAN / LEGAL REPRESENTATIVE: PHONE:

ADDRESS: LANGUAGE: IDENTIFIES AS: MALE □ FEMALE □ OTHER

INSURANCE:

PRIMARY CARE: PCP LOCATION / PHONE:

PERSON / PROGRAM / AGENCY MAKING REFERRAL:

REFERRING PARTY CONTACT INFORMATION ph: fx:

FOR CWS/MH ONLY: NO RIO NEEDED REASON:

EMAIL:

REASON FOR REFERRAL:

CURRENT WORKING DIAGNOSIS:

CURRENT MEDICATIONS:

ALLERGIES: ADA ACCOMODATIONS NEEDED:

SERVICE REQUESTED: Primary Care Visit Substance Recovery Assessment Mental Health Assessment

REQUEST FOR ADS PHYSICAL EXAM: YES NO BEACON SCREEEN COMPLETE: YES NO

*PCP NPI# (ADS Referrals only) LCSMI# (Criminal Justice / Probation only)

DISPOSITION: (Receiving agency to complete this section and return to referring agency):

Revised 03.15.2017
Napa County ADS Assessment Population Screener

Date: __________  Caller Name: _____________________________  Screened by: ______________________________
Assessment Scheduled With: ______________________________

In order to ensure you are seen by a counselor who can best meet your assessment and treatment needs I need to ask you a few questions. Is that okay with you?

1. Urgent Care: “Urgent care referral shall be offered within 24 hours”
   a. Withdrawal – Refer to detox
   b. Medical complications – Refer to QVC or Ole Health
   c. Pregnant – Schedule soonest appointment & offer walk-in within 24 hours
   d. IV drug user - Schedule soonest appointment & offer walk-in within 24 hours
   e. Immediately following detox – Schedule soonest appointment & offer walk-in within 24 hours

2. Individual is: MALE   FEMALE

3. Is caller monolingual Spanish? YES  NO  (yes=automatic assignment to Spanish track counselor; If Spanish/English bilingual ask if they would prefer treatment in Spanish or English)

4. If Female: Are you pregnant or have you delivered a baby in the last 60 days? YES  NO

5. Are you on Probation? YES  NO
   a. (If yes) Did Probation refer you? YES  NO
   b. (If not on probation) Do you have any recent arrests or pending charges? YES  NO

6. Do you have an open case with CWS? YES  NO
   a. (If yes) Did CWS refer you? YES  NO
   b. (If no) Do you have any pending issues or potential cases with CWS? YES  NO

7. Are you receiving mental health services or psychiatric medication from any provider, including Napa County Mental Health and Ole Health? YES  NO

8. Have you been in substance abuse treatment within the last 5 years? YES  NO
   a. (If yes) How many times have you been in residential treatment? _______  
   b. (If yes) How many of these were in outpatient treatment? _______
- Non perinatal females to female track counselor for assessment
- Perinatal females to Perinatal counselor for assessment
- Yes to #3 to probation track counselor for assessment
- Yes to #6 to co-occurring track counselor for assessment
- Yes to #7 to “chronic” track counselor for assessment
- Yes to #5 assignment may vary depending on how other questions are answered
- All others to Self-referred track counselor for assessment

29.21 **APPENDIX V: SIX DIMENSIONS OF THE ASAM**

![At a Glance: The Six Dimensions of Multidimensional Assessment](image)

ASAM’s criteria uses six dimensions to create holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

- **Dimension 1:** Acute Intoxication and/or Withdrawal Potential
  Exploring an individual’s past and current experiences of substance use and withdrawal

- **Dimension 2:** Biomedical Conditions and Complications
  Exploring an individual’s health history and current physical condition

- **Dimension 3:** Emotional, Behavioral, or Cognitive Conditions and Complications
  Exploring an individual’s thoughts, emotions, and mental health issues

- **Dimension 4:** Readiness to Change
  Exploring an individual’s readiness and interest in changing

- **Dimension 5:** Relapse, Continued Use, or Continued Problem Potential
  Exploring an individual’s unique relationship with relapse or continued use or problems

- **Dimension 6:** Recovery/Living Environment
  Exploring an individual’s recovery or living situation, and the surrounding people, places, and things

*Figure 1. ASAM’s Six Dimensions of Multidimensional Assessment*
### 29.22 APPENDIX W: SUICIDE RISK SCREENING TOOL

**Ask the patient:**

1. In the past few weeks, have you wished you were dead?  
   - ☐ Yes  ☐ No

2. In the past few weeks, have you felt that you or your family would be better off if you were dead?  
   - ☐ Yes  ☐ No

3. In the past week, have you been having thoughts about killing yourself?  
   - ☐ Yes  ☐ No

4. Have you ever tried to kill yourself?  
   - ☐ Yes  ☐ No
   
   If yes, how?  
   ________________________________________________________________
   ________________________________________________________________
   When?  
   ________________________________________________________________
   ________________________________________________________________

   If the patient answers *Yes* to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now?  
   - ☐ Yes  ☐ No
   
   If yes, please describe:  
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

**Next steps:**

- If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen*).

- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
  - ☐ “Yes” to question #5 = **acute positive screen** (imminent risk identified)
    - Patient requires a STAT safety/full mental health evaluation.
    - Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.
  - ☐ “No” to question #5 = **non-acute positive screen** (potential risk identified)
    - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient’s care.

**Provide resources to all patients**

- 24/7 National Suicide Prevention Lifeline: 1-800-273-TALK (8255)  
  En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741

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**NIMH TOOLKIT**

**Suicide Risk Screening Tool**

**asQ Suicide Risk Screening Toolkit**

**NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)**

6/25/2017
APPENDIX X: GROUP SIGN-IN SHEET TEMPLATE

Napa County Health and Human Services Agency
Alcohol and Drug Services Division, Adult Outpatient Treatment and Recovery

**Group Sign In Sheet**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Start Time:</th>
<th>Stop Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic:</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Participants Scheduled in Group:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Server Name PRINT</th>
<th>Server Name SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name (PRINT)</td>
<td>Client Name (SIGNATURE)</td>
</tr>
<tr>
<td>1</td>
<td></td>
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<tr>
<td>2</td>
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<td>12</td>
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</tbody>
</table>

Revision Date: 9/16/18

APPENDIX Y: DOCUMENTATION FEEDBACK FORM

**Documentation Feedback Form Template:**

Email Subject Line: FEEDBACK FORM (Reviewer identify topic i.e. Intake 9/8, PN 8/12 doc time, Group Sign-in Sheet, CalOMS, etc.)

Hello ADS Staff,

I have reviewed the following (Supervisor/Reviewer indicates progress note, clinical document, intake packet, etc.) you completed. Please make the following corrections and then place a copy of the corrected items in my mailbox. I have placed the (add progress note, clinical document, intake packet, etc.) in your mail slot along with a copy of this email. Please let me know if you have any questions about the feedback and requests for correction contained in this email.

**Feedback for Client:** (Client Name & Client #)
Date(s) of Document: (Date)

Corrections Needed in the Following Area(s):

1.
2.
3.

Please return correction within one business day upon notice.

Thank you,

Supervisor/Reviewer

**Billing Suspense Report Feedback Form Template:**

Email Subject Line: FEEDBACK FORM (Identify Suspense Report i.e. Zero Bill, Duplicate, No Valid Billable Dx, Progress Notes not FA, 2.1 LOC)

Hello ADS Staff,

One of the many reports generated for fiscal DMC-ODS billing is the duplicate report. The duplicate report needs to corrected so there is no overlap in time recorded for our services. Your duplicate error report is in your mailbox for corrections needed.

How you read the report is by looking at the time overlap of services for the two services rendered, you will need to go into the ANA record and make the corrected time of services.

INSERT RECORD #, Client initials, DATE

Please make corrections for report within 24 hours of this notice. Please notify me when this is completed so I can process billing with fiscal.

Thank you,

Supervisor/Reviewer
## APPENDIX Z: BILLING CHANGE FORM (BCF)

### Anasazi Internal Billing Change Form

<table>
<thead>
<tr>
<th>Fiscal Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BCF ID:</strong> ____________</td>
</tr>
</tbody>
</table>

**Please check division:** Mental Health ☐  ADS ☒

**As originally submitted:** Please fill out the entire schedule line as originally entered.

| Client Name:* || Case Number:* |
|---------------|--------------|
| **Form:** || **Date:** |
| **Unit:** || **SubUnit:** |
| **Server:** || [ ] Single Contact  [ ] Collateral Servers |
| **Service:** |  |
| **Start Time:** || **Duration:** || **Stop Time:** || **Billing Type:** |
| **Travel Time:** || **Person Contacted:*** || **Place:*** |
| **Doc Time:** || **Contact Type:*** || **Appt. Type:*** |

* Required fields

**Corrected Information:** Please fill in only the boxes that require changes.

| Client Name: || Case Number: |
|---------------|--------------|
| **Form:** || **Date:** |
| **Unit:** || **SubUnit:** |
| **Server:** || [ ] Single Contact  [ ] Collateral Servers |
| **Service:** |  |
| **Start Time:** || **Duration:** || **Stop Time:** || **Billing Type:** |
| **Travel Time:** || **Person Contacted:*** || **Place:*** |
| **Doc Time:** || **Contact Type:*** || **Appt. Type:*** |

**Approval of Supervisor Required**

| Staff requesting correction: || Date: |
|-----------------------------|-------|
| Authorized By: || Date: |
| Fiscal staff processing change: || Date: |

**Reason for Change:**

**FISCAL USE ONLY**

- [ ] Able to Change:  [ ] Yes  [ ] No
- Issue: [ ]
- Discovery Date: [ ]
- Pay Source: [ ]
- Claim Batch: [ ]  Claim #: [ ]
- Payment: [ ]  Payment Date: [ ]
- [ ] Void Batch #:  Void Claim #: [ ]
- [ ] Replace Batch #:  Replace Claim #: [ ]
- V/R Submit Date: [ ]  V/R Ajudication Date: [ ]
- Write Off: [ ]
- Comment: [ ]

### Distribution:
1. Staff to complete form and sign.
2. Person reviewing form and authorizing, sign.
3. Forward completed and signed form to HHIS Fiscal Division - BCF
30 AFTERWORD

The final version was reviewed and approved by ADS Supervisors, with final approval from Deputy Director, Jacqueline Connors, LMFT. Every attempt was made to review and include Medi-Cal, DHCS State and Federal Guidelines current HHSA ADS policy and procedures and current practices to create this manual. This document will continue to evolve and change, particularly in light of the DMC-ODS Waiver. If you believe there are errors or corrections needed in the manual, please contact the ADS UR Coordinator and reference the section and page number.