SUD Support Newsletter

Authority & Quality Improvement Services

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Network Provider Directory (NPD)

Per DHCS, the Directory is a requirement that needs to be updated every 30 days.

Monthly Network Provider Directory Workflow:

- Provider/SC reviews directory roster for updates and changes.
- Provider/SC submits directory roster to their monitor/lead by the 15th of each month.

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WHAT'S NEW?

As of April 1, 2019, 26 counties were approved to deliver DMC-ODS services, representing nearly 88% of the Medi-Cal population statewide. There are 14 additional counties in various phases of implementation. The DMC-ODS provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for substance use disorder treatment services. ASAM designations continue to be processed for licensed residential alcohol and other drug program providers. DHCS has issued a total of 810 designations to alcohol and drug treatment providers in California. More information about the DMC-ODS is available on the website:

https://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx

Upcoming Documentation Trainings

- July 1st & 3rd (fulfills ASAM B)
- July 24th (1 day)*
- August 5th & 7th (fulfills ASAM B)
- August 28th (1 day)*
- September 9th & 11th (fulfills ASAM B)
- September 25th (1 day)*

**Prerequisites: ASAM A and ASAM B*

For county staff: sign up through Training Partner. For contract staff: e-mail us at AQISSUDSupport@ochca.com.

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- Monitor/Lead reviews directory for accuracy and forwards to the AQIS SST by the 20th of each month.
- AQIS SST combines directories, reviews for accuracy, verifies information and submits to IT for posting by the 30th.

For more information, please visit:
http://www.ochealthinfo.com/bhs/about/aqis/dmc_ods

CalOMS Improvement Tips

Interested in improving your CalOMS Report Card grade? Here's how:

- Go to the CalOMS Open Client Report found near the CalOMS Error Detail Report. Select your program and a date range. It defaults to the previous thirty days. To check if your new admissions have a signed CalOMS Admission record in IRIS, pay close attention to the "ENCNTR TYPE" and "ADM 1ST SIGN" columns.
- If you see anything other than "CalOMS Encounter" in the "ENCNTR TYPE" column, you have problem with your CalOMS data.
- If you do not see a date in the "ADM 1ST SIGN" column, you have a client without a signed CalOMS Admission record in IRIS.
- If you act quickly, the clinician can complete the CalOMS Admission record, sign it, check for errors and it can be sent to the state in a timely manner

Following these steps will help you to improve your CalOMS Report Card grade.

Documentation FAQ's

1. What are some examples of billable case management activities?

- Peer-to-peer consultations (such as between the primary counselor and the group facilitator, primary counselor and support staff, etc.)
- Non-LPHA and LPHA consultation for the preliminary diagnosis (within the first three days or sooner) and the required face-to-face consultation for completing the assessment
  - Both parties involved in the consultation can bill (provided that both staff are certified providers and have the appropriate training), making sure that the start/end times match (if the EHR or EMR does not allow for two appointments at the same time, the actual start/end times can be indicated in the body of the note)
- Coordination with outside agencies involved in the client's care (social services, probation, teachers, medical providers, etc. – to discuss progress, coordinate resources/interventions, with or without the client present)
- Checking in with the client for monitoring purposes (not individual counseling)

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Practice Guidelines

Clinical practice guidelines are recommendations for clinicians about the care of patients with specific conditions. They should be based upon the best available research evidence and practice experience.

The Institute of Medicine (IOM) defines clinical practice guidelines as "statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."

Practice Guidelines are not requirements or mandates. They are aspirational best practices.

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- Time spent reviewing documents (such as reviewing the chart for completing the discharge summary of unplanned discharges, reviewing paperwork from other agencies where client may be receiving or have received services, hospital discharge paperwork, Minute Orders or other court documents, progress reports from school, psychological evaluations, LPHA reviewing the assessment to determine the diagnosis or prepare for the face-to-face consultation, etc.)
- Change in level of care or transfers to another program (with or without the client present to conduct warm hand-offs and help the client to transition smoothly)
- Coordination with community resources or services needed, such as for physical health and mental health care needs (gathering relevant information to ensure access, informing the client about available options and actions needed by the client to access services, following up with providers and/or client about linkages)

Each documented case management activity needs to be clear as to why the activity was necessary and how it is relevant to the client's treatment.

2. What do I need to include in the intake note?

- The intake note is a progress note that documents that the client was met with on the day of admission. Part of the purpose of an intake note is to provide evidence that the client was properly informed of the services that he or she will be offered. Therefore, it needs to mention that the legal paperwork for opening the client's case was reviewed with the client. The initial legal paperwork includes documents like the informed consent, limits of confidentiality, informing clients of their rights, the rules and requirements of the program, etc. It is not necessary to list every document that is reviewed with the client.
- The recommendation is to highlight those that require clinical knowledge to explain to the client. Additionally, the intake note should show that some of the basic information about the client's substance use and his or her needs were obtained to begin determining the client's medical necessity for treatment (i.e., reason the client is seeking services, referral source, basic history of substance use and primary drug of choice, main problem that he or she is wanting help with, etc.).

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Did you know that Orange County Behavioral Health Services (BHS) has practice guidelines in place? Our practice guidelines meet the following requirements:

a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
b. Consider the needs of our beneficiaries;
c. Are adopted in consultation with contracting health care professionals; and
d. Are reviewed and updated periodically as appropriate.

New Practice Guidelines are posted on the Behavioral Health Services Website, and accessible from the main Webpage: (http://www.ochealthinfo.com/bhs/about/aqis/practice_guidelines). In addition to the Practice Guideline, a Quick Guide and other resources are posted for each Guideline. Additionally, the DMC-ODS plan also has adopted the utilization of the State of California Youth Treatment Guidelines and the Perinatal Practice Guidelines into programs that serve those populations. The plan also has provided training on SUD treatment for people with physical and cognitive disabilities guideline from SAMHSA.

Practice guidelines are very important in our system. BHS uses these practice guidelines to ensure that all decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

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Reminders

Medical Necessity for SUD Treatment are reasonable and necessary to:

- Protect life
- Prevent significant illness or significant disability
- Alleviate severe pain through the diagnosis or treatment of a disease, illness or injury

Documentation for Medical Necessity:

- The medical director or LPHA evaluated the beneficiary's assessment and intake information.
- If the beneficiary's assessment and intake information is completed by a counselor, the medical director or LPHA shall also document that they met with the counselor through a face-to-face or telehealth review to establish a beneficiary meets medical necessity criteria.
- Substance Use Disorder Diagnosis based on the DSM
- Identification of level of care based on ASAM

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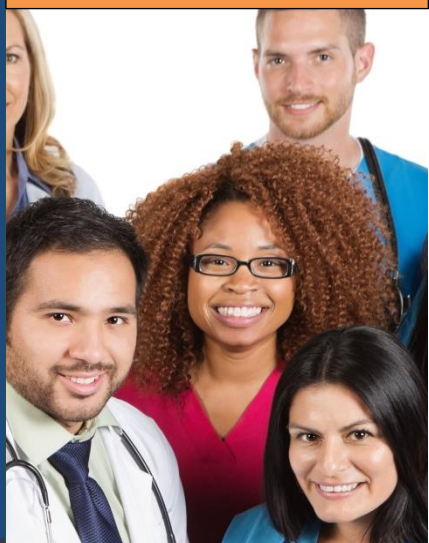
Answers for "What's the Number?" game:
6, 5, 90, 7, 2, 10, 30, 35, 73, 64, 8



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Practice guidelines are available to you and to beneficiaries and potential beneficiaries upon request. If you haven't visited the practice guidelines page recently, take a look. There are exciting updates happening now. You can also talk with your service chief or program director about how to get involved in the process.

Reference:
Consensus report, Institute of Medicine. Clinical practice guidelines we can trust. March 23, 2011. http://www.iom.edu/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx (Accessed on January 13, 2012).

What's the number?

1. There are a total of _____ dimensions on the ASAM

2. Dimension _____ is concerned with Relapse, Continued Use or Continued Problem Potential

3. Treatment plan updates are due at least every _____ calendar days from the date of admission to treatment

4. All progress notes are due within _____ calendar days from the date of service

5. NOABDs for denial, delay or modification of services are mailed within _____ business days of the decision to deny, delay or modify services

6. NOABDs for termination of services are mailed at least _____ calendar days before discharging the beneficiary

7. At ODF and IOT level of care, the initial assessment and treatment plan are due within _____ calendar days

8. Report staff changes via PAVE within _____ days and notify AQIS SST & IRIS

9. The face-to-face time was 49 minutes, consultation with Psychiatrist was 13 minutes, talking to Probation Officer about client's case was 11 minutes, travel time was 25 minutes, and documentation was 9 minutes. The total service minutes for this encounter would be: _____

10. Individual counseling with the client took 53 minutes, talking to a co-worker about the weather was 7 minutes, meeting with supervisor for professional supervision was 49 minutes, and documentation was 11 minutes. The total billable minutes for this encounter would be: _____

Bonus. There are a total of _____ seasons in the HBO series Game of Thrones.

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MORE Reminders…

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Documentation for Progress Notes:

- The topic of the session
- A description of the beneficiary's progress towards treatment plan goals
- Date of each treatment service
- Start and end time of each treatment service
- Typed or legibly printed name of LPHA or counselor, signature and date progress noted was documented

Documentation for Continuing Services:

Review of the following:

- Beneficiary's personal, medical, substance use history
- Most recent physical exam
- Progress notes and treatment plan goals
- LPHA's/counselor's recommendation
- Beneficiary's prognosis

Documentation for Discharge Planning:

- List of relapse triggers
- Plan for avoiding relapse when faced with triggers
- Support plan
  - People
  - Organizations
- A copy provided to beneficiary (must be documented)

Documentation for Discharge Summary:

- Unexpected lapse in treatment services for 30+ days
  - Duration of the treatment episode
  - Reason for discharge
  - Narrative summary of the treatment episode
  - Prognosis