DMC-ODS Assessment & Treatment Plan Training

Santa Cruz County Behavioral Health
Cybele Lolley, LMFT
Substance Use Disorder Services / Quality Improvement
12/27/17 (rev 07.2018)

Training Goals & Objectives

Goals

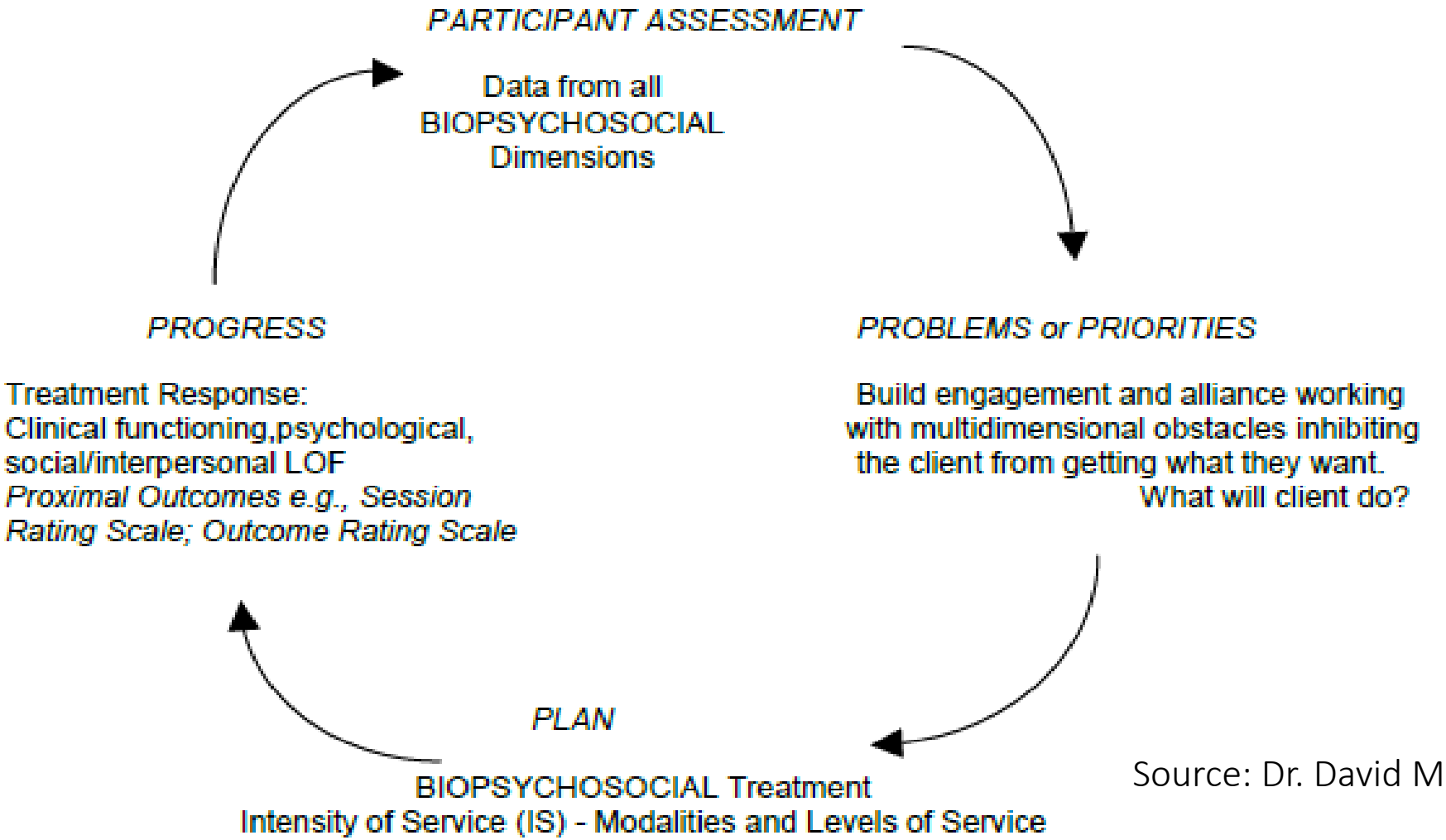
- To Improve your understanding of DMC-ODS Assessment and Treatment Plan services, including documentation requirements and associated service codes

Objectives

- ✓ You will learn how Medical Necessity and documentation supports client care
- ✓ You will learn the required elements for each component of Individualized care
- ✓ ***Assessment, Treatment Planning, Progress Notes, Continuing Services Justification***
- ✓ You will be able to identify the Service Codes by level of care

Treatment Paradigm Shift: Focus shifts from Program Needs to Client Needs & Goals

Client-Directed, Outcome-Informed Treatment (Feedback Informed Treatment)



Source: Dr. David Mee-Lee

Expanded Delivery Services

1. **Case Management Service – all levels of care**
2. **Method of delivery – Telephone and Telehealth (in addition to in-person)**
3. **Physician Consultation – physician/prescriber service**
4. **Recovery Support Services – all levels of care**

**** All methods utilized must be documented by whomever provided the service under their scope of practice**

Who can provide client services -

Licensed Practitioner of the Healing Arts (LPHA) - must have current good standing license/registered status.

- Physician
- Nurse Practitioner
- Physician Assistant
- Registered Nurse
- Registered Pharmacist
- Licensed Clinical Psychologist
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Eligible Practitioner working under the supervision of licensed clinician (ASW, AMFT, APCC)

Registered SUD Counselor (must complete certification process within the 5 year requirement)

Certified SUD Counselor (must have current good standing certification status)

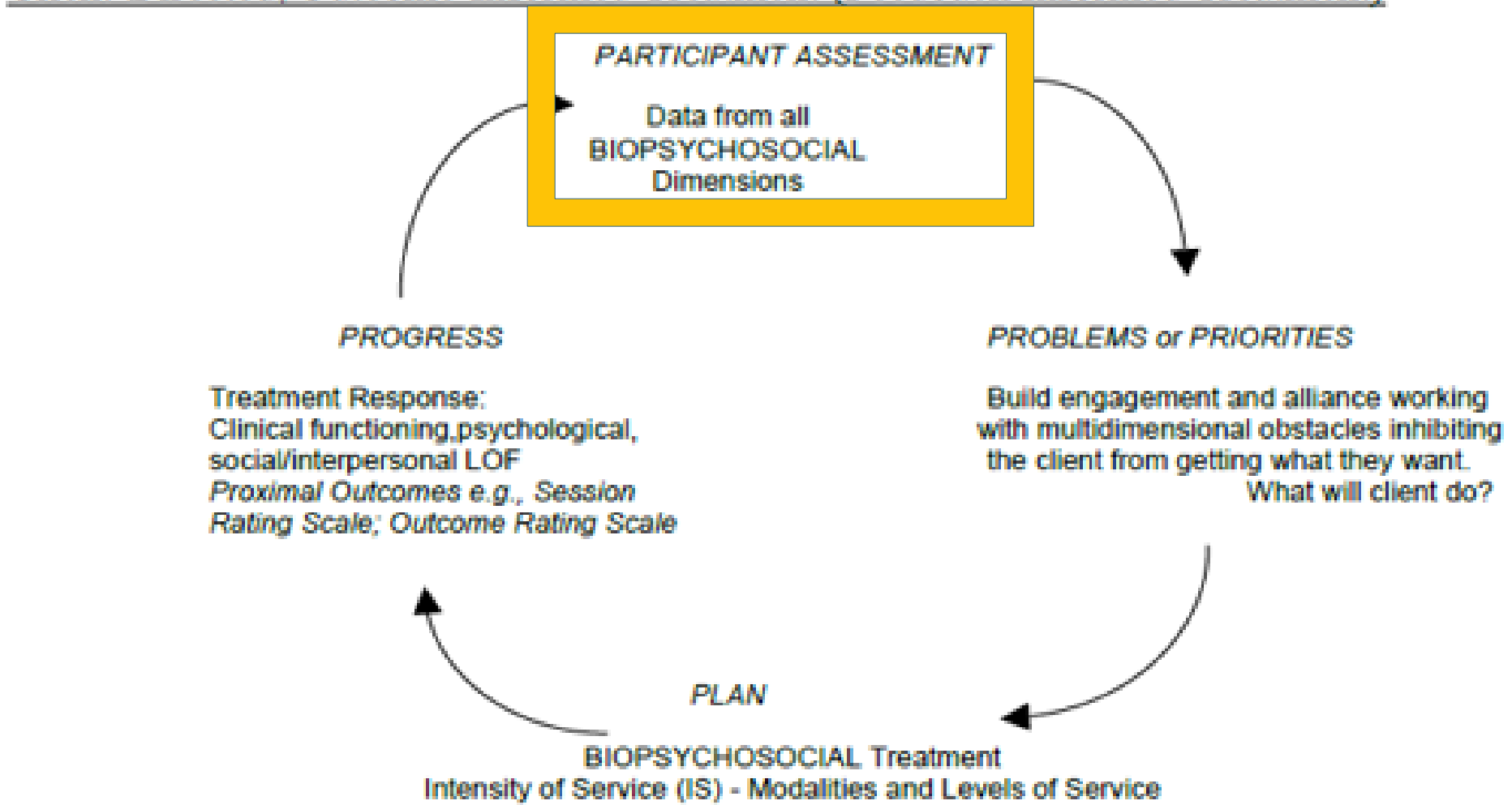
* All direct service staff (master program "trainees", volunteers, or other groups) must be a Registered SUD Counselor at a minimum to provide direct client services.

Assessment Requirements

Medical Necessity:

1. ASAM Level of Care (ALOC)
2. Diagnostic

Client-Directed, Outcome-Informed Treatment (Feedback Informed Treatment)



Medical Necessity & ASAM Criteria

(American Society of Addiction Medicine)

Drives:

- Multi-dimensional assessment of client's needs and goals
- Determination of appropriate level of care (LOC)
- Individualized treatment planning & service delivery
- Coordination of Care with other providers
- Length of stay/enrollment in current LOC services
- Continuum of care focus: transitional treatment services available: detox, residential, intensive outpatient, outpatient, MAT and recovery

Medical Necessity – What is it?

California Code of Regulations, Title 22, Section 51303: (State Service Delivery Rules)

SUD Treatment Services that 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

Federal Code of Regulations, Title 42, Section 438.210(a)(4) (Federal Managed Care Rules)

Place appropriate limits on a service

- ✓ On the basis of criteria applied under the State plan, such as medical necessity; **or**

For the purpose of utilization control, provided that

- ✓ The service 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 services are furnished.

Throughout the course of treatment, from initial ASAM assessment to discharge, all SUD services are based on Medical Necessity. Meaning, every service provided to the client/family is medically necessary to support the client/family in their path to recovery.

Medical Necessity: **Reasonable and Necessary Services**

Document Justification for service need based on impairments/distress

- ✓ Specifically referring to services, treatments, related activities which are necessary and appropriate **based on medical evidence** and standards to diagnose and/or treat an illness or injury.

- ✓ Areas of **significant impairment or distress** within the last 12 months must be documented.

- ✓ Examples:
  - Withdrawal symptoms
  - Increased frequency of use or amount of substance
  - Persistent use in spite of negative consequences

Clinical Assessments: Outpatient, Intensive Outpatient= **within 30 days;** Residential programs = **within 10 days &** NTP programs = **28 days**

Diagnosis

SUD diagnosis must be based on DSM 5 criteria

Documented separately from the treatment plan (Avatar Diagnosis form)

Avatar form needs to be completed before billable services can be submitted.

- **Completed by LPHA upon admission**

ALOC Focus: (Areas of need, risk/impairments)

Six Dimensions:

D 1: Acute Intoxication and/or Withdrawal Potential

D2: Biomedical Conditions and Complications

D3: Emotional, Behavioral or Cognitive Conditions and Complications

D4: Readiness to Change

D5: Relapse, Continued Use or Continued Problem Potential

D6: Recovery Environment

- **Completed by Counselor or LPHA**

Other DMC-ODS Requirements – captures in Admission process, including Cal-OMS Admission & Eligibility

Drug/Alcohol History

Medical History (proof of physical exam within 12 months of admission?)

Family History

Psychiatric/Psychological History

Social/recreational History

Financial Status/History

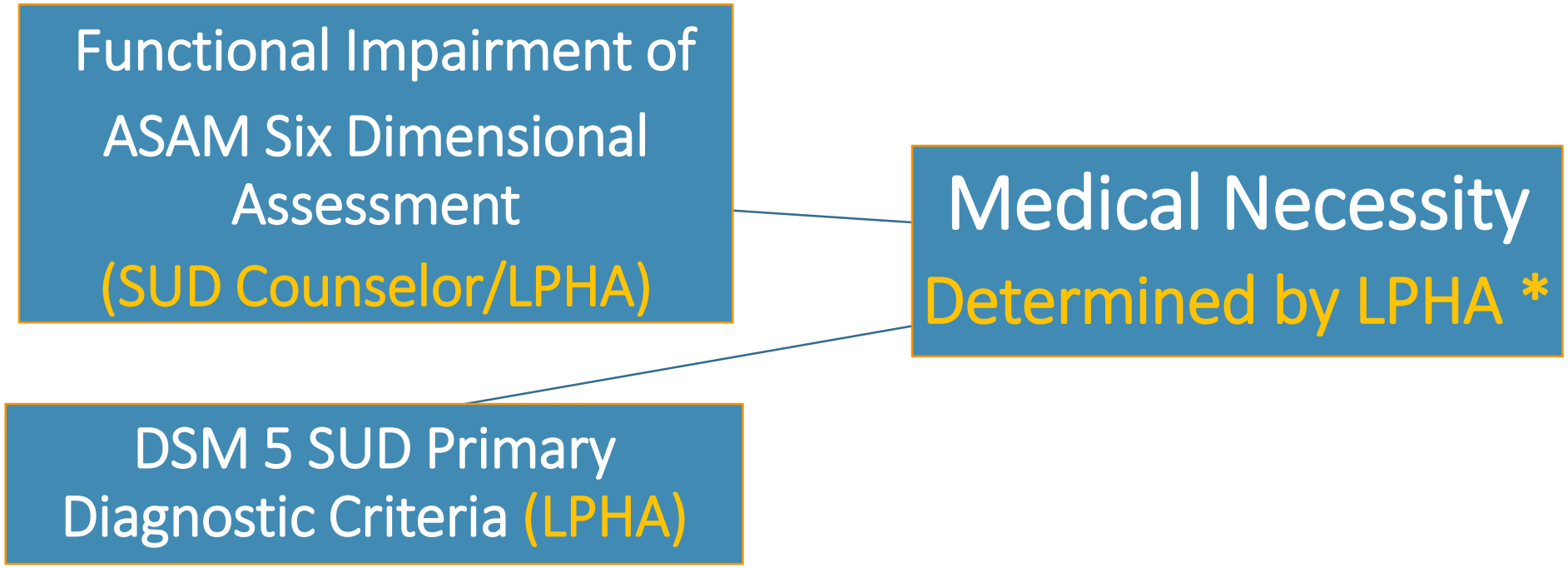
Employment History

Criminal, Legal Status

Previous SUD Treatment History

- **Completed by Counselor or LPHA**

Admission: How to determine Medical Necessity & Document



- Counselor/LPHA completed ALOC (ASAM Level of Care Assessment)
  - If Counselor – Counselor presents case to LPHA and LPHA to determine SUD Diagnosis (either by F2F session with client or verifying suggested Dx).
- * **LPHA completes Avatar Dx. form and writes Admission Progress Note that indicated review of all assessment records and medical necessity justification.**
- Assessment directs Individualized Treatment Plan development and provided services

Physical exam requirement: 30 days from admission for completed physical exam

Physical Examinations

Who can document?

- ✓ Physician
- ✓ Registered nurse practitioner
- ✓ Physician's assistant (physician extenders)

Timeframe

Within thirty (30) calendar days of the beneficiary's admission to treatment date

What Must be Documented?

- ➢ Copy of physical examination completed within prior 12 months in beneficiary record, OR
- ➢ The beneficiary's initial and updated treatment plans include a goal to obtain a physical examination, until this goal has been met.

Scan proof of physical exam into EMR/Avatar & document receipt

Assessment Documentation

Staff can utilize the Assessment Service code to write a progress note that summarizes the client's ALOC Assessment and Diagnosis, including dimensional strengths, challenges and any identified referrals needing immediate attention (i.e. referral to PC for physical exam).

Assessment Service Codes – unique to level of care

OP Adult = A1411

OP Youth = A2411

IOS Adult = A1211

IOS Youth = A2211

NTP (Adult only) = A1311

Residential 3.1 = A1511

Residential 3.3 = A1611

Residential 3.5 = A1111

Withdrawal Management 3.2 = A1711

Trackable non-billable service code: Also can use A001

Assessment Documentation: Assessment Progress Notes - LPHA

1. Areas of significant impairment or distress within the last 12 months must be documented.

What are the client's "significant impairments or distress" identified within each ASAM dimension?

What are areas that need immediate referrals (medical, psychiatric, financial)?

- Medical/Physical exam need: Referral to PCP for exam; Referral to Alliance for PCP assignment; Follow up with PCP office to obtain medical exam summary if has been completed with 12 months of admission date.

2. **Summarize case presentation in Progress Note based on: Review of clients medical, psychiatric, family and substance history, referral source, ALOC, Dx form, UA results if medically appropriate to recommended level of care justification**.

Medical Necessity – Cont.

Who Can Document?

- ✓ Medical Director
- ✓ LPHA

Timeframe

Within 30 days from admission to treatment

What Must be Documented?

- 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 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

Example: LPHA note to determine Medical Necessity

LPHA must indicate review of the client's personal, medical and substance history as part of the Medical Necessity determination.

Example of a LPHA summary:

"Based on the review of the client's personal, medical, psychiatric and substance use history, current ASAM assessment and diagnosis, medical necessity for SUD treatment has been met. Client presents with active increase use of heroin (Heroin Dependence Dx.); poor insight of substance use triggers/craving; reports negative consequences of use as removal of child/CPS involvement; demonstrates minimal coping skills for recovery; and is at high risk for continued use without external prompts and interventions. Client is referred to ASAM LOC 3.1 residential treatment services to address current substance use risks, increase multi-dimensional stabilization and develop recovery skills in a clinically structured environment."

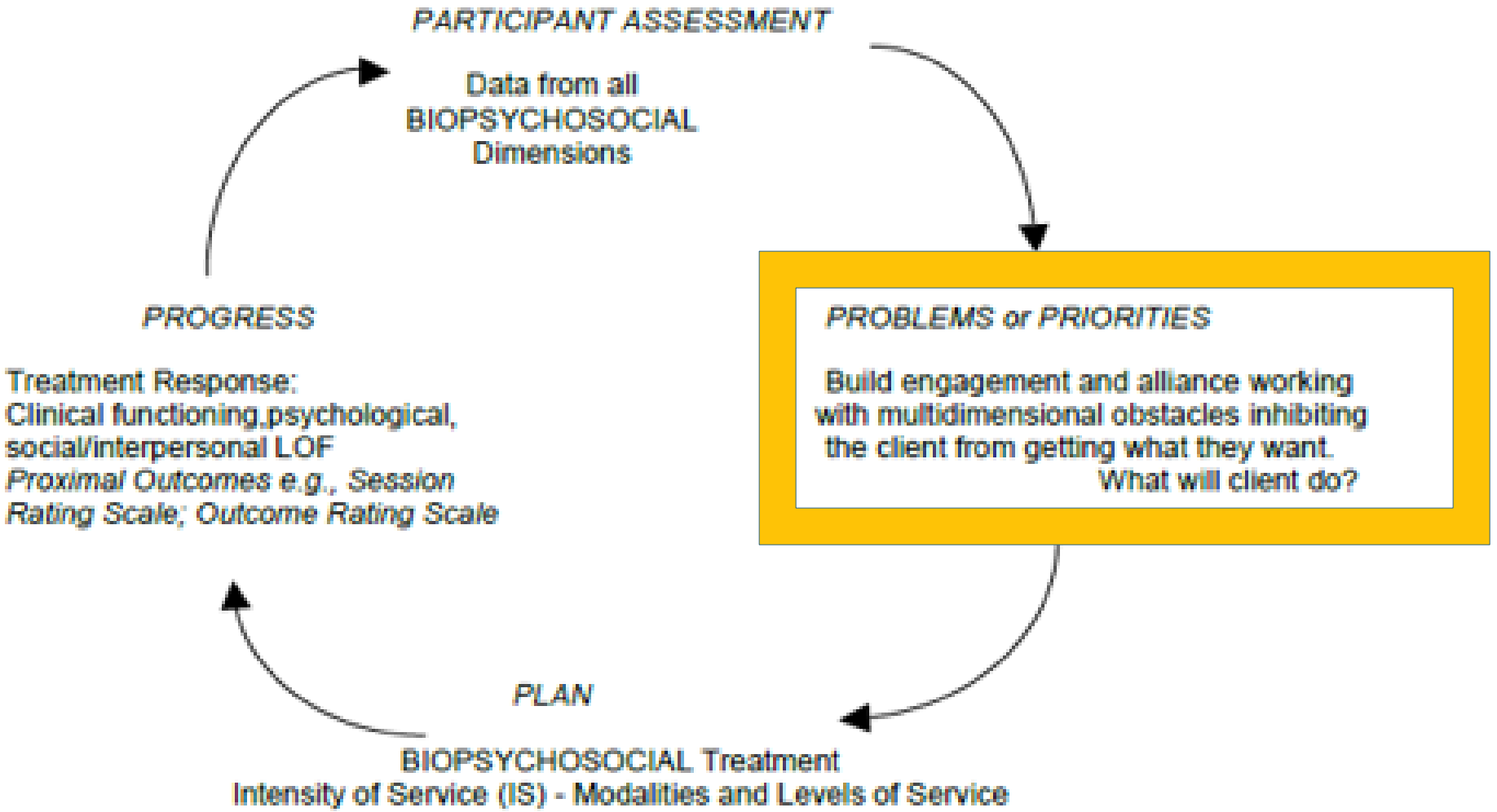
Treatment Plan Requirements

Residential LOC – finalized in Avatar within 10 calendar days of Admission date

Outpatient (OP, IOS) – Finalized in Avatar within 30 calendar days of Admission date

NTP – Finalized in Avatar within 28 calendar days of Admission date

Client-Directed, Outcome-Informed Treatment (Feedback Informed Treatment)



Individualized treatment is about collaborating on a treatment plan that matches the specific needs of the participant, makes sense to the participant and therefore has the best chance to actually work and succeed.

David Mee-Lee

Treatment Plan: Identified impairments/needs

A Counselor or LPHA can develop a treatment plan, but a LPHA must review and sign a treatment plan if created by Counselor.

** The treatment plan is a primary way of involving clients in their own care. The development of the Treatment Plan is an interactive process between the client and the treatment team. **

Treatment Plan focuses on:

1. Client's strengths, needs and preferences as related to SUD treatment
2. What ASAM Dimension needs/goal are directly addressed by program services; and
3. What ASAM Dimension needs/goals need referrals/linkage to a provider who can provide a service
4. A Primary SUD Diagnosis Treatment Goal in Active status
5. A Physical Exam Goal if not completed within 12 months of admission date

Purpose of Treatment Planning & Timeline

PURPOSE: A Treatment Plan is used to document the collaborative identification of client problem(s), quantifiable goals/action steps (objectives), target dates for these objectives and clinical staff interventions.

- **WM** = Initial TP signed/dated and finalized within 72 hours of admission date
- **Residential** = **Initial TP** signed/dated and finalized within 10 days of admission date
- **NTP** **= Initial TP** signed/dated and finalized within 28 days of admission date
- **OP/IOS** = **Initial TP** signed/dated and finalized within 30 days of admission date
- **Updated TP** = within 90 days of initial TP, and thereafter or as there are changes to TP goals

Before creating your treatment plan, refer to Avatar SUD Treatment Plan Guide to make sure that you understand the dates you are going to use, and the title or plan name you are going to use.

❖ The Treatment Plan also include the primary diagnosis (Problem) and name of the primary counselor/therapist working with the client.

Under DMC-ODS: Treatment plans needs to be approved and signed by LPHA, as well as Client and Primary Counselor. LPHA Signature indicates that identified goals and services meet medical necessity requirement.

Treatment Planning

Who can document?

- ✓ LPHA
- ✓ Counselor

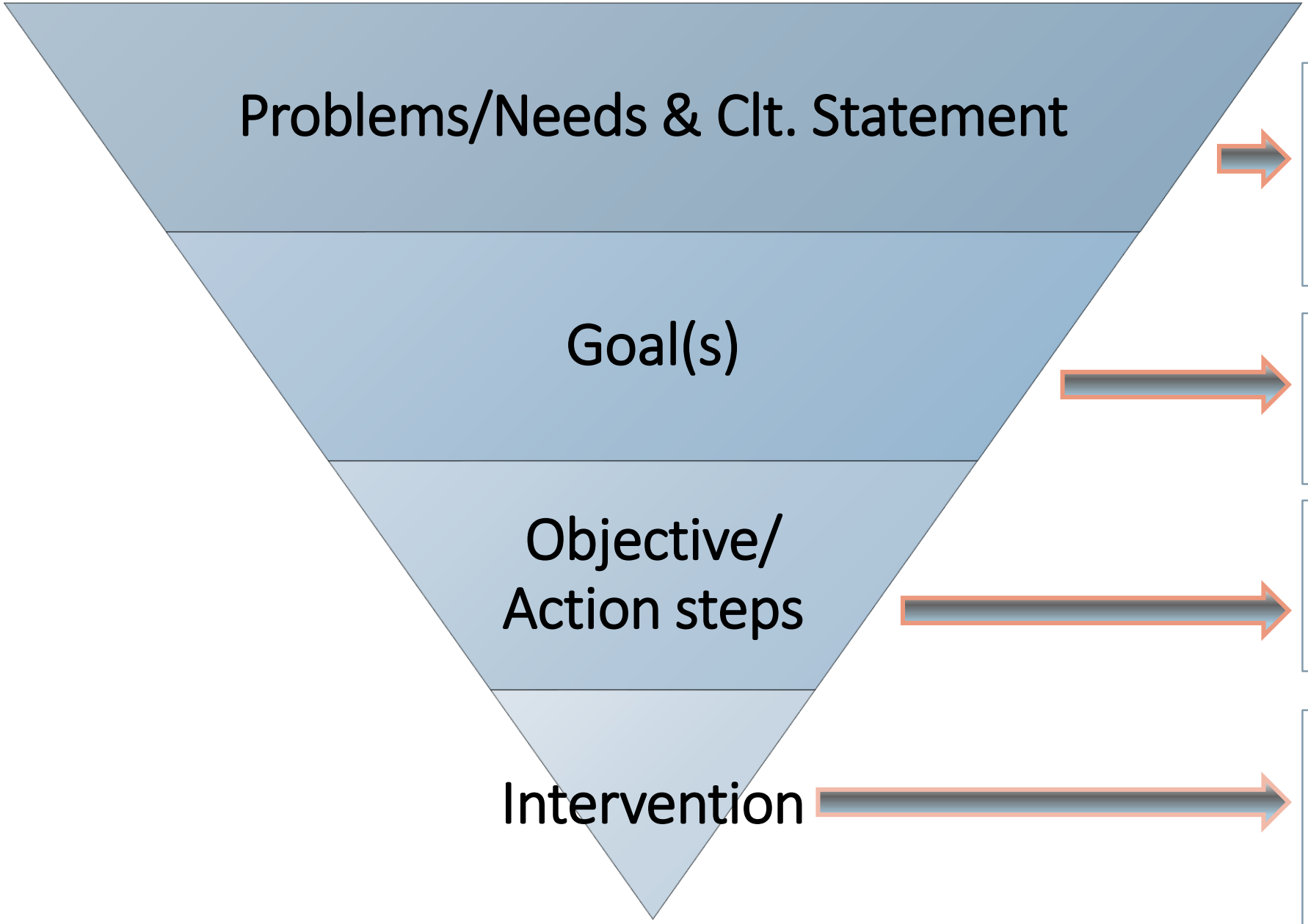
Timeframe

Within 30 days from admission to treatment

Initial TP deadline for OP services.

What must be documented?

- Statement of problems
- Goals
  - Physical exam, if needed
  - Goal of obtaining treatment for an identified significant medical illness
- Action steps
- Target dates
- Type & frequency of counseling/services
- Diagnosis
- Assignment of primary therapist or counselor



Problem: Area of focus related to SUD condition, ASAM Dimensions & Diagnosis

Goal(s): What the client wants to achieve & connected to SUD.

Objective/Action Steps: how the client will get to goal. Target date required

Intervention: What services YOU will provide to help the client reach goal.

It is important for treatment plans to have objectives and interventions which direct/outline a reasonable path to improved functioning.

Problem & Client Statement:

- ✓**The "Problem" is initially identified in the Assessment and that need is carried over to the treatment plan.**
- ✓**The "Client Statement" describes the specific functional impairment the client has described, include paraphrase or quote by client.**

Resource: **AVATAR SUD Treatment Plan Manual**

In Avatar's treatment plan the Problem is described using a SNO-MED* code.

Only add Problems to the Problem List on the first page, never use the "Add Problem" button on the Plan Builder page.

~~"Specify Other"~~ **You are STRONGLY DISCOURAGED from using "Specify Other" Problem Code in the Treatment Plan.**

AVATAR Tx Plan Problem Example:

Problem Code Box: Opioid Dependence (SNOMED)

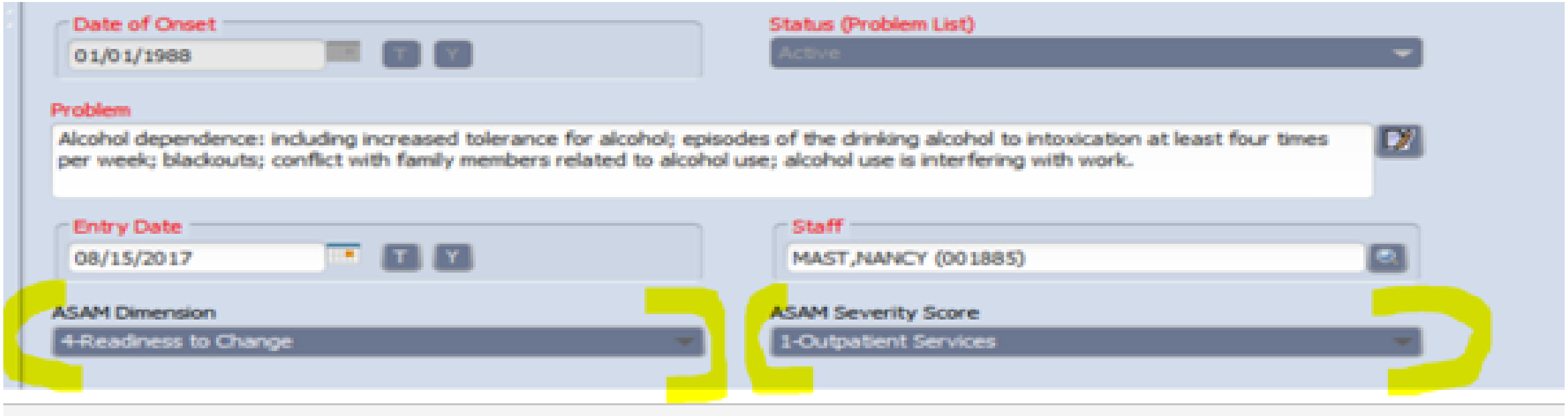
Narrative Box- Opioid Dependence (keep this auto-fill info): Client statement follows:

Example: Opioid Dependence: Client states “I have to stop using. It’s ruining my life.” Client reports daily use of heroin for last 6 months; loss of job; loss of family support; and now homeless.

Problem + ASAM Dimension + ASAM Severity Score

Enter the ASAM dimension from the ASAM form for this client. This is the ASAM dimension that informs the problem you are using. The ASAM is completed as part of the client's intake assessment and should be completed before the Treatment Plan.

Enter the severity score from the client's ASAM that is applicable to the problem



Goals: At least 1 goal per problem

- A Global/Broad Statement that reflects a positive resolution to the identified need or problem, consistent with the problem/challenge which is based functional impairment.
- An effective goal embodies hope and offers an alternative to current circumstances. They are shared achievable visions of success.
- And is written in words the client and family can easily understand.
- Treatment is shown to be most effective when the goals are tailored to an individual's personal characteristics (not one-size fits all) and includes addressing the circumstances that cause use & how to cope so they can manage recovery.

Example 1 Goal for a Problem related to different ASAM dimensions:

Problem: Opioid Dependence

Goal 1: D1 – Client want to abstain from substance use so can have a recovery lifestyle.

Goal 2 : D3 – Client wants to identify current emotional triggers for substance use and learn relapse preventions skills for each identified trigger.

Objectives/Action Steps

- ✓Objectives/"Action Steps" are the identified achievable tasks for the client to complete as related to the treatment goal.

- ✓Effective Objectives = SMART
- ✓(Specific, Measurable, Attainable, Realistic and Timely)

- ✓Easily understood for client and all stakeholders
- ✓Build on client's strengths
- ✓Clear target date (short-term) – has to be included on Avatar Tx plan
- ✓Agreeable tasks between client and counselor/therapist

Don't forget to include Target Date

Interventions: Individualized & SUD focused

5 W's:

Who: Clinical discipline of practitioner (e.g., therapist, counselor)

What: Modality/Service type provided (e.g. Individual counseling, Group counseling, Case Management)

When: Frequency/intensity/duration (e.g., 1-2 X per month, ___ minutes)

Where: Location

Why: Purpose/intent/impact to address a specific SUD impairment

Intervention Examples: OP & IOS

OP: **Counselor will provide weekly individual counseling session for 50 minutes using Motivational Interviewing to help client identify barriers to utilizing recovery support.**

OP: **Counselor will provide weekly group counseling sessions for 1.5 hours to help identify relapse triggers and teach coping skills.**

IOS: **Clinician will provide monthly family group for 90 minutes with focus on teaching the family members about the dynamics of addiction and positive ways to support client's recovery environment.**

IOS: **Counselor will provide a 30 minutes group once a week to teach and practice new mindfulness skills for improving relapse prevention skills.**

Intervention Examples: Residential

Counselor will provide a minimum of weekly individual counseling session for 50 minutes to help client identify barriers to utilizing recovery support.

Counselor will provide daily group counseling sessions for 90 minutes per group to provide illness psychoeducation, help identify relapse triggers and teach recovery lifestyle skills.

Clinician will provide monthly family group for 90 minutes with focus on teaching the family members about the dynamics of addiction and positive ways to support client's recovery environment.

Counselor will provide a daily 30 minutes group to teach and practice new mindfulness skills for improving relapse prevention skills.

SUD Treatment Plan Example

Goal: Develop a drug-free lifestyle.

Objective/Action Steps: Client will increase management of relapse prevention by identifying triggers of use and utilizing at least 4 activities per day that support a non-use life style.

Interventions – (Staff/program):

Individual counseling using EBPs 2X a week for 30-45 minutes to discuss goal progress/challenges, including triggers for use and develop list of support activities to prevent relapse of use.

Group counseling 3X a day for 90 minutes focused on illness management and skill development for alternative coping skills and choices.

Case management weekly to monitor treatment progress and perform ASAM reassessment.

Minimum Requirement - Summarize

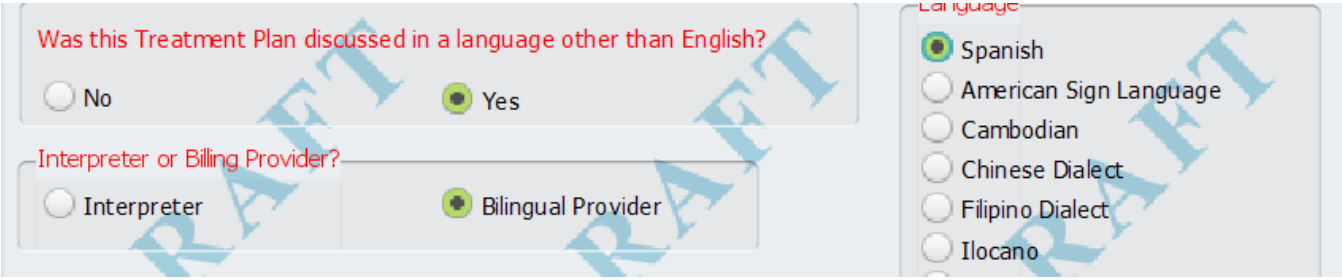
- At lease two (2) Problems, one being SUD Diagnosis,
- At least one (1) Goal per problem
- *each Goal has at least one (1) Objective*
- *each Objective has at least one (1) Intervention*

- Problem 1
- Goal A
- *Objective A*
- Intervention A

- Problem 2
- Goal A
- *Objective A*
- Intervention A

Language: New Change to SUD Tx Plan

- Treatment Plan should be in the client's/family's preferred language.
- For clients who do not speak English, the clinician/counselor should type both English and Spanish (or other language) into the plan. The format is [English text] / [Spanish translation text]. For each item, the English first, then a slash, then the Spanish text.
- Example: Client has demonstrated resiliency with problems in the past. /El cliente ha demostrado resiliencia con problemas en el pasado.



Collaborative Process – Signatures & Date

- The client's participation in and understanding of all elements of the plan is essential and is expected by DHCS reviewers.
- List each of the people involved in the client plan In the Plan Participants Section.
- *Client, Primary Counselor, LPHA Professional, MD - Include full name and title.*

- The client's participation in and understanding of all elements of the plan is essential and is expected by DHCS reviewers. <u>At a minimum, client participation is documented by obtaining the signature & date of the client/parent/guardian and providing a copy of the plan to the client/family member.</u>
- **Client Refusals to sign must be documented in medical records, including reasons for refusal and Staff's efforts/strategies used to attempt obtaining signature from client.**

- Offer a copy of the plan to the client/family member as it is an acknowledgment of their participation in its development and of the clinician's commitment to involving clients/families as full participants in their own recovery process. This process must be documented in Avatar by including the date a copy was offered.

Staff signatures/date – DHCS Requirement

- The staff person providing the service(s), or a person representing a team or program providing services must sign the plan. When the clinical staff person signing is not licensed/registered/waivered, the plan must be co-signed by a licensed/registered/waived LPHA staff.
- Staff signature is obtained when the author provides their electronic signature & date. Finalizing the Treatment Plan.

- **Critical Note: If the staff member developing the plan is not a LPHA, they must obtain the signature of a LPHA through Routing the document to the LPHA.** (This is required even when the LPHA provided a "wet" signature on a hard-copy plan)

LPHA needs to actually sign and date TPs.

- The SUD Counselor saves Final version and chooses "Accept and Route" button to Supervisor.

Signature & Date- Avatar Reminder

- Hard-copy, “wet” signature
- If the client/guardian is unable to utilize the signature pad to sign the electronic version of the Treatment Plan…
- *Complete the Date Copy Offered field*
- *In the area labeled, “If client has not signed the Treatment Plan, please explain” indicate the scanned plan should be viewed for signature.*
- *Leave in Draft, in case you and the client/guardian agree on changes that you will return to the office and make before the plan is signed.*
- *Print the plan*
- *Get “wet” signature in the appropriate Participants area from yourself, the client, the guardian if applicable, and the LPHA if applicable. Staff should be sure to date their signatures.*
- *As soon as possible after obtaining signatures have the plan scanned into Avatar and Finalize the Treatment Plan.*

Treatment Plan Documentation

Staff can utilize the Treatment Planning Service code to write a progress note that summarizes the Treatment Plan – client's goals, strengths, challenges and any identified referrals needing immediate attention (i.e. referral to PC for physical exam).

Treatment Planning Service Codes – unique to level of care

OP Adult = A1420

OP Youth = A2420

IOS Adult = A1220

IOS Youth = A2220

NTP (Adult only) = A1320

Residential 3.1 = A1520 (non-billable)

Residential 3.3 = A1620 (non-billable)

Residential 3.5 = A1120 (non-billable)

Withdrawal Management 3.2 = A1720 (non-billable)

(Youth Res 3.1 = A2520) (non-billable)

Progress Note – Initial Treatment Plan

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D – Staff and client met to discuss treatment goals and identify achievable action steps towards goal success.

I - Staff met with client to focus on treatment goals and action steps to support client's treatment engagement and recovery. Staff utilized motivational interviewing and cognitive behavioral skills to foster a safe and solution-focused session.

R – Client was forthcoming with identified goals and prior challenges to meet goals. Client able to identify ambivalence regarding obtaining housing due to the stress of such responsibility.

P – Staff to follow up with client next week with updated treatment plan to ensure accuracy and signed agreement. Staff to outreach housing resources to gather additional information on best strategies for maintaining housing in early recovery.

Progress Note – Updated Treatment Plan

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D – Staff provided case management service to monitor clients treatment progress towards goals and action steps.

I - Staff met with client to review current treatment goals, successes and outstanding action steps to determine if there has been significant changes that may require a change in treatment plan and services.

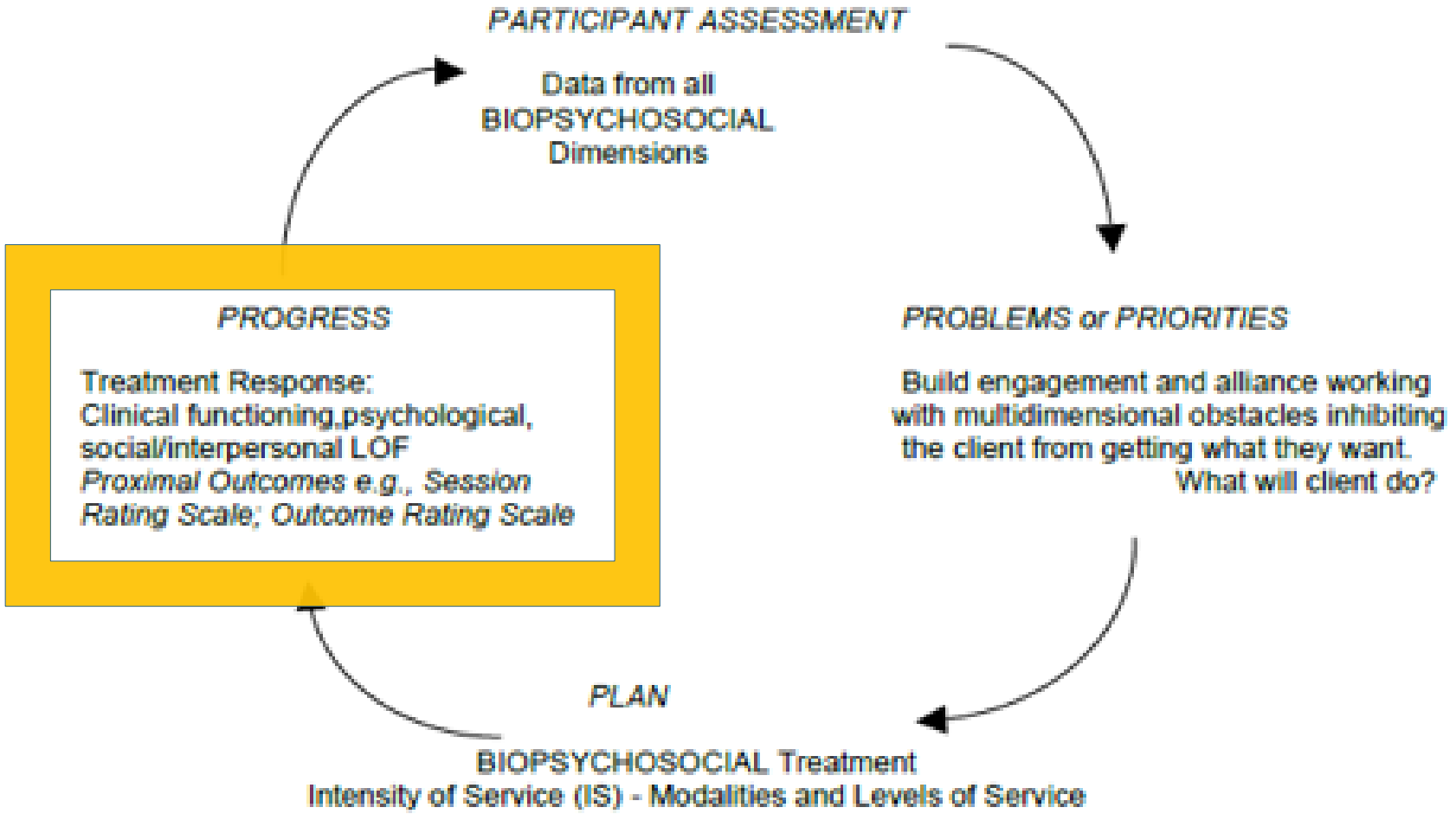
R – Client was forthcoming with current status and identified areas of improvement and continue struggle. Client and staff determined that client met key action step by securing a sponsor and obtaining use daily basis. Client identified new triggers for cravings and new actions steps focused on relapse prevention strategies.

P – Staff to follow up with client next week with updated treatment plan to ensure accuracy and signed agreement.

Progress Note Requirements

See “DMC-ODS Service Codes & Progress Note” Training material for details.

Client-Directed, Outcome-Informed Treatment (Feedback Informed Treatment)



Notes! – Another Paradigm Attitude shift

Small Picture Attitude~

Notes are:

- Busy work
- A bothersome requirement
- Not central to client care. F2F contact seems more important and/or satisfying
- Pointless – no impact on client's care
- Adds compliance stress and frustration

Big Picture Attitude ~

Notes are:

- Opportunity to reflect on session, your role and work with client & the client's progress or barriers to progress.
- Big Picture: Clinical review of treatment effectiveness and path.
- Antidote to the cycle of reactivity: (responding to latest crisis w/out the foundation setting that may prevent future crisis, repeating past mistakes or doing what has always been done.
- Move from client unsuccessful to program's services need adjustment.

Medical Necessity's "Golden Thread"

❖"Unplanned Services" – The services not listed on Treatment Plan

1. Assessment & Diagnosis
   - *Evaluation and Establishing Medical Necessity*
2. Treatment Planning
   - *Authorized Collaborative Treatment Plan*
3. Crisis Intervention Services – *imminent risk interventions to stabilize crisis*
4. Case Management Services *to link client to immediate services*

❖Planned Services – The services identified on Treatment Plan

- Individual & Group Counseling, Collateral, Family Counseling, and Case Management

Non-Reimbursable Services

- Reviewing a chart for assignment of therapist.
- Any documentation after client is deceased.
- Preparing documents for court testimony.
- Voicemail, texting, or email message
- Mandated reporting such as CPS or APS reports
- No service provided: Missed visit. Waiting for a “no show”
- Documenting that a client missed an appointment.
- Traveling to a site when no service is provided due to a “no show”
- Leaving a message on an answering machine
- Personal care services
- Transportation
- Purely clerical activities
- Recreation
- Socialization
- Academic/Educational
- Vocational services
- Multiple Staff in Case Conference:
- Supervision: BBS
- Utilization management, peer review, or other quality improvement activities
- Interpretation/Translation only

No Faxing or Emails

No Recreation

No Translation

No Transportation

No internet Research

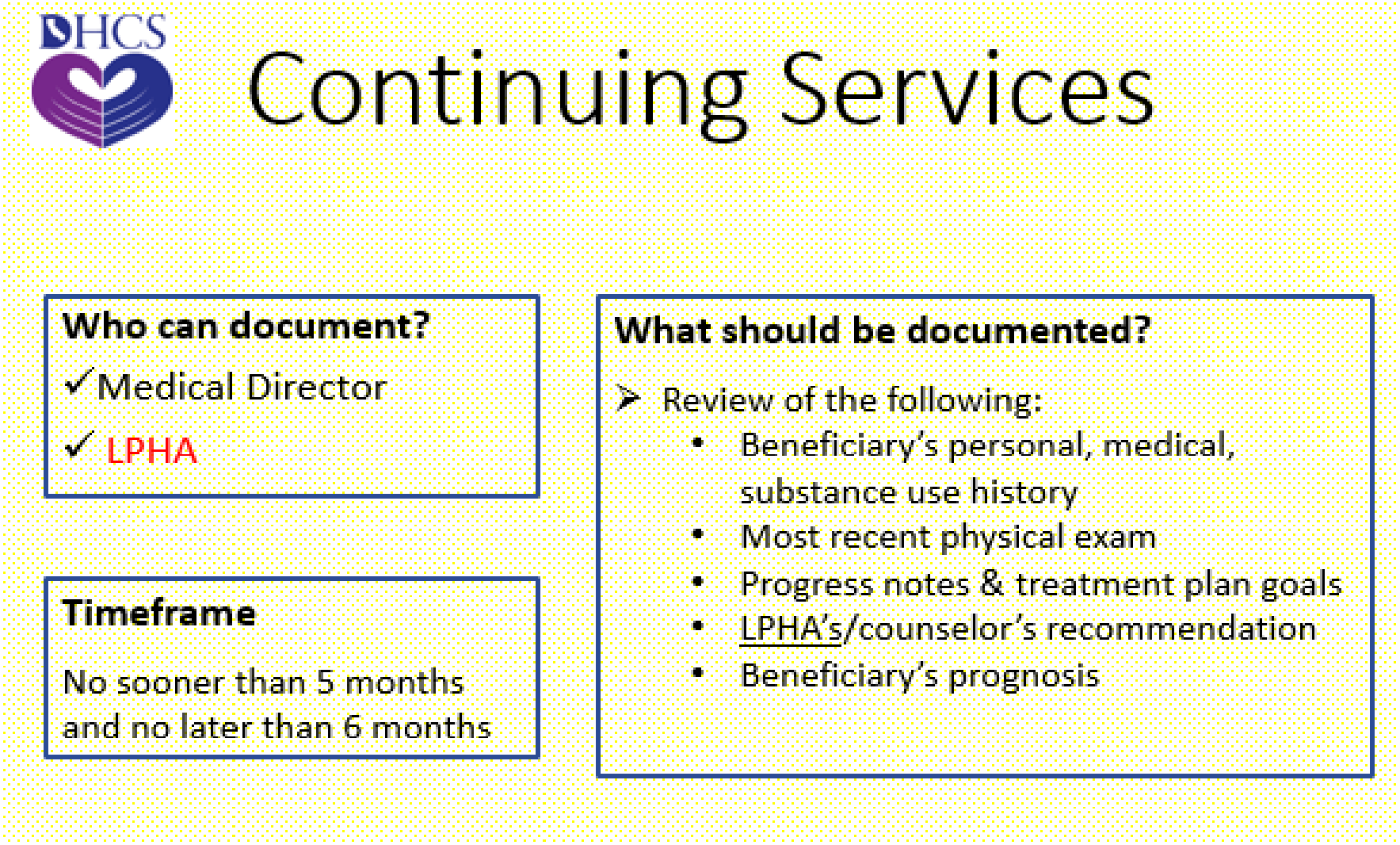
No Voicemails

No Texting

AVATAR Changes – SUD Related

1. New SUD ALOC Assessment
2. New SUD Treatment Plan with English/Spanish Headers
3. New ASAM Level of Care Reassessment form – minimum weekly activity
4. Progress Note Templates being developed for Residential Weekly
5. Start & End time field being added to Progress Note form
6. Review of Discharge Summary and Discharge Planning forms (new requirements)
7. Recovery Services- function in Avatar
8. No Show and Non-billable codes
9. More to come

Continuing Services – LPHA responsibility



LPHA writes a Case Management Progress Note that captures the review of all the required elements and determination of medical necessity for ongoing services at current LOC .

If not medically necessary, then client is ready for discharge.

Confidentiality

Because we must protect client confidentiality, and because the medical record is a legal document that may be subpoenaed by the court, please observe the following standards in completing progress notes:

- Do not write another client's name in client's chart
- Names of family members should be recorded only when needed to complete assessment, registration and financial documents.
- On progress notes and most assessments, refer to the relationship - mother, husband, friend, but do not use names.
- Use a first name or initials of another person only when needed for clarification.

Thank You