EFFECTIVE
October
2026

DMC-ODS Documentation Guidelines

CONTINUUM OF CARE: DOCUMENTATION STANDARDS & REQUIREMENTS

BEHAVIORAL HEALTH DEPARTMENT

QUALITY SUPPORT TEAM DIVISION

The Health Agency complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or any other protected class.

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY | Behavioral Health 2180 Johnson Ave. San Luis Obispo, CA 93401

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OVERVIEW

County of San Luis Obispo Behavioral Health Department's (SLOBHD) Quality Support Team (QST) produces and periodically updates the Documentation Guidelines to serve as the official reference for all outpatient clinical documentation. This manual serves as guidance to promote excellent, accurate and timely documentation of the services we provide to our community. We strive to provide high quality care to our clients, and accurate documentation is a crucial step in the process of delivering excellent care.

A client's record should depict an integrated record of treatment and have a "flow."



The documentation manual defines key concepts, explains documentation requirements, and provides examples of how to document various types of Substance Use Disorder (SUD) treatment services. This manual should be used along with agency policy and procedures.

All staff providing clinical services should refer to the manual whenever they need an answer to a documentation question. Inevitably, situations will arise when staff have questions not answered here – imagine the size of a manual that anticipated every contingency! In such cases, the Program Supervisor should be consulted. QST staff is also available to address questions concerning documentation.

Examples are illustrative and are not meant to replace clinical supervision or sound clinical judgment. Examples are not meant as "cut and paste," or one-size-fits-all solutions.

The manual will be used for all client records regardless of payer source. Specialty programs within the SLOBHD may have unique documentation requirements (i.e., grant funded programs).

SOURCES OF INFORMATION

This Documentation Guidelines includes standards based on the following sources: California Code of Regulations (Title 22), California Department of Health Care Service's (DHCS) Information Notices, SLOBHD's Policies & Procedures, and the contract between DHCS and SLOBHD for Drug Medi-Cal Organized Delivery System (DMC-ODS) services. Additional information and guidance is gathered based on consultation between QST staff and our counterparts in other counties. For more information and details, readers are directed to the sources of information listed above.

DOCUMENTATION TRAINING REQUIREMENT

All treatment staff must attend an extensive, multiple-day DMC-ODS Documentation Guidelines training upon hire. Then, on an annual basis, all treatment staff must attend documentation "refresher" training(s). Documentation training is offered by QST and covers documentation requirements for DMC-ODS, Title 22, as well as other service standards (i.e., AOD Standards, Perinatal Treatment Guidelines, Youth Treatment Guidelines).

REPORTING NON-STANDARD DOCUMENTATION

For reporting suspected inappropriate or non-standard documentation, coding, billing, or clinical issues practices you may:

- Report through your supervisory structure
- Report to the Compliance Officer: 805-781-4788
- Contact the anonymous, toll-free hotline at 855-326-9623
- Email the anonymous hotline at www.reportlineweb.com/sanluisobispo

DEFINITION OF KEY TERMS

ASAM Criteria: American Society of Addiction Medicine's national set of criteria for providing outcome-oriented and results-based care for the treatment of Substance Use Disorders (SUD).

Certified/Registered Treatment Staff: This group includes professionally certified Alcohol and Drug Counselors, and Counselors who have registered with one of the following as their governing board: 1) California Association for Alcohol and Drug Educators (CAADE),

2) California Association of DUI Treatment Programs (CADTP), and 3) California Consortium of Addiction Programs and Professionals (CCAPP).

Client: An individual is an outpatient client when they give informed consent for treatment (evidenced by signature) and has an expectation of privacy. Legally Responsible Persons may consent on behalf of clients who are minors or LPS conservatees. A client is assigned a medical record number.

Community Based Organizations (CBO): Aegis Treatment Centers, Bryan's House Recovery Home, Community Action Partnership (CAPSLO), Family Care Network (FCNI), Sun Street Centers, and Transitions Mental Health Association (TMHA).

Electronic Health Record (EHR): SLOBHD requires that client case records are maintained in a legible manner—typed into the EHR. All entries are electronically signed and dated. All information relating to a client and their services at the program is kept in a single case file with a standard format because of the EHR. While maintaining appropriate confidentiality safeguards, records are kept in such a manner to be easily accessible to DAS staff providing services. Information contained in the client EHR is considered confidential and is disclosed only to authorized persons in accordance with federal, state, and local laws, particularly HIPAA and 42 CFR Part 2.

Licensed Practitioner of the Healing Arts (LPHA): This group includes any professionally licensed staff (Psychologist/LMFT/LCSW/LPCC) or staff registered with a licensing board (registered AMFT/ASW/APCC).

Significant Support Person: A person who could have a significant role in the successful outcome of the treatment of the client (i.e., parents, siblings, sponsor, legal guardian of a minor, legal representative of an adult, spouse, a person living in the same household).

Youth/Transitional Aged Youth (TAY): A client between the ages of 12-18 (day before their 18th birthday) is a "Youth" client. A client between the ages of 18-21 (day before their 21st birthday) is a "TAY" client.

DAS BASIC STAFF POSITION INFORMATION

Drug and Alcohol Services (DAS) complies with the confidentiality requirements of HIPAA and 42 CFR, Part 2. All staff are trained on confidentiality and required to sign a confidentiality statement prior to commencing employment.

Division Manager: Kristina Paramore, LMFT, is the DAS Division Manager. All treatment clinic staff work under her direction.

Program Supervisor: Program Supervisor staff possess a clinical license, such as Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Licensed Professional Counselor, or Certified Clinical Supervisor (or equivalent) from an alcohol and drug certification program. They also possess specialized experience in alcohol and drug treatment programs including clinical evaluation, treatment interventions, and individual and group counseling.

Clinical Supervisor: Clinical Supervisors assist both clinical and non-clinical treatment staff with individual or group supervision, education, and SUD treatment training. Clinical Supervisors may provide supervision to staff seeking their Board of Behavioral Sciences (BBS) training hours towards licensure.

Assessment Coordinator: LPHA's who have been assigned to the Access Team are Assessment Coordinators. They are the lead Clinicians for the clinics and can act in the absence of a Program Supervisor.

BH Specialist/Clinician: The Specialist/Clinician positions for DAS provide SUD treatment services. Specialists are Certified or Registered Counselors. Clinicians are LPHA's (see definitions of key terms).

Medical Staff: Any Physician, Physician Assistant, Registered Nurse, Nurse Practitioner, Licensed Vocational Nurse, or Licensed Psychiatric Technician.

Medical Director: Dr. Siddarth Puri is the Medical Director for SLOBHD.

BH Worker: The Drug and Alcohol Services Worker positions provide childcare, transportation, drug testing services, and other duties as assigned.

Administrative Assistant (AA) and Administrative Services Officer (ASO): Administrative staff provide reception, medical records maintenance, billing, and financial assessments. ASO staff are management staff members that evaluate outcome and programmatic data.

Health Information Technician (HIT): The duties of the HIT staff are to oversee the management and movement of both physical and electronic health records. The HIT team works closely with QST to audit charts for compliance and to maximize billable services.

UTILIZATION REVIEW

Each client is assigned a primary Specialist/Clinician who is responsible for overseeing all components of the client's treatment. The primary Specialist/Clinician is responsible for ensuring that the following activities occur:

- Required services are provided as clinically necessary and in accordance with Title 22 regulations, DMC-ODS requirements, and AOD Standards, and that these services are accurately documented.
- Attendance and/or non-compliance issues are documented and discussed with the client.
- Progress or barriers in achieving treatment goals are assessed and documented on a continuous basis.
- All relevant documents (releases, correspondence, referrals, consent to treat, etc.) are contained in the EHR.
- Referrals are made and documented as they occur.
- Lack of progress in the current level of care necessitates a change which must be recorded in the EHR.
- A Discharge Plan or Discharge Summary is developed.

All EHR documentation is reviewed regularly by the Clinical Supervisor, Program Supervisor, or designated LPHA to assure compliance with DMC-ODS standards. Additionally, the HIT office produces biweekly compliance reports, and a Clinician from QST conducts monthly auditing activities.

DAS SUD TREATMENT SERVICES CONTINUUM OF CARE

ASAM LEVELS OF CARE

The ASAM Criteria is an instrument to help determine the appropriate level of care to treat an individual with substance-related needs and risks. All staff must complete ASAM trainings prior to providing services.

ASAM is a single, common standard for assessing client treatment needs, optimizing placement, and documenting the appropriateness of reimbursement. The ASAM Criteria is used during the assessment process, as well as throughout the treatment episode to evaluate the client's progress/regression and further treatment needs. 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. Levels of care are reviewed in the next section along with information about the agency(s) providing each level of care in contract with SLOBHD.

The ASAM Criteria supports and promotes a collaborative process of assessment and service planning where services are matched to the client's unique multidimensional needs. Needs across six specific dimensions/life areas are identified so that the whole person is treated including substance use, mental health, physical health, living situation, and social support network. Conceptualizing client needs by dimension creates a common language amongst professionals in substance use treatment.

1) Dimension One: Acute Intoxication and/or Withdrawal Potential
2) Dimension Two: Biomedical Conditions and Complications
3) Dimension Three: Emotional, Behavioral, or Cognitive Conditions and Complications
4) Dimension Four: Readiness to Change
5) Dimension Five: Relapse, Continued Use, or Continued Problem Potential
6) Dimension Six: Recovery/Living Environment

Each dimension is rated on a risk rating scale (0 to 4) to determine need needs, risks, and areas of imminent risk. The rating of each dimension is ultimately used to determine level of care placement.

COUNTY OPERATED SERVICES

Services must be provided in the client's preferred language and with respect to culture. Best practice requires that all authorizations, consents, and advisements be explained to clients in their preferred language and in a developmentally appropriate manner. Services must also be provided at the clinically assessed appropriate level of care, and a client's care must be coordinated when changing levels of care.

OUTPATIENT TREATMENT

ASAM Level 0.5 Early Intervention:

- Clients at risk of developing a SUD or those with an existing 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 is not a DMC-ODS benefit and therefore is not provided by SLOBHD.

- Early intervention services are covered by DMC-ODS services for clients under the age of 21 who are screened and determined to be at risk of developing a SUD may receive services. Early intervention services are provided by the Prevention & Outreach Division of the Health Agency, primarily in school settings. (A full assessment using the ASAM criteria is not required for a client under 21 years old to receive early invention services).

ASAM Level 1.0 Outpatient Treatment:

- Up to 9 hours of service per week of medically necessary services for adults.
- Less than 6 hours of services per week for youth.
- Can be provided in person, by telehealth, or by telephone.
- Includes recovery or motivational enhancement therapies/strategies.

ASAM Level 2.1 Intensive Outpatient Treatment:

- Minimum of 9 hours per week and a maximum of 19 service hours per week of medically necessary services for adults.
- Minimum of 6 hours to a maximum of 19 service hours per week for youth.
- Can be provided in person, by telehealth, or by telephone.
- Multidimensional instability is treated.

Both 1.0 and 2.1 Outpatient Treatment services include: Assessment, Care Coordination, Counseling (Individual and Group), Family Therapy, Medication Services, MAT, Patient Education, Recovery Services, SUD Crisis Intervention Services.

Withdrawal Management (Detoxification)

Withdrawal Management (WM) is the use of medications to help suppress the symptoms of withdrawal. WM services are urgent and provided on a short-term basis. The focus of services is on the stabilization of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where comprehensive treatment services are provided.

WM services include Assessment, Care Coordination, Medication Services, MAT, Observation, and Recovery Services. The medication services are provided by a licensed physician or licensed prescriber.

1-WM Ambulatory Withdrawal Management Without Extended On-Site Monitoring:

- Mild withdrawal with daily or less than daily outpatient supervision.

Medication Assisted Treatment

Medication Assisted Treatment (MAT): Outpatient treatment that includes the use of prescription medications, in combination with counseling and behavioral therapies, to treat SUD. Primarily used to treat opioid and alcohol use disorders.

IN-COUNTY CONTRACTED SERVICES

ASAM LEVEL 3.1 RESIDENTIAL TREATMENT:

- Clinically managed, low-intensity residential services.
- 24-hour structure with at least 5 hours of clinical service per week in preparation for outpatient services.

Currently, there are two in-County Residential Treatment providers that are contacted with SLOBHD: Bryan's House, which serves pregnant and post-partum women, and Sun Street 34 Prado which serves adult men.

ASAM LEVEL 3.2 RESIDENTIAL WITHDRAWAL MANAGEMENT:

- Clinically Managed Residential Withdrawal Management.
- 24-hour support is needed for moderate withdrawal symptoms that are not manageable in an outpatient setting.

Currently, there is one in-County Residential Treatment provider that is contacted with SLOBHD to provide 3.2 WM: Sun Street 34 Prado which serves adult men.

ASAM LEVEL 3.5 RESIDENTIAL TREATMENT:

- Adult: Clinically managed high intensity residential services.
- Adolescent: Clinically Managed Medium-Intensity Residential Services.
- 24-hour care to stabilize multidimensional imminent danger and prepare for outpatient.
- Social & psychological problems have multiple limitations.
- Able to tolerate and use full milieu or therapeutic community.
- Majority of services must be provided in-person, however, can also be provided by telehealth, or by telephone.

Currently, SLOBHD is contracted with the following provider for this level of service as authorized by SLOBHD:

- Sun Street 34 Prado (adult men)

NARCOTIC TREATMENT PROGRAM (NTP):

- Outpatient program in which medications, which include methadone, buprenorphine (transmucosal and long-acting injectable), naloxone (oral and long-acting injectable), disulfiram, and naloxone are prescribed by a licensed physician/prescriber to treat substance use disorders.
- The client must also receive at minimum 50 minutes of counseling per calendar month.
- Can be provided in person, by telehealth, or by telephone.
- The medical evaluation for methadone treatment (which consists of a medical history, laboratory tests, and a physical exam) must be conducted in-person.

NTP services include Assessment, Care Coordination, Counseling (Individual and Group), Family Therapy, Medical Psychotherapy, Medication Services, MAT, Patient Education, Recovery Services, and SUD Crisis Intervention Services. The medication services are provided by a licensed physician or licensed prescriber.

There is one NTP (also called an Opioid Treatment Program (OTP)) in the county, Aegis Treatment Centers in Atascadero, California. Residents of southern San Luis Obispo County can attend Aegis Treatment Centers in Santa Maria, California where SLOBHD has an additional contract with this provider. Aegis also offers a clinic location in San Luis Obispo for medication dispensing only (treatment services are not provided at the San Luis Obispo location).

OUT-OF-COUNTY SERVICES (CONTRACTED PROVIDERS)

ASAM LEVEL 3.2 RESIDENTIAL WITHDRAWAL MANAGEMENT:

- Clinically Managed Residential Withdrawal Management.
- Licensed Residential Facility.
- Moderate withdrawal but needs 24-hour support to complete withdrawal management & increase likelihood of continuing treatment or recovery.

Currently, SLOBHD is contracted with the following providers for this level of service as authorized by SLOBHD:

- Tarzana Treatment Centers (adult)
- Sun Street (adult)
- Good Samaritan (adult)

ASAM LEVEL 3.1 RESIDENTIAL TREATMENT:

- Clinically managed, low-intensity residential services.
- 24-hour structure with at least 5 hours of clinical service per week.
- Preparation for outpatient services.
- Majority of services must be provided in-person, however, can also be provided by telehealth, or by telephone.

Currently, SLOBHD is contracted with the following providers for this level of service as authorized by SLOBHD:

- Tarzana Treatment Centers (adult & adolescent youth)
- Sun Street (adult and perinatal)
- Good Samaritan (adult and perinatal)

ASAM LEVEL 3.3 RESIDENTIAL TREATMENT:

- Clinically managed population specific high intensity residential services.
- 24-hour care with trained counselors to stabilize multidimensional instability.
- Less intense milieu and group treatment for those with cognitive or other impairments.
- Specialized, Individual Services.
- Cognitive impairments due to aging, traumatic brain injury, developmental disability, acute but lasting injury, or illness.
- Majority of services must be provided in-person, however, can also be provided by telehealth, or by telephone.
- This LOC not designated for adolescent population.

Currently, SLOBHD is contracted with the following provider for this level of service as authorized by SLOBHD:

- Tarzana Treatment Centers (adult)

ASAM LEVEL 3.5 RESIDENTIAL TREATMENT:

- Adult: Clinically managed high intensity residential services.
- Adolescent: Clinically Managed Medium-Intensity Residential Services.
- 24-hour care to stabilize multidimensional imminent danger and prepare for outpatient.
- Social & psychological problems have multiple limitations.
- Able to tolerate and use full milieu or therapeutic community.

- Majority of services must be provided in-person, however, can also be provided by telehealth, or by telephone.

Currently, SLOBHD is contracted with the following providers for this level of service as authorized by SLOBHD:

- Tarzana Treatment Centers (adult & adolescent youth)
- Sun Street (adult and perinatal)

AUTHORIZATION FOR RESIDENTIAL TREATMENT

A client's length of stay for residential treatment services shall be determined by a LPHA based on individualized clinical need and access criteria. SLOBHD must provide prior authorization for residential treatment services within 24-hours of the prior authorization request being submitted by the residential treatment provider. SLOBHD will review the DSM and ASAM Criteria to ensure that the client meets the requirements for the service. In SmartCare, the form used to authorize initial and ongoing SUD residential treatment is the Authorization Tracking (Client) document. SUD residential treatment lengths of stay are re-evaluated for authorization every 30-days by SLOBHD.

OUT-OF-COUNTY SERVICES (NON-CONTRACTED, NO-FEE PROVIDERS)

There are various no-fee Residential Treatment Facilities in California (ex. Salvation Army). An authorization (Authorization Tracking (Client)) is not necessary should a client go to a facility with no cost. DAS will, however, track the client for a period of up to 6 months via case management services to monitor the client's progress and needs related to care transition.

OTHER COUNTY SERVICES

SOBER LIVING ENVIRONMENTS

Sober Living Environments, also referred to as Recovery Residences, are contracted entities with SLOBHD, available to clients who require housing assistance to support their health, wellness, and recovery. There is no formal treatment provided at these facilities, however, residents are required to actively participate in outpatient treatment and/or Recovery Support Services during their stay.

To refer a client to a Sober Living Environment, the Specialist/Clinician completes a Recovery Residence Authorization (paper form that must be provided to HIT to scan into the EHR), and the client must sign a Release of Information (SmartCare form). The

Recovery Residence Authorization form covers payment arrangements with the Recovery Residence/Sober Living Environment and must be signed by a Program Supervisor to authorize the referral.

Drug Testing

DAS maintains a sophisticated drug testing division of services, including observed (same gender) random urine screening, laboratory testing for a variety of drug substances, breathalyzer, and on-site random and non-random urine screening. Hair drug testing is seldom conducted but can be in special circumstances where it is court ordered. At intake, each client is assigned to one of three test levels: High (6 times per month), Moderate (4 times per month), or Low (2 times per month). The assignment is based upon the program they are participating in and based upon each client's individual drug use history. Based upon subsequent progress in treatment, drug testing can be moved up or down in testing intensity.

The standard drug testing 10-panel tests for the following substances:

- Barbiturates
- Benzodiazepines
- Cocaine
- Amphetamine/Methamphetamine
- Opiates-Morphine
- Cannabinoids Marijuana (THC)
- Buprenorphine/Suboxone
- Ethyl Glucuronide Alcohol (EtG) ingested within 80 hours of testing
- Buprenorphine
- Fentanyl
- Creatinine Levels

Another drug testing panel can be requested if there is concern that a client is using Methadone, Oxycodone, or Phencyclidine (PCP). Additionally, a Specialist/Clinician can order (either randomly or consistently) specialized testing for various other chemicals such as bath salts, Kratom, Spice, Tramadol and Gabapentin. This is approved by the Program Supervisor.

Urine test results are recorded in a database called "National Labs." A notification is immediately sent to the primary Specialist/Clinician for any positive drug test results to allow for prompt intervention. Positive results are discussed with the client and may be

cause for a review of treatment services or increase in the intensity of the services. Upon continued lack of progress in treatment (not solely based upon drug testing results), a client may be considered for a higher level of care.

The Specialist/Clinician utilizes the client's drug testing history as one measure of progress in treatment. Drug test history can be important in several documents such as: Progress Notes, Treatment Court Reports, and the Discharge Summary/Plan.

In the circumstance where a Specialist/Clinician completes a drug test as part of another service (ex. case management or individual counseling session), then the time spent collecting the sample can be added to the service time. The intervention of drug testing should be added to the progress note narrative, for example:

- "Due to client's presentation of potentially being under the influence of a substance today, this Specialist completed a drug test as part of this service."

Perinatal Services

DAS operates a certified outpatient perinatal SUD program. Additional services are available to women who are pregnant or postpartum (within two months after delivery) to address issues specific to the population. Perinatal services include:

- Gender-specific SUD treatment services that address relationships, sexual and physical abuse, and parenting skills.
- Case management to ensure that women have access to primary medical care, pediatric care, and therapeutic interventions for children.
- Transportation to medically necessary SUD treatment and medical services (for both women and their children).
- Childcare services while women are receiving SUD services and medical care.

DAS operates a perinatal intensive outpatient treatment program called POEG (Perinatal Outpatient Extended Group). This program serves women that are pregnant, and/or women and their children aged 0-5 years old.

Pregnancy Indication in Record

Documentation of pregnancy status is required in the EHR. For pregnant and postpartum women, medical documentation is necessary to substantiate the pregnancy (verification from the client's physician or verification from a urine screening test at DAS). The last day of pregnancy also must also be substantiated with a medical document (from physician or hospital, or the birth certificate) that indicates delivery date of a child or other outcome.

Additionally, pregnancy code Z34.90 must be added to the Problem List in SmartCare and kept open/active for 12 months after the end of the pregnancy. This is added to the Problem List so SmartCare will automatically add a pregnancy/post-partum billing modifier to the Medi-Cal claim. Medi-Cal reimbursement is higher for treatment services provided to pregnant/post-partum clients. The post-partum period for Medi-Cal claims is a 12-month period. When the perinatal/post-partum period has reached 12-months, end date this problem.

- The Z Code for pregnancy and the post-partum period is Z34.90 and the SNOMED code is 248985009. The pregnancy end date must be added at the end of the 12-month post-partum period (12 months after the end of the pregnancy).

When staff learn a client is pregnant, or a client starts treatment with an infant 0-11 months:

- Add the pregnancy/post-partum code to the problem list.
- Email site HIT to inform them of the client's pregnancy (include approximate start date of pregnancy) or that they are the parent of an infant 0-11 months (include the date of the infant's birth). HIT will follow up regarding any additional needed information.

Interim Services

In instances when clients are waiting to be placed in a treatment level of care, DAS is required to provide Interim Services due to the high risk involved with substance use. Interim Services can be provided in individual sessions (case management or individual counseling) or in a group setting (group counseling). The education provided must cover the following information:

- HIV
- Tuberculosis
- Risk of needle sharing
- Risk of HIV and TB transmission to sexual partners and infants
- Hepatitis C
- If necessary, referral to HIV, HepC, or TB treatment services

For pregnant women, interim services must cover the topics above and include additional counseling on:

- The effects of alcohol and drugs use on the fetus

- Referral for prenatal care

- Please click here to view Interim Services Progress Note templates.

Naloxone Services

For any client with an opioid use disorder or history of opioid use, it is the policy and procedure of DAS to provide information about Naloxone, resources where the medication can be obtained, and, if the client accepts, to arrange for the client to be provided with a prescription written by a prescriber within DAS. In many instances, DAS can provide the client with a free Naloxone kit and the rescue medication. For any client using a substance that could also contain fentanyl, the client is also provided information and immediate access to Naloxone.

- Please click here to view Naloxone Progress Note templates.

Referral Services

The following service needs are assessed and either provided directly by DAS or referred out and are not limited to educational opportunities, vocational counseling and training, job referral and placements, legal services, medical services, dental services, social/recreational services, individual counseling and group counseling for clients, spouses, and significant others. All referrals are documented in the client's EHR.

Clients who do not meet access criteria for SUD treatment are referred to other community agencies which offer services appropriate to their needs. Referrals are typically made via phone conversation with a staff member of the community agency. A release signed by the client is necessary for each referral.

Recovery Support Services

Clients can access medically necessary Recovery Support Services (RSS) after completing their course of treatment. RSS are available to clients whether they are triggered, have relapsed, or as a measure to prevent relapse. When Discharge Planning at the end of treatment, the continued support plan for the client may include transition to RSS. Client's receiving MAT may continue to access RSS after treatment has been completed to remain on maintenance medications.

ACCESS LINE

Referrals to DMC-ODS can take place through calls to the SLOBHD Access Line (1-800-838-

1831). The caller can request SUD, Mental Health (MH), or crisis services.

CLIENT INQUIRY

When a phone call request for SUD services is received by the SLOBHD Central Access Line, the Managed Care Specialist will complete a Client Inquiries (Client) in SmartCare with information from the phone call. The Clinician refers the individual to attend a walk-in clinic or a screening appointment at the desired time/location with an Assessment Coordinator.

ADMISSION PAPERWORK

An EHR (electronic health record/medical chart) is established for each client when the treatment episode is opened. Client information is maintained and released in accordance with the requirements of HIPAA and 42 CFR Part 2. All records contain the following client demographic and identifying information: unique client identifier, date of birth, gender, race/ethnic background, language preference, address, telephone number, next of kin, emergency contact, consent for treatment, referral source and reason for referral, and date and type of admission. This information, along with the CalOMS dataset, and all other data obtained in the intake and assessment process outlined below is maintained in the EHR. **Clients must be offered copies of all forms that they sign.**

Adult Intake Paperwork (Screening & Assessment Process)		
Document	**Who Will Complete**	**Co-Signature Needed**
Consent to Treat	AA	
Consent for Email Communication	AA	
Consent for Text Communication	AA	
Consent for Telehealth	AA	
Coordinated Care Consent	AA	
Cost Agreement (Completed for Full-Scope MediCal or Grant Funding Source) (Paper Form)	AA	
UMDAP Financial Assessment (Completed Only if there is No Funding Source, MediCare Only,	Specialist/Clinician	Program Supervisor *Give to AA to enter into SmartCare

or Self Pay) (Paper Form)		
Health Questionnaire	AA	
BQuIP SUD Screening	Specialist/Clinician	LPHA/Program Supervisor
Diagnosis Document	Specialist/Clinician	LPHA/Program Supervisor
Problem List	Specialist/Clinician	
NOABD Denial (as needed)	HIT	LPHA
CA ASAM	Specialist/Clinician	LPHA/Program Supervisor
CalOMS Admission	Specialist/Clinician	HIT
Youth Intake Paperwork (Screening & Assessment Process)		
Consent to Treat	AA/Field Based Clinician	
Consent to Email Communication	AA/Field Based Clinician	
Consent for Text Communication	AA/Field Based Clinician	
Consent for Telehealth	AA/Field Based Clinician	
Coordinated Care Consent	AA/Field Based Clinician	
Cost Agreement (Completed for Full-Scope MediCal or Grant Funding Source) (Paper Form)	AA/Field Based Clinician	
UMDAP Financial Assessment (Completed Only if there is No Funding Source, MediCare Only, or Self Pay) (Paper Form)	Specialist/Clinician	Program Supervisor *Give to AA to enter into SmartCare
Health Questionnaire	AA/Field Based Clinician	
Caregiver Affidavit (if applicable)	AA/Field Based Clinician	
Audio Video Consent (if applicable)	AA/Field Based Clinician	
BQuIP SUD Screening	Specialist/Clinician	LPHA/Program Supervisor
Diagnosis Document	Specialist/Clinician	LPHA/Program Supervisor
Problem List	Specialist/Clinician	
NOABD Denial (as needed)	HIT	LPHA
CA ASAM	Specialist/Clinician	LPHA
CalOMS Admission	Specialist/Clinician	HIT

CONSENT FORMS

Coordinated Care Consent: The client is presented with this consent form, which when signed, allows organizations using SmartCare to share information for treatment purposes. For example, if a client receiving SUD treatment services signs the coordinated consent form, a mental health treatment provider/team also working with the client would be able to view the SUD treatment documentation.

- Below is a script which a Counselor/Clinician may find helpful to describe the Coordinated Care Consent to the client:

  "Mental Health Services, Drug & Alcohol Services, and Crisis Services. These programs and services use the same behavioral health record. By signing this Coordinated Care Consent, it will allow the staff in this program to coordinate effectively with the other providers I have mentioned, if you also utilize their services. The purpose of coordination is to provide you with the best care possible. Signing this consent does not allow us to redisclose or share other parts of your behavioral health record with others outside of Behavioral Health without your specific permission."

- If the client asks, "what information would you share?"

  For example, by signing the Coordinated Care Consent, it would allow us to coordinate with staff in the other programs to make sure you are receiving the services that you need, and that medications are being prescribed in a coordinated way, for example.

Consent to Treat: Prior to beginning outpatient services, each client and/or Legally Responsible Person must make an informed decision about the risks and benefits of treatment (including no treatment). The decision to participate in treatment is documented by obtaining the signature of each client (age 12 and older) on the Consent to Treat in SmartCare. A Legally Responsible Person must sign on behalf of all minor clients who are not consenting for treatment on their own and for all LPS conservatees. Consent for treatment is valid from the date of signature until treatment ends or until revoked by the client/Legally Responsible Person. Services provided after informed consent for treatment has been obtained can be billed.

Every client must read and sign Consent to Treat prior to admission to the program. The consent to treat discusses the mutual roles and responsibilities of the client and the

program. Signature(s) on the Consent to Treat must be obtained to document that the client/Legally Responsible Person understands and agrees to participate in treatment. As stated on the Consent for Treatment, all clients are notified of their rights and offered a copy of the Privacy Practices and Beneficiary Guide for Substance Use Services.

RELEASE OF INFORMATION

Depending upon the referral source, an Authorization to Disclose and/or Release of Information may be necessary at admission and/or at any time during the treatment episode. All Authorizations to Disclose and/or Release of Information expire in 1 calendar year, unless otherwise noted below. 42 CFR Part 2 allows DAS to share information with other treatment providers after a general treatment release of information is obtained. This must be updated annually. Non-treatment providers must be named by entity on an Authorization to Disclose and/or Release of Information (ex. DSS, Attorney, family member). The Authorization to Disclose and/or Release of Information must state what health information the client has authorized to be exchanged: all health information or specifically limited information.

Multi-Party Release of Information and Criminal Involved or Court Mandated Programs: These are paper forms. Multi-Party Releases of Information will be utilized to provide collaborative care for a client with non-treatment providers. Criminal Involved or Court Mandated Programs will authorize participation by initialing the box on the form acknowledging all conditions on the Multi-Party Criminal Involved or Court Mandated Program Release of Information. While the client is involved in a court treatment program (AB109, ADC, ATCC, BHTC, CMD, MHD, Prop36, PTD/DEJ, VTC, Care Court), the client agrees and acknowledges that the criminal involved/court mandated entities cannot be revoked, or this can or will jeopardize the continued participation in the Criminal Involved or Court Mandated Program(s). This acknowledgment is contained in the Multi-Party Release Criminal Involved or Court Mandated Program Release of Information paper form.

Note: SLOBHD staff primarily use the releases named above for most disclosure authorization needs. The Form 815 SLO County Multi-Agency Referral and Client Release of Information is a multi-agency release form. For DAS clients, this form is scanned into the EHR. Here are regulations that apply when the Form 815 is used:

1) DAS Staff must not disclose information to any individual from a non-treatment provider entity if that person is not specifically named on Form 815 or other consent. That means that DAS Staff will not be able to participate in a discussion

unless all parties to that discussion are named on the consent.

2) For many years, the law has stated that a person or entity who receives DAS information from the Part 2 program is now subject to the same privacy regulations (42 CFR Part 2) as DAS staff. That means recipients of DAS information must not re-disclose the information without authorization from the client. This does not apply to information shared directly by the client, it only applies to information initially generated at DAS. The last page of Form 815 is for agencies to use when they need client consent to re-disclose DAS information.
3) 42 CFR Part 2.32(a)(2) requires that a notice accompany any disclosure or re-disclosure of information generated at DAS.

Authorization to Disclose and/or Consent to Release Information Quick Tips

- All Authorization to Disclose and/or Consent to Release Information must have an expiration date entered. If there is no expiration date or event entered, the form is invalid.
- Authorization to Disclose and/or Consent to Release Information cannot include blanks.
- If an Authorization to Disclose and/or Consent to Release Information has expired, information cannot be exchanged until the client signs a new release. Therefore, treatment staff are encouraged to check releases frequently.

TREATMENT PROGRAM AGREEMENTS

Specialty treatment programs such as Prop. 36, Medication Assisted Treatment (MAT), Pre-Trial Diversion (PTD), Post-Release Treatment Services (PRTS), Intensive Outpatient Treatment (IOT), Perinatal Outpatient Extended Group (POEG), etc., have additional Treatment Agreements that are reviewed with the client at admission. To verify that the client has reviewed and agreed to their specialty program rules/requirements, the Treatment Program Agreement is paper form that is signed by the client and Counselor/Clinician when treatment commences. The paper form is scanned into the EHR.

DEMOGRAPHIC INFORMATION

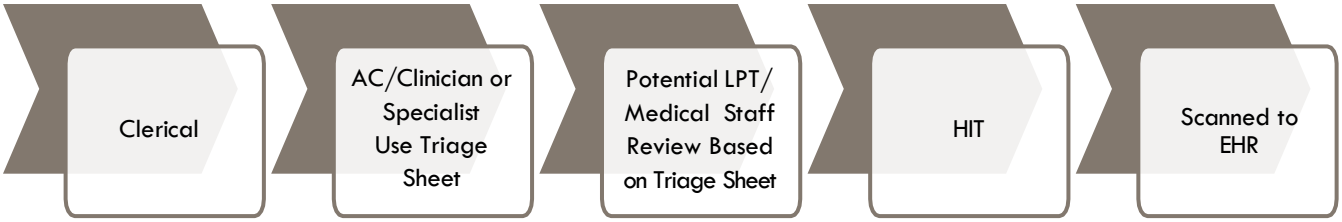
Clerical staff enter demographic information in SmartCare into Client Information (Client). This includes the client's contact information (name, address, phone number), emergency contact, preferred language, financial and employment information. When this form needs to be updated, such as when there is a change to contact information or to

pregnancy status, the Specialist/Clinician can update this information directly onto the Client Information screen.

HEALTH QUESTIONNAIRE & PHYSICAL EXAM REFERRAL

In addition to the alcohol and other drug history obtained through the screening process, the client will provide a self-report of their medical history on the SLOBHD Health Questionnaire. In the interest of minimizing the spread of infectious disease, the medical history is obtained as early as possible in the screening process. The Health Questionnaire is part of the intake packet of forms. This is a paper document and the client's signature is collected. Clerical reviews the Health Questionnaire with the client for accuracy of information and for completion.

The Health Questionnaire flows as follows:



The Health Questionnaire is reviewed by the Assessment Coordinator and discussed with the client to screen for infectious disease, mental health diagnosis, medications, suicide risk, as well as the need for WM and MAT services, noting any possible urgent medical needs. The Specialist/Clinician will note in the Screening (BQuIP) that they completed a review of the Health Questionnaire. Please see BQuIP Screening Practice Guidelines for template text/prompts to assist Counselor/Clinician.

The Specialist/Clinician/Assessment Coordinator will review the Health Questionnaire completed by the client during the Screening appointment. The Specialist/Clinician will utilize the Triage Sheet to determine if the Health Questionnaire should be reviewed further by a medical staff member, such as an LPT. If a client notes on the Triage Sheet that they have had physical health problems for 15+ of the last 30-days, the Specialist/Clinician must provide the Triage Sheet and Health Questionnaire to a medical staff member for review/consultation. A medical staff member is a LVN/LPT, RN, NP, PA, or MD/DO. This consultation can take place in person or by telephone.

DAS medical staff are available for consultation (NP, LPT). The SLOBHD Medical Director is also available for consultation and for admission to the local hospitals or Psychiatric Health Facility (PHF) as needed. All emergency and urgent medical concerns need to be

addressed immediately and documented in the BQuIP, Progress Note, or an informational/non-billable note.

PHYSICAL EXAMINATION

All clients entering DMC-ODS treatment services must have a physical examination documented in their record. The physical must have occurred within the 12-months prior to admission. Options for the completion of this requirement include:

1) Within 30 calendar days of admission to treatment, the MD, NP, or PA shall review the documentation of a physical exam that took place in the 12-months prior to treatment.
   a) Copy of physical exam records can be obtained directly from the client.
   b) Physical exam records can be obtained from the client's primary care provider. At intake, the Client signs a Release of Information that is used to request physical exam records/receive subsequent physical exam results.
   c) If provider is unable to obtain documentation of a client's most recent physical exam, the provider must describe efforts made to obtain this documentation in the EHR.
2) Medical staff may perform a physician examination of the client within 30 days of admission to treatment.
3) Primary Specialist/Clinician will monitor the client's completion of a physical examination and document this information in ongoing progress notes.

When physical examination and medical records are received by the Health Information Department (HITs), a flag is set in SmartCare to alert and assign medical staff (MD, DO, NP, PA) that there are medical records to be reviewed. It is a DMC-ODS requirement that the medical examination is reviewed.

CLIENT RIGHTS

As part of every admission process, the client is informed of the program's policy of non-discrimination, their rights as a client, program rules and regulations, grievance procedures, appeal process for discharge, and fees and insurance information. The client is given a written copy of the aforementioned documents and the SLOBHD Client Rights statement is posted on program premises. All clients are given the DAS Client Services Handbook which describes the various documents signed, program rules, and potential referral information. The DAS Client Services Handbook contains community resource information and program orientation information. The client receives additional program orientation information during the Screening and Assessment appointments (thus the

client is oriented to the program within 72-hours of admission).
SLOBHD employs a Patient's Rights Advocate who can help the client with filing appeals, expedited appeals, and grievances.

ADMISSION CRITERIA FOR SUD SERVICES

ADMISSION OVERVIEW

1) Screening (Walk-In): 1-2 Visits with LPHA
    - Introduction to program, describe the treatment process.
    - Discussion of presenting problem (substance use & interference with functioning).
    - Obtain medical history (Health Questionnaire).
    - Review Health Questionnaire with Client and give referrals if necessary and/or contact medical staff.
    - Obtain consent for treatment.
    - Schedule SUD Assessment (CA ASAM) appointment.

2) Assessment: 1-2 Visits with LPHA

    - Administer SUD Assessment (CA ASAM) which includes the full ASAM Placement Criteria.
    - Discuss SUD Assessment findings with client including level of care recommendation.
    - Obtain CalOMS Admission data.
    - Administer any other applicable assessment tools.

MEDICAL NECESSITY FOR SUD TREATMENT SERVICES

Medical Necessity refers to appropriate, non-fraudulent medical services.

- For individuals 21 years of age and older: a service is "medically necessary" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- For individual s under the age of 21: services are "medically necessary" if the service is needed to correct or ameliorate metal illness and conditions. Services do not need to be curative or completely restorative to ameliorate a mental health condition. A service is considered to ameliorate if it serves to sustain, support, improve, or make a mental health condition more tolerable.

ACCESS CRITERIA: INITIAL ASSESSMENT AND SERVICES PROVIDED DURING THE ASSESSMENT PERIOD

DAS provides treatment services to persons with SUD's in the county who meet the access criteria for services. Services provided during the assessment process are covered by DMC-ODS if the full assessment determines that the client does not meet access criteria after assessment.

DMC-ODS services must be recommended by LPHA's within their scope of practice. To ensure that clients receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each client's clinical needs.

SUD SCREENING

SCREENING (WALK-IN)/INITIAL ASSESSMENT

Walk-in screenings are available at the five DAS clinics on a weekly basis. It is best practice and the standard for SLOBHD that the screening be conducted face-to-face by an LPHA, however, screenings can be completed by telehealth or telephone in necessary circumstances. Screening is typically one session but can take place over two contacts and is usually the first billable service.

Screenings are typically conducted by a Clinician/LPHA (Assessment Coordinator). However, if the initial assessment of a client is completed by a Specialist (registered for certified Counselor), then the LPHA shall evaluate that assessment with the Specialist and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the Specialist can be conducted in person, by telehealth, or by telephone. The consultation must be documented in the client's record. Please see BQuIP Screening Practice Guidelines for template text/prompt to assist Counselor/Clinician with the documentation of this consultation.

Clients who present with serious emotional disturbance or severe and persistent mental illness are referred to Mental Health for appropriate treatment. If the client presents with a Co-Occurring Disorder, the referral is made to the appropriate Co-Occurring Disorders Program.

Prior to the screening session, the client completes the admission paperwork described above. During screening, the client is assigned to drug testing. If immediate outpatient

treatment services are needed, the client can be assigned to begin groups and educational sessions immediately prior to the full assessment with a primary Specialist/Clinician. The client can also receive case management services.

SUD SCREENING (BQUIP)

The assessment document utilized for the walk-in screening is called the BQuIP – SUD Screening. As stated above, screenings are generally conducted by LPHA's. The purpose of the screening session is for the admitting Clinician (Assessment Coordinator) to gather information about the client's basic needs, current substance use and substance use history, mental health status, and any past or immediate risk factors such as suicidality, homelessness, and emergency physical health needs, such as withdrawal symptoms.

The outcome of the screening will be documented in the BQuIP – SUD Screening as:

1) Provide referrals and recommendations if the client does not meet access criteria for SUD treatment services. If this is the case, a NOABD Denial Notice is also provided to the client.
2) Schedule a SUD assessment session when SUD criteria is met and a full assessment and ASAM criteria assessment are warranted.
3) Schedule client for stabilization group services or assign client to treatment groups/treatment program if immediate placement in treatment is indicated.
4) Schedule client for an appointment with the MAT Team if requested or indicated.

SCREENING FREQUENTLY ASKED QUESTIONS

1) How do I find the BQuIP – SUD Screening in the EHR?

   With the client open in SmartCare, there are two ways to start a BQuIP. First, BQuIP can be entered in the search bar. Second, this path can be followed: Client > Assessments/Screening Tools > BQuIP.

2) What information is critical to obtain during the screening?

   It is imperative that every question on the BQuIP is answered, and that risk to self and others is assessed and documented.

3) What signatures are required on the BQuIP?

   Because screenings and assessments are generally completed by licensed or licensed-track clinicians, the LPHA signature is the sole signature required on this document. If the screening is completed by a Specialist (registered or certified Counselor), and LPHA

must evaluate the screening with the Specialist and co-sign the BQuIP.

- Please click here to view Screening Progress Note example.

URGENCY/TIMELINESS OF ACCESS

As part of screening a client for SUD services, the Clinician must decide about the urgency in which the client will be seen for their next service (often the CA ASAM Assessment appointment). If a client is not seen for their first service or follow up service within the required number of business days, a letter titled Notice of Adverse Beneficiary Determination (NOABD) Timely Access Notice must be sent to the client. Urgency requirements are as follows:

CRISIS WITHIN 24 HOURS:

The client must be seen within 24 hours of the request for services. The client is considered crisis/emergency due to one or more of the following:

1) Substance Use Crisis
- Mental Health Crisis (danger to self, danger to others, grave disability)

URGENT WITHIN 48 HOURS:

The client must be seen within 48 hours of the request for services. The client is considered urgent due to the following:

- Pregnancy (must contact within 48 hours as directed by DHCS Perinatal Guidelines)
- Those using drugs through IV methods
- Those that are parenting children

URGENT WITHIN 72 HOURS (MAT/NTP/OTP):

Services are urgent. The client must be seen within 72 hours of the request for services. The client is considered urgent due to one or more of the following:

- Requesting Detox and/or MAT services
- Requesting NTP/OTP services (Aegis)

ROUTINE:

The client must be seen within 10 business days from the request for service.

FOLLOW UP:

The client must be seen for a follow-up service within 10 business days of their first

service/screening.

PROVISIONAL DIAGNOSIS

A substance use diagnosis is not a prerequisite for access to SUD Treatment Services, however it does not eliminate the requirement for all Medi-Cal claims, including claims for SUD Treatment Services, to include an approved ICD-10 diagnostic code. Services provided prior to the determination of a diagnosis or prior to determination of whether criteria are met are covered and reimbursable by DMC-ODS. The Clinician can diagnose a Substance Related and Addictive Disorder diagnosis(es) at Screening. However, the Clinician may choose to use the following diagnostic options during the assessment phase when a diagnosis has yet to be established:

- Clinician's (LPHA's) can diagnose ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out."
- Clinician's (LPHA's) can diagnose a suspected disorder that has not yet been diagnosed. These include codes for:
  - "Other specified"
  - "Unspecified" disorders"
  - "Factors influencing health status and contact with health services"
- All Specialists/Clinicians and LPT's can diagnose ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" during the assessment period. These are diagnoses related to Social Determinants of Health (SDOH). An LPHA approval is not required.

Description	Z Code	SNOMED CODE
Academic or Educational Problem	Z55.9	4506002
Problem related to Current Military Deployment Status	Z56.82	
Other Problem Related to Employment	Z56.9	75148009
Homelessness	Z59.0	32911000
Inadequate Housing	Z59.1	105528000
Discord with Neighbor, Lodger, or Landlord	Z59.2	287991000119107
Problem Related to Living in a Residential Institution	Z59.3	15929301000119104
Lack of Adequate Food or Safe Drinking Water	Z59.4	1078229009
Extreme Poverty	Z59.5	160932005
Low Income	Z59.6	424860001
Insufficient Social Insurance or Welfare Support	Z59.7	365558004
Unspecified Housing or Economic Problem	Z59.9	160932005
Phase of Life Problem	Z60.0	9431000

Problem Related to Living Alone	Z60.2	620981000124101
Acculturation Difficulty	Z60.3	105413002
Social Exclusion or Rejection	Z60.4	77096008
Target of (Perceived) Adverse Discrimination or Persecution	Z60.5	620961000124106
Unspecified Problem Related to Social Environment	Z60.9	161152002
Upbringing Away from Parents	Z62.29	
Personal History (past history) of Physical Abuse in Childhood	Z62.81	288391000119107
Parent-Child Relational Problem	Z62.82	52184009
Personal History (past history) of Sexual Abuse in Childhood	Z62.81	288391000119107
Personal History (past history) of Psychological Abuse in Childhood	Z62.811	288401000119109
Personal History (past history) of Neglect in Childhood	Z62.812	288381000119109
Sibling Relational Problem	Z62.891	
Child Affected by Parental Relationship Distress	Z62.898	14345008
Relationship Distress with Spouse or Intimate Partner	Z63.0	1041000119100
Uncomplicated Bereavement	Z63.4	3763000
Disruption of Family by Separation or Divorce	Z63.5	28332004
High Expressed Emotional Level Within Family	Z63.8	166491000119100
Problems Related to Unwanted Pregnancy	Z64.0	151901000119101
Problems Related to Multiparity	Z64.1	288571000119100
Discord with Social Service Provider, Including Probation Officer, Case Manager, or Social Services Worker	Z64.4	Social Worker: 105519001 Probation Officer: 105521006 Counselor: 105520007
Conviction in Civil or Criminal Proceedings without Imprisonment	Z65.0	224340002
Imprisonment or Other Incarceration	Z65.1	45361006
Problems Related to Release from Prison	Z65.2	
Problems Related to Other Legal Circumstances	Z65.3	
Victim of Crime	Z65.4	
Victim of Terrorism or Torture	Z65.4	
Exposure to Disaster, War, or Other Hostilities	Z65.5	
Religious or Spiritual Problem	Z65.8	
Other Problem Related to Psychosocial Circumstances	Z65.8	
Unspecified Problem Related to Unspecified Psychosocial Circumstances	Z65.9	

There are Behavioral Health Services Act (BHSA) reporting requirements for clients who are unhoused or experiencing housing instability. There are certain housing statuses that must be documented in SmartCare so that they can be included in mandated BHSA reporting. These housing status will be captured in SmartCare using:

1) A social determinant of health diagnosis on the Problem List
2) A Special Population assignment

Documenting housing status in SmartCare will assist the treatment team in identifying clients who would benefit from interventions related to housing. Staff are required to:

- Add the most appropriate diagnosis to the client's Problem List
- Open the appropriate Special Population assignment
- Or do both, if that will best describe the client's housing circumstance.

HOUSING DIAGNOSES TO ADD TO PROBLEM LIST:

ICD 10 Code	Description	Definition
Z59.00	Homelessness, unspecified	Client is unhoused, and additional specific information is not known.
Z59.01	Sheltered Homelessness	Living in a shelter such as: motel, emergency/homeless shelter, scattered site housing, temporary or transitional living situation.
Z59.02	Unsheltered Homelessness	Living in a place not meant for human habitation such as: abandoned buildings, cars, parks, sidewalks, street.
Z59.811	Housing Instability, Housed, with Risk of Homelessness	Lacks resources and support networks and currently housed but could lose housing in the next 30 days, with no subsequence residence identified. Examples of this type of housing include: • Residing in a hotel/motel • Living in the home of another due to economic hardship • Sober Living Environment/Recovery Residence

		• Fleeing or attempting to flee domestic violence, sexual assault, or stalking • Unaccompanied youth under 25 with no lease and 2+ moves in the last 60 days
Z59.812	Housing Instability, Housed, Homelessness in Past 12 Months	Currently housed but history of homelessness in past 12 months.
Z59.819	Housing Instability, Housing Unspecified	Currently housed but housing is unstable, but specific sub-category is not known.

SPECIAL POPULATIONS FOR CAPTURING HOUSING STATUS:

ICD 10 Code	Description
Homeless – Chronic	Unhoused for a combined total of 12 months during the past three years; individual exiting an institution that met other chronic homeless criteria prior to entering institution.
Homeless – Living in an encampment	Unhoused and living with a group of people sleeping outside in the same location with some type of physical structure (e.g. tents, tarps) personal belongings, and a sense of community or social support.

DIAGNOSIS DOCUMENT

In the gathering of the client's history, a diagnosis is tentatively developed by the Clinician (Assessment Coordinator) and recorded on the Diagnostic Document (Client) form in the EHR on the date of walk-in screening.

The Diagnosis Document contains important clinical information used to determine access criteria for SUD Treatment. It also contains information needed for billing. Changes to diagnosis are made by adding a new Diagnostic Document.

DIAGNOSTIC RECONCILIATION

SmartCare brings forward all previously entered diagnoses to the current Diagnosis Document, within the same Clinical Access Data Group (CDAG)/program. As a result, a client could acquire multiple, sometimes conflicting diagnoses if staff add new diagnoses without ending those that are no longer applicable.

Every active diagnosis must be reviewed for consistency each time a Diagnosis Document is completed. If diagnostic criteria continue to be met, the diagnosis remains active. Enter an end date for every diagnosis that is no longer applicable.

Carefully evaluate multiple diagnoses within a class to determine if contradictory

diagnoses exist. Often, rendering a specific diagnosis should result in ending a more general diagnosis of the same class. Some diagnoses have exclusions and cannot occur at the same time as another diagnosis. For example, Alcohol Use Disorder, Mild, was initially diagnosed during screening. However, after gathering information from a Probation Officer and spouse (with Authorizations to Release Information in place), and following the full assessment, it is clear that the diagnosis is Alcohol Use Disorder, Severe. The diagnosis of Alcohol Use Disorder, Mild, must end because Severe is a more accurate for the client's presenting problem. The begin date for the Alcohol Use Disorder, Severe, is the day it was rendered, and the end date for Alcohol Use Disorder, Mild, is the day before.

Sections of the Diagnosis Document (Client)

Diagnosis List: LPHA or a medical provider (MD, DO, PA, NP) must include a diagnosis from the Substance-Related and Addictive Disorders section of the DSM 5 to establish access criteria for treatment services. However, during the intake and assessment phase, a SDOH Z code can be used while a diagnosis is being evaluated.

SmartCare requires that "Primary," "Additional," or "Provisional" is selected for each diagnosis that is added. For SUD diagnoses, the severity (Mild, Moderate, Severe) must be chosen. A Remission status (Early, Sustained, In a Controlled Environment) should be chosen if his is applicable.

Smart Care requires that the order of diagnoses is chosen. The order of diagnoses on the Diagnosis Document has no implications on claims being billed correctly.

Screening Tools Used: This field allows for a staff member to indicate a screening tool that was used to aid in evaluating a diagnosis. Example, "BQuIP – SUD Screening," "GAD-7," or "PHQ-9."

Other General Medical Conditions: This field allows for staff of any discipline to document the client's report of medical problems in a general manner. This does not imply that the staff member is making a medical diagnosis. Example, "High blood pressure per client report." If no medical condition is known, "None reported" can be entered into this field.

Rule Outs (R/O): A diagnosis can be indicated as a disorder to rule out by checking the "Rule Out" box when adding the diagnosis. A diagnosis to be ruled out, or evaluated further, can also be entered in the "Comments" box.

Level of Functioning Score: These fields do not need to be completed.

CLIENTS OPEN TO BOTH SUD TREATMENT AND MENTAL HEALTH

Because SUD Treatment Services/DAS and Mental Health are separated by CDAG/programs in SmartCare, each will have their own separate Diagnosis Document. If the Coordinated Care Consent is signed by the client, Mental Health staff will be able to view the Diagnosis Document created by the SUD Treatment Program/DAS.

CHANGING A DIAGNOSIS

The client's working diagnosis in SmartCare is documented on the Diagnosis Document (Client). Formulations written in Progress Notes or other assessments do not change the Diagnosis Document. If a diagnosis change is made following an evaluation by an MD/DO/NP, for example, the Diagnosis Document must be updated to reflect the new diagnosis. The new diagnosis may be entered by any agreed upon member of the treatment team (LPHA, MD/DO/NP).

To change a client's diagnosis, this is completed by adding a new Diagnosis Document (client). If an error is made on a Diagnosis Document and the document is signed, the document can be edited to create a new version to correct the error and then must be saved and signed again.

When a new diagnosis is rendered for a client, a new Diagnosis Document must be added. The criteria for the new diagnosis should be documented in the "comments" section of the Diagnosis Document.

CO-OCCURRING DISORDER DIAGNOSIS

Co-Occurring Disorder Treatment is an evidenced based program wherein the SUD is treated concurrently with the client's mental health issues. DAS has specific Clinicians that treat Co-Occurring Disorders. These LPHA staff members can diagnose both substance use disorders and mental health disorders.

Diagnosis Document Frequently Asked Questions:

1) Where do I find the Diagnosis Document (Client) in SmartCare?

   With a client chart open, start typing "Diagnosis Document (Client)" in the search bar and the document will become available.

2) What date do I use for the Diagnosis Document (Client)?

The Diagnosis Document (Client) should be dated on or before the date of the first billable service. For DAS the first billable service is typically the screening appointment.

3) How often must a Diagnosis Document (Client) be completed?
   - When first receiving services (walk-in screening, crisis contact, PHF admission).
   - Whenever a change of diagnosis is indicated, including at discharge.

4) Who completes and signs a Diagnosis Document (Client)?

   Diagnosis Document (Client) are completed by staff within established scopes of practice. LPHA's are responsible for making and updating the diagnosis. Interns without waiver and all trainees require clinical co-signature from a LPHA. With special arrangements made by a Program Supervisor, some staff treatment members are authorized for "add-on access" to diagnose substance use disorder(s) with LPHA consultation and co-signature (example: Certified Counselor that is trained to complete Screenings and Assessments).

   The treating MD/DO/NP/PA must concur with the ongoing diagnosis when medication support services are provided. In some instances, the Diagnosis Document (Client) will reflect the working diagnosis of the MD/DO/NP/PA.

5) What if there is a difference of opinion about a client's diagnosis?

   Although it can be worthwhile for the members of the treatment team to have a difference of opinion, eventually it is in the best interest of the client that the team discusses and agrees on a unified diagnosis. If an agreement is reached, an LPHA updates the diagnosis. If an agreement is not reached, a Clinical Supervisor is consulted.

Diagnosis Tip

A SUD diagnosis or a mental health diagnosis reported by non-treatment providers (ex. Probation, CWS) or family members should not be recorded in the chart as a substantiated diagnosis. Likewise, a client's self-report of a diagnosis would not be documented as a final determination. Instead, state for example:

- "Client self-reported a diagnosis of bipolar disorder. Clinician will assess further."
- "Client's wife reported that the client has schizophrenia. To be assessed further and release obtained to speak with client's primary care physician who is

prescribing psychotropic medication."

PROBLEM LIST

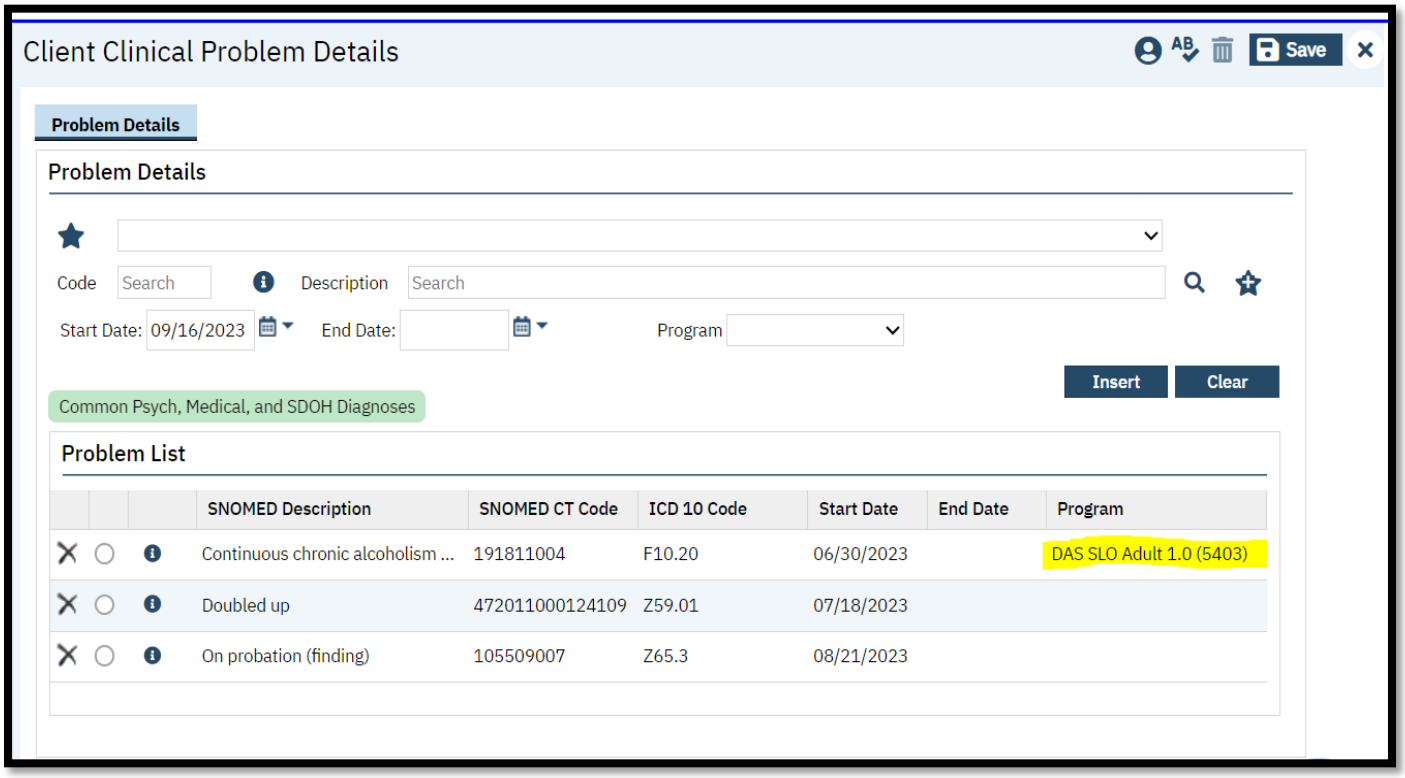
The Problem List is a dynamic list that can be added to and updated by all team members working with the client, within their different scopes of practice. Mental Health and Substance Use Disorder Diagnosis must be rendered by an LPHA, however Registered/Certified Counselors and LPT's can add psychosocial and contextual factors (Z codes). The Problem List does not need a client signature, however, needs to include:

- Name and title of person who added problem.
- Problem start date & end date.

The Client Clinical Problems Detail in SmartCare is utilized to capture the Problem List. The problem list can be added to directly on this SmartCare page. Additionally, new problems can be added to a service note and they will be automatically added to the Problem List.

The screening and assessment process will generally be completed within 30 days; therefore, the Problem List should be well-developed by different members of the treatment team. Team members can include: Clinician (LPHA), Counselor (as the primary Counselor for the client or as the case manager), medical personnel from the MAT program, etc. The problems that each of these team members help the client work on is indicated in service notes.

Problems that are added to the problem list require that a program is selected. If the Coordinated Care Consent document has been signed, all problems will be viewable (problems added by both SMHS and DMC-ODS programs).



UPDATING THE PROBLEM LIST

There is not a required timeline for the problem list to be updated. Providers shall add to or remove problems from the problem list when there is a relevant change in the client's condition.

When a new problem is identified by a provider during a service, the problem can be addressed by the provider during that service, and then the problem can be added to the problem list within a reasonable amount of time. In SmartCare, the new problem can also be added directly on to the service note.

TREATMENT ADMISSION

Access criteria is determined by a DSM 5 diagnosis(s) of a Substance Related and Addictive Disorder. If criteria is met, a client is formally admitted to SUD Treatment on the date that the SUD Assessment (CA ASAM Assessment), which must be the same date that the client is enrolled in a treatment program.

ACCESS CRITERIA: SERVICES PROVIDED AFTER THE ASSESSMENT

SUD DIAGNOSIS CRITERIA (DSM 5)

- Clients 21 years and older 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) **or** must have had at least one diagnosis from the DSM 5 for Substance-Related and Addictive Disorders prior to being incarcerated or during incarceration, determined by substance use history.

- Clients under the age of 21 qualify to receive all medically necessary services needed to correct and ameliorate health conditions (Early Periodic Screening, Diagnostic, and Treatment, EPSDT). Services do not need to be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs. Services that sustain, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and thus are covered as EPSDT services.

- The diagnosis of SUD is 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.

Specify Current Severity of the SUD:

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

Further Specifiers:

- In early remission: after full criteria for the SUD were previously met, none of the criteria for the SUD 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 SUD were previously met, none of the criteria for the SUD 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: used if the client is in an environment where access to alcohol or substances of abuse is restricted.
- On maintenance therapy: used if the client is a prescribed agonist/antagonist medication (i.e. naltrexone, buprenorphine, methadone).

DSM 5 CLASSIFICATION OF SUBSTANCES

The DSM 5 lists 10 classes of substances that have associated diagnoses.

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) substance

* 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 sole SUD. Nicotine Use Disorder is not included on the list of included diagnoses for Drug Medi-Cal. However, if client presents with a Tobacco Use Disorder in conjunction with other SUD(s), DAS medical staff can treat client for tobacco cessation.

While the Specialist/Clinician should record the class of substance in a client's diagnosis, the specific problematic substance should be identified in the assessment document and although not required, *can be* included in the comments section of the Diagnosis Document. For example:

- F11.20 Opioid Use Disorder, Moderate (Dilaudid and Heroin).

DIFFERENTIAL DIAGNOSIS

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 mental health conditions. Therefore, seek guidance/consultation from a Program Supervisor, Clinical Supervisor, and/or medical staff.

ASAM CRITERIA/LEVEL OF CARE DETERMINATION

Once access criteria is established, DMC-ODS providers must use the ASAM Criteria to determine the appropriate level of SUD treatment service for the client. This is separate and distinct from determining medical necessity.

The ASAM Criteria assessment is imbedded/included with the SUD Assessment (CA ASAM Assessment). Client placement and level of care determinations must ensure that clients are able to receive care in the least restrictive level of care that is clinically appropriate to treatment their condition.

ASSESSMENT

Assessment is the process of gathering and evaluating 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 process leads to diagnostic formulation, access criteria determination, and an initial treatment level of care recommendation. The process may be completed in one session, or if necessary, may be

completed in up to 2 sessions.

Recognizing that a client may not be willing to disclose sensitive personal information prior to the development of rapport with the Clinician (Assessment Coordinator) and engagement in treatment, assessment is an ongoing process. Assessment information is updated as the client is willing to share more information about themselves over the course of treatment.

The assessment process includes completing: CA ASAM Assessment (which includes the ASAM Criteria) and the CalOMS Admission (Client) in the EHR.

The limits of confidentiality and risks/benefits of treatment must be explained at the beginning of the assessment process and revisited as often as needed to ensure that the client understands program requirements and their personal rights.

CA ASAM ASSESSMENT

The Clinician (Assessment Coordinator) conducts the intake assessment utilizing the CA ASAM (Client) Assessment. The CA ASAM Assessment contains the following information:

- Drug/alcohol history (Dimension 1, 5).
- Medical history (Dimension 2).
- Family history (Dimension 2, 3, 6).
- Psychiatric/psychological history (Dimension 3).
- Social/recreational history (Dimension 6).
- Financial status/history (Dimension 6).
- Educational history.
- Employment history.
- Criminal history.
- Legal status.
- Previous SUD treatment history (Dimension 1, 5).

The final page of the CA ASAM Assessment is the conclusion of the assessment, which includes:

- Summary rating of each ASAM Dimension 1-6.
- Treatment recommendations.
- Relapse prevention plan.
- Level of Care Recommended.
- Actual Level of Care Received.
- Explanation if there is a different level of care received than recommended.

Template text to assist Assessment Coordinators with the completion of the CA ASAM is available in the document titled "Practice Guidelines CA ASAM."

Other optional assessment tools may be used during the assessment process including Beck Depression Inventory, Substance Abuse Subtle Screening Inventory (SASSI-3), Mental Health Adult/Youth Assessment, etc. The PHQ 9 and GAD 7 are available in SmartCare.

Some assessment activities must be conducted face-to-face with the client. A Mental Status examination and behavioral observation to formulate initial diagnostic impressions are examples. Other assessment activities may be performed either face-to-face or by telehealth or telephone and may involve family members or other significant parties without the client. For example, sensitive family and developmental history may be better collected in a separate session with the parent of a youth rather than with the youth present. Assessment services may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the client.

Assessments are typically conducted by a Clinician/LPHA (Assessment Coordinator). However, if the SUD Assessment of a client is completed by a Specialist (registered for certified Counselor), then the LPHA shall evaluate that assessment with the Specialist and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the Specialist can be conducted in person, by telehealth, or by telephone. The consultation must be documented in the client's record. Please see CA ASAM Practice Guidelines for template text/prompt to assist Counselor/Clinician with the documentation of this consultation.

Note: It is best practice and the standard for SLOBHD that the assessment be conducted face-to-face by an LPHA, however, assessments can be completed by telehealth or telephone in necessary circumstances.

If a screening or assessment is started but is not completed because the client terminates the contact or does not keep a follow up appointment, the Clinician must complete the screening or assessment to the degree possible and document the reason for the incomplete assessment in the Care Plan section of the service progress note. Additionally, indicate in the assessment (either BQuIP or CA ASAM) that the assessment was not completed and document the reason.

TIMELINESS OF ASSESSMENT COMPLETION

Providers shall use their clinical expertise to complete initial and follow-up assessments as quickly as possible, in accordance with each client's needs and generally accepted standards of practice.

Assessment Frequently Asked Questions

1) Where do I find the CA ASAM in SmartCare?

   With the client open in SmartCare, there are two ways to start a CA ASAM. First, CA ASAM can be entered in the search bar. Second, this path can be followed: Client > Documents > CA ASAM.

2) What information is critical to obtain during the assessment?

   It is imperative that every question on the assessment is answered. Assessments must have risk questions answered and include access criteria information.

3) What signatures are required on the CA ASAM Assessment?

   The CA ASAM Assessment is signed by the staff member that completed the assessment service, whether they are a Specialist or Clinician. A LPHA Co-Signature must be added for associates, interns without waiver, and for registered/certified Counselors.

Assessment Progress Note Tips

- Clinicians must give and review informational material with every client, in a language understood by the client, at the screening and assessment appointments.
- The number of assessment sessions and total time for the assessment must be reasonable and supported by the documentation contained in the Progress Note(s) and in the CA ASAM Assessment. Most comprehensive assessments will be completed in about 3-4 hours on average. Some cases require less time, while other, complex cases may require more time.
- If a Clinician sees a client on Monday and finishes the assessment write-up on Tuesday (when client is not present), the time spent writing/formulating the assessment is added to Monday's assessment and billed as one bundled service. The write up is an important part of the assessment process, but it is not a separate, stand-alone service.
- Bundle time spent with the client/family, reviewing the client's record, and writing

up the clinical assessment documentation for the total amount of service time included on the progress note.

- Please click here to view Assessment Progress Note example.

CALOMS

CalOMS Treatment (CalOMS Tx) is California's data collection and reporting system for SUD treatment services. The State collects data and compares admission, annual updates, and discharges to measure individual client progress, and uses the same benchmarks to compare between types of service and counties. Treatment providers are required to send client treatment data to DHCS each month. This treatment data builds a comprehensive picture of: client behavior, alcohol/drug use, employment and education, legal/criminal justice, medical/physical health, mental health, and social/family life. Summary reports, created from this treatment outcome data, contribute to the understanding of treatment and the improvement of SUD treatment programs in the continuum of prevention, treatment, and recovery services.

The CalOMS is completed at treatment admission for Adult and Youth admissions. The CalOMS must be dated the same date as when the client is enrolled in the treatment program. The CalOMS type at admission must match the CalOMS type at discharge. Outpatient Treatment programs use CalOMS types 1, 2, 3, and Residential Treatment programs use CalOMS types 5 and 7.

3) Type 1 = Outpatient Treatment
4) Type 2 = Intensive Outpatient Treatment
5) Type 3 = Outpatient Withdrawal Management
6) Type 5 = Residential Withdrawal Management
7) Type 7 = Residential Treatment

A CalOMS Admission (Client) is completed in SmartCare for treatment admissions. It is not necessary to open a CalOMS for the Walk-In program, Capacity List programs, or when Case Management or Recovery Support Services are being provided. For clients that go to Residential Treatment, the CalOMS Admission (Client) is completed by the Residential Program. The Residential Program also completes the CalOMS Standalone Update/Discharge.

CalOMS Frequently Asked Questions

1) Where do I find CalOMS in SmartCare?

   With the client open in SmartCare, there are two ways to start a CalOMS Admission (Client). First, CalOMS Admission (Client) can be entered in the search bar. Second, this path can be followed: Client > Documents > CalOMS Admission (Client). The CalOMS Admission can also be completed from the "To Do" widget in SmartCare.

2) What do I date the CalOMS?

   The CalOMS is dated with the date of the CA ASAM Assessment which must also match the date that the client is enrolled in a treatment program. SmartCare defaults to making the effective date the date that the CalOMS is being completed, therefore the effective date must be the first data point that is selected.

3) What signatures are needed on the CalOMS?

   The Specialist/Clinician obtaining the information signs the form and then adds the designated Health Information Technician (HIT) as a co-signer for quality/data review.

- Please click here to view the Appendix for CalOMS cheat sheet.

The most common problems that cause a CalOMS to suspend are:

- Error example: The Drug Name field is filled in for a specific drug.
- Error example: The Drug Name field is left blank and the Alcohol/Drug Problem is a generic drug. In these cases, the CalOMS will suspend if the Specialist/Clinician does not name the drug. The Specialist/Clinician must name the actual substance being used in a larger class.
    - Correct example: Drug Name is Other Opiates or Synthetics, and the Specialist/Clinician names Dilaudid as the drug being abused.
- Error example: The Age of First Use is left blank.

PROGRAM

A program selection in SmartCare serves several functions. When a client is enrolled in a program, a specific staff member is assigned as their service provider. A client can be enrolled in multiple programs when receiving services from a treatment team or multiple providers (DAS and MH). Additional staff members can be added to the client's treatment

team. A program also serves an important role in billing.

PROGRESS NOTES

GENERAL CONSIDERATIONS

Progress/Service Notes are the heart of the clinical record. A service provided for a client, regardless how powerful or effective, is incomplete until documented. Effective documentation of clinical interventions is a professional, legal, and ethical responsibility of all staff. Progress notes should use person-centered, strength-based language that acknowledges clients are more than their symptoms or substance use/mental health illness.

Service notes must document the medically necessary service provided and the planned next steps. Service notes do not need evidence access criteria. They should be written in plain language to describe to the reader what was discussed, what happened during the service, and next steps. SLOBHD Progress Notes are not process or "psychotherapy notes" defined in HIPAA (CFR 45 §164.501). Co-occurring treatment allows DMC-ODS providers to address mental health needs within a progress note documenting a substance use disorder service and vice versa.

The key functions of Progress Notes are:

1) Care Planning: service notes provide a basis for planning treatment among providers and across programs. Notes should be understandable when read independently of other progress notes. Notes should provide an accurate picture of the service provided and the future plan of care.
2) Communication: service notes allow communication between providers to coordinate care, avoid duplication of services, and improve outcomes by reflecting the service provided and next steps.
3) Reimbursement: service notes are required for verification of services as part of the client's legal health record.

Who are service notes for:

1) Client: Client access to health records will increase with technology advances and the implementation of a patient portal. Access to health records can empower clients to be more in control of their health care services.

2) Treatment team: service notes serve to keep all providers informed.

3) Yourself: documenting what happened helps clinicians formulate next steps and can serve as a reminder of past services.

What should NOT be included on a service note:

1) Lengthy narrative.
2) Copy and paste from previous notes.
3) Jargon that makes notes difficult for others to understand.
4) Protected Health Information (PHI) of family/caregivers of the client or other clients.
5) Extraneous information, especially negative comments about other staff members or other clinical disagreements, does not belong in the record.

Progress Notes must document relevant aspects of client care, including clinical decisions made, interventions used, and referrals given to the client. Progress Notes must describe how the intervention reduced a client's impairment, restored functioning, or prevented significant deterioration in an important area of life. In addition, entries in the EHR may be made after phone contact with the client or their parents, conferences with school or probation staff, or other interaction or communication with the client or another person which provides information that is clinically relevant to the client's treatment.

APPROPRIATE LANGUAGE IN DOCUMENTATION

- Third Party Information: State information gathered from third parties as a report, not a fact (ex. "Client's father reports that…").
- Recovery Language: Documentation must be written using strength-based language that reflects the culture of the client and respect for the collaborative process. Relate your interventions to a recovery-oriented paradigm. Remember that a client has broad (and rapidly increasing) access to his/her medical record.
- Protected Health Information: Documentation should be related to the health information of the client. Notes should not include PHI about the client's family member(s)/caregivers. Example, in utero substance use would be relevant information for the client's record. However, extensive information about the client's mother's medical information does not belong in the record.
- Abbreviations: Standard abbreviations are acceptable in a note. If you need to abbreviate a word or acronym that is not on the Approved Standard Abbreviation list, spell it out first, and then the abbreviation can be used throughout the rest of the document. Example:
  - California (CA)

⌘ Please click here to view Approved Standard Abbreviation list.

FREQUENCY

Every outpatient service contact must be documented in a Progress Note.

For services that are billed daily, a daily Progress Note is required. This includes:

- SMHS: MH Residential programs, STRTP programs
- DMC-ODS: SUD Residential Treatment programs.

PROGRESS NOTE TIMELINESS

Progress Notes must be completed within:

- 3 business days for routine services.
- 24-hours for crisis services.

It is essential for clinical information to be in the chart as quickly as possible to ensure we are best able to meet the needs of clients and coordinate care. Timeliness is determined by the service provider completing the progress note and signing it. If a progress note requires a cosigner, the cosigner needs to sign the note as soon as possible so that it can be finalized.

Timeliness is counted starting the day after the service. For example, if a service was provided on a Monday, the first business day for progress note timeliness is counted on Tuesday. Therefore, for the progress note to be considered timely, it must be completed and signed by Thursday that week. Additionally, if there is a holiday during the work week, the holiday is not counted as a business day for progress note timeliness.

Example timeline for a service provided on Friday, 6/27/2025 at 9:00 AM:

- Routine service: must be written and signed by the staff member who provided the service by Wednesday, 7/2/2025.
- Crisis service: must be written and signed by the staff member who provided the service by Saturday, 6/28/2025 at 9:00 AM.

For Progress Notes submitted outside of 3 business days, it is good practice for the Specialist/Clinician to document why the note is late. For example:

- "Progress note is submitted late due to additional time needed to formulate the assessment."

- "This progress note is being submitted four days after the service due to Counselor illness."
- "This progress note was completed five days after the service due to Clinician covering two additional groups due to the unplanned absences of other staff members."

Late progress notes should not be withheld from the claiming process. The timeliness of progress notes will be monitored regularly as a quality standard.

PROGRESS NOTE CO-SIGNATURE TIMELINESS

SLOBHD has set a timeliness standard for co-signatures. The timeliness standard will be 14 calendar days (10 business days) following the signature date of the service provider.

ACCURACY OF BILLING INFORMATION

The service, travel and documentation time in a Progress Note must accurately reflect the time spent providing the service and must be reasonable for the service provided. The service note documentation must support the amount of service time that is being claimed. When a service is a long length of time due to the client's presentation or due to specific circumstances, but minimal interventions were provided and documented, this additional information must be included in the note. Examples:

- The service time for an Assessment service was long because the client was frequently perseverating and distracted:
    - "This Clinician minimized distractions as much as possible and prompted the client to return/refocus on the assessment process throughout the session because the client was distracted and perseverating throughout this service."
- An Individual Counseling service was a long length of time because the client was dysregulated throughout most of the session:
    - "This Counselor focused the majority of session interventions and time on helping and the client regulate his/her/their emotional state as the client presented as highly dysregulated today."
- A Medication Training and Support service was long because the client was reporting medication concerns/side effects:
    - "This LPT gathered the list of client medication concerns and side effects that she is experiencing and communicated these to the MD who was

available for consultation."

For group counseling, the Progress Note must accurately record the amount of time each group member participated in the group. Therefore, if one client is excused to leave a group early or arrives late, the time attended must be changed.

Additional Billing Information Tips

- Billable services must include an intervention that addresses a clinical need for the client.
- Clerical tasks are not billable because no intervention occurred that would benefit the client.
- The actual number of minutes a service took should be entered. It is not acceptable to estimate the service time. Refer to the Health Agency's Fraud, Waste and Abuse Policy for additional detail.

SERVICE INDICATORS IN A PROGRESS NOTE: SERVICE TAB

Within the Progress/Service Note, service indicators are selected to indicate where and how a service was delivered, the mode of the service delivery, what service was delivered, and the length of the service.

STATUS

Counselor/Clinician must indicate the status of a service using the drop-down menu.

- Error
- Scheduled
- Show
- No Show
- Cancelled. DAS uses "cancelled" to excuse a client from a service.

PROGRAM

The program menu lists the client's current program assignments. Counselor/Clinician must indicate which program the service was provided in. If the correct program is not available, contact HIT to help with the client's program enrollment.

PROCEDURE

Counselor/Clinician must select the procedure/service name that best describes the

service that was provided.

- Please see procedure/service code section for detailed information on procedure codes.

LOCATION

Select the location of the client at the time of receiving the service. Commonly used locations are:

- Emergency Room - Hospital
- Home
- Office
- Other Place of Service (use this for a service provided at a partner agency or in the field)
- Prison/Correctional Facility
- School
- Telehealth - Audio & Video
- Telehealth - Audio Only
- Telehealth – Audio & Video – Home (choose this location if the client is participating in a service via telehealth at their home)
- Telehealth – Audio Only – Home (choose this location if the client is participating in a service via telephone at their home)

Note: For appointments with a prescriber via telehealth:

- If Provider is Remote, but Client is Present in Office for Telehealth Appointment:
  - Location: Office
  - Mode of Delivery: Video Conference

- If Provider is in Office, but Client is at Home for Telehealth Appointment:
  - Location: Telehealth – Audio Video – Home
  - Mode of Delivery: Video Conference

Note: The Board of Behavioral Sciences requires that the address of the present location of the client be documented when a service is provided via telehealth. Therefore, a sentence must be added to the progress note narrative such as:

Address of the present location of the client during telehealth service:

MODE OF DELIVERY

Counselor/Clinician must indicate the mode of the service using the drop-down menu.

- Face-to-Face
- Telephone (this should match the selected location of the service as either being Telehealth – Audio Only, or Telehealth – Audio Only – Home).
- Video Conference (this should match the selected location of the service as either being Telehealth – Audio & Video, or Telehealth – Audio & Video – Home).
- Written

CANCEL REASON

This field becomes active when “Cancel” is selected as the Status of the service. Use the drop-down menu:

- Agency/Staff Cancelled
- Consumer Cancelled (Reason Unknown)
- Consumer Cancelled (Childcare/Dependent Care Issues)
- Consumer Cancelled (Illness)
- Consumer Cancelled (Other Reason)
- Consumer Cancelled (Transport Issue)
- Consumer Cancelled (Conflict)

CLIENT WAS PRESENT

- Checking the "Client was present" box means the service was delivered directly to the client via face-to-face, telehealth, or telephone.
- This box is automatically checked.
- Uncheck this box if the client was not present for the service. Examples:
    - TCM service which took place on the telephone and focused on a discussion about a referral with a partner from another agency.

COLLATERAL PERSON(S) PRESENT

For collateral person(s) that were present during a service, use this text field to name the role/relationship to the client. More than one collateral person can be entered. Do not enter the name of the collateral(s). Examples:

- Guardian
- Friend/Sponsor.

Collateral:	Non-Collateral:
Significant support person(s) in a client's life who are not present because of their employment	Individuals who also support a client's treatment
Examples: • Parent/family member • Friend • Love interest/partner • Coach • Clergy • Neighbor • Service group leader	Examples: • Social Worker • Probation Officer • Teacher • CASA workers

Additional Details/Tips

- If both the client and collateral people are present, then the "Client was present" field should stay checked AND the "Collateral Person(s) present" field should be filled out.
- If the service was delivered to a collateral person, such as a parent or guardian, and the client was not there, then "Client was present" should be unchecked and the name and relationship of the collateral person should be typed into the "Collateral Person(s) present" field.
- Collateral people are individuals who are important to the client. If you are meeting only with another provider to coordinate care for the client, such as a Therapist and a Peer Support Specialist, both fields should be left blank.

EVIDENCED BASED PRACTICE

Counselor/Clinician, if trained in a utilized EBP for the service, must select the EBP from the drop-down menu.

Commonly used EBP's utilized by DAS are:

- Family Psychoeducation (ex: Celebrating Families)
- Integrated Dual Disorder Treatment (used by cooccurring programs)
- Illness Management & Recovery (used by cooccurring programs)

TRANSPORTATION SERVICE

This field defaults to "No." Enter information if transportation services were provided to the client by selecting from the drop-down menu.

START DATE

Enter the date of the service. This will automatically fill-in if the service was scheduled from the SmartCare calendar.

START TIME

Enter the time that the service started. This will automatically fill-in if the service was scheduled from the SmartCare calendar.

TRAVEL TIME (FOR INDIVIDUAL SERVICES)

When travel in relation to a service occurs by a Specialist/Clinician, total travel time must be recorded in the Progress Note encounter. Travel time is not billed as part of the service claim, but it must be entered so that data about staff time/activities can be studied over time to evaluate the overall costs of providing and being reimbursed for behavioral health services.

When traveling to provide a service, while not required, it is encouraged that the Specialist/Clinician also briefly document the travel information in the narrative. Examples:

- Clinician traveled round trip to a Multidisciplinary Team meeting at Social Services.
- Counselor traveled to the client's residential program for this case management service (one way).

Note: Travel time is different from transportation. Please see later information about transportation.

DOCUMENTATION TIME

The Specialist/Clinician must record the total time that was spent completing the Progress Note for individual services in the Progress Note encounter. Documentation time is not billed as part of the service claim, but it must be entered so that data about staff time/activities can be studied over time to evaluate the costs of providing and being reimbursed for behavioral health services. However, if concurrent or collaborative documentation was completed during the service, documentation time must not be added.

DOCUMENTATION TIME GROUP SERVICES

The Specialist/Clinician must record the total time that was spent completing the Group Counseling Progress Note in the Progress Note encounter for each participant. This includes time spent recording client attendance.

SERVICE TIME

In SmartCare, service time includes all modes of service delivery including face-to-face, telephone (telehealth audio only), video conferencing (telehealth video + audio), and written. This field is where staff should capture the total service time, which for screening and assessment services includes time spent completing the screening and assessment documentation and time spent reviewing the client record (electronic record and intake paperwork).

For group counseling, the Progress Note must accurately record the amount of time each group member participated in the group. Therefore, if one client is excused to leave a group early or arrives late, the time attended must be changed.

Note: Time spent fulfilling mandated reporting activities can be added to the total service time of a service. Time cannot be claimed for completing the written report, however time can be claimed for coordinating/consulting with Child Welfare Services/Adult Protective Services to ensure client safety.

ATTENDING

Do not use this field.

REFERRING

Do not use this field.

INTERPRETER SERVICES NEEDED

Select “yes” if interpreter was needed and enter the interpreter’s agency/name.

LANGUAGE SERVICE WAS PROVIDED IN

If the service was provided in a language other than English, use the drop-down menu to select the language. Complete this if the staff member providing the service provided the service in another language, or if an interpreter was utilized.

PROGRESS NOTE CONTENT

Progress Notes must include the following elements which are chosen in the service indicators or are captured in the background of SmartCare:

- Service type (chosen in procedure code)
- Date of service
- Duration of service, including travel and documentation time
- Location of the beneficiary at the time of receiving the service
- Typed or legibly printed name, signature of the service provider and date of signature
- ICD 10 code (on billing diagnosis tab of progress note)

The content of the Progress Note must include the **Interventions** provided by the treating Specialist/Clinician and the **Plan**. These are the minimum requirements for the content of the Progress Note. The Specialist/Clinician can document more (such as Client Response and Client Progress) as clinically indicated.

1) Narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom(s), condition, diagnosis and/or risk factors). Provider interventions.
2) Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.

PROGRESS NOTE STRUCTURE: NOTE TAB

In SmartCare, the progress note prompts following:

1) PROBLEMS ADDRESSED DURING THIS SERVICE
2) INFORMATION (Describe current service(s), how the service addressed the client's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors):

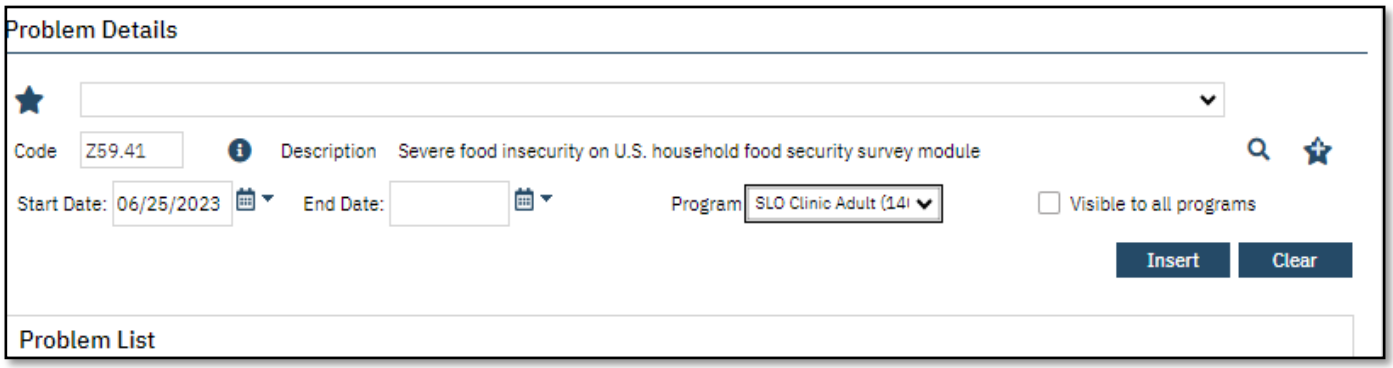
3) CARE PLAN (Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the client. Include how the client or their representatives helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan):

PROBLEMS ADDRESSED DURING THIS SERVICE

The problems listed on Client Problem List Details will be available for selection in this part of the progress note. The problem(s) that were focused on during the session must be selected here.



New problems can be added to the Problem Details section of the note by adding an ICD 10 code in the "Code" field, or searching for a problem in the "Description" field. After the appropriate problem is selected, click insert to add the problem to the Problem List.



INTERVENTIONS

The "Information" section of the note is where the Specialist/Clinician must document their interventions. It is not necessary to write an extensive narrative of dialogue during a session or to restate the client's diagnosis or impairment in each note. Interventions are what staff did for the client during the contact to reduce the client's impairments due to their SUD or mental illness, or to prevent deterioration in functioning. Clearly written interventions are the primary proof that the service provided addressed the beneficiary's condition and are the most important part of the note. Bulleted phrases or narrative text are equally acceptable writing styles. Most interventions are directed toward the client,

but sometimes directed toward someone other than the client (ex. family).

Intervention Starters:

Acknowledged, Assisted, Brainstormed, Clarified, Created, Defined, Developed, Discussed, Encouraged, Engaged, Explained, Explored, Facilitated, Identified, Inquired, Modeled, Normalized, Practiced, Praised, Prompted, Provided Feedback, Reframed, Reinforced, Reminded, Reviewed, Solicited, Suggested, Supported.

- Click here to view the Interventions Starter list in the Appendix.

PLAN

Completing this section of the progress note is required. The Care Plan section of the progress note will carry forward to future progress notes in the same program. It is important that this information is updated/edited to avoid notes with duplicative text.

The "Care Plan" section of the progress note is where the Specialist/Clinician must document the plans related to treatment. This can include the plan for the next service or staff plans to follow up on specific treatment issues (ex. referrals, crisis follow up). The Plan could also include plans/action steps identified that the client plans to take. This section can contain plans for goals that are short-term or long term, and this section can also include overall information about client progress.

- Short-term plans for treatment such as action steps the provider will take, actions that the client has agreed to, next appointments, or plans for coordination with other treatment providers. Examples:
    - Next appointment is scheduled with _____ on _____.
    - Client will complete their physical/dental examination on ____.
- Long-term care plans or goals. This information may not change for each service. Examples:
    - Staff will continue to support client/provide services to address ____.
    - Staff will continue to provide individual and group counseling, case management, and MAT medication management to assist client with improving functioning in the areas of ____/reducing symptoms of _____.
    - Client wants/plans to seek employment (or return to school).
- Optional content: Client Progress. While interventions and plan/next steps are the required elements of a progress note, it can be clinically important to document

the client's progress in treatment. Without occasionally documenting progress/regression, it can be difficult for treatment team members to identify how the client is doing in overall in their services and areas of life functioning. Examples:

- Client has consistently attended all services for two months. Client has improved in their ability to cope with stressors and has voiced a reduction in anxiety (1-2 days of anxiety experienced per week as opposed to 6-7 days at the start of treatment).
- Client has recently regressed (last two weeks) in their treatment plan goals by starting to spend time with peers that use. Client reports that they have not relapsed, but that being present with these peers has increased their experience of triggers.
- Client reports 3 months of consistent medication regimen.
- Client appears to be working on the stabilization of their living environment as evidenced by moving in with a roommate that does not use drugs or alcohol.
- Client attended 1 out the last 3 individual/group counseling sessions.

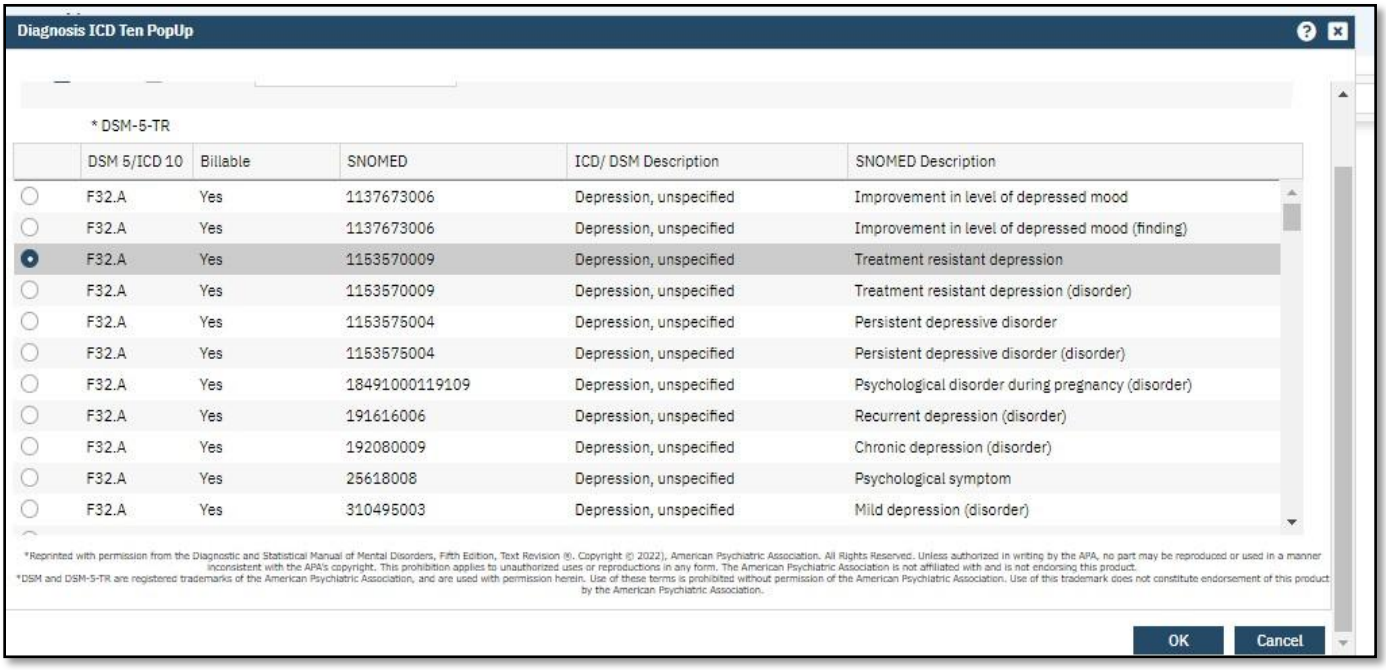
⌘ Please click here Individual Counseling Progress Notes example.

DIAGNOSIS: BILLING DIAGNOSIS TAB

There must be a diagnosis(es) on the Billing Diagnosis tab for the note to be completed and to generate a claim. When there is a Diagnosis Document entered for the program under which a service was provided, the Billing Diagnosis tab lists the ICD 10 diagnosis(es). The Billing Diagnosis tab lists the ICD 10 diagnoses from the Diagnosis Document associated with the program for which the service was provided.

If a provider is documenting a service provided prior to establishing an ICD10 diagnosis, the provider may add a one-time billing diagnosis on this tab by clicking the "ICD 10" icon, selecting the appropriate diagnosis, and click "OK."





GROUP PROGRESS NOTES

LIST OF GROUP PARTICIPANTS

For outpatient treatment services, the Group List is maintained in the EHR. Therefore, it is important to make sure that the list of group participants is kept up to date and accurate.

TWO GROUP FACILITATORS

When there is more than one Specialist/Clinician providing a group service, one progress note is sufficient. The progress note must include information about the specific involvement and specific amount of time of each Specialist/Clinician in the group activity, including time spent traveling to/from the service and documenting the service. The service must be within the scope of practice of both staff.

GROUP SIZE

A group can be billed to DMC-ODS when there are between 2-12 participants only.

- For groups where only 1 participant attends, follow the directions in the Group Service Tip section.
- More than 12 clients can be enrolled in a group, but only 12 can participate.

"GROUP NOTE SUMMARY" SECTION

GROUP INTERVENTIONS:

Write the focus/purpose of the group here. Examples:

- "The goal of the group is to develop conflict resolution skills to help clients improve social relationships."
- "The group focused on teaching budgeting skills to help clients maintain housing."

Next, document specific skill building interventions provided to the entire group in this section. Examples:

- "Specialist utilized the EBP Moral Reconation material and facilitated a group on the topic of honesty.
- "Clinician used the Seeking Safety curriculum and facilitated a group on the topic of safety.
- "Case Manager taught the group to develop a budget by listing expenses."
- "Welcomed new group member, reviewed group rules, and lead discussion about confidentiality."
- "Modeled effective communication…"
- "Rehearsed…"
- "Role played…"
- "Practiced…"
- "Provided materials and reviewed information on…"
- "Facilitated discussion about resources for…"

"CLIENT NOTE" SECTION

PROBLEMS ADDRESSED DURING THIS SESSION

The problems listed on Client Problem List Details will be available for selection in this part of the progress note. The problems that were focused on for each client during the session must be selected and individualized here. New problems can be added to the Problem Details section of the note.

CLIENT RESPONSE & PLAN

1) Individualize the note by listing any interventions or decisions for each group member.
2) Document a brief description of how the client responded to the service. Each

client has unique interactions with other group members and reactions to the topic; document the individual responses as appropriate.

3) Document plan/next steps for the client related to treatment. This can include the plan for the next service or staff plans to follow up on specific treatment issues (ex. referrals, crisis follow up). The Plan could also include plans/action steps identified that the client plans to take. The Specialist/Clinician can choose to individualize the Progress Note further and discuss the client's overall progress or regression in treatment, in measurable terms.

Group Service Tips

1) Time spent preparing for a group session (i.e. researching or modifying group material) is not time that can be claimed as service time. Clerical functions (photocopying, shopping for supplies, setting up the room, etc.) are not billable interventions and are not included in the progress note.
2) When one client is in attendance for a group service:

- Leave group service in SmartCare (do not delete).
- Group Progress Note:
  - Use "cancel" or "no show" on the progress note service indicators as appropriate for each client scheduled to be in the group. Excuse the sole client that attended the group by choosing "cancel."
    - For the cancel reason, chose "Agency/Staff Cancelled" for the client that attended and is provided an individual service.
  - In the progress note narrative write "Group cancelled due to one client in attendance."
  - On the group note summary portion of the group note for the sole client that attended, write "Individual session held with client in lieu of group because client was the only person in attendance."
  - The client note section tab will gray out when "Cancel" or "No Show" are selected for the status field.
  - Because there is not a comment box available on the group progress note when a service is cancelled or a client does not show, information such as the reason why a client was excused must be entered in a "Client Non-Billable Must Document" individual service note.
  - The Specialist/Clinician must document an individual service for the sole

client that attended. The treatment staff member can decide what service to provide based on the client's presentation and needs (example: Individual Counseling or Case Management).

3) When a group service is cancelled (examples: Counselor ill and group not covered, group not held due to an all-staff training):
   - Leave group service in SmartCare (do not delete).
   - Progress Note:
     - Use "cancel" on the progress note service indicators for each client in the group.
     - Use "Agency/Staff Cancelled" for the cancelation reason selection.
     - In the progress note narrative it is okay to write "Group cancelled by clinic due to…"
4) When a recurring service (groups or individual sessions) falls on a Federal Holiday, the service should be cancelled.
   - Leave service in SmartCare (do not delete).
   - Cancel the service and select the cancel reason "agency/staff cancelled."
   - In the Group Summary box or Comments box (for individual services), write "Service cancelled due to holiday."

NON-BILLABLE NOTES

A "Client Non-Billable Service Note Must Document" is created when a Specialist/Clinician wants to document an unscheduled activity during which no service was provided. Here are some examples:

- Leaving a message for a treatment team member.
- Listening to a voice message that requires documentation.
- Clerical tasks (scheduling, faxing).

Note: When a clerical activity is part of a longer billable service, it is not necessary to write a separate informational note. Document the clerical activity but clearly indicate that the clerical activity was not billed.

TARGETED OUTEACH NOTE (NON-BILLABLE)

A Targeted Outreach note is created when a Specialist/Clinician wants to document an

attempt to reach the client that was not successful. The use of this specific progress note will help outreach attempts stand out in the record from other documentation. Example:

- Outreach call and client does not answer.

CASE MANAGEMENT PROGRESS NOTES

Case management individual service Progress Notes are completed with the format of Interventions and Plan.

PROBLEMS ADDRESSED DURING THIS SESSION

The problems listed on Client Problem List Details will be available for selection in this part of the progress note. The problems that were focused on during the session must be selected here. New problems can be added to the Problem Details section of the note.

INTERVENTIONS

The interventions that the Case Manager Specialist/Clinician performed are listed in this section. These are the staff actions that occurred to assist the client in identifying or achieving needs. Examples are:

- "Assisted Client with phone call to Social Services to make an appointment for food stamps. Rehearsed phone call with Client."
- "Researched current Sober Living Environment openings and provided client with 2 program names and contact information where there were available beds."
- "Collaborated between Client's Mother (release on file) and Residential Treatment Facility to plan for the client to arrive via family transportation at Residential Treatment tomorrow at 11:00 AM."

PLAN:

The plan that the client makes, coordination that will occur, or the plan for future services are listed in this section. Examples are:

- "Client completed her physical examination today and scheduled her dental examination. Client will attend this appointment on xx/xx/xx."
- "Client obtained an appointment at Social Services for xx/xx/xx at 9:00 AM. This Case Manager will provide Client with transportation to the appointment."
- "Client was accepted into a Sober Living Environment and will move in today."

TRANSPORTATION DURING CASE MANAGEMENT SERVICE:

Transportation, when provided during a case management service, to link a client to physical healthcare, mental healthcare, medically necessary treatment, and other ancillary services is an Intervention. Therefore, transportation is recorded in the service time. The details of transportation must be recorded in the narrative section of the Progress Note. Examples:

- "Provided transportation to Client from DAS SLO Clinic to medical appointment to continue to link the client to physical healthcare."
- "Provided transportation to Client from GB DAS Clinic to medical appointment. Transportation was round trip."
- "Provided transportation from DAS Atascadero Clinic to Residential Placement at Bryan's House."

⌘ Please click here to view Progress Note Time Entry Guidance

SIGNATURE

To complete a progress note, simply click "Sign," and a PDF of the note will be created.



To add a co-signature, or ensure your clinical supervisor's co-signature has been added to the note, click the "More Detail" + icon to the right of Sign (shown above).

Electronically sign progress notes as soon as possible after the content is complete to create a date and time stamp that verifies when you wrote the note. You may edit a progress note that you were the author of by selecting the "Edit" icon next to Sign (shown above). This will create a new progress note document. The original progress note document will be saved in the client's record, but will be replaced by the new, edited version on the Service Note list page.

Progress Note Tips

- Any new problems/treatment issues must be documented in the Progress Note.
- Attempts to contact the client should be entered in a Progress Note when there is a no-show for a service(s). However, the time spent outreaching a client cannot be billed (unless the client is able to be contacted and interventions other than

scheduling are provided).
- The service minutes must be documented (do not round time).
- Do not use names of other people in progress notes. Instead, refer to the relationship such as "wife," "spouse," "sponsor," "Probation Officer."
- For Screening and Assessment, the entire information recorded on the corresponding forms is not repeated in the Progress Note. The Progress Note should include summary information about the service, interventions, and decisions made about treatment.
- Do not copy/paste notes.
- Use plain language, no jargon.
- Use person-centered language.

BUNDLING SERVICES/INTERVENTIONS

Services must be bundled for the same procedure code/service type provided on the same date. If not bundled and entered separately, there is risk of Medi-Cal denying one of the services because it might be considered a duplicate service.

To save time, bundle like services/interventions that take place during the same date of service by the same provider into one progress note. Example:

- Do Bundle: On the same date, TCM was provided directly to client for 30 minutes in the morning, and then on behalf of the client for 60 minutes in the afternoon (contacting resources, collaborating with other professionals, linking client to services). Write one progress note for 90 minutes.
- Do Not Bundle: On the same date, Individual Therapy/Counseling provided directly to client for 60 minutes, then TCM service provided to the same client for 30 minutes by the same provider. These are two separate progress notes because the services rendered are different.

Bundling can be documented in the narrative of the progress note in two different ways, depending on staff preference.

1) Bundle by noting time spent on each activity. Example of 115-minute bundled service:
    - 11:15-12:05 PM: Contacted three Sober Living providers to inquire about availability for placement (ROI in place). Provided information about one available bed/placement to client's primary Counselor.
    - 3:00-3:25 PM: Provided client with Sober Living contact information when client

returned this Case Manger's phone call and notified client that a bed/placement was available immediately. Assessed for client needs for transportation to Sober Living and learned that the client had a relative that was prepared to take them this evening. Discussed Sober Living funding plan with client (sober living will be funded 100% for the first 2 months of placement by AB109 program). Contacted Sober Living owner to notify of client's intention to make contact and enter the sober residence today.

- 5:15-5:55 PM: Confirmed by telephone call to Sober Living owner that the client arrived at the residence. Communicated this information to client's team (PO and client's primary Counselor). Completed Sober Living authorization form and sent copy to Sober Living owner via fax.

2) Bundle by timeframe. Example of a 260-minute bundled service:

- Prior the face-to-face assessment, reviewed client's medical record to identify historical clinical information, safety concerns, and history of treatment (35 mins).
- Reviewed consents and informing materials with client/client's parent or guardian to ensure their understanding. Discussed confidentiality and the limits of confidentiality including mandated reporting and safety (self and others). Completed compressive assessment with client/client's parent or guardian to gather psychosocial information, and information about current concerns and functioning (2.5 hours).
- Formulated the client's strengths and needs in the MH Assessment dated 6/12/2026 which includes access criteria for services and diagnostic information (75 mins).
- Scheduled a follow-up appointment with client/family on 6/15/2026 to discuss treatment recommendations and next steps.

NO SHOWS & OUTREACH

When a client fails to show for a scheduled service and does not contact their assigned Specialist/Clinician, it is best practice that the Specialist/Clinician complete an outreach phone call. When resolving a service as "no show," the service provider must go a step further and document an outreach attempt in the Comments box that is available. Examples:

- "Client FTS. This Specialist left client a phone message to follow-up on his absence today."
- "April FTS for the third time this week. Specialist left a second phone message to outreach April to encourage her return to services. CWS Social Worker contacted and message left to coordinate case management."
- "FTS for 4 services. Due to Howard's homelessness and no cell phone, Clinician is not able to call him or send a letter."

When a client stops attending treatment, it is important to conduct outreach and to document outreach attempts. A minimum of 3 outreach attempts is recommended. A Discharge Summary might state:

- Clinician attempted outreach calls on 3 occasions (see progress notes). Client has not been in contact with Clinician for 30 days and therefore case will be closed. Probation notified xx/xx/xx."

TYPES OF SERVICES (PROCEDURE/SERVICE CODES)

All outpatient SUD treatment services must be provided by a Registered/Certified Counselor, or LPHA (see section: Definition of Key Terms).

⌘ Please click here to view the full Service Code Crosswalk

EVIDENCE BASED PRACTICES (EBP)

It is required that a minimum of two EBP's are used in all SUD treatment service programs. All providers must use two of the following: Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Relapse Prevention, Trauma Informed Treatment, and Psycho-Education. EBP curriculums used by DAS include:

- Matrix Outpatient Model
- Helping Women Recover/Helping Men Recover: gender specific trauma-based service.
- Seeking Safety: gender specific trauma-based service.
- Moral Reconation Therapy (MRT): treatment of criminogenic factors.
- Integrated Dual Diagnosis Treatment (IDDT): Co-Occurring Disorders.

- Illness Management and Recovery (IMR): Co-Occurring Disorders.
- New Directions: treatment of criminogenic factors.
- Interactive Journaling: youth treatment.
- Prime for Life or Prime Solutions Group

When an EBP curriculum is used, it is important that the curriculum is followed with fidelity.

SCREENING/ASSESSMENT SERVICES

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
SUD Screening	Alcohol and/or drug screening, 15 Mins (H0049)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	Screening to determine the appropriate services for an individual seeking treatment.	Prescribers, BH Clinicians, AOD Counselors Detail: MD/DO, PA, Psy, LCSW, LMFT, RN, NP, LPCC, AOD
SUD Assessment	Alcohol or Drug Assessment, 15 Mins (H0001)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Use to determine the ASAM Criteria. • Assessment may be initial and periodic. • May include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary.	Prescribers, BH Clinicians, AOD Counselors Detail: MD/DO, Pharma, PA, Psy, LCSW, LMFT, RN, NP, LPCC, AOD

CASE MANAGEMENT SERVICES

Case management services assist clients in accessing needed medical, educational, social, prevocational, rehabilitative, or other community services. Case Management services also focus on coordination of SUD treatment and integration with physical health and

mental health care to monitor and support comorbid health conditions. Case Management services help clients move through the system and access other needed health and ancillary services to support their recovery. Case Management is provided to a client in conjunction with all levels of treatment.

Case management services can be provided in clinical and non-clinical settings (including the community) and can be provided face-to-face, by telehealth or telephone. Case management can be provided by an LPHA or a Registered/Certified Counselor.

Should case management be provided in the community, the location of the service and how confidentiality was ensured must be documented. Examples:

- "Employee badge was removed."
- "A meeting room as obtained with a door."
- "Paperwork was covered."
- "Client and Case Manager relocated meeting area when other people moved into the area."

Case management comprises of coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

Case Management activities related to making a referral include discussing a resource with a client, contacting the resource, completing a written referral form, helping a client access the referral and following up to make sure the connection happened. A referral is considered complete when the referral source accepts responsibility for providing a service. Multiple components of a referral completed on the same day for a client may be bundled together as part of one Case Management Progress Note.

Examples of Case Management:

1) "During service, Specialist/Clinician contacted Mental Health Therapist to coordinate care."
2) "Specialist/Clinician referred client to Managed Care (CenCal) for mild/moderate mental health services."
3) "Following case management service, Specialist/Clinician called Probation Officer (PO) and gave him an update on client's progress in treatment in the areas of…"

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Targeted Case Management (TCM/ICC)	Targeted Case Management, 15 Mins (T1017)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Used for SUD case management/care coordination. • Coordination with primary care and mental health care providers to monitor and support comorbid health conditions. • Ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, and mutual aid support groups.	All Detail: MD/DO, PA, Pharma, Psy, LCSW, LMFT, NP, LPCC, AOD, RN, LVN/LPT
Report Generation for Care Coordination	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals,	Min Time: 8 Min Billed: Code is Not Extended Past 15 Min Billing: Claims 1 Unit if 8 Min of Service Provided	• An LPHA can use this code for writing a Treatment Court Report (not a legal court report, ex. Return to Court report). • A medical staff member (LVN/LPT, RN) can use this code to document preparing reports for other individuals, agencies, etc. for the purposes of care	Prescribers, BH Clinicians Detail: MD/DO, PA, Psy, LCSW, LMFT, RN, NP, LPCC, LVN/LPT

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
	agencies, or insurance carriers, 15 Minutes (90889)		coordination (not for legal purposes).	

COMPLETING PAPERWORK WITH A CLIENT

Clients often ask for help with forms and paperwork. If all you do is type or fill out a form for a client, then you are not providing a billable service because your license and/or training are not necessary to accomplish the task. However, the intervention(s)/service you provide while helping a client complete paperwork or access a service may be billable as Case Management. In general, if you emphasize what you did that required your specific training and professional skill, then the service you provided (linking, collaborating with or teaching the client how to access resources) may be billable. In your Progress Note, focus less on the unbillable clerical part (typing/filling out the form) and include more about your interventions and how they helped the client.

Tips for Documenting Paperwork Completion

- Bundle the completion of the form with a face-to-face service with the client.
- Focus on the interventions you provided and how those interventions helped your client by reducing impairment or to reach treatment goals.
- Be specific about the symptoms would prevent the client from filling out the form independently.
- Write about what might happen to the client if you don't help (ex. deterioration, need for a higher level of care).
- Indicate in your note that you are billing for the interventions, not the typing/completion of the form(s).

Here is an example of a Case Management Progress Note that follows these tips:

Interventions:

Mary arrived for her scheduled appointment and asked this Specialist/Clinician to help link her to Housing Authority of San Luis Obispo. Mary reports that she is losing her housing in two months, and she is worried that this will place her sobriety in jeopardy if

she loses this structured part of her life. Mary's worry around this issue includes a high degree of disorganization and prevents her from completing the application or accessing community resources on her own. Without assistance, she is highly likely to deteriorate to the point that a higher level of care.

- Helped Mary identify needed resources and supports.
- Discussed the importance of action (versus passivity) to reduce her worry.
- Reminded Mary of her treatment gains and successes.
- Prompted her to use her coping skills to reduce level of distress in session.
- Assisted her in formulating answers and completing application.
- Helped Mary develop a plan for managing anxiety while waiting for response to her application.
- Typed and electronically filed her application (15 minutes, not billed).

Plan:

The application was submitted. The plan is for this Clinician to support Mary with checking the status of her housing application at the next session.

⌘ Please click here to Case Management Progress Note example.

INDIVIDUAL COUNSELING SERVICES

An individual counseling service is typically a 1:1 interaction between a client and a Specialist/Clinician which focuses on the identification and resolution of alcohol and/or drug-related problems. Also examined are personal attitudes and behavior and other barriers to recovery.

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Individual Counseling	Behavioral Health Counseling and Therapy, 15 minutes (H0004)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Includes contacts with the client. • Individual Counseling can also include contact with other family members or other collaterals for the purpose if the purpose of the	All Detail: MD/DO, PA, Psy, LCSW, LMFT, RN, NP, AOD

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
			collateral's participation is to focus on the treatment needs of the client by supporting the achievement of the beneficiary's treatment goals.	
Psychoeducation	Psychoeducational Service, per 15 minutes (H2027)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Includes providing information regarding mental illness and substance abuse. • Teaches problem-solving, communication, and coping skills to support recovery and resilience.	All Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, LPCC, AOD
Client Education	Skills training and development, per 15 minutes (H2014)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Use for Patient Education Services. • Education for the client on addiction, treatment, recovery and associated health risks. • Treatment planning is a service activity that consists of development and updates to documentation needed to plan and address the client's needs, planned interventions, and to address and monitor a client's progress and restoration to	All Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, LPCC, AOD

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
			their best possible functional level.	
Family Therapy—client not present	Family Psychotherapy (Conjoint psychotherapy without Patient Present), 26-50 minutes (90846)	Min Time: 26 Billed: If service extends beyond 58 mins, T2021 can be billed (therapy substitute) Billing: Claims 1 Unit if 26 Min of Service Provided	• Family members are included in the treatment process, provided with education about factors that are important to the client's recovery as well as the holistic recovery of the family system. • Family members can provide social support to the client and help motivate their loved one to remain in treatment. • Utilized when the client is not present. • Based on clinical judgment, the client is not present during the service, but the service is for the direct benefit of the client.	Prescribers, BH Clinicians Detail: PA, Psy, LCSW, LMFT, NP, LPCC
Family Therapy—client present	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes (90847) Add-on Code G2212 can be used to document a Family Psychotherapy service that goes beyond 50	Min Time: 26 Billed: If service extends beyond 58 mins, T2021 can be billed (therapy substitute)	• Utilized when the client is present.	Prescribers, BH Clinicians Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, LPCC

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
	minutes (G2212 is in 15 minutes increments). SmartCare will automatically add these add on codes if staff enter time longer than the procedure code's maximum.	Billing: Claims 1 Unit if 26 Min of Service Provided		
Family/Couple Counseling	Alcohol and/or substance abuse services, family/couple counseling (T1006)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Alcohol and/or substance abuse services provided with a family/couple.	All Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, LPCC, AOD

CRISIS SERVICES

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
SUD Crisis Intervention	Alcohol and/or drug services; crisis intervention (outpatient) (H0007)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• SUD Crisis means an actual relapse or an unforeseen event or circumstance, which presents to the client an imminent threat of relapse. • If client is experiencing thoughts/risks such as Danger to Self, Danger to Others, or Grave Disability, use this procedure code and document in the service note to how the safety concerns are connected to the client's SUD (ex. risk of relapse, safety concerns intensified due to substance use). • Services should focus on alleviating the crisis	All Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, AOD, RN, LVN/LPT

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
			problem, be limited to the stabilization of the client's immediate situation and be provided in the least intensive level of care that is medically necessary to treat their condition.	

⌘ Please click here to view Crisis Intervention Progress Note example.

Crisis Progress Note Tips

- A common reason for disallowed crisis sessions are failure to document the client's relapse or imminent threat of relapse, or documentation that shows services being provided beyond stabilization of the client's emergency.

GROUP COUNSELING SERVICES

Group counseling services are intended to assist clients in identifying attitudes and behaviors specifically connected to their SUD and the resulting issues with functioning, and to provide support for positive changes in lifestyle and recovery. In addition, group counseling helps clients to address personal, family, educational/vocational and other problems related to substance use. Group Counseling is a face-to-face contact in which one or more Specialist/Clinician's treat two or more clients at the same time (with a maximum of 12 in the group), focusing on the needs of the individuals served.

Should more than one Counselor/Clinician render a group service, one progress note may be completed for a group session and signed by one provider. While one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each Counselor/Clinician of the group activity, including documentation time.

In addition to the EBP Groups listed on pages 54-55, the Specialist/Clinician has the flexibility to provide other groups that do not use an EBP curriculum. These can include a general process group, education group, parenting group, or a multi-family group.

Groups can also focus on health topics such as Naloxone, Tobacco Cessation, HIV, HepC.

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Group Counseling	Alcohol and/or drug services; group counseling by a clinician, 15 minutes (H0005)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Face-to-face contacts in which one or more therapist or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served.	All Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, LPCC, AOD
Multiple-Family Group Psychotherapy	Multiple-Family Group Psychotherapy, 15 minutes (90849)	Min Time: 43 Min Billed: If service extends beyond 92 mins, T2021 can be billed (therapy substitute) Billing: Claims 1 Unit if 43 Min of Service Provided	• Family therapy group that includes multiple families.	Prescribers, BH Clinicians Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, LPCC

⌘ Please click here to Group Counseling Progress Note example.

CONSULTATION SERVICES

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Medical Team Conference, Participation by Physician.	Medical Team Conference with Interdisciplinary Team of HealthCare Professionals,	Min Time: 30 Mins (Up to 1440 Mins)	• Only the DMC-ODS providers directly rendering care to the client can bill for Clinician Consultation.	MD/DO

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Pt and/or Family Not Present	Participation by Physician. Patient and/or Family Not Present, 30 mins or More (99367)	Billing: Claims 1 Unit if 30 Min of Service Provided	The "consulting" physician cannot bill Clinician Consultation.	
Team Case Conference with Client/Family Absent	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non-Physician. Patient and/or Family Not Present. 30 Minutes or More (99368)	Min Time: 30 Mins (Up to 1440 Mins) Billing: Claims 1 Unit if 30 Min of Service Provided	• Clinicians (LPHA's) consulting with licensed professionals (addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists to support the provision of care. • Only the DMC-ODS providers directly rendering care to the client can bill for Clinician Consultation. The "consulting" clinician cannot bill clinician Consultation.	Prescribers, BH Clinicians Detail: MD/DO, Pharma, PA, Psy, LCSW, LMFT, RN, NP, LPCC
Physician-to-Physician Consultation	Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Minutes (99451)	Min Time: 5 Minutes (Up to 15 Mins) Billing: Claims 1 Unit if 5 Min of Service Provided	• Only the DMC-ODS providers directly rendering care to the client can bill for Clinician Consultation. The "consulting" clinician cannot bill Clinician Consultation.	MD/DO

MEDICAL/MEDICATION SERVICES

PSYCHOTROPIC MEDICATION SERVICES

DAS offers some psychotropic medication services to clients in SUD outpatient treatment services with mild to moderate mental illness. It is most often clients receiving forensic services, post-release treatment services, co-occurring treatment, and Medication Assisted Treatment that access psychotropic medications services from DAS. In some cases, the

client may be referred to their primary care provider, Mental Health, or to CenCal/CHC for psychotropic medication needs.

MEDICAL INDIVIDUAL SERVICES

For medical and physical wellness concerns associated with SUD's, some medical services can be provided at DAS.

WITHDRAWAL MANAGEMENT SERVICES

WM, also called ambulatory withdrawal, is a medically monitored detoxification process. Access criteria for WM must be determined by the Medical Director or designee, or an LPHA. Some of the medications used for Withdrawal Management are: Librium, Naltrexone, Buprenorphine. The goal of Withdrawal Management is to safely illuminate the physical signs and symptoms of withdrawal.

The components of Withdrawal Management services are:

- Intake: The process of admitting a client into a SUD treatment program. Intake includes the evaluation or analysis of SUD's, the diagnosis of SUD's, and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for SUD treatment.
- Observation: The process of monitoring the client's course of withdrawal. To be conducted as frequently as deemed appropriate for the client and the level of care the client is receiving. This may include but is not limited to observation of the client's health status.
- Medication Services: The prescription or administration related to SUD treatment services, or the assessment of the side effects or results of that medication, conducted by staff lawfully authorized to provide such services within their scope of practice or license.
- Discharge Services: The process to prepare the client for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

Withdrawal Management services can be documented by medical staff (MD, DO, NP, PA, RN, LPT/LVN).

MEDICATION ASSISTED TREATMENT (MAT)

MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of SUD's. MAT includes the ordering, prescribing, administering, and monitoring of all medications for SUD's. Opioid

and alcohol dependence have well established medication options. Some of the medications used for the treatment of SUD's are: Buprenorphine, Naltrexone, Disulfiram (Antabuse) for example. DAS provides MAT services with clients in concurrent treatment across levels of care (Level 1.0, Level 2.1, Level 3.1).

The Components of Medication Assisted Treatment are:

- Intake
- Individual and Group Counseling
- Patient Education
- Medication Services
- Crisis Intervention Services
- Medical Psychotherapy
- Discharge Services

The following services can be documented by medical staff (MD, DO, NP, PA, LPT).

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Prescriber Assessment E/M (OP) Note	Psychiatric diagnostic evaluation with medical services, 15 minutes (90792)	Min Time: 31 Mins claims 60 Mins Billed: If service extends beyond 68 mins, T2024 can be billed (assessment substitute)	• To be used for assessment services scheduled with prescribers for new clients. • Code can be used again with an existing client if there is an extended break in services (6 months), for post-PHF appointments, for second opinions, or if there is significant change in mental status requiring assessment.	Prescribers Detail: MD/DO, PA, NP
Prescriber Progress E/M (OP)	Office or Other Outpatient Visit (E&M) Established Patient – face to face or telehealth		• Established Patient = Within the last 3 years the individual has received services from the physician or	Prescriber Detail: MD/DO, PA, NP

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
	(audio + video) • 10-19 min (99212) • 20-29 min (99213) • 30-39 min (99214) • 40-54 min (99215)	Min Time: 10 Mins Min Time: 20 Mins Min Time: 30 Mins Min Time: 40 Mins	another physician of the same specialty at the county • Use for face-to-face or telehealth (audio and video).	
	For a Prolonged Visit, SmartCare with Automatically Add: 99415 and 99416 as appropriate		• This is added to the service in the background of SmartCare.	Prescriber Details: MD/DO, PA, NP Pharma
SUD Screening	Alcohol and/or drug screening, 15 Mins (H0049)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Prescribers to use this procedure code when providing a E/M service via telephone (audio only).	Prescribers, BH Clinicians, AOD Counselors Detail: MD/DO, PA, Psy, LCSW, LMFT, RN, NP, LPCC, AOD
Medication Training and Support	Medication Training and Support, per 15 minutes (H0034)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Medication education, training and support, monitoring/discussing/reviewing side effects.	Prescriber, RN Detail: MD/DO, PA, Pharma, NP, RN, LVN/LPT
Lab Specimen Collection	Alcohol and/or drug testing (H0048)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15	• Use to document administration of an alcohol and/or other drug testing when collecting and handling specimens other than	MD/DO, NP, PA, RN, LVN/LPT

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
		Minute Increments	blood.	
Alcohol and/or drug screening, Lab analysis	Alcohol and/or drug screening, Lab analysis (H0003)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Use to document review/interpretation/analysis of laboratory results related to an alcohol or drug screening.	MD/DO, NP, PA, RN, LVN/LPT
Medication Administration	Oral Medication Administration, Direct Observation, 15 minutes (H0033)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Administration of oral medication or injection medication with direct observation.	Prescriber, RN Detail: MD/DO, PA, Pharma, NP, RN, LVN/LPT
Health Risk Assessment NEW	Administration of patient-focused health risk assessment instrument (96160)	Min Time: 8 Minutes Billed: Code is Not Extended Past 8 Min Billing: Claims 1 Unit if 8 Min of Service Provided	• Administration and review/interpretation of findings related to health risk assessments. • Use for evaluation of Health Questionnaire and Walk-In Triage Form.	MD/DO, PA, NP, LMFT, LCSW, LPCC, RN, LVN/LPT
Health Behavior Intervention – with family	Health behavior intervention, family (without client present), 30 minutes (96170) Each additional 15 mins (96171)	Min Time: 16 Mins claims 30 Mins, 46 Mins claims 60 Mins Billing: Claims 1 Unit if 15 Min of Service Provided	• Includes supporting improvements in function, minimizing psychological and/or psychosocial barriers to recovery, and improved coping skills related to medical conditions. • Client is not present.	MD/DO, PA, NP, LMFT, LCSW, LPCC, RN, LVN/LPT

Medication Refill Frequently Asked Questions

1) If I get a verbal order from the MD/NP and call it in to the pharmacy, do I have to do anything else?

   Yes! No matter how the prescription information gets to the pharmacy – phone, electronic transmission through SureScripts, or handwritten by the MD/NP – all refill information MUST be entered in SmartCare.

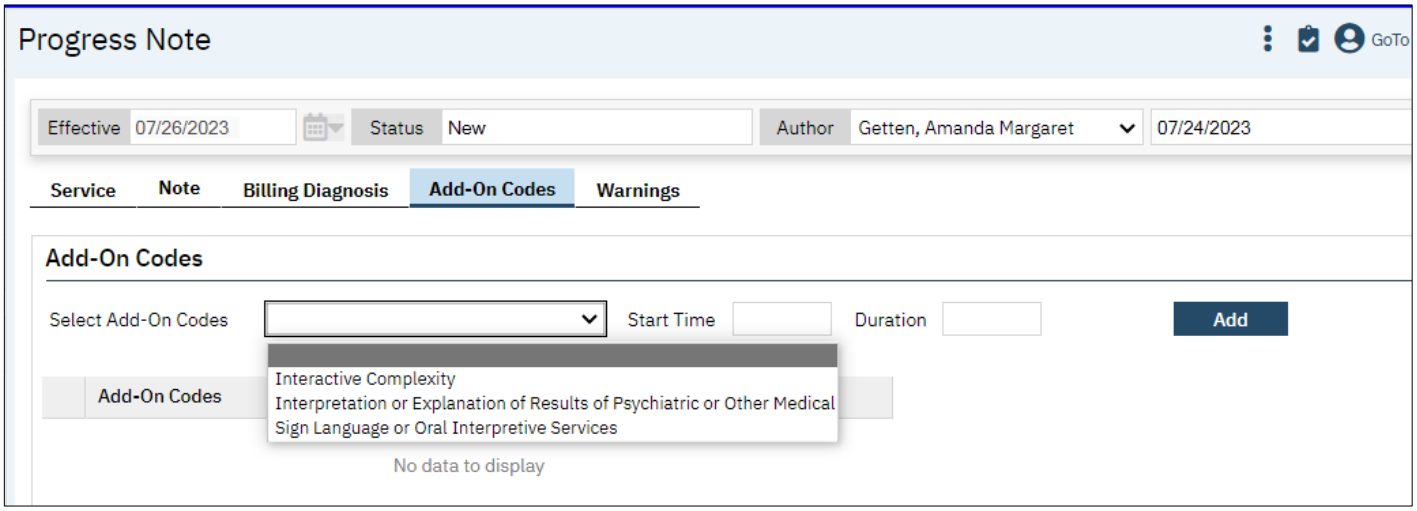
2) Preapproving the prescription and routing it to the MD:
   - Ensures that the medication information is in SmartCare for all future treatment providers to reference.
   - Provides the mechanism for the MD/NP to sign the order.
   - Protects LPT/LVN/RN staff (refill orders without an MD/NP signature = prescribing without a license!).

3) Do I have to have a signed Authorization to Use/Disclose PHI with the pharmacy to help get the meds refilled or to provide information for the TAR?
   Yes, due to 42 CFR Part 2. The Multi-Purpose Consent can be used, with the name of the Pharmacy listed as the treatment provider.

ADD ON CODES

Add On Code Name	Description	Procedures this add on can be added to
Interactive Complexity	Used to document communication difficulties including: • Managing maladaptive communications that complicate service delivery (high anxiety, confrontation/disagreement, reactivity, repeated questions, etc.). • Caregiver emotions or behavior that interferes with ability to support the treatment of the individual in care. • Use of play equipment or other devices to overcome barriers to therapeutic interaction.	Only used by LPHA staff documenting Assessment, Medication Support, & Therapy services

Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons	Used to document interpretation or explanation of results of psychiatric or other medical procedures to a family/collateral source.	Only used by LPHA staff documenting Family Therapy, Multi-Family Group Therapy, Group Therapy, & Medication Support services
Sign Language or Oral Interpretive Services	Utilized when interpretation services are utilized but does not include interpretation by the provider – it must be a person external to the session. The external person providing interpretation services can be a county or CBO employee.	Can be used by all staff for all services when an interpreter is utilized to provide treatment.



EXPANDED INFORMATION ON RISK ASSESSMENT, CRISIS SERVICE & SAFETY PLANNING

When a client first enters services with SLOBHD, it is necessary to assess current risks. There are many risk areas to assess for which must be assessed during their first contact with a Counselor/Clinician and the client's answers documented:

- Current thoughts about suicide, recent suicide attempt(s), historical information about suicidal ideation/attempts.
- Current thoughts about homicide, historical information about homicidal ideation.
- Self-injurious behavior (history of and current).
- Grave disability due to a:
    - Mental health disorder

- Severe substance use disorder
- Co-Occurring mental health disorder and severe substance use disorder

Crisis Intervention Services Definition: Crisis Condition means a situation experienced by the client that, without timely intervention, is likely to result in an immediate emergency psychiatric condition. Crisis Intervention lasts less than 24 hours and requires a timelier response than a scheduled visit. (CCR Title 9, 1810.209).

SUD "Crisis intervention" consists of an interview or series of interviews within a brief period of time, conducted by qualified professionals, and designed to alleviate personal or family situations which present a serious and imminent threat to the health or stability of the person or the family. The interview or interviews may be conducted in the home of the person or family, or on an inpatient or outpatient basis with such therapy, or other services, as may be appropriate. The interview or interviews may include family members, significant support persons, providers, or other entities or individuals, as appropriate and as authorized by law. Crisis intervention may, as appropriate, include suicide prevention, psychiatric, welfare, psychological, legal, or other social services. (WIC 5008 (e)).

When a client shares that they have current thoughts about suicide or homicide, a further risk assessment must take place to assess for intent and planning. If it is concluded that a client is a potential danger to self or others, or is gravely disabled, the risk assessment will assist with determining the level of need for further intervention(s). For clients in treatment for substance use, assess and document how the safety concerns are connected to the client's current or potential substance use (potential for relapse).

The Crisis Assessment must be document in SmartCare in one of the following ways:

1) Staff can document the Crisis Intervention service and full crisis assessment in a service note using the Crisis Progress Note Template (see Appendix). For the emergency indicator on the progress note, choose "Yes."

2) The Crisis Assessment (Client) in SmartCare guides staff in completing and documenting a thorough assessment of risk to ensure high quality care and to standardize the assessment of risk to self or others. This is recommended as it demonstrates the full scope of the service including the assessment that was completed, outcome, and plan for follow-up. Staff must direct the reader to the Crisis Assessment document dated __/__/__ on the SUD Crisis Intervention service note. For the emergency indicator on the progress note, choose "Yes."

A client must be assessed the same day, urgently, if there is concern that they may be a danger to self or to others or gravely disabled. This may seem obvious, but it is discussed here because a client may say something to another staff member that is of concern (ex. front desk staff), may leave a message that causes concern, and as sometimes comes up at DAS, a client may share thoughts about suicide or information about a suicide attempt during a Group Counseling service. It is important the Counselor/Clinician speak with the client further before they leave the clinic to determine risk. Further discussion with the client may involve a full risk assessment and involvement of others (ex. MHET, CSU, any open Mental Health provider) to maintain safety.

When a client makes any statement about…

- Suicidal Ideation
- Suicidal Plan/Attempt
- Homicidal Ideation
- Homicidal Plan
- Experienced a Relapse (Relapse Analysis during Individual Counseling or could be a SUD Crisis Intervention Service)
- Or they present in Crisis *at risk* of Relapsing (this is SUD Crisis Individual Counseling but does not require a BHCI unless the client is also experiencing SI/SA/HI/GD)
- Or Positive Drug Test Result is Received (Relapse Analysis during Individual Counseling)
- Self-Injurious Behavior
- Grave Disability*

THINK: Individual or Crisis Counseling Session!

*Gravely Disabled is defined by Welfare and Institutions code section 5008 (h)(1)(A) and (h)(2) as a condition in which a person:

- as a result of a mental disorder, impairment by chronic alcoholism, severe substance used disorder, or a co-occurring mental health disorder and severe substance use disorder,
- is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care.

Note that, the existence of a mental disorder does not, in itself, justify a finding of grave disability. (W&I Code 5008(3)).

Crisis Intervention Frequently Asked Questions:

- Crisis Intervention does not need prior authorization.

Crisis Documentation Tips:

- A prompt, well written, and objective risk assessment is the best way to ensure quality client care and to manage risk for clients in a crisis.
- Every crisis contact must be documented promptly.
- During a crisis contact, always ask about and document risks to self or others.
  - Document risks clearly. Do not limit your risk assessment to the presence or absence of SI/HI. Other risk factors are documented as thoroughly as possible, including:
    - The presence of mental illness.
    - Past attempts, especially if serious and if medical follow-up was needed.
    - Access to means/lethality of means.
    - Current plan/intent/preparatory behavior.
    - Current drug and alcohol use.
    - Risk of potential substance use relapse.
    - Recent stressors, especially trauma.
    - Hopelessness/lack of future orientation.
    - Lack of social support.
    - Demographic factors, including age and gender, which may increase or mitigate risk.
- Consider medical issues. Consult with SLOBHD medical staff and/or refer the client to Primary Care or Emergency Department for evaluation/medical clearance if needed.
- Document any consultation with others.
- Elements of a Well Written Crisis Note: A prompt, well written, and objective Crisis Intervention note is the best way to ensure quality client care and to manage risk for clients in a crisis.
    - Presenting Problem is clearly stated.
    - Use client quotes, when appropriate, to illustrate.
    - When known, precipitating events and stresses are documented.
    - Clinical behavioral observations are clearly stated in an objective,
    - nonjudgmental manner.
    - Clinical interventions including consultations with others are

clearly documented. Example:

- "This Clinician contacted Program Supervisor for consultation. Program Supervisor advised Clinician to call MHET for additional assessment."

- A follow-up plan is clearly stated. Examples:
  - "Client will contact this Specialist/Clinician with a phone check-in today at 4:00 PM. Client planned to attend an AA/NA group tonight, and to use their list of support phone numbers if continuing to feel at risk of relapse tonight. Client will attend group tomorrow morning at 8:30 AM."
  - "Client will call PCP (805-461-xxxx) this afternoon."
  - "Client was 5150'd to PHF for evaluation."

DEVELOP AND IMPLEMENT A SAFETY PLAN

1) Document all your follow-up contacts and consultation.
2) Communicate with the entire treatment team to improve outcome and to reduce risk.
   - Alert everyone on the team to the crisis, including Mental Health staff.
   - Another team member might be able to respond or follow up sooner than you are able to, which may improve the results for the client.
3) Work with MHET.
   - When you contact MHET, you have added a valuable resource to the client's treatment team, but you have not given away responsibility for ongoing follow-up.
   - Expect to hear from the MHET evaluator regarding outcome, but if you do not hear back, call to request information.
4) Follow up with your client promptly.
   - If you were concerned enough to contact MHET or to complete a crisis service, follow up the next day by phone or face-to-face (even better).
5) Consider scheduling an urgent appointment with the psychiatrist or NP – having additional input can be very helpful!

SAFETY PLANS

Creating a safety plan can serve as an important crisis intervention tool. Safety plans include coping strategies, social contacts, family contacts, professional contacts, and emergency phone numbers that a client can use when in crisis (anyone who is part of the safety plan should be aware that they are a part of it). Safety plans can be updated as needed when a client develops more coping strategies/supports, and it should be revisited when the client is experiencing thoughts about suicide or there is another

crisis/risk situation. A safety plan does not replace a risk assessment – it is a tool that can accompany a comprehensive risk assessment.

For clients receiving substance use disorder treatment services, relapse prevention strategies should be incorporated into the safety plan. These may include: attending a social support group (AA/NA), contacting sponsor, and listing coping skills that help client avoid triggers and triggering situations.

When a safety plan is created with a client in-person, the client shall be provided with a copy of the safety plan. The Counselor/Clinician must take a copy of the safety plan so that it can be scanned into the client's medical record. It is a good idea to make a plan with the client about where they are going to keep their safety plan should they need it.

Crisis intervention services are often provided by telephone and could even be provided by telehealth. When not face-to-face with a client, yet engaging the client in safety planning, the Counselor/Clinician shall ask the client if they would like to receive a copy of the safety plan. The client having a copy of their own safety plan is highly recommended so that they can refer to it if needed. If the client has signed the Consent for Text Communication/Consent for Email Communication (Client) Form, then a copy of the safety plan can be sent to the client via one of these electronic methods. Important: to protect privacy, a Counselor/Clinician should only email from the County email system and any text messages that are sent should only be sent via a County issued cellular phone. Another option is to mail the client a copy of their safety plan, or to give them a copy at the next scheduled face-to-face contact. However, providing a copy via text or email gives the client an opportunity to receive the document quickly.

For more information see the current resources posted on MySLO: https://myslo/DepartmentsNew/Health/Behavioral-Health/BH-Wide-Documentation-Resources/Risk-Assessment-Tarasoff-Documentation-Resources.aspx. A guide to safety planning and safety plan forms can also be found at this location.

CONTINUED SERVICES

When a client needs an updated ASAM (needs an evaluation for an increase in level of care, or decrease, or is returning to Outpatient Treatment from Residential Treatment), the Specialist/Clinician should not rewrite the entire CA ASAM and instead, focus on the Dimension 1 through 6 narrative boxes at the bottom (these will need updated information to support the new treatment recommendation) and the narrative boxes in

the questions throughout the body of the CA ASAM. If there is a previous CA ASAM and the information has not pulled forward due to a program change, please use the language below:

- "This assessment is an update and does not contain the full original psychosocial assessment." (However, if referring to a higher level of care, each dimension will need to be completed with detailed, up to date, clinical information).

ASAM

At the period of full assessment, the CA ASAM Assessment captures the full ASAM Placement Criteria. When the CA ASAM Assessment is launched to complete an assessment update, the information from the previously completed CA ASAM Assessment will pre-populate into the new version.

Level of care is reassessed when clinically indicated and/or when the client's condition changes. In the record, the level of care is updated by starting a new CA ASAM Assessment form. Re-assessment can be completed by Registered/Certified Counselors (assessment will be reviewed and approved by an LPHA) and LPHA's. The client's level of care can be changed at any time during the treatment episode which can result in additional services being added to meet treatment needs, or movement to a lower level of service due to improved functioning. Additional clinical reasons to update the CA ASAM include:

- Client has continued drug/alcohol use or has experienced continued relapses.
- There have been changes in the client's withdrawal symptoms or medical conditions due to drug/alcohol use.
- Client has participated in Level 2.1 Outpatient Treatment and has made significant improvement/progress in managing their SUD. Client and Specialist/Clinician agree that Level 1.0 is a clinically appropriate level of care for the client.

Treatment staff can also utilize the CA ASAM Assessment as an assessment tool when the client's level of care needs may not be clear.

When a client's level of care must change, the CA ASAM Assessment must be completed. Progress Notes must also reflect a level of care change.

Sections of the CA ASAM Assessment

ASAM Dimension Ratings 1-6: Specialist/Clinician must rate each dimension scale.

Comments about the client's progress or status in each dimension: Specialist/Clinician must enter a narrative description for each dimension. The narrative description shall provide an update as to the client's status in each dimension and justify any changes in the client's treatment episode that result in a change to the recommended or actual level of care received.

Final Placement Determinations: Specialist/Clinician must enter narrative comments about the final placement determination. If there is a discrepancy between the level of care indicated/referred and the level of care, the reason for the discrepancy should be addressed in narrative format here. Further clinical information, such as the use of behavioral contracts and drug testing can be added here. Additionally, any reason for a delay in admission should be expanded upon here. Client safety should be addressed if necessary.

Template text to assist Specialist/Clinician's with the completion of the CA ASAM is available in the document titled "Practice Guidelines CA ASAM." Each section of this document is covered.

Example narratives for a discrepancy between Level of Care Recommended and Level of Care Received:

- Client has been recommended for Level of Care 2.1 but will receive 1.0. Client will be monitored and reassessed for an increase in Level of Care if necessary. Client was placed in the least restrictive level of care first (Level 1.0) due to his/her full-time employment and impacted family schedule.
- Client was assessed as in need of 3.1 Residential Placement. However, because his CWS case in in County of San Luis Obispo, and there are no current Residential placements currently available within 30-minutes of his children, Client will be placed in Level 2.1 Outpatient Treatment in conjunction with Sober Living Environment. Client's needs will be monitored, and he was informed that Level of Care will increase to 3.1 if needed to support his recovery.
- Client was medically cleared to participate in Outpatient Treatment/Outpatient MAT.
- Safety plan was re-reviewed with client so that emergency/crisis phone numbers are known due to recent discharge from the PHF.
- Client meets the need for 3.1 Residential Treatment and is willing to go, however, their legal status is preventing them from leaving the County (no In-County Residential Treatment Facilities are currently available). Probation is aware of the additional risks

that may accrue due to client receiving a lower Level of Care than has been assessed. Client has been placed in 2.1 plus Sober Living Environment, which is the most intensive Outpatient Treatment we are able to offer. Specialist/Clinician will continue to monitor and work with our partnering agency as needed.

- Client has been recommended for Level 2.1 plus additional Sober Living Environment to target Dimension 5 (Relapse Prevention) and Dimension 6 (Recovery Environment). However, Client has declined this recommendation as he/she/they do not feel they meet that level of intensity, and their housing will be safe moving forward. They are willing to participate in Level 1.0 Outpatient Treatment with the understanding that this Level of Care is lower that what is recommended based on their Screening and Assessment and understands that this may come with a risk to their Substance Use and/or Mental Health stability as well as safe housing. Specialist/Clinician will continue to monitor and adjust the Level of Care as indicated.
- Client meets ASAM criteria for 3.1 Residential Treatment + 3.2 Withdrawal Management for opioid withdrawal; however, client has declined Residential Treatment but is willing to be placed in 2.1 Intensive Outpatient Treatment + Sober Living Environment + MAT for initial Ambulatory 1.0 Withdrawal Management services (with transition to MAT).
- Client meets criteria for 3.1 Residential Treatment + 3.2 Withdrawal Management for alcohol withdrawal purposes. Client has declined this recommendation and is willing to go to ER for potential alcohol-related withdrawal risks and has a family member present who agreed to take them today. Client has requested to be placed in Level 1.0 Outpatient Treatment and is interested in adjunct MAT services. Client is specifically interested in Vivitrol, and this may be a possibility once Client is no longer at risk for medical complications due to alcohol-related withdrawal. Client and family member stated that they understand that there is risk by entering a Lower Level of Care than recommended. Specialist/Counselor will continue to monitor and provide referrals (medical care or increased Level of Care), as necessary.

Level of Care Indicated/Recommended: 3 lists of treatment levels of care are listed in this section. Specialist/Clinician must make a selection in each list (not applicable is an option in each list). The lists are as follows:

Indicated/Referred Level: Choose ONE

- None
- 0.5 Early Intervention
- Outpatient Services

- 2.1 Intensive Outpatient Services
- 2.5 Partial Hospitalization Services
- 3.1 Clinically Managed Low-Intensity Residential Services
- 3.2 WM Clinically Managed Residential Withdrawal Management
- 3.3 Clinically Managed Pop-Specific High-Intensity Res Svcs
- 3.5 Clinically Managed High-Intensity Residential Services
- 3.7 Medically Monitored Intensive Inpatient Services
- 4.0 Medically Managed Intensive Inpatient Services
- Narcotic Treatment Program/Opiate Treatment Program (Aegis, MAT)

Provided Level:

- None
- 0.5 Early Intervention
- Outpatient Services
- 2.1 Intensive Outpatient Services
- 2.5 Partial Hospitalization Services
- 3.1 Clinically Managed Low-Intensity Residential Services
- 3.2 WM Clinically Managed Residential Withdrawal Management
- 3.3 Clinically Managed Pop-Specific High-Intensity Res Svcs
- 3.5 Clinically Managed High-Intensity Residential Services
- 3.7 Medically Monitored Intensive Inpatient Services
- 4.0 Medically Managed Intensive Inpatient Services
- Narcotic Treatment Program/Opiate Treatment Program (Aegis, MAT)

Additional Indicated Level of Care: Choose ONE

- None
- 0.5 Early Intervention
- Outpatient Services
- 2.1 Intensive Outpatient Services
- 2.5 Partial Hospitalization Services
- 3.1 Clinically Managed Low-Intensity Residential Services
- 3.2 WM Clinically Managed Residential Withdrawal Management
- 3.3 Clinically Managed Pop-Specific High-Intensity Res Svcs
- 3.5 Clinically Managed High-Intensity Residential Services
- 3.7 Medically Monitored Intensive Inpatient Services
- 4.0 Medically Managed Intensive Inpatient Services

- Narcotic Treatment Program/Opiate Treatment Program (Aegis, MAT)

Provided Additional Level of Care: Choose ONE

- None
- 0.5 Early Intervention
- Outpatient Services
- 2.1 Intensive Outpatient Services
- 2.5 Partial Hospitalization Services
- 3.1 Clinically Managed Low-Intensity Residential Services
- 3.2 WM Clinically Managed Residential Withdrawal Management
- 3.3 Clinically Managed Pop-Specific High-Intensity Res Svcs
- 3.5 Clinically Managed High-Intensity Residential Services
- 3.7 Medically Monitored Intensive Inpatient Services
- 4.0 Medically Managed Intensive Inpatient Services
- Narcotic Treatment Program/Opiate Treatment Program (Aegis, MAT)

Second Additional Level of Care: Choose ONE

- None
- 0.5 Early Intervention
- Outpatient Services
- 2.1 Intensive Outpatient Services
- 2.5 Partial Hospitalization Services
- 3.1 Clinically Managed Low-Intensity Residential Services
- 3.2 WM Clinically Managed Residential Withdrawal Management
- 3.3 Clinically Managed Pop-Specific High-Intensity Res Svcs
- 3.5 Clinically Managed High-Intensity Residential Services
- 3.7 Medically Monitored Intensive Inpatient Services
- 4.0 Medically Managed Intensive Inpatient Services
- Narcotic Treatment Program/Opiate Treatment Program (Aegis, MAT)

Discrepancy: If there is no discrepancy between level of care recommended and actual level of care received, then the question about discrepancy is answered "not applicable – no difference." If there is a discrepancy, the primary reason for the discrepancy is chosen.

Choose Primary Reason for Discrepancy:

- Clinical Judgement

- Lack of insurance/payment source
- Legal issues
- Level of care not available
- Managed care refusal
- Patient preference
- Geographic accessibility
- Family responsibility
- Language
- Other (explain)

Referral Made but Admission Delayed: Specialist/Clinician must make a selection. Not applicable is available, however if admission is delayed, the primary reason for delay is chosen.

Referral made but admission delayed, primary reason:

- Not applicable – no delay
- Waiting for language-specific services
- Waiting for other special population-specific services
- Hospitalized
- Incarcerated
- Patient preference
- Other (explain)

CALOMS ANNUAL UPDATE

Once a client has been in treatment services for a period of one year at the same clinic and same level of care, a CalOMS annual update must be completed. In SmartCare, the form is called CalOMS Standalone Update/Discharge (Client). The information requested on the form is brief and includes alcohol/drug use in the last 30 days, arrests in last 30 days, school, pregnancy, and mental health information. Please follow signature instructions for the CalOMS included in the admission section of this guideline manual. The CalOMS type (1, 2, 3, 5, 7) at admission must match the type chosen for the annual update.

SPECIAL DOCUMENTATION SCENARIOS

Scenario	Explanation	Instructions
EHR system is down for an extended period of longer than 5 business days	EHR cannot be accessed to enter progress notes according to DMC-ODS timeliness requirements (3 calendar days).	This is a contingency plan – not an alternative way to complete progress notes. • Write Progress Note in a timely manner, even if it cannot be done in SmartCare. Write in Microsoft Word. • Secure Progress Note on H Drive, and do not use client name within progress note. • When system is restored, copy and paste note into SmartCare. • Lead with line in progress note narrative that states "Late entry into the EHR due to system outage. Note written on 8/1/ @ 2:00PM." • Delete Progress Note on H Drive. Delete Progress Note from Recycle Bin. • If all network access is unavailable, progress note must be written on paper and locked in a file cabinet until it can be transferred to the EHR.

Outpatient services provided to a client who is at Jail/PHF (not JSC)	When a client is incarcerated or at inpatient psychiatric hospital, Outpatient SUD services are not billable.	Write a Progress Note using the appropriate service code. Select the Place of Service (Prison/Correctional Facility, Inpatient Psychiatric Facility). Include the service time. No bill will be generated.
Outpatient services provided to a youth client who is at JSC	When a youth is at JSC, Outpatient SUD services are not billable.	Write a Progress Note using the appropriate service code. Select the Place of Service as Prison/Correctional Facility.
Spanish-language Interpretation Services	NA	If a bilingual staff member conducts a service in Spanish, this must be chosen in the Language drop-down menu in the progress note. When a Spanish-speaking staff member or other interpreter is asked to join a session to provide interpretation between the treating provider(s) and the client(s), the Interpreter Service section/fields must be completed on the progress note. In the Add-On-Codes section of the progress note, the following must also be selected: "Sign Language or Oral Interpretation Service." The start time and minutes that interpretation was provided must also be selected.

DOCUMENTATION FOR A DECEASED CLIENT

When the unfortunate situation of a client passing away occurs, the staff member that was notified of the information must notify the site HIT and complete an incident report. The incident report must be reviewed by the Program Supervisor and Division Mnager before it is routed to QSS.

Additionally, when a client passes away, the record is closed and sequestered. Below is guidance on what can/cannot be added to the record.

FOR CLIENT OPEN TO TREATMENT SERVICES:

- Services cannot be documented after a client passes away.
- Unresolved service notes after a client's death:
    - Services notes that have been written but not completed before the client's passing and Service Notes that were completed after the client's passing before staff learns of the client's death: HIT will make these services nonbillable, error out the service, and associate a PDF of the Service Note to the Discharge Summary, so the information will be accessible in the client's record.
- Only the CalMHSA Discharge Summary and CalOMS Discharge can be added to the record.
- If there are outreach calls or other services that were not able to be documented before learning of the client's passing, this information should be added the CalMHSA Discharge Summary.

FOR CLIENT OPEN TO WALK-IN PROGRAM

- Services cannot be documented after a client passes away.
- Unresolved service notes after a client's death:
    - Services notes that have been written but not completed before the client's passing and Service Notes that were completed after the client's passing before staff learns of the client's death: HIT will make these services nonbillable, error out the service, and associate a PDF of the Service Note to the Client Non-Billable Must Document note (see below), so the information will be accessible in the client's record.
- Only a Client Non-Billable Must Document progress note can be added to the record to serve as the Discharge Summary.
- A CalOMS Discharge is not needed if the client was not open to a treatment program.

CLOSINGS & DISCHARGE SUMMARY/PLAN

When a client is discharged, an updated Diagnosis Document (Client) (if necessary), Discharge Plan/Summary, CalOMS Standalone Update/Discharge (Client), and any other final entries in the client EHR are completed within thirty days. After review by the Program Supervisor, the chart is closed. DAS maintains client records for not less than 10 years after discharge.

DISCHARGE SERVICES

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Discharge Planning	CPT Code Detail: Alcohol and/or substance abuse services, treatment plan development and/or modification (T1007)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Used for SUD case management/care coordination. • Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary/specialty medical providers.	All Detail: MD/DO, PA, Pharma, Psy, LCSW, LMFT, RN, NP, LPCC, AOD

FINAL CLOSING CHECKLIST TOOL

A final closing checklist tool is available to assist Specialists/Clinicians to complete all closing documentation and chart requirements.

UPDATE DIAGNOSIS DOCUMENT (IF NECESSARY)

It is important that the diagnosis is correct at discharge to maintain an accurate health record and so that the next treating provider will have accurate information should the client return to services. Example reasons to update a diagnosis:

- Change of diagnosis to a SUD in remission.
- End date of a diagnosis or psychosocial/contextual factor.
- Change to SUD diagnosis due to a change in severity.
- Addition of a diagnosis.

The Diagnosis Document (Client) does not need to be updated when there is no change to

the diagnosis or when the case is an open/close.

UPDATE PROBLEM LIST (IF NECESSARY)

It is important that the problem list is corrected/updated at discharge. Update the problem list to add an end date to problems that were resolved.

DISCHARGE REASON

The discharge reason chosen for the close of the treatment episode must correlate on the CalOMS and the program close reason. Discharge reasons define the criteria for successful completion, unsuccessful discharge, and referrals.

A "referral" for CalOMS close reasons is considered a referral to SUD Treatment or MAT Provider (not to NA/AA, Recovery Support Services, nor Mental Health Services or other Physical Healthcare).

Type of Close	Close Reason	Close Name	Definition
Standard Discharge Close Reasons: Talked/Planned with client about their Discharge (Face-to-Face, Telehealth, or by Telephone) is a Standard Discharge.			
STANDARD CLOSE	**1**	**SA Completed Tx Referred**	• This is considered a **treatment completion** status. • Client completed treatment/recovery plan goals and is being referred. • Client completed a SUD treatment service and is being referred to another SUD treatment service. • Client has successfully completed a level of care but is being referred to a different level of care and/or provider. • The client does not have to accept the referral for this to be valid. **Examples:** • Client completed Intensive Outpatient Treatment and is being referred to Outpatient Treatment (stepping down in level of care). • Client completed Residential Treatment and is being referred to Outpatient Treatment (either IOT or Outpatient). • Client completed treatment at DAS but is being referred for continued treatment with a MAT physician in the community.

Type of Close	Close Reason	Close Name	Definition
STANDARD CLOSE	2	**SA Completed Tx Not Referred**	• This is considered a **treatment completion** status. • Client completed treatment/recovery plan goals and is **NOT** being referred. • Client completed a SUD treatment service and is **NOT** being referred to another SUD treatment service. • Client has successfully finished treatment and is **NOT** being referred for further SUD services. • Client and Specialist/Clinician agree that treatment is completed at the current time. **Examples:** • Client completed Outpatient Treatment and is going to attend NA/AA as their continued support. This is not a SUD treatment referral. • Client completed Outpatient Treatment and is going to attend Recovery Support Services for aftercare. This is not a SUD treatment referral.

Type of Close	Close Reason	Close Name	Definition
STANDARD CLOSE	3	**SA Quit Sufficient Prog Ref**	• Client left before treatment completion but made satisfactory progress and was given a referral for SUD treatment. • Client has made progress and is being referred or moved to another site/provider at the same and/or different level of care. • Client is staying at the same site/provider and is being moved to a different level of care. • Client is terminating treatment but has made some progress and is being referred for further SUD services. • Client and Specialist/Clinician agree that treatment is sufficient at the current time (vs. complete). • The client does not have to accept the referral for this to be valid. **Examples:** • Client has made some progress in IOT but has told you that they will no longer attend that many days/hours of treatment a week. Client did not complete IOT (Quit). Client is moved to Outpatient 1.0 to continue treatment. • Client tells you that they are moving to Santa Barbara County. You provide the Client with a referral to Santa Barbara County Substance Use Treatment Services and engage the client in discharge planning. You discuss progress the client has made in some areas of treatment and talk to the client about the areas where they could continue to improve their recovery plan. • Client tells you they are going to stop coming to treatment. You assess that the client has made some progress while in treatment but do not consider that their treatment is complete. You refer the client to return to DAS should they need services in the future and/or you provide client with a list of SUD Treatment referrals in the community.
STANDARD CLOSE	5	**SA Inadequate Prog Ref**	• Client left treatment before completion with unsatisfactory progress and was given a referral for SUD treatment. • Client has made poor progress and is being referred or moved to another site/provider at the same and/or different level of care. • Client has made poor progress and is staying with the same site/provider and is being moved to a different level of care. • The client does not have to accept the referral for this to be valid. **Examples:** • Client is not able to stop alcohol/drug use while in Outpatient Level 1.0 treatment. Client stays in treatment and level of care is increased to Level 2.1 at the same clinic site. • Client has made poor progress in level 2.1 Outpatient treatment (positive drug test results, attendance issues, lack of behavioral changes). Client's level of care is increased to Level 3.2 for Residential Withdrawal Management.

Type of Close	Close Reason	Close Name	Definition
Administrative Discharge Close Reasons: The Specialist/Clinician has made outreach attempts and has lost contact with a client. Outreach attempts are completed and documented. Appropriate to use when a client has been in services for less than 30-days and you cannot reach them to discuss the closing.			
ADMINISTRATIVE CLOSE	**4**	**SA Quit Sufficient Prog No Ref**	• Client left treatment before treatment was complete and made satisfactory progress. Client could not be located to provide a SUD treatment referral. • Contact with client was lost. Outreach attempts were made and documented. Client made some progress in treatment but stopped attending. **Example:** • Client stopped coming to treatment but up until contact was lost the client appeared to be making some progress in treatment (evidenced by testing, working towards goals/objectives, developing relapse prevention skills).
ADMINISTRATIVE CLOSE	**6**	**SA Quit Inadequate Progress No Ref**	• Client left treatment before treatment was complete and made unsatisfactory progress. Client could not be located to provide a SUD treatment referral. • Contact with client was lost. Outreach attempts were made and documented. Client did not make progress in treatment and stopped attending. **Examples:** Client stopped coming to treatment and up until contact was lost the client had not made progress in treatment (evidenced by testing results/attendance, treatment attendance/participation, no behavioral change).
ADMINISTRATIVE CLOSE	**7**	**Deceased**	Client dies while enrolled in a treatment program/receiving services.
	8	**Jail**	Client has been incarcerated (jail or prison) while enrolled in a treatment program and will not return to treatment within 30-days.

DISCHARGE PLAN VS. DISCHARGE SUMMARY

The concluding entry in the client's record is the Discharge Plan or Discharge Summary. The Discharge Summary/Plan is an overall description of the treatment episode, the reason for discharge, the client's plan for ongoing post-treatment support, and any referrals made by program staff. In addition, the Discharge Summary/Plan contains a description of the client's status at the time of discharge in the following areas: alcohol

and other drug use, vocational or educational achievements, completion of physical examination, and legal status. The document used in SmartCare to complete both a Discharge Plan or a Discharge Summary is called the CalMHSA Discharge Summary.

DISCHARGE PLAN

When there is a planned termination from treatment, a Discharge Plan is completed. The plan will include activities and referrals that will help the client continue to work on long-term recovery and is completed with the client during the termination phase.

Discharge Planning is a reimbursable individual service and takes place over one or more services. The Specialist/Clinician creates a Discharge Planning Progress Note to claim for the service, and the Discharge Plan is written using the CalMHSA Discharge Summary. The reader can be referred to the CalMHSA Discharge Summary in the progress note (Ex. "Please see CalMHSA Discharge Summary dated xx/xx/xxxx").

The Discharge Plan must include:

- Description of client's relapse triggers.
- Plan to assist the client to avoid relapse when confronted with each trigger.
- Support plan.

The client must be offered a copy of the Discharge Plan, and the client must sign the plan.

Please use the template text (Key Phrases) that is available in SmartCare to complete the Discharge Plan. The Program Supervisor and the site HIT must be assigned to the CalMHSA Discharge Summary. This will prompt the HIT to discharge the client from the program(s).

⌘ Please click here to view information on how to use Key Phrases.

DISCHARGE SUMMARY

For any client that the Specialist/Clinician has lost contact with, a Discharge Summary is completed. The Discharge Summary is completed within 30-days of the Specialist/Clinician's last face-to-face, telehealth, or telephone service contact with the client. The date of the Discharge Summary must be the date of the final contact with a Specialist/Clinician (cannot be a drug test date or the date the report is being written). The Discharge Summary must include:

- Dates of treatment episode.
- Reason for discharge.
- Narrative summary of the treatment episode.

- Statement about the client's prognosis.

Contact attempts made to reach the client can be documented on the Discharge Summary.

Writing a Discharge Summary is not a billable service, therefore a progress note does not need to be entered; however, the Discharge Summary is still required. The document used to complete a Discharge Summary is the CalMHSA Discharge Summary. Please use the template text (Key Phrases) that is available in SmartCare to complete the Discharge Summary. The Program Supervisor and the site HIT must be assigned to the CalMHSA Discharge Summary. This will prompt the HIT to discharge the client from the program(s).

Sections of the CalMHSA Discharge Summary

Effective Date:

- For a Discharge Plan, the effective date will be the first date that the Discharge Plan is being formulated.
- For a Discharge Summary, the effective date will match with:
    - Discharge Date
    - Date NOABD requested a response from client (most of the time it will match - there may be some exceptions)

Admission Date: Enter treatment episode begin date.

Discharge Date: Enter treatment episode end date (last day of face-to-face contact).

Discharge Reason: Choose a discharge reason from the following list:

- Administrative discharge
- Client not appropriate for treatment
- Deceased
- Discharged against medical advice
- Disengaged from service/non-compliant with treatment

- Incarcerated
- Involuntary discharge
- Moved out of area
- Never engaged in services
- Services no longer needed
- Successful completion
- Transfer to higher level of care
- Transfer to lower level of care
- Transferred to a different program

FOR DISCHARGE PLANNING:

Add Discharge Plan Comments (for CalOMS close reasons 1, 2, 3, 5) narrative for discharge reason, collaboration with other agencies regarding close, transfers and referrals, recommendations for future services including other levels of SUD care).

FOR DISCHARGE SUMMARY:

Add Discharge Summary Comments (for CalOMS close reasons 4, 6, 7, 8) narrative for discharge reason, collaboration with other agencies regarding close, transfers and referrals, recommendations for future services including other levels of SUD care).

Add date of last contact.

Add documentation about whether an NOABD Termination Notice sent to the client (N/A, yes, no, explanation if necessary).

Add date NOABD sent.

Add date NOABD requested a response from client.

FOR DISCHARGE PLANNING:

- Add client's relapse triggers and plan to assist client to avoid relapse when confronted with each trigger.

- Add client's Discharge/Support Plan for Continued Recovery (people, organizations, Recovery Support Services) and comments at the close of treatment.
- Note if the client offered/provided a copy of their Discharge Support Plan (yes, no, explanation if necessary).

FOR DISCHARGE SUMMARY:

- Enter details about loss of contact with client and client contact attempts (if not documented in progress notes).

Episode Summary

FOR DISCHARGE PLAN & DISCHARGE SUMMARY:

- Enter a description of the treatment episode (duration of treatment with admission date and discharge date, narrative summary of the treatment episode, description of recovery services completed).
- Enter current alcohol and/or other drug use.
- Enter current medications prescribed by Behavioral Health (including dosage and response, plan for continued medication, and list other medical issues/medications prescribed by other providers).
- Enter vocational and educational achievements (achievements, scheduled time, structured time, activities such as volunteering, caring for family, or note no change since admission).
- Add legal status and comments:
- Add current living situation (status at discharge, recovery environment support).

Current Mental/Psychosocial Status: This section is not completed by staff member.

Prognosis: This section is not completed by staff member.

Client Strengths: This section is not completed by staff member.

Other Important Information: Complete as applicable or enter N/A.

Discharge Summary/Plan Tips

- Referral to RSS should be included in the Discharge Plan.
- No section should be blank. Write "NA" as necessary.
- If a client was AWOL, did the Specialist/Clinician document attempts to contact the client by phone to re-engage them in services?

Discharge Summary/Plan Frequency Asked Questions

- If a client came for walk-in screening, but did not attend any treatment services (ex. assessment, group) what closing paperwork do I need to complete?

  If a client becomes absent following a walk-in screening, and contact cannot be established, if a treatment program was NOT opened, then a CalOMS Standalone Update/Discharge (Client) is not needed. Other progress notes must summarize the outreach efforts completed by treatment staff. While a Discharge Summary/Plan Progress Note is also not needed, there must be a non-billable note that indicates the discharge date and the reason for discharge.

- When is a Discharge Plan due?

  The Discharge Planning session is conducted with the client during the termination phase of treatment. It can be completed in one session, or in more than one session if necessary.

- When is the Discharge Summary due?

  The Discharge Summary, for a client who has been out of contact with the Specialist/Clinician and is not attending services, is due within 30 days of the last service contact with a Specialist/Clinician. The Discharge Summary is documented in a CalMHSA Discharge Summary document. A Non-Billable Client Must Document note can be added so that the Specialist/Clinician can document their time spent completing the non-billable activity of formulating a discharge summary.

- What signatures are needed on a Discharge Summary/Plan?

  Discharge Plan:

  - Client
  - Specialist/Clinician

- Program Supervisor
- HIT

Discharge Summary:

- Specialist/Clinician
- Program Supervisor
- HIT

NOTICE OF INTENDED ACTION BENEFICIARY DETERMINATION (NOABD) TERMINATION

If a client has stopped attending services, a NOABD Termination Notice must be sent to the client at least 10 business days prior to the effective date that the client will be discharged from treatment services. This letter includes the rights of the client to appeal their discharge status, offers additional referrals, and encourages the client to return to services should that be needed.

- Send a NOABD Termination if a client has informed a Specialist/Clinician that they plan to stop coming to treatment, although it is advised that they continue treatment (planned end to treatment, but treatment end is not recommended by SLOBHD).
- Send a NOABD Termination if contact with a client is lost (unplanned end to treatment).

DISCHARGE CALOMS

At discharge, the Specialist/Clinician will complete a discharge CalOMS (not including for .5 Early Intervention services). In SmartCare this form is called CalOMS Standalone Update/Discharge (Client). The information requested on the form is brief and includes alcohol/drug use in the last 30-days, arrests in last 30-days, school, pregnancy, and mental health information. Please follow signature instructions for the CalOMS included in the admission section of this document. The CalOMS discharge type (1, 2, 3, 5, or 7) must match the opening CalOMS type.

DISCHARGE STATUS

Specialist/Clinician choose the correct discharge status/close reason.

STANDARD DISCHARGE CLOSE REASONS

Contact with the client at discharge was intact. The Counselor/Clinician talked/planned

Discharge with client (Face-to-Face, by Telehealth, or Telephone). A "referral" for CalOMS close reasons is considered a referral to SUD Treatment or MAT Provider (not to NA/AA, Recovery Support Services, nor Mental Health Services or other Physical Healthcare).

- Completed Treatment Plan & Goals/Referred/Standard (all questions)
- Completed Treatment Plan & Goals/Not Referred/Standard (all questions)
- Left Before Completion with Satisfactory Progress/Standard (all questions)
- Left Before Completion with Unsatisfactory Progress/Standard (all questions)

ADMINISTRATIVE DISCHARGE CLOSE REASONS

An administrative discharge is chosen when the Counselor/Clinician has made outreach attempts and has lost contact with a client. Outreach attempts are completed and documented.

- Left Before Completion with Satisfactory Progress/Administrative (minimum questions)
- Left Before Completion with Unsatisfactory Progress/Administrative (minimum questions)
- Death
- Incarceration

Discharge CalOMS Frequently Asked Questions

1) What should I date the CalOMS Standalone Update/Discharge (Client)?

   The date of the discharge CalOMS must match the date that the client is discharged from the treatment program. The HIT will close the treatment program. The discharge reason for the program close and the CalOMS Discharge must also match. (This will not necessarily be the same date as the Discharge Plan or Discharge Summary Progress Note.

RECOVERY SUPPORT SERVICES

As part of the continuum of care for SUD treatment services, Recovery Support Services (RSS) are aftercare support services designed to help individuals become and stay

engaged in the recovery process. RSS are available for youth and adult clients. As client's complete treatment, they are connected to RSS to continue building connections within the recovery community, learn about community resources to support ongoing self-management, and to continue to develop coping skills to prevent relapse. Therefore, RSS are important to the client's continued recovery and continued work towards wellness. RSS is available to clients if they have been triggered, are experiencing challenges, or have experienced a relapse.

Given the value of RSS, the Specialist/Clinician should explain the benefits of RSS at the beginning of treatment, during treatment, and as treatment is concluding. If the client will experience a change in their primary assigned Specialist/Clinician when entering RSS, introductions and a warm hand-off should be completed. The client must be discharged from the outpatient treatment episode to be opened to RSS.

Recovery services can be provided via face-to-face contact, by telephone, telehealth, or in the community. Recovery services can be provided by a LPHA or a Registered/Certified Counselor.

The client shall attend two services per month to remain in RSS. A client in RSS will continue to participate in drug testing at a low frequency however, the Specialist/Clinician may adjust the client's testing frequency if medically necessary. If a client fails to show for a scheduled service while enrolled in RSS, outreach to the client should take place at the same frequency as when the client is open to outpatient treatment. When a client stops attending treatment, it is important to conduct outreach and to document outreach attempts. A minimum of 3 outreach attempts is recommended.

ACCESS CRITERIA FOR RECOVERY SUPPORT SERVICES

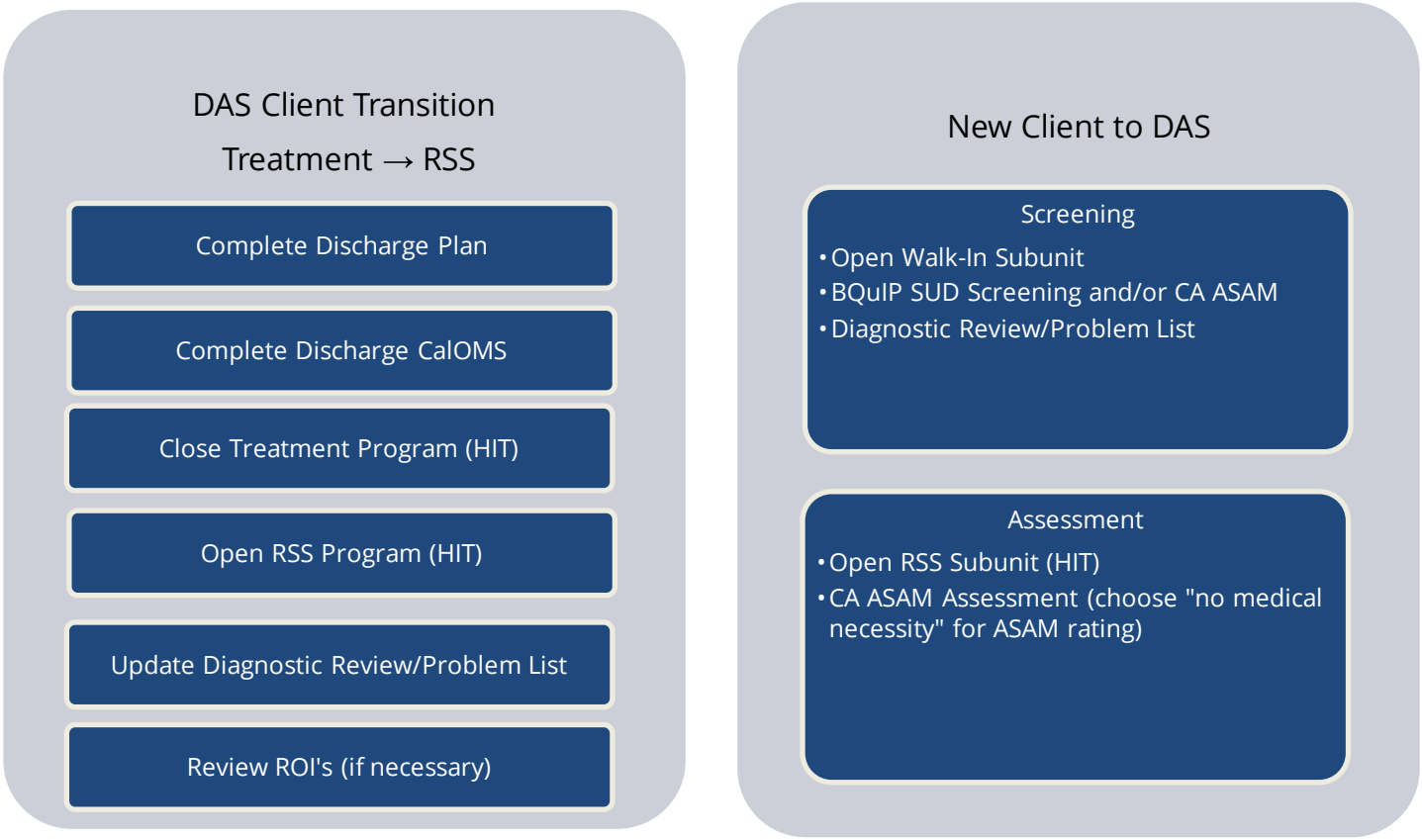
Access criteria was previously established for a client that transitions directly from treatment with DAS into RSS. The client will be in early or sustained remission from a SUD(s), and this must be documented by updating the Diagnosis Document (Client). Clients without a remission diagnosis may also receive recovery services and do not need to be abstinent from drugs for any specified period of time.

If there is a lapse between treatment discharge and RSS, a screening and an assessment needs to occur to determine if RSS is the appropriate level of care. When a new client requests RSS (without having completed treatment services with DAS), likely through a walk-in, a screening and/or assessment must take place to determine the appropriate

level of care. The diagnosis will be recorded as an ICD-10 code for a SUD in early or sustained remission.

⌘ Please click here to view Diagnosis Information for Recovery Support Services

REQUIRED DOCUMENTATION



RECOVERY SUPPORT SERVICES

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Psychosocial Rehab - Individual	Psychosocial Rehabilitation, 15 minutes (H2017)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	For DMC-ODS, rehabilitation falls under RSS and can document education related to mental health, substance use, independent living, social, coping and interpersonal skills, relapse prevention, etc.	All Detail: MD/DO, PA, Pharma, Psy, LCSW, LMFT, RN, NP, LPCC, AOD, LPT/LVN

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Comprehensive Community Supports	Comprehensive community support services, per 15 minutes (H2015)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Use for Recovery Support Services. • Accessing needed medical, social, educational, and other health-related services.	All Detail: MD/DO, PA, Psy, LCSW, LMFT, RN, NP, LPCC, AOD
Psychosocial Rehabilitation Group	Psychosocial Rehabilitation (H2017)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• For DMC-ODS, rehabilitation falls under RSS and can document education related to mental health, substance abuse, independent living, social, coping and interpersonal skills, relapse prevention, etc.	All Detail: MD/DO, PA, Pharma, Psy, LCSW, LMFT, RN, NP, LPCC, AOD, LVN/LPT

CLOSING A CLIENT FROM RECOVERY SUPPORT SERVICES

To close a client from RSS, the closing process is simplified compared to closing a client from a Treatment Level of Care.

1) Complete a closing progress note entry. If possible, provide a Discharge Planning service or an Individual Counseling service to the client to discuss transition out of RSS. At a minimum, enter an informational progress note with information about the close of the client's RSS.
2) A Discharge Plan/Summary is NOT needed.
3) A Discharge CalOMS is NOT needed.
4) Close the Drug Testing program and other applicable programs.
5) Notify HIT via email of case close. HIT will close the RSS program.

Recovery Support Services Frequently Asked Questions

1) Does a client in Recovery Support Services need to complete a Health Questionnaire and be referred to complete a physical examination?

While a client in Recovery Support Services may identify goals/needs related to their health for which they need case management support, it is not required that a Health Questionnaire nor a physical examination is completed and maintained in the chart for this phase of aftercare services.

2) What documentation is needed if a client in Recovery Support Services is not doing well and needs to return to active Outpatient/Inpatient Treatment?

   If there has been no break in the treatment episode (client moved from treatment to RSS and is going to move back to treatment without any lapse in dates), access criteria can be re-established with an updated CA ASAM Assessment and a Diagnosis Form. It is not necessary to complete a Screening (BQuIP) or full CA ASAM assessment. However, a current SUD diagnosis must be documented in the record. An Assessment service can be scheduled and billed to meet with the client to assess for level of care and complete an updated CA ASAM.

APPENDIX A: FLOW SHEET FOR DMC-ODS DOCUMENTATION

Initial Screening Request for Services			
(AA) Open Walk-In Client Programs	**BQuIP**	**Diagnosis Document + Client Clinical Problem Details**	**Interim Services**
• (AA) Open Walk-In **Client Programs** • (AA) Open Case Management Client Program	• Dated with screening date • Complete **Service Note** & use procedure **SUD Screening** • Signed by Clinician/LPHA	• Dated with BQuIP screening date • Signed by: ➢ Clinician/LPHA ➢ LPHA ➢ Reg./Cert. Counselors • If needed, complete NOABD Denial	• Add client to engagement groups • Contact MAT staff to schedule client for MAT services as clinically indicated

Treatment Admission = CA ASAM and Treatment Assignment (Client Programs) Opened ***Client is assigned LOC and opened to treatment when the CA ASAM is completed.**				
CA ASAM	**Access Team Close Walk-In Client Program**	**Access Team Open Client Treatment Programs**	**Update Documents as Needed: Diagnosis Document + Client Clinical Problem Details**	**CalOMS Admission**
• Linked to Treatment Program (initially launched in Walk-In Program & updated when Treatment Program is determined) • Complete **Service Note** linked to Treatment	• Access Team close Walk-In Program • Dated the same day as Treatment Program date (close Walk-In Program and open Treatment Program on same day)	• Access Team open Treatment Program • Dated with CA ASAM Assessment Date	• Effective Date matches the CA ASAM Assessment Date • Signed by: ➢ Clinician/LPHA ➢ LPHA ➢ Reg./Cert. Counselors • If needed, complete NOABD Denial	• **Effective Date must match the "Enrolled" Date of the Treatment Program** • Signed by: ➢ Staff ➢ HIT

Program & use procedure **ASAM or Other Structured SUD Assessment** • Signed by: ➢ Clinician/LPHA ➢ LPHA				

Continued Services		
CA ASAM	**Problem List Updates (Client Clinical Problem Details OR Problem List on Service Note)**	**CalOMS Annual Update (CalOMS Standalone Discharge/Update)**
• Update as clinically appropriate for **Level of Care changes** • Signed by: ➢ Staff ➢ LPHA	• Update as clinically appropriate for **Problem List changes** • Signed by: ➢ Clinician/LPHA ➢ LPHA ➢ Reg./Cert. Counselors	• Necessary if client in services for 1-Year in the same Level of Care AND at the same site • Signed by: ➢ Staff ➢ HIT

Discharge Procedure (Complete in Left to Right Order)			
Update Documents as Needed: Diagnosis Document + Client Clinical Problem Details	**Discharge Summary: * Lost Contact with a Client**	**Discharge Plan: *Planned Termination of Treatment**	**CalOMS Standalone Discharge/Update**
• Update when there is a **change to the Diagnosis,** remission status or **change to the Problem List** • Signed by: ➢ Clinician/LPHA ➢ LPHA	• Complete **CalMHSA Discharge Summary** using **Key Phrases** designated for the Discharge Summary • Discharge Summary is due within 30-days of	• Complete **CalMHSA Discharge Summary** using **Key Phrases** designated for the Discharge Plan • Complete **Service Note** & use procedure	• **Effective Date Must Match the Discharge Date of the Treatment Program (Close Date)** • Discharge Close Reason Must Match on: ➢ Discharge CalOMS

	Last Contact with the client (Face-to-Face, Telephone, or Telehealth) • Dated with date of **Last Contact** with the client (Face-to-Face, Telephone, or Telehealth) • CalMHSA Discharge Summary signed by: ➢ Staff ➢ LPHA ➢ HIT • Complete NOABD Termination	**Discharge Planning** • Discharge Plan is signed during the last 30-days of treatment • CalMSHA Discharge Summary signed by: ➢ Client ➢ Staff ➢ LPHA ➢ HIT • Complete NOABD Termination	➢ Treatment Program Close • Signed by ➢ Staff ➢ HIT • Email HIT to discharge client & include: ➢ CLIENT # ➢ SERVER NAME ➢ PROGRAM NAME ➢ DISCHARGE DATE ➢ REASON FOR DISCHARGE • Email AdminOps to update National Labs

APPENDIX B: CALOMS BASICS FOR CLINICIANS

Under Construction

APPENDIX C: PROGRESS NOTE TIME ENTRY GUIDANCE

Service Time	•Time Specalist/Clinician spent providing a service. •Enter total service time in Service Time box. •Includes all modes of service delivery: face-to-face, telephone (telehealth audio only), video conferencing (telehealth video + audio), and written.
Documentation Time	•Time Specialist/Clinician spent writing the Progress Note. •Enter total documentation time in Documenation Time box. •Documentation time is not billed as part of the service, but it must be entered so that data about staff time/activities can be studied over time by State. •Note: If concurrent or collaborative documentation was completed during the service, documetnation time must not be added.
Travel Time	•Time Specialist/Clinician spent traveling to provide a service. •Enter total travel time in Travel Time box. •Travel time can be one way or round trip. •Travel time is time spent traveling from a Medi-Cal certfied site to the service location (ex. client home, school, another office such as DSS). •Travel time does not include traveling from one Behavioral Health site to another. •Travel time is not billed as part of the service, but it must be entered so that data about staff time/activities can be studied over time.
Tranportation Time (DMC-ODS Services Only)	•Time Specialist/Clinician spent transporting a client to link them to physical healthcare, mental health care, medically necessary treatment, or to other ancillary services is a Case Management intervention. •Must be part of a TCM/ICC service only. No other DMC-ODS procedures/services allow for transportation to be billed as part of the service time. •Transportion time is service time. •Progress note must include statement(S) about transportation in the Progress Note narrative intervention section.

APPENDIX D: APPROVED STANDARD ABBREVIATIONS

AA	Alcoholics Anonymous
Acct	Account
ADC	Adult Drug Court
ADHD	Attention Deficit Hyperactivity Disorder
adj.	Adjustment
ADL	Activities of Daily Living
AG	Arroyo Grande
AH	Auditory Hallucinations
appt.	Appointment
APS	Adult Protective Services
ASAM	American Society of Addiction Medicine
ASAP	as soon as possible
ASH	Atascadero State Hospital
Assmt	Assessment
AT	Atascadero
Avg	Average
AWOL	absent without leave
B.I.D.	2 times per day
B/D/F	Black divorced female
b/f	Boyfriend
B/M/F	Black married female
b/o	because of
B/P	blood pressure
b/u	broke up
BAL	blood alcohol level
Bro	Brother
Bx	Behavior
c/o	complained of
Cauc	Caucasian
CBD	Cannabidiol
CBT	Cognitive Behavioral Therapy
CHC	Community Health Center
Cigs	Cigarettes
Clt	Client
CM	case manager
Co	County
COD/CD	Co-Occurring Disorders
COE	County Office of Education
Collat	Collateral
Coord.	coordination (as in coordination team)
Cnslr/Coun	Counselor
CPR	Cardiopulmonary Resuscitation
C-Section	caesarean section
CVA	Coastal Valley Academy
CWS	Child Welfare Services
D/O	Disorder
DAS	Drug and Alcohol Services
Dbl	Double
DBT	Dialectical Behavioral Therapy
DC'd	discharged or discontinued
DD	developmentally disabled
DOB	date of birth
DOC	drug of choice
DSS	Department of Social Services
DUI	driving under the influence
DV	domestic violence
Dx	Diagnosis
ED	emergency department
HER	electronic health record
EMR	electronic medical record
ER	emergency room
ETOH	Alcohol
Eval	Evaluation
F/U	follow up
Fa	Father
Fam	Family

FoBro/FoSis/FoMo/FoFa	Foster Brother, Sister, Mother, Father
Freq	Frequency
FSP	Full-Service Partnership
FTC	Family Treatment Court
FTS	failed to show
g/f	Girlfriend
g/u	grew up
GAF	Global Assessment Functioning
GB	Grover Beach
GrGraFa	great grandfather
GrGraMo	great grandmother
group tx	group therapy
Grp	Group
h/o	history of
Halluc	Hallucination
HBP	high blood pressure
HMR	Helping Men Recover (EBP Curriculum)
HWR	Helping Women Recover (EBP Curriculum)
HI/SI	homicidal ideation/suicidal ideation
Hisp	Hispanic
HIV	human immunodeficiency virus
HS	at bedtime
Hx	History
IEP	individual education plan
IOT	Intensive Outpatient Treatment
Irreg	irregular
L/M	left message
LCSW	Licensed Clinical Social Worker
Lg	Large
LMFT	Licensed Marriage and Family Therapist
LO	Los Osos
LOC	Level of care
LPHA	Licensed Practitioner of the Healing Arts
LPT	Licensed Psychiatric Technician
LVN	Licensed Vocational Nurse
MH	Mental Health
M/C	Medi-Cal
max	Maximum
MAT	Medication Assisted Treatment
MB	Morro Bay
Med Eval	medication evaluation with M.D.
Med Hx	medical history
meds	medicine; medication
Meth	Methamphetamine
MH	Mental Health
MHS	Mental Health Services
min/min.	minimum/minute
misc	Miscellaneous
MJ	Marijuana
mo	month(ly)
Mo	Mother
mod	Moderate
MR	medical record
MRI	magnetic resonance imaging
MRT	Moral Reconation Therapy
MS	multiple sclerosis
MSE	Mental Status Exam
mtg	Meeting
NA	Narcotics Anonymous
NTP	Narcotic Treatment Program
NOABD	Notice of Adverse Beneficiary Determination
NOS	not otherwise specified
NP	nurse practitioner

NP	Nipomo
NRT	nicotine replacement therapy
O.A.	Overeaters Anonymous
OCD	obsessive compulsive disorder
OD	Overdose
OH	olfactory hallucination
Op	Operation.
OP	Outpatient
oriented x3	oriented by person, place, date
Os	Mouth
OTP	Opioid Treatment Program
P	After
P/C	phone call
Paso	Paso Robles
PCP	angel dust/phencyclidine
PCP	primary care physician
Pd	paid
PD	Police Department
PDD	Pervasive Developmental Disorder
PHF	Psychiatric Health Facility
PHI	protected health information
PHN	Public Health Nurse
PI	paranoid ideation
Po	by mouth
POEG	Perinatal Outpatient
PR	Paso Robles
Pre	before
Prep	Preparation
PRN	as needed
Prob	SLO County Probation Department
Prog	Program
PRTS	Post Release Treatment Services
Psych	Psychiatric
Pt	Patient
PTSD	Post-Traumatic Stress Disorder
pvt	Private
QAM	in the morning
QD	Daily
QHS	at hour of sleep
QID	4 times per day
QPM	in the afternoon
Qt	Quart
R/O	rule out
Rec	Recommend
reg	Regular
Rehab	Rehabilitation
rel	Relationship
Res. Tx.	residential treatment
Ret'd	Returned
Rm	Room
RN	Registered Nurse
RTC	return to court
Rx	Prescription
S/H/M	single Hispanic male
S/W/F	single white female
SA	suicide attempt
SAFE	Systems Affirming Family Empowerment
sched appt	schedule appointment
Schiz	Schizophrenia
SDI	state disability insurance
SE	side effect
sec	second, secondary
SED	serious emotional disturbance
SI	suicidal ideation
Sib	Sibling
Surg	surgery, surgeon

SIB	self-injurious behavior
SIDS	sudden infant death syndrome
Sis	Sister
Sit	Situation
SLCUSD	San Luis Coastal Unified School District
SLOBHD	County of SLO Behavioral Health Dept.
SLOCO	San Luis Obispo County
SLOPD	San Luis Obispo Police Department
SLOSD	San Luis Obispo Sheriff's Department
Sm	Small
SMHS	Specialty Mental Health Services
SNF	skilled nursing facility
SO	significant other
SOC	share of cost
Soc.	Socialization
Soc. Serv.	Social Services
Spx	Specialist
SSA	Social Security Administration
SSD	Social Security Disability
SSI	Supplemental Security Income
StBro	stepbrother
StFa	stepfather
StFam	Stepfamily
STI	sexually transmitted infection
StMo	Stepmother
StSis	stepsister
Sub	substitute
SUD	Substance Use Disorder
sup grp	support group
SVRMC	Sierra Vista Regional Medical Center
SW	social worker
Sx	Symptoms
T/C	telephone call
TAY	transitional age youth
TBI	traumatic brain injury
tbsp	Tablespoon
TCCH	Twin Cities Community Hospital
TD	tardive dyskinesia
Temp	Temperature
THC	Marijuana
THPP	Transitional Housing Placement Program
Th	Therapist
TMHA	Transitions Mental Health Association
TMJ	tempo mandibular joint disorder
tox	Toxicology
trans	Transfer
tsp	Teaspoon
Tx	Treatment
UA	urine analysis
unk	Unknown
UR	utilization review
UTI	urinary tract infection
w/	With
w/d	Withdrawn
w/o	Without
wk.	Week
WM	Withdrawal Management
WNL	within normal limits
work comp	Workers' Compensation
y/o	year(s) old
yr.	Year

YS	Youth Services (Mental Health)		**YTP**	Youth Treatment Program (TMHA)

APPENDIX E: INTERIM SERVICES PROGRESS NOTE TEMPLATES

FOR ALL CLIENTS

INTERVENTIONS:

Interim services counseling and education provided for the following areas:

[ ] HIV

[ ] Tuberculosis

[ ] Risk of needle sharing

[ ] Risk of HIV and TB transmission to sexual partners and infants

[ ] HepC

[ ] If necessary, referral to HIV, HepC, or TB treatment services

FOR PREGNANT CLIENTS

Interim services counseling and education provided for the following areas to pregnant women who cannot be placed in treatment:

[ ] Counseling on the effects of alcohol and drug use on the fetus

[ ] Referral for prenatal care

Interim services counseling and education provided for the following areas:

[ ] HIV

[ ] Tuberculosis

[ ] Risk of needle sharing

[ ] HepC

[ ] Risk of HIV and TB transmission to sexual partners and infants

[ ] If necessary, referral to HIV, HepC, or TB treatment services

APPENDIX F: PROGRESS NOTE INTERVENTION STARTERS

Acknowledged	Actively Listened	Asked	Assessed	Assisted
Brainstormed	Clarified	Completed	Created	Defined
Developed	Discussed	Encouraged	Engaged	Evaluated
Explained	Explored	Facilitated	Identified	Inquired
Led	Modeled	Normalized	Practiced	Praised
Prompted	Provided	Provided Referral	Redirected	Reframed
Reinforced	Rehearsed	Reminded	Reviewed	Reviewed Progress
Solicited	Suggested	Supported	Taught	Utlized

APPENDIX G: NALOXONE PROGRESS NOTE TEMPLATES

INDIVIDUAL SERVICE

INTERVENTIONS:

Staff provided Naloxone training to the client. Client completed Naloxone Screening Sheet. Staff reviewed Opioid Overdose Response Instruction sheet with client. The training went over the overdose epidemic in America today; California laws regarding Naloxone; agencies collaborating in SLO County addressing the overdose issue; what Naloxone is; how to prevent, recognize, and respond to an overdose; how to administer Naloxone; aftercare of Naloxone and how to obtain refills. After the training, client was able to verbalize how to prevent, recognize and respond to an opiate overdose.

A Screening Sheet was filled out in order to be prescribed Naloxone by SLOBHD Prescriber. Client received an overdose prevention bag, and written instructions on how to properly administer and use Naloxone.

Staff trained client on the following: Client was able to identify two ways to prevent an overdose. They were able to distinguish between "nodding" and an overdose as evidenced by unresponsiveness to stimulation, shallow breathing, and blue/grayish skin-lips and fingertips. They were able to demonstrate rescue breathing- lay person on back, tilt head and lift chin, two normal sized breaths/ one every five seconds and watching for chest to rise with each breath given. Client was able to demonstrate administration of Nasal Naloxone.

PLAN: Prescription: Client will pick up Opioid Rescue Kit from desired pharmacy.

[ ] Phoned into (PREFERRED PHARMACY INDICATED BY CLIENT) by (LPT NAME WHOM YOU GAVE SCREENING SHEET TO) as directed and authorized by DAS NP.

AND/OR:

[ ] Client was given a sample Opiate Overdose Rescue Kit by DAS and/or MAT staff _____.

GROUP SERVICE

INTERVENTIONS:

Naloxone Education Group. Group participated in overdose prevention and education training facilitated by a DAS Overdose Prevention Educator (OPE). Educational information was provided so that after the training, clients will be able to verbalize how to prevent, recognize and respond to an opiate overdose. The educational group went over:

- Overdose epidemic in America today
- California laws regarding Naloxone
- Agencies collaborating in SLO County addressing the overdose issue
- What Naloxone is
- How to prevent, recognize, and respond to an overdose
- How to administer Naloxone
- Aftercare of Naloxone
- How to obtain refills

After the training, there was a brief session for Q&A, and then interested clients were given Naloxone Screening Sheets to fill out to be prescribed Naloxone by a SLOBHD Prescriber. The OPE will then assist the client with filling prescription as needed. Client will receive an overdose prevention kit, including the overdose bag, and written instructions on how to properly administer and use Naloxone.

PLAN:

(Client Name) was able to identify two ways to prevent an overdose. (Client Name) was able to distinguish between "nodding" and an overdose as evidenced by unresponsiveness to stimulation, shallow breathing and blue/grayish skin, lips, and fingertips. (Client Name) was able to demonstrate rescue breathing- lay person on back, tilt head and lift chin, two normal sized breaths/ one every five seconds and watching for

chest to rise with each breath given. (Client Name) was able to demonstrate administration of Nasal Naloxone.

PLAN: Prescription: Client will pick up Opioid Rescue Kit from desired pharmacy.

[ ] Phoned into (PREFERRED PHARMACY INDICATED BY CLIENT) by (LPT NAME WHOM YOU GAVE SCREENING SHEET TO) as directed and authorized by DAS NP.

AND/OR:

[ ] Client was given a sample Opiate Overdose Rescue Kit by DAS and/or MAT staff _____.

APPENDIX H: CRISIS INTERVENTION/ASSESSMENT PROGRESS NOTE TEMPLATE

PRESENTING PROBLEM:

FOR THE FOLLOWING, IF YES, PLEASE CHECK & DESCRIBE:

[ ] Suicidal ideation:

    [ ] Evidence of Planning:

    [ ] Access/Means:

[ ] Homicidal ideation:

    [ ] Evidence of Planning:

    [ ] Access/Means:

[ ] Self Injurious Behavior:

    [ ] Access/Means:

[ ] Gravely Disabled:

[ ] Other:

RISK FACTORS, IF YES, PLEASE CHECK & DESCRIBE:

[ ] Presence of mental illness:

[ ] Substance use/Abuse, potential for substance use relapse:

[ ] History of prior violence/self-injury/trauma:

[ ] Recent stressors:

[ ] Past attempts:

[ ] Hopelessness/lack of future orientation:

[ ] Lack of support:

[ ] Demographic factors (age, gender, etc.):

BEHAVIORAL OBSERVATIONS (DESCRIBE ANYTHING SIGNIFICANT RE: APPEARANCE, BEHAVIOR, SPEECH, MOOD, ETC.):

PROTECTIVE FACTORS:

CURRENT OVERALL LEVEL OF RISK

[ ] Low (e.g., Develop/review Safety Plan and provide after hours emergency/crisis numbers)
[ ] Moderate (e.g., Develop/review Safety Plan and provide after-hours emergency/crisis numbers. Consider further need for immediate crisis assessment and intervention)
[ ] High (e.g., Engage in additional immediate crisis assessment and intervention and determine appropriate level of care)

SAFETY PLANNING & RELAPSE PREVENTION:

DISPOSITION AND NEXT STEPS:

IF CLIENT IS A DANGER TO OTHERS (TARASOFF), DID YOU:

[ ] Phone call to intended victim(s)

[ ] Send Tarasoff notification letter

[ ] Phone call to law enforcement

[ ] Send Tarasoff worksheet to law enforcement

APPENDIX J: SAMPLE PROGRESS NOTES

EXAMPLE OF A SCREENING PROGRESS NOTE:

INFORMATION (Describe current service(s), how the service addressed the client's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors):

Clinician welcomed client into screening session to increase rapport and engagement in the brief interview.

Clinician reviewed confidentiality and limits of confidentiality in accordance with 42 CFR.
Clinician completed walk-in screening.
Specialist/Clinician scheduled client for assessment appointment.

Specialist provided a referral for the client to MH for a MH assessment.

Clinician provided client with to brochure on Naloxone and scheduled client appointment with LPT for Naloxone training.

CARE PLAN (Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the client. Include how the client or their representatives helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan):

Client meets access criteria for SUD treatment services and will attend an assessment appointment. Client made progress today by attending screening for services.

EXAMPLE OF AN ASSESSMENT PROGRESS NOTE:

INFORMATION (Describe current service(s), how the service addressed the client's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors):

Clinician utilized active listening and empathetic statements to engage client in the session and promote the client's engagement in services.

Clinician completed Assessment and utilized the ASAM Criteria to determine the appropriate level of treatment.

CARE PLAN (Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the client. Include how the client or their representatives helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan):

Client will start treatment groups on xx/xx/xx and will have a case management appointment for Sober Living Environment housing on xx/xx/xx. Client made progress by attending the assessment session and making plan to start services.

EXAMPLE OF A CRISIS PROGRESS NOTE:

INFORMATION (Describe current service(s), how the service addressed the client's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors):

Client reported that she felt highly triggered to use alcohol today due to a fight with her mother.

Client reported that he had thoughts about wanting to cut himself related to his recent relapse.

Specialist/Clinician actively listened to client and provided supportive feedback as the client processed their SUD crisis.

Specialist/Clinician engaged client in an inventory of their supports and a plan to avoid relapse, including scheduling and planning phone calls until next scheduled treatment service.

Specialist/Clinician reviewed the client's relapse prevention plan, making changes so that the client would be less likely to relapse when experiencing internal and external triggers.

Specialist/Clinician referred the client to MAT Services to address cravings that cause relapse after short periods of sobriety.

Specialist/Clinician engaged client in an evaluation of their relapse to avoid further use/relapse.

Specialist/Clinician assessed for suicide risk based upon client's statement "I want to give up – maybe I will overdose" (i.e. access to means, history of suicidal gestures or attempts, current plan, and proximity of support system).

Specialist/Clinician contacted Mobile Crisis to evaluate client as their relapse/use over the last 3 days has included thoughts and plan for suicide.

Specialist/Clinician completed a safety plan; reviewing crisis phone numbers that client can access 24/7 should thoughts about suicide return.

Client completed a relapse prevention plan during the crisis session and placed a call to his sponsor to discuss the plan for this evening.

CARE PLAN (Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the client. Include how the client or their representatives helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan):

Client agreed to attend a social support meeting tonight (NA) and to meet with Specialist/Clinician prior to group tomorrow morning to check-in.
Client agreed to call Specialist/Clinician at 4:00 PM today for check-in.
Client denied current plan for self-harm and agreed to remain sober tonight to reduce the likelihood of continued self-harm thoughts. Client contracted for safety and agreed to attend scheduled MH assessment appointment.

Client made progress during this crisis session as evidenced by identifying the increased social support she has developed in her recovery network that she would utilize to avoid using today.

Client was aware of community resources (crisis phone numbers) and identified progress he has made in treatment to avoid people, places, and things that cause triggers. Client will employ this learning tonight by avoiding a part of the city that causes triggers.

EXAMPLE OF AN INDIVIDUAL COUNSELING PROGRESS NOTE:

INFORMATION (Describe current service(s), how the service addressed the client's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors):

Specialist/Clinician and client rehearsed "I-Statements" that client will use in social settings to maintain sober behaviors.

Specialist/Clinician encouraged client to explore fears related to obtaining a physical.

Specialist/Clinician provided the client with a relapse prevention plan and assisted client with the completion of her plan.

Specialist/Clinician assessed for risk factors and ruled out mandatory reporting obligations at this time.

CARE PLAN (Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the client. Include how the client or their representatives helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan):

Client identified 1 new coping skill (knitting) to manage feelings of boredom.

Client identified two events he wants to take his children to in the next month in order to engage the family in fun sober activities.

Client completed his physical examination which demonstrates progress towards the client's goal of increasing his attention towards his physical health.

EXAMPLE OF A GROUP COUNSELING PROGRESS NOTE:

Overview Progress Note Section

INFORMATION (Describe current service(s), how the service addressed the client's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors):

Specialist/Clinician facilitated a treatment group using the Matrix Model EBP on the top of Scheduling.

Specialist/Clinician facilitated a treatment group on using the Seeking Safety EBP on the topic of Safety.

Specialist/Clinician facilitated a breathing exercise to ground session and bring focus to the group.

Specialist/Clinician led group members in a social skills activity using "I-Statements," and Clinician facilitated discussion about the importance of assertive communication.

Specialist/Clinician provided scheduling materials and monitored the group of clients for any needs with scheduling assistance. Specialist provided an example schedule to model how one must structure their time to reduce likelihood of relapse.

Client Progress Note Section

CARE PLAN (Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the client. Include how the client or their representatives helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan):

Client has improved upon his attendance this week to treatment, attending all 4 treatment services and 1 drug screening.

Client has reduced his treatment service by 1 group as she completed Matrix Early Recovery groups last week.

Client has demonstrated poor attendance and had a positive drug test yesterday for THC. Specialist/Clinician has scheduled an individual session to occur tomorrow.

EXAMPLE OF A CASE MANAGEMENT PROGRESS NOTE:

INFORMATION (Describe current service(s), how the service addressed the client's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors):

Rehearsed phone calls with client to Sober Living Environments/Residential Treatment providers.
Provided client with a list of resources for xyz. Scheduled client for Naloxone education with LPT.

CARE PLAN (Indicate the goals, treatment, service activities, and assistance to address the

objectives of the plan and the medical, social, educational, and other services needed by the client. Include how the client or their representatives helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan):

Client followed through on contacting 5 Sober Living Environments and located 1 that had an opening. Client will move into Sober Living Environment tomorrow.

Client is scheduled for Naloxone training on xx/xx/xx.

EXAMPLE OF A DISCHARGE PLANNING PROGRESS NOTE:

INFORMATION (Describe current service(s), how the service addressed the client's behavioral health need (e.g. symptom, condition, diagnosis, and/or risk factors):

Specialist/Clinician met with Client for a Discharge Planning session.

Specialist/Clinician provided positive feedback to Client about the gains they have made in recovery, describing observed strengths that will assist client with their continued sobriety.

Specialist/Clinician informed Client about the availability of after care services (Recovery Support Services) that are available should they choose to return to DAS for further support.

Specialist/Clinician completed a Discharge Plan with Client, walking through triggers and assisting client with identifying how they will respond to each trigger to prevent return to substance use.

Specialist/Clinician provided Client with a copy of their Discharge Plan.

CARE PLAN (Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the client. Include how the client or their representatives helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan):

Client successfully completed Level 1.0 Outpatient Treatment. Client's drug testing for the

5 months prior to completion was negative.

Client does not plan to participate in Recovery Support Services at this time.
See Discharge Plan dated xx/xx/xx.

APPENDIX K: SAMPLE MEDICATION MANAGER PROGRESS NOTES

Mental Health Medication Example Note #1

Reason for today's visit: Medication Training & Support for current/continued medications to treat OCD.

Services provided (medication refills, injectable ordered/administered, patient education, care coordination, lab reviews, etc): Medication refills, patient education, care coordination.

Ordering MN/DO/NP: Dr. Puri

Name of pharmacy (for refill verification): Vons Pharmacy, Grover Beach

Interval History (describe any relevant events since last visit, symptoms reported, adherence to medication, side effects): Client has been taking Fluoxetine 40mg to treat OCD D/O for 6 months. Client reported a reduction in obsessive thoughts and compulsive behaviors since the last medication support visit (2 months ago). Client estimated that she is engaging in checking behaviors 5 times a week for approximately 10 minutes, which is a large reduction since starting medications where she was engaging in checking behaviors 7-days a week for up to 3 hours a day. Client reported that she was not concerned about any side effects at this time and reported she is taking her medication daily, although sometimes forgets to take her medication when she sleeps in. LPT provided education about different strategies/reminders to take medications consistently (ex. alert/reminder on telephone).

List any new problems identified: Client reported that she would like to have even more control over obsessive/compulsive symptoms and requested that the dosage of Fluoxetine be increased. This LPT sent a message request to MD listed above with the client's request to increase Fluoxetine dosage.

Vital Signs (enter vitals on New Entry Flow Sheet document): See New Entry Flow Sheet dated 10/6/2023 for vitals.

Next Steps (Referrals provided/needed, Follow Up appointment): Client was scheduled for another medication support follow up session for 4-weeks on 11/6/2023. This LPT

will contact client with the outcome of the MD's response about increasing the dosage of Fluoxetine. Client has two weeks of medication supply currently.

Mental Health Medication Example Note #2

Reason for today's visit: Client called the clinic because she was out of her medication Lamotrigine. Client missed her medication support visit with Dr. Lampe last week and has run out of her medication.

Services provided (medication refills, injectable ordered/administered, patient education, care coordination, lab reviews, etc): Medication refills, patient education, care coordination.

Ordering MN/DO/NP: Dr. Lampe

Name of pharmacy (for refill verification): CVS, San Luis Obispo, Marigold Shopping Center

Interval History (describe any relevant events since last visit, symptoms reported, adherence to medication, side effects): Client has been taking 100mg of Lamotrigine for 3 months to treat her bipolar disorder. This LPT coordinated with the prescriber, and the client was prescribed two weeks of medication until her rescheduled medication support appointment with Dr. Lampe on 10/15/2023. This LPT informed Client of this refill being completed, and the importance of the client following through with attending the next medication appointment with the doctor. Client reported no barriers for being able to attend the next appointment and no current concerns about side effects. LPT reviewed that Lamotrigine is a high-risk medication that can cause a rash that is potentially life threatening. LPT reminded the client to self-monitor for a rash and to immediately contact the clinic or go to the ER if a rash develops. Client denied having any current rash and indicated that she understood the instructions.

List any new problems identified: No new problems identified. The client has missed 1 appointment with the MD on 9/30/2023.

Vital Signs (enter vitals on New Entry Flow Sheet document): NA because service took place by telephone.

Next Steps (Referrals provided/needed, Follow Up appointment): Client was rescheduled medication support appointment with Dr. Lampe on 10/15/2023.

SUD/MAT Injection Medication Example Note #3

Reason for today's visit: Medication Training & Support visit for injection medication.

Services provided (medication refills, injectable ordered/administered, patient education, care coordination, lab reviews, etc):

- Prior to administering the injection, LPT reviewed the risks, benefits, and alternatives to the medication with the client, and the client provided verbal consent for the injection.
- Patient education provided for information about injection/injection site.
- Gluteal injection medication administered (Vivitrol/Naltrexone, 380mg).
- Injection logged onto the MAT Injection Flow Sheet. Medication refill request sent to NP for next month.

Ordering MN/DO/NP: Avery Paulsen, NP

Name of pharmacy (for refill verification): BestCare Pharmacy, Arroyo Grande

Interval History (describe any relevant events since last visit, symptoms reported, adherence to medication, side effects): Client has been taking Vivitrol/Naloxone for 28-days to treat Alcohol Use Disorder, Severe. Client reported a reduction in cravings for alcohol since starting the medication. Today Client was present for the second injection.

List any new problems identified: Client has not been consistently attending his DAS Level 1.0 Treatment Program. Client identified not connecting with other group members as the largest barrier.

Vital Signs (enter vitals on New Entry Flow Sheet document): See New Entry Flow Sheet dated 10/10/2023 for vitals.

Next Steps (Referrals provided/needed, Follow Up appointment):

- Client was scheduled for another medication support follow up session for 28-

days scheduled on 11/07/2023.

- Client reported that he is already working with his Counselor on how to get more out of groups so that his group attendance will increase.

Mental Health Injection Medication Example Note #4

Reason for today's visit: Medication Training & Support visit for injection medication.

Services provided (medication refills, injectable ordered/administered, patient education, care coordination, lab reviews, etc): Prior to administering the injection, LPT reviewed the risks, benefits, and alternatives to the medication with the client, and the client provided verbal consent for the injection. Patient education provided for information about injection/injection site. Injection medication administered - Invega Sustenna 234mg IM into right deltoid without incident. Vivitrol/Naltrexone, 380mg). Injection logged onto the Long Acting Injection Flow Sheet. Medication refill request sent to MD for next month.

Ordering MN/DO/NP: Dr. Penepacker

Name of pharmacy (for refill verification): Genoa Pharmacy, San Luis Obispo

Interval History (describe any relevant events since last visit, symptoms reported, adherence to medication, side effects): Client has been taking Invega Sustenna for 6 months to treat Schizophrenia. Client reported he likes taking his medication via injection and wants to continue with this plan. LPT reviewed injection site information with Client and administered the medication. List any new problems identified: Client reported that his hours were reduced at work and that this has caused some financial stress, but that he has been told his hours will increase next month.

Vital Signs (enter vitals on New Entry Flow Sheet document): See New Entry Flow Sheet dated 10/16/2023 for vitals.

Next Steps (Referrals provided/needed, Follow Up appointment): Client was scheduled for another medication support follow up session for 28-days scheduled on 11/10/2023.

APPENDIX L: PROCEDURE/SERVICE CODES

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Screening/Assessment Services				
SUD Screening	Alcohol and/or drug screening,15 Mins (H0049)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	Screening to determine the appropriate services for an individual seeking treatment.	Prescribers, BH Clinicians, AOD Counselors Detail: MD/DO, PA, Psy, LCSW, LMFT, RN, NP, LPCC, AOD
SUD Assessment	Alcohol or Drug Assessment, 15 Mins (H0001)		• Use to determine the ASAM Criteria. • Assessment may be initial and periodic. • May include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary.	Prescribers, BH Clinicians, AOD Counselors Detail: MD/DO, Pharma, PA, Psy, LCSW, LMFT, RN, NP, LPCC, AOD
Case Management Services				
Targeted Case Management (TCM/ICC)	Targeted Case Management, 15 Mins (T1017)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins	• Used for SUD case management/care coordination. • Coordination with primary	All Detail: MD/DO, PA, Pharma,

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
		Billed: 15 Minute Increments	care and mental health care providers to monitor and support comorbid health conditions. • Ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, and mutual aid support groups.	Psy, LCSW, LMFT, NP, LPCC, AOD, RN, LVN/LPT
Report Generation for Care Coordination	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals,	Min Time: 8 Min Billed: Code is Not Extended Past 15 Min Billing: Claims 1 Unit if 8 Min of Service Provided	• An LPHA can use this code for writing a Treatment Court Report (not a legal court report, ex. Return to Court report). • A medical staff member (LVN/LPT, RN) can use this code to document preparing reports for other individuals, agencies, etc. for the	Prescribers, BH Clinicians Detail: MD/DO, PA, Psy, LCSW, LMFT, RN, NP, LPCC, LVN/LPT

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
	agencies, or insurance carriers, 15 Minutes (90889)		purposes of care coordination (not for legal purposes).	
Individual Counseling Services				
Individual Counseling	Behavioral Health Counseling and Therapy, 15 minutes (H0004)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Includes contacts with the client. • Individual Counseling can also include contact with other family members or other collaterals for the purpose if the purpose of the collateral's participation is to focus on the treatment needs of the client by supporting the achievement of the beneficiary's treatment goals.	All Detail: MD/DO, PA, Psy, LCSW, LMFT, RN, NP, AOD
Psychoeducation	Psychoeducational Service, per 15 minutes (H2027)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Includes providing information regarding mental illness and substance abuse. • Teaches problem-solving, communication, and coping skills to support recovery and resilience.	All Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, LPCC, AOD

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Client Education	Skills training and development, per 15 minutes (H2014)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Use for Patient Education Services. • Education for the client on addiction, treatment, recovery and associated health risks. • Treatment planning is a service activity that consists of development and updates to documentation needed to plan and address the client's needs, planned interventions, and to address and monitor a client's progress and restoration to their best possible functional level.	All Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, LPCC, AOD
Family Therapy—client not present	Family Psychotherapy (Conjoint psychotherapy without Patient Present), 26-50 minutes (90846)	Min Time: 26 Billed: If service extends beyond 58 mins, T2021 can be billed (therapy substitute) Billing: Claims 1 Unit if 26 Min of Service Provided	• Family members are included in the treatment process, provided with education about factors that are important to the client's recovery as well as the holistic recovery of the family system. • Family members can provide social support	Prescribers, BH Clinicians Detail: PA, Psy, LCSW, LMFT, NP, LPCC

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
			to the client and help motivate their loved one to remain in treatment. • Utilized when the client is not present. • Based on clinical judgment, the client is not present during the service, but the service is for the direct benefit of the client.	
Family Therapy—client present	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes (90847) Add-on Code G2212 can be used to document a Family Psychotherapy service that goes beyond 50 minutes (G2212 is in 15 minutes increments). SmartCare will automatically add these add on codes if staff enter time	Min Time: 26 Billed: If service extends beyond 58 mins, T2021 can be billed (therapy substitute) Billing: Claims 1 Unit if 26 Min of Service Provided	• Utilized when the client is present.	Prescribers, BH Clinicians Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, LPCC

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
	longer than the procedure code's maximum.			
Family/Couple Counseling	Alcohol and/or substance abuse services, family/couple counseling (T1006)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Alcohol and/or substance abuse services provided with a family/couple.	All Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, LPCC, AOD
Crisis Services				
SUD Crisis Intervention	Alcohol and/or drug services; crisis intervention (outpatient) (H0007)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• SUD Crisis means an actual relapse or an unforeseen event or circumstance, which presents to the client an imminent threat of relapse. • If client is experiencing thoughts/risks such as Danger to Self, Danger to Others, or Grave Disability, use this procedure code and document in the service note to how the safety concerns are connected to the client's SUD (ex. risk of relapse, safety concerns intensified due to substance use). • Services should focus on alleviating the crisis	All Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, AOD, RN, LVN/LPT

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
			problem, be limited to the stabilization of the client's immediate situation and be provided in the least intensive level of care that is medically necessary to treat their condition.	
Group Counseling Services				
Group Counseling	Alcohol and/or drug services; group counseling by a clinician, 15 minutes (H0005)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Face-to-face contacts in which one or more therapist or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served.	All Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, LPCC, AOD
Multiple-Family Group Psychotherapy	Multiple-Family Group Psychotherapy, 15 minutes (90849)	Min Time: 43 Min Billed: If service extends beyond 92 mins, T2021 can be billed (therapy substitute) Billing: Claims 1 Unit if 43 Min of Service Provided	• Family therapy group that includes multiple families.	Prescribers, BH Clinicians Detail: MD/DO, PA, Psy, LCSW, LMFT, NP, LPCC
Consultation/Case Conference Services				

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Medical Team Conference, Participation by Physician. Pt and/or Family Not Present	Medical Team Conference with Interdisciplinary Team of HealthCare Professionals, Participation by Physician. Patient and/or Family Not Present, 30 mins or More (99367)	Min Time: 30 Mins (Up to 1440 Mins) Billing: Claims 1 Unit if 30 Min of Service Provided	• Only the DMC-ODS providers directly rendering care to the client can bill for Clinician Consultation. The "consulting" physician cannot bill Clinician Consultation.	MD/DO
Team Case Conference with Client/Family Absent	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non-Physician. Patient and/or Family Not Present. 30 Minutes or More (99368)	Min Time: 30 Mins (Up to 1440 Mins) Billing: Claims 1 Unit if 30 Min of Service Provided	• Clinicians (LPHA's) consulting with licensed professionals (addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists to support the provision of care. • Only the DMC-ODS providers directly rendering care to the client can bill for Clinician Consultation. The "consulting" clinician cannot bill clinician Consultation.	Prescribers, BH Clinicians Detail: MD/DO, Pharma, PA, Psy, LCSW, LMFT, RN, NP, LPCC
Physician-to-Physician Consultation	Inter-Professional Telephone/Internet/Electronic Health Record Assessment Provided by a	Min Time: 5 Minutes (Up to 15 Mins) Billing: Claims 1 Unit if 5 Min of	• Only the DMC-ODS providers directly rendering care to the client can bill for Clinician Consultation. The "consulting"	MD/DO

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
	Consultative Physician, 5-15 Minutes (99451)	Service Provided	clinician cannot bill Clinician Consultation.	
Medical/Medication Services				
Prescriber Assessment E/M (OP) Note	Psychiatric diagnostic evaluation with medical services, 60 minutes (90792)	Min Time: 31 Mins claims 60 Mins Billed: If service extends beyond 68 mins, T2024 can be billed (assessment substitute)	• To be used for assessment services scheduled with prescribers for new clients. • Code can be used again with an existing client if there is an extended break in services (6 months), for post-PHF appointments, for second opinions, or if there is significant change in mental status requiring assessment.	Prescribers Detail: MD/DO, PA, NP
Prescriber Progress E/M (OP)	Office or Other Outpatient Visit (E&M) Established Patient – face to face or telehealth (audio + video) • 10-19 min (99212) • 20-29 min (99213) • 30-39 min (99214) • 40-54 min (99215)	Min Time: 10 Mins Min Time: 20 Mins Min Time: 30 Mins Min Time: 40 Mins	• Established Patient = Within the last 3 years the individual has received services from the physician or another physician of the same specialty at the county • Use for face-to-face or telehealth (audio and video).	Prescriber Detail: MD/DO, PA, NP

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
	For a Prolonged Visit, SmartCare with Automatically Add: 99415 and 99416 as appropriate		• This is added to the service in the background of SmartCare.	Prescriber Details: MD/DO, PA, NP Pharma
SUD Screening	Alcohol and/or drug screening, 15 Mins (H0049)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Prescribers to use this procedure code when providing a E/M service via telephone (audio only).	Prescribers, BH Clinicians, AOD Counselors Detail: MD/DO, PA, Psy, LCSW, LMFT, RN, NP, LPCC, AOD
Medication Training and Support	Medication Training and Support, per 15 minutes (H0034)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Medication education, training and support, monitoring/discussing/ reviewing side effects.	Prescriber, RN Detail: MD/DO, PA, Pharma, NP, RN, LVN/LPT
Lab Specimen Collection	Alcohol and/or drug testing (H0048)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Use to document administration of an alcohol and/or other drug testing when collecting and handling specimens other than blood.	MD/DO, NP, PA, RN, LVN/LPT

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Alcohol and/or drug screening, Lab analysis	Alcohol and/or drug screening, Lab analysis (H0003)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Use to document review/interpretation/ analysis of laboratory results related to an alcohol or drug screening.	MD/DO, NP, PA, RN, LVN/LPT
Medication Administration	Oral Medication Administration, Direct Observation, 15 minutes (H0033)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Administration of oral medication or injection medication with direct observation.	Prescriber, RN Detail: MD/DO, PA, Pharma, NP, RN, LVN/LPT
Health Risk Assessment	Administration of patient-focused health risk assessment instrument (96160)	Min Time: 8 Minutes Billed: Code is Not Extended Past 8 Min Billing: Claims 1 Unit if 8 Min of Service Provided	• Administration and review/interpretation of findings related to health risk assessments. • Use for evaluation of Health Questionnaire and Walk-In Triage Form.	MD/DO, PA, NP, LMFT, LCSW, LPCC, RN, LVN/LPT
Health Behavior Intervention – with family	Health behavior intervention, family (without client present), 30 minutes (96170) • Each additional 15 mins (96171)	Min Time: 16 Mins claims 30 Mins, 46 Mins claims 60 Mins Billing: Claims 1 Unit if 15 Min of Service	• Includes supporting improvements in function, minimizing psychological and/or psychosocial barriers to recovery, and improved coping skills related to medical	MD/DO, PA, NP, LMFT, LCSW, LPCC, RN, LVN/LPT

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
		Provided	conditions. • Client is not present.	
Discharge Services				
Discharge Planning	CPT Code Detail: Alcohol and/or substance abuse services, treatment plan development and/or modification (T1007)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Used for SUD case management/care coordination. • Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary/specialty medical providers.	All Detail: MD/DO, PA, Pharma, Psy, LCSW, LMFT, RN, NP, LPCC, AOD
Recovery Support Services				
Psychosocial Rehab - Individual	Psychosocial Rehabilitation, 15 minutes (H2017)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• For DMC-ODS, rehabilitation falls under RSS and can document education related to mental health, substance use, independent living, social, coping and interpersonal skills, relapse prevention, etc.	All Detail: MD/DO, PA, Pharma, Psy, LCSW, LMFT, RN, NP, LPCC, AOD, LPT/LVN

SmartCare Procedure Name	Procedure Code Detail	Billing Information Minimum Time to Claim One Unit	Definition/More Information	Disciplines
Comprehensive Community Supports	Comprehensive community support services, per 15 minutes (H2015)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• Use for Recovery Support Services. • Accessing needed medical, social, educational, and other health-related services.	All Detail: MD/DO, PA, Psy, LCSW, LMFT, RN, NP, LPCC, AOD
Psychosocial Rehabilitation Group	Psychosocial Rehabilitation (H2017)	Min Time: 8 Mins claims 15 Mins, 23 Mins claims 30 Mins Billed: 15 Minute Increments	• For DMC-ODS, rehabilitation falls under RSS and can document education related to mental health, substance abuse, independent living, social, coping and interpersonal skills, relapse prevention, etc.	All Detail: MD/DO, PA, Pharma, Psy, LCSW, LMFT, RN, NP, LPCC, AOD, LVN/LPT

APPENDIX M: TREATMENT COURT REPORTS

Treatment Courts include:

- Family Treatment Court (FTC)
- Adult Drug Court (ADC)
- Adult Treatment Court Collaborative (ATCC)
- Behavioral Health Treatment Court Collaborative (BHTCC)

1) Treatment Court Reports are documented on a PDF paper document. The PDF document can be found here: MySLO - Paper Forms
2) A Program Supervisor must review the Treatment Court Report to approve the information that is being reported/released.
3) The Treatment Court report is given to the assigned court officer to provide to the court.
4) The Treatment Court report is given to the site HIT to be scanned into the record.
5) An LPHA can write a service note under the following procedure code to capture this as a service. Time spent formulating the court report (monitoring the client's progress in treatment) is recorded in the service time. This is limited to LPHA's.

SmartCare Procedure Name	Procedure Code Detail	Definition/More Information	Disciplines
Report Generation for Care Coordination	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carriers (90889)	An LPHA can use this code for writing a Treatment Court Report (not a legal court report, ex. Return to Court report).	Prescribers, BH Clinicians Detail: MD/DO, PA, Psy, LCSW, LMFT, RN, NP, LPCC

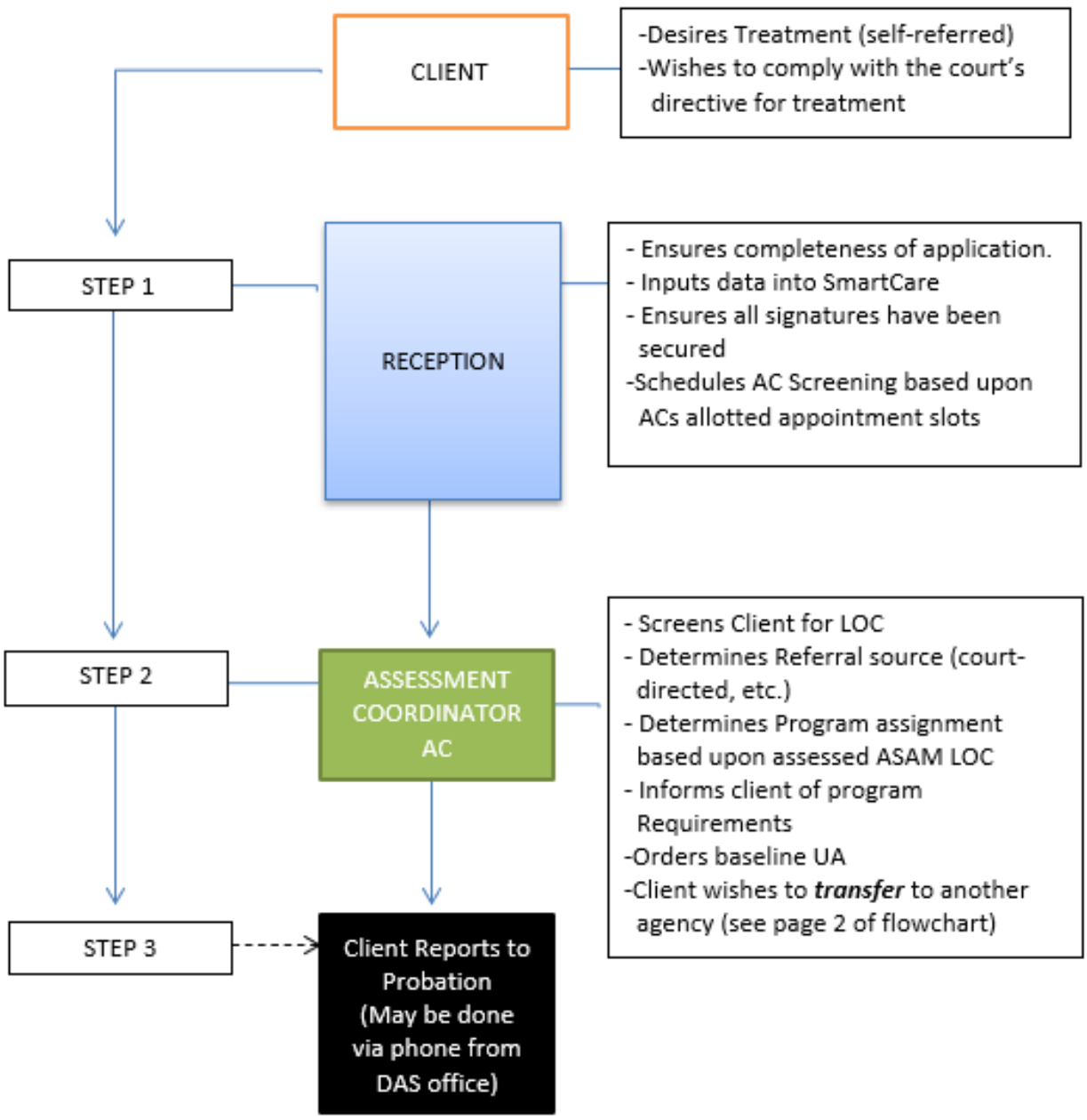
APPENDIX N: PROGRESS REPORTS

A Progress Report can be completed in the following circumstances:

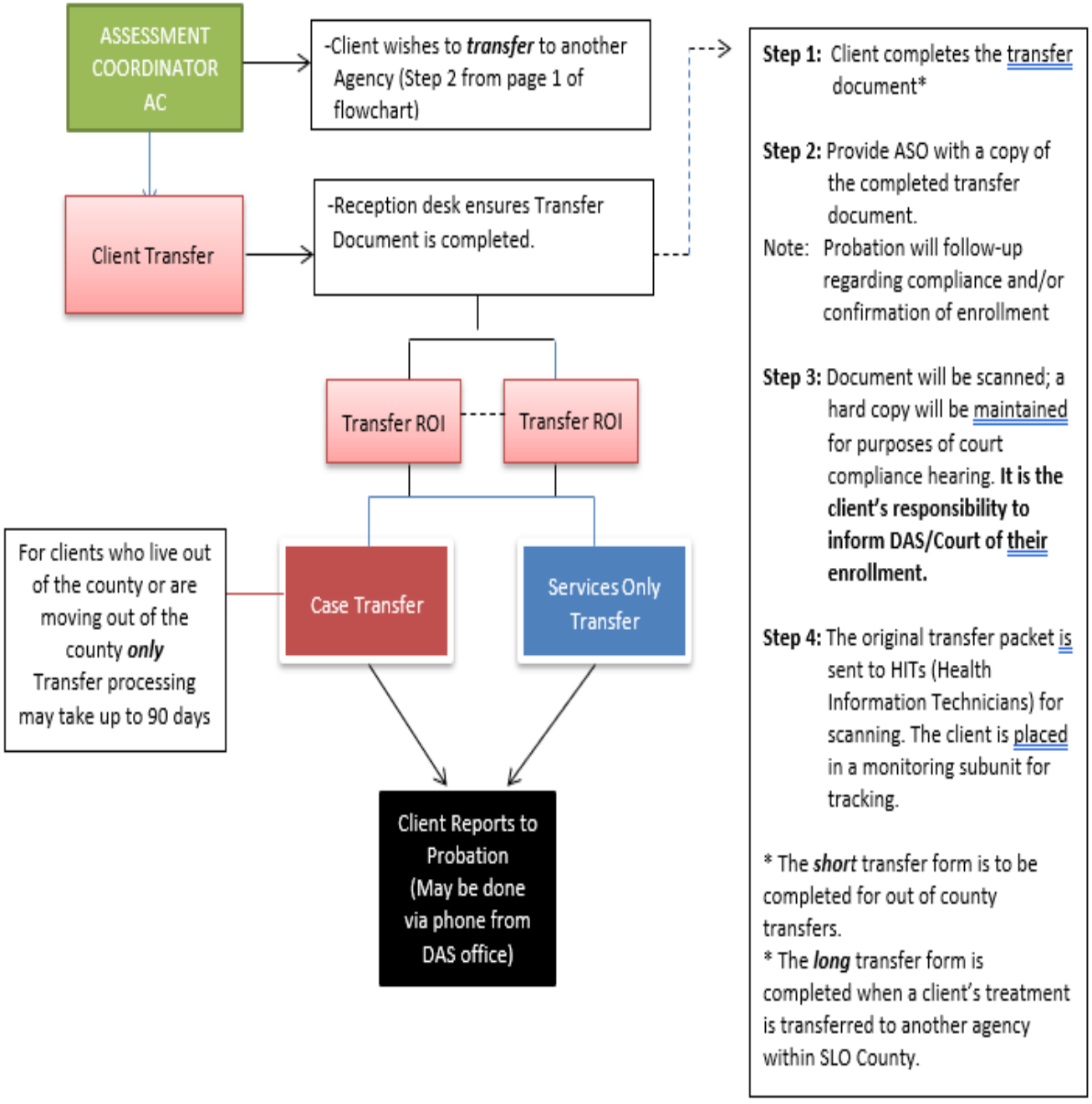
- Client requests a Progress Report to provide to another agency/requesting party (ex: Court, Probation). Once the Progress Report is completed, following the instructions below, the report can be given to the client to provide to the requesting party.
- Used as a progress report when a client needs to be returned to court for Prop. 36 and DEJ.

1) Progress Reports are documented on a PDF paper document. The PDF document can be found here: MySLO - Paper Forms
2) A Program Supervisor must review the Progress Report to approve the information that is being reported/released.
3) The Progress Report is given to a designated Administrative Services Officer (ASO) to provide to a court, if applicable.
4) The Progress Report is given to the site HIT to be scanned into the record.

APPENDIX O: CRIMINAL JUSTICE INTAKE PROCESS (PTD, PROP 36)



APPENDIX P: CRIMINAL JUSTICE TRANSFER PROCESS (PTD, PROP 36)



APPENDIX Q: DIAGNOSIS FOR RECOVERY SUPPORT SERVICES

1) DAS Client Transitioning to Recovery Support Services
OR
2) Former DAS Client with a Previous DSM 5 SUD Diagnosis from SLOBHD

- Use DSM 5 SUD Diagnosis (mild, moderate, severe) in early or sustained remission as active diagnosis

For Client New to DAS without a Previous DSM 5 SUD Diagnosis from SLOBHD

Personal History of Other Specified Conditions

- Z87.898 "personal history of other specified conditions"

Mild Substance Use Disorder, in Remission

- F10.11 Alcohol Use Disorder, Mild, in early or sustained remission
- F11.11 Opioid Use Disorder, Mild, in early or sustained remission
- F12.11 Cannabis Use Disorder, Mild, in early or sustained remission
- F13.11 Sedative, Hypnotic, or Anxiolytic Use Disorder, Mild, in early or sustained remission
- F14.11 Cocaine Use Disorder, Mild, in early or sustained remission
- F15.11 Other Stimulant Use Disorder, Mild, in early or sustained remission
- F16.11 Hallucinogen Use Disorder, Mild, in early or sustained remission
- F18.11 Inhalant Use Disorder, Mild, in early or sustained remission
- F19.11 Other Psychoactive Substance Use Disorder, Mild, in early or sustained remission

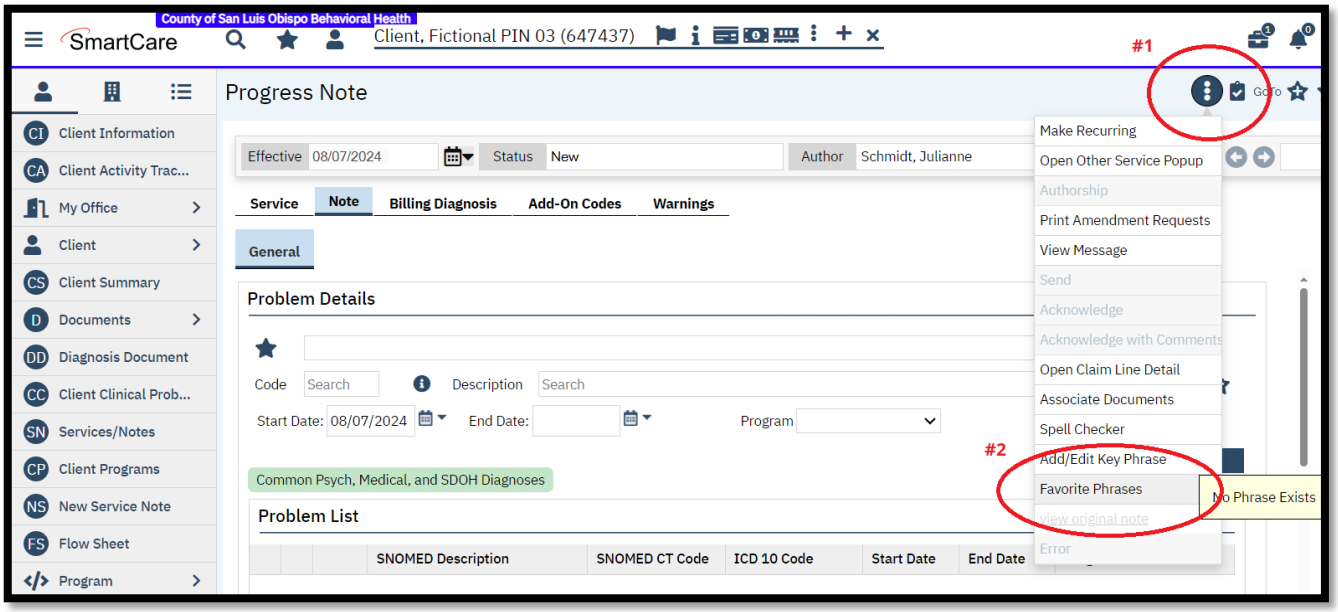
Moderate or Severe Substance Use Disorder, in Remission

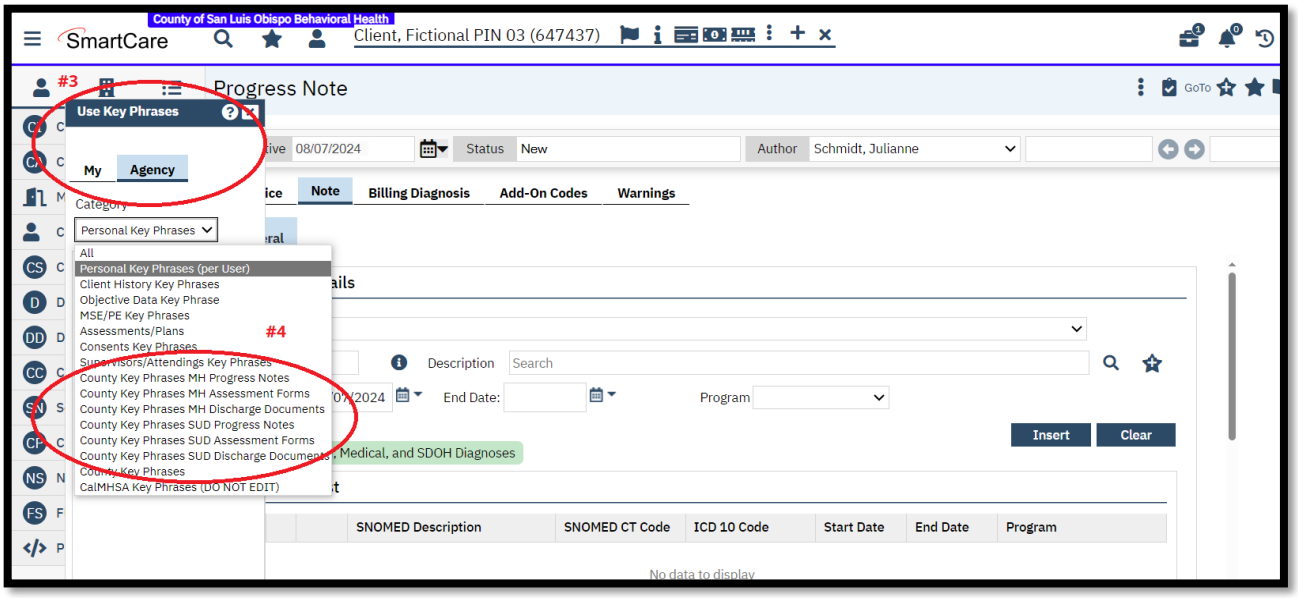
- F10.21 Alcohol Use Disorder, Moderate or Severe, in early or sustained remission
- F11.21 Opioid Use Disorder, Moderate or Severe, in early or sustained remission
- F12.21 Cannabis Use Disorder, Moderate or Severe, in early or sustained remission
- F13.21 Sedative Use Disorder, Moderate or Severe, in early or sustained remission
- F14.21 Cocaine Use Disorder, Moderate or Severe, in early or sustained remission
- F15.21 Other Stimulant Use Disorder, Moderate or Severe, in early or sustained remission
- F16.21 Hallucinogen Use Disorder, Moderate or Severe, in early or sustained remission
- F18.21 Inhalant Use Disorder, Moderate or Severe, in early or sustained in remission
- F19.21 Other Psychoactive Substance Use Disorder, in early or sustained remission

APPENDIX R: KEY PHRASES

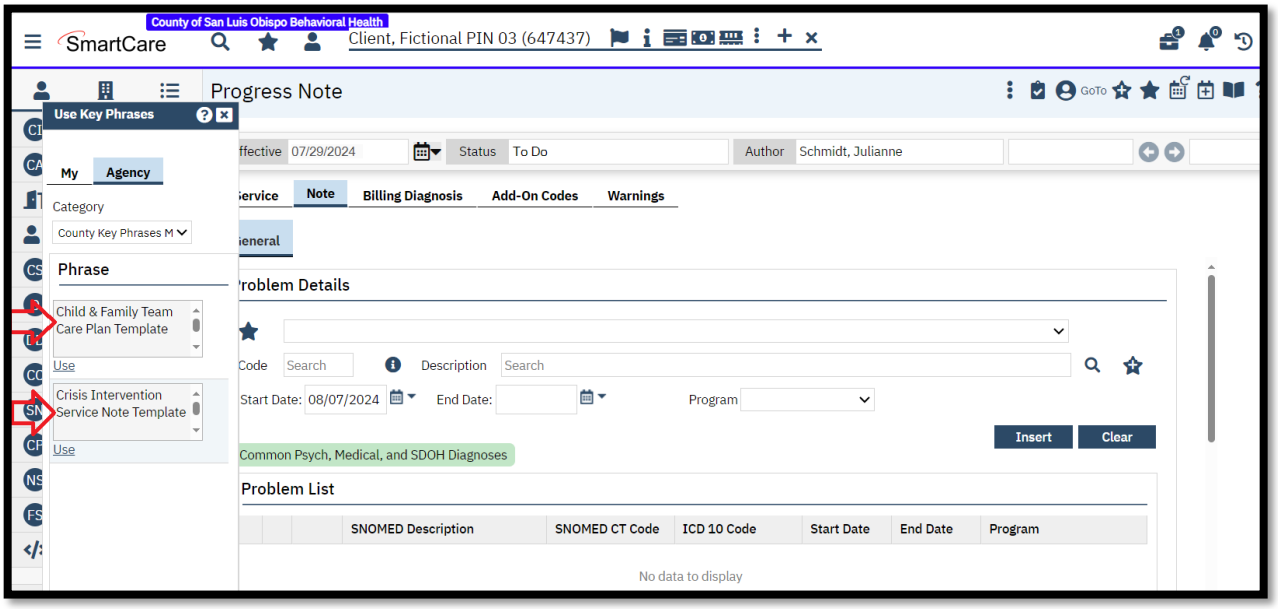
How to Use Key Phrases in SmartCare

- Key Phrases is what template text is called in SmartCare.
- Directions:
  - Open Client Chart
  - Start a new version of the documentation you are entering, whether that be a service note, an assessment, or a discharge summary.
  - Select the three dots icon (#1 below), and then select "Favorite Phrases" (#2 below). A new menu will open on the left side of your screen called "Use Key Phrases."
  - Select "Agency" (#3 next page), and then select the category of the key phrases you would like to view/use (#4 next page) from the "County Key Phrases" choices available.
  - Key Phrases have been developed that are Mental Health treatment specific (denoted by "MH" in the title) and Substance Use Disorder treatment specific (denoted by "SUD" in the title).





- Each Key Phrase available displays in a separate box (see arrows below). Each box has been titled to indicate what the template text is intended for.
- Put your cursor where you want the key phrase/template text to go. Then click the "use" link. The text will populate in the location you have chosen with your cursor.



- Delete template text that is not needed (directional template text).