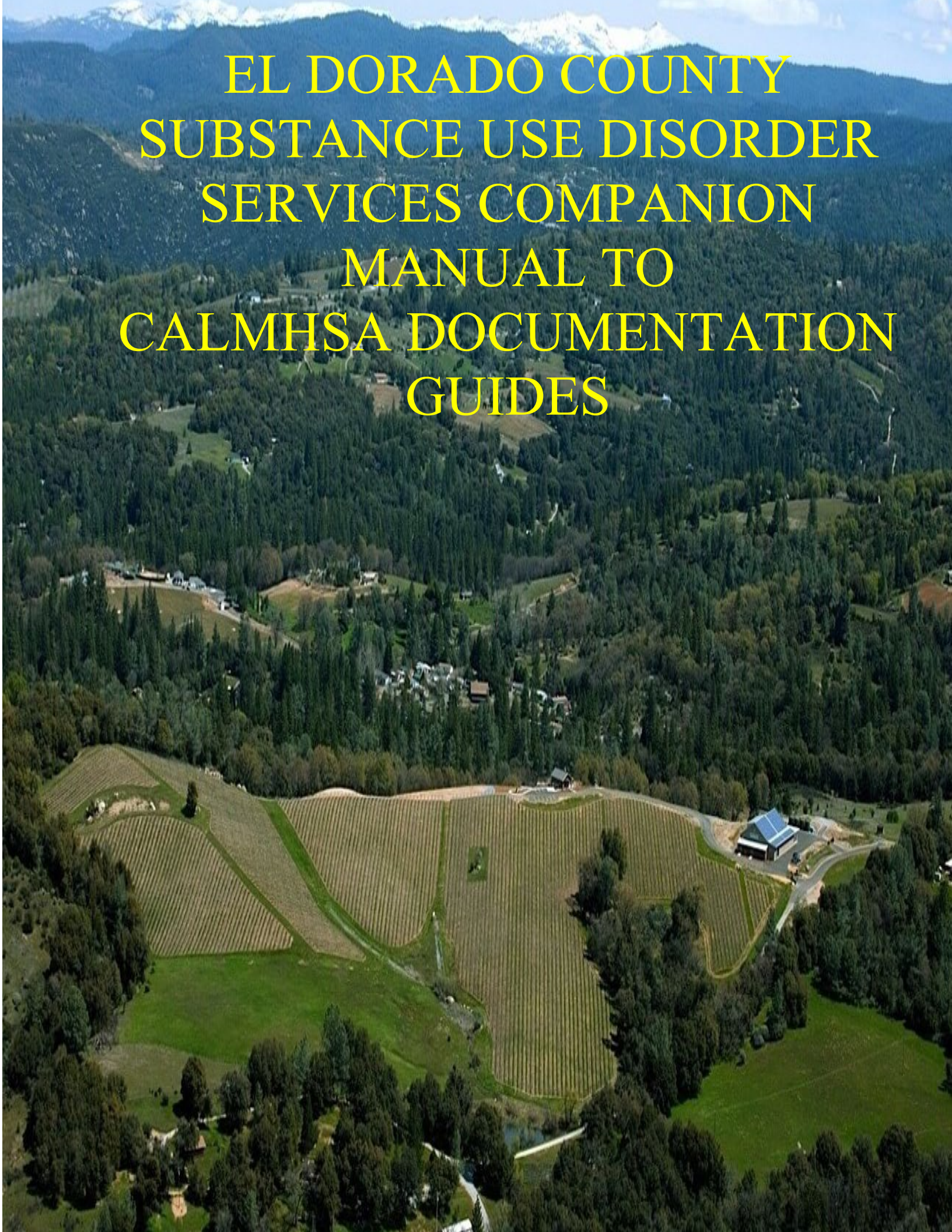
EL DORADO COUNTY SUBSTANCE USE DISORDER SERVICES COMPANION MANUAL TO CALMHSA DOCUMENTATION GUIDES



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Introduction to This Manual

This manual is meant to be a companion guide to the California Mental Health Services Authority (CalMHSA) Documentation Guides that are posted on www.calmhsa.org/documentation-guides/. There are multiple guides targeted toward different types of disciplines in the mental health and substance use fields. These guides are updated by CalMHSA regularly, so we recommend **NOT** downloading and saving these, but rather accessing them from the website whenever possible. This manual will provide guidance on El Dorado County DMC-ODS specific processes.

Overview of Standards

Substance Use Services administered in El Dorado County are held to varying, and at times overlapping, regulations depending on, but not limited to, the service modality, activities being performed and funding source. The El Dorado County (EDC) DMC-ODS will operate according to the regulations set forth by the Federal Government, the State of California, as well as its own provisions outlined in specific provider contracts. It is common for providers in El Dorado County to offer a variety of services each of which with their own set or multiple sets of regulations to follow. No one set of regulations addresses all components of the provision of Substance Use Services but the California Advancing and Innovating Medi-Cal (CalAIM) initiative is a multiyear plan to make services more standardized and more equitable across the state, bringing consistency to the current patchwork of regulations. **This documentation guide is written with the goal to support and/or clarify the standards found in the CalMHSA documentation guides by detailing El Dorado specific practices that fall within new regulations and will be updated as needed to reflect the most up to date information as we progress through CalAIM's multiyear plan.**

Standard and Philosophy of Care, Strategic Priorities andDocumentation

Behavioral Health – Substance Use Disorder Mission Statement

The Substance Use Disorder (SUD) Services program leads efforts in our community to prevent and reduce the impact of substance use disorders by developing, administering, and implementing evidence-based approaches to youth prevention, treatment, and recovery programs in El Dorado County.

Standard of Care

This documentation standards companion manual has been created in accordance with the Drug Medi-Cal Organized Delivery System (DMC-ODS) Intergovernmental Agreement (I/A) between the DHCS and EDC, DHCS Behavioral Health Information Notices (BHIN), CalAIM initiatives, and County policies. It is meant to guide EDC DMC-ODS Standard of Care and applies to all SUDS clients regardless of payer source.

All staff must be trained in and adhere to the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition. The ASAM Criteria was created to improve the quality of and access to addiction care and is a proven model in the SUDS field. ASAM Criteria is the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

Program and modality-specific documentation requirements have been included where possible. CalAIM is changing the landscape of documentation, but because of competing federal and state requirements, not all of the CalAIM initiatives are able to override federal guidance. When competing requirements occur, please contact SUDS Quality Assurance (sudsqualityassurance@edcgov.us) to review guidance and identify the correct plan of action.

Philosophy of Care

EDC SUDS adheres to a philosophy of client-centered care that focuses on providing services, which are individualized to the client's needs. Treatment plans are created collaboratively with the client to support the client in achieving their goals. County SUDS staff are supported to utilize a

client-centered approach when providing care to our clients. Client-centered refers to a counseling perspective where the client must make the choices which affect their lives. Clients are autonomous decision makers. The counselor's role is to support the client so they can make the best decisions possible, and not make decisions based on fear**.** The client-centered approach is based on building a supportive relationship.

Motivational Interviewing (MI) is an effective route to establishing a client-centered and supportive relationship with the client. MI is defined as a directive, client-centered approach for eliciting behavior change by helping clients explore and resolve ambivalence. This counseling style includes the use of reflective listening, rolling with resistance, agenda-setting, and eliciting self-motivational statements and change talk. More information on Motivational Interviewing can be found at:

https://motivationalinterviewing.org/sites/default/files/understanding_mi_aug_2019.pdf

It is our hope that through application of the client-centered philosophy, clients will be able to live healthy and meaningful lives within their community.

Strategic Priorities

The DMC-ODS approach is expected to provide EDC SUDS clients with improved access, expanded services, greater appointment availability and a focus on individualized treatment to ensure clients are receiving the best care possible. It also presents an opportunity for the County to achieve:

- Integration of physical and mental health service needs with SUD services
- Higher quality standards to improve health outcomes
- Provision of the right number of services, at the right time, in the right setting

Documentation

This manual was created in order to provide network providers with a resource that can be used to increase an understanding of and skill in application of new CalAIM documentation standard requirements. The hope is that treatment staff will be able to efficiently and accurately document services with a focus on client engagement and in consideration of Federal, State and County requirements for billing. To maintain simplicity and brevity of this manual, treatment

staff should familiarize them-selves with ODS documents that include but are not limited to, El Dorado County Policy N-SUDS-05, DHCS BHINs 21-075, 22-019, 42 CFR 8.12 and other federal guidelines, as well as EDC BeneficiaryHandbook, and the EDC Grievance & Appeal Policy and Procedures. These documents provide a deeper understanding of why documentation is required as outlined in this manual, we encourage you to refer to these resources as needed for clarification, as well as consult with your Supervisor, Program Manager and/or the Quality Assurance Team

Benefits of Good Documentation

Documentation plays a crucial role in any treatment setting. Documentation helps assure continuity of care. There are many important moments in treatment and proper documentation can help the practitioner to recall those moments. Behaviors and emotions can help tell a story; being able to discover patterns can help to uncover reasons for certain behavior. Documentation is a very simple tool to help any practitioner is unveiling patterns. It can help track the progress in addressing thought patterns and unhealthy behaviors. If a practitioner isn't utilizing the tool of documentation it would prove to be very difficult to track continual progress on any one area, let alone multiple areas.

Thorough documentation helps to assist the client's subsequent care. It's important for practitioners, who may serve the client down the line, to have proper information. Without meaningful documentation, it would prove difficult for any future practitioner to continue timely progress. As mentioned earlier, it is important to identify patterns and track the client's progress; if the new practitioner isn't aware of the knowledge, insight, and progress the client has made, it could be a hindrance to any further progress of the client. This is not only a detriment to the subsequent practitioners but to clients as well.

Good Documentation:

- Increases compliance with State, Federal, and DMC-ODS contractual requirements.
- Documents medical necessity for services provided.
- Ensures that treatment goals remain on target.
- Demonstrates the effectiveness and outcomes of therapeutic interventions.
- Increases effective communication between treatment providers.
- Serves as a defense against litigation.

- Reduces the risk of Medi-Cal funding disallowances.
- Follows The Golden Thread.

Good documentation not only helps clients and providers -- it protects you and the county as a whole. Remember: "***If it wasn't documented, it wasn't done***."

Requirements & Expectations

The California Department of Health Care Services (DHCS) has contracted with the El Dorado County Health and Human Services Agency to provide Substance Use Treatment Services. EDC SUDS must ensure Federal and State regulations are met under the contract. EDC SUDS' obligation is to monitor all provider agencies to ensure they are appropriately licensed and credentialed, follow all regulatory standards, monitor provider billing, process claims for reimbursement, conduct compliance audits, and offer training, quality improvement and technical assistance to network treatment providers. El Dorado County is considered a Network Provider and so our services are subject to all the requirements as other Network Providers.

System Performance

DMC-ODS requires specific performance metrics in areas such as network adequacy, timely access to care, appropriate placement, and client engagement, authorization for residential services, quality of care, cost effectiveness, and client satisfaction. Multiple data measures will be collected and reported to DHCS including *but not limited to:*

- **Timeliness to Treatment Services:** The following metrics are tracked: time from initial screening/referral to 1st appointment, timely appointments, no-shows and other measures.
- **Quality of Care Standards:** EDC SUDS will ensure providers operate within their scope of practice, have documented evidence of fidelity to the ASAM model and medical necessity as well as requiring authorization for residential treatment services. EDC SUDS will measure clinical and/or functional outcomes of clients along with other measures.
- **Use of:** Evidenced Based Practices.

Client Records

All providers, regardless of DMC certification status, must establish, maintain, and update as necessary, an individual client record for each client admitted to treatment and receiving services. This includes, but is not limited to:

- A client identifier
- Client date of birth
- Client gender/sex
- Client's emergency contact and if none, so indicate

- Referral source and reason for referral
- Client race/ethnicity
- Client address & phone number
- Client authorization for treatment
- Date of admission and type of admission (LOC)
- Primary counselor identified on Treatment Plan
- Appropriate advisements, authorizations and acknowledgement of receipts

In addition, providers are required to include, in each client's individual client record, all activities, assessments and services. This ***may*** include but is not limited to:

- Intake and admission data, CalOMS, Health Screening Questionnaire (HSQ) and physical examination, where applicable
- Evidence of:
    - Compliance with minimum client contact requirements
    - Compliance with specific treatment modality requirements
- Care coordination with Mental Health and/or Primary Care and or MAT Services
- Problem Lists
- Treatment Plans (NTP/OTP, Peer Support Services only)
- Discharge Plan
- Clinical Discharge Summary
- Continuing Services Justifications
- Laboratory test orders and results
- Medication Dosage
- For pregnant and postpartum women, medical documentation must substantiate a client's pregnancy & the last day of pregnancy.

Client Record Retention Requirements

All providers must maintain the above documentation in the individual client record for a minimum of ten (10) years from the date of the last face-to-face contact with the client, in alignmentwith I/A. Minor client records will be retained at least until the minor attains the age of 20 years, and in any case, for no less than ten (10) years following the minor's date of discharge or client care visit.

Quality Management

SUDS Quality Management is responsible for performing regular compliance reviews. These reviews, also referred to as monitoring, conform to Federal and State regulations as applied within the I/A and the SABG Funding contract. SUDS Administration also conducts fiscal and administrative compliance monitoring annually. The reviews identify areas of compliance and deficiencies that may affect quality of care, access to and timeliness of treatment and provider reimbursement.

Compliance monitoring includes review of the following:

- Personnel Files
- Client Charts
- Facilities Review
- Medication Practices
- Recovery Residences
- Utilization Reviews
- Provider Credentialing

Quality Assurance

It is one of the goals of the ODS to build a system that ensures the overall quality of services. Quality Management monitors member and system outcomes, and resolution of client grievances and appeals. Quality management activities ensure linguistically and culturally accessible, quality-focused, evidence-based and appropriate treatment services. Data is gathered to assess performance to ensure that services follow generally accepted standards of clinical practice and to continuously improve service delivery. Areas of focus in the county QM Work plan include:

- Access to care
- Timeliness of care
- Performance Measures
- Network Adequacy
- Treatment Perception Survey
- Grievances and Appeals

Maintaining a Welcoming and Safe Place

It is very important that every client feels welcomed for care, exactly as they are and that they are in a safe environment. Counselors should inform the client that they can let the provider know if there is anything that causes the client to feel unwelcome, unsafe, or disrespected.

It is also very important that the provider's service locations are safe and welcoming places. Counselors should inform the client to tell the counselor or the provider if anything happens at the service locations that makes the client feel unsafe, so the provider can try to address it.

Clients should be made aware of the safety expectations and responsibilities. One way the provider helps to create safety is by having rules that ask everyone (providers and clients) to have safe and respectful behaviors. These rules are:

- Safe and Respectful Behaviors
- Behave in safe ways towards yourself and others.
- Be free of weapons of any kind. Speak with courtesy towards others.
- Respect people's privacy.
- Respect the property of others and of this service site.
- Sale and/or distribution of alcohol, drugs, nicotine/tobacco products and e-cigarettes are prohibited on premises.
- Use of alcohol and drugs are prohibited on premises.

The provider will work hard to help clients feel welcome in a way that feels safe to the clients and those around them. However:

- To have a welcoming place for all, anyone who is intentionally unsafe may be asked to leave the facility, services may be stopped temporarily or completely, and, if necessary, legal action could be taken.
- If the client appears to be actively under the influence of alcohol or drugs, the client may have the appointment rescheduled.
- For those that appear under the influence, the following steps should be followed
- Developing a Safety Plan should client appear to be actively under the influence ofalcohol or drugs
- Make sure client is not driving themselves. If they did drive to the appointment alone, work to ensure they get a safe ride home. If client is able to give consent, thenyou may call their emergency contact on file in AVATAR

- Should they refuse and drive away, driving under the influence poses an immediatedanger to others and proper authorities should be contacted.

The Progress Note

A progress note is recorded for each service and shall be written by the counselor providing the service. **Progress notes must be completed within 72 hours of service provision (24 hours for crisis).**

Progress notes are individual narrative summaries and may differ substantially based on location and services provided. Progress notes must document relevant aspects of client care, including clinical decisions made, interventions used, and referrals given to the client.

Documentation of all services is required regardless of reimbursement, including no shows and cancellations. Progress notes must include the topic or purpose of the session, **for all service types.** In addition, notes must include the problem(s) addressed, specific interventions, and responses to these interventions and must have enough detail to accurately describe the client's individual story. Generalized statements such as, "Client completed relapse prevention plan", does not address a description of progress. Content, such as personal triggers, specific warning signs, and people the client can turn to when in distress, etc., provides a more thorough understanding of progress.

Notes shall refer to the client's strengths and the efforts the counselor has made to help the individual on the symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters found on the problem list. Progress notes will demonstrate the client's progress in achieving the client goals. Notes will also document those actions steps and interventions are being applied and the client's stage of change.

Notes shall reflect the application or utilization of Evidenced Based Practices (EBP) during the course of treatment. They will also show whether services were offered in the client's preferred language, including whether any paper handouts or other types of assignments given to the client was in client's preferred language.

In addition to recording progress made in treatment, based on individual and group sessions, it is also important to note significant clinical observations. Make sure to distinguish between observationsand personal opinions or judgments.

Here is an example of a clinical observation: *"Client appeared extremely angry in group; sat with fists clenched and rigid posture. When asked to talk, client refused."*

An opinion or judgment by the counselor would be, *"Client was hostile toward others and looked like he was ready to hit someone. Client probably drank last night."* Documenting clinical observations is important – documenting opinions and judgments is inappropriate.

Progress notes are the heart of the clinical record. A service provided for a client, regardless how powerful or effective, is incomplete until documented. The progress note is also required to substantiate the services which are billed to the state for reimbursement. Effective documentation of clinical interventions is a professional, legal and ethical responsibility of all clinical staff.

Scope of Practice

It is expected that all County SUDS treatment staff that are involved in providing SUD services are properly licensed or certified, per their scope of practice (SOP). A treatment provider's scope of practice refers to what a treatment provider can and cannot do to or for a client and is defined by state professional regulatory boards—typically with the guidance or instruction of the state's legislature. The SOP ensures that SUDS treatment provider staff are performing within the scope of their training and competence.

Program Requirements

The following requirements are a summation meant for quick reference. The entirety of requirements can be found through the hyperlinks associated with each standard.

Narcotic Treatment Programs

Narcotic Treatment Programs (NTP) are required by Federal law to create treatment plans for their beneficiaries. Furthermore, NTP requirements for documentation and program requirements were not changed under BHIN 22-019. **NTP/OTP will continue to operate under Federal Opioid Treatment Standards** as detailed in 42 C.F.R. § 8.12 and California Code of Regulations, Title 9, Chapter 4, Division 4.

Initial Assessment Services During Assessment Process (Non-Residential Services)

As detailed in BHIN 21-075, covered and clinically appropriate services (**except for residential**

treatment services) are Medi-Cal reimbursable for up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a DSM diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days if the beneficiary is under age 21, or if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment. If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day time period starts over.

The initial assessment is to be performed face-to-face, by telehealth ("telehealth" throughout this document is defined as synchronous audio and video) or by telephone (synchronous audio-only) by an LPHA or registered or certified counselor and may be done in the community or the home.3 If the assessment of the beneficiary is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

Regarding medically necessary covered DMC-ODS services delivered by DMC-ODS providers are covered and reimbursable Medi-Cal services whether or not the beneficiary has a co-occurring mental health condition. El Dorado County will not disallow reimbursement for covered DMC-ODS services provided to a beneficiary who has a co-occurring mental health condition if the beneficiary meets the DMC-ODS criteria after the assessment.

Narcotic Treatment Programs (NTPs)

For El Dorado County NTP providers, assessments can be performed face-to-face, by telehealth ("telehealth" throughout this document is defined as synchronous audio and video) or by telephone (synchronous audio-only) by an LPHA or registered or certified counselor and may be done in the community or the home. **NTPs shall conduct a history and physical exam by an LPHA pursuant to state and federal regulations. The history and physical exam done at admission to a NTP qualifies for the purpose of determining medical necessity under the El Dorado County DMC-ODS program.**

Level of Care Determination

El Dorado County network providers are required to use the ASAM Criteria to determine placement into the appropriate level of care for all beneficiaries and is separate and distinct from determining medical necessity.

a. For beneficiaries 21 and over, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with an LPHA or registered/certified counselor.

b. For beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary's first visit with an LPHA or registered/certified counselor.

c. A full ASAM Criteria Assessment is not required to deliver prevention and early intervention services for beneficiaries under 21; a brief screening ASAM Criteria tool is sufficient for these services (see below regarding details about ASAM level of care 0.5).

d. If a beneficiary withdraws from treatment prior to completing the ASAM Criteria assessment and later returns, the time period starts over.

e. A full ASAM assessment, or initial provisional referral tool for preliminary level of care recommendations, shall not be required to begin receiving DMC-ODS services.

f. A full ASAM assessment does not need to be repeated unless the beneficiary's condition changes.

Beneficiary placement and level of care determinations shall ensure that beneficiaries are able to receive care in the **least intensive level of care** that is clinically appropriate to treat their condition.

Medical Necessity of Services

Under CalAIM, services provided within El Dorado's network must still be medically necessary. Pursuant to W&I Section 14059.5(a). However, for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions. For individuals under

21 years of age, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered services. This means that for individuals under the age of 21, treatment services may be provided even if they are "at risk" of developing a substance use disorder.

Residential Services

Authorization for residential services (excluding withdrawal management services) are still required to be authorized. El Dorado County will authorize services within 24 hours of prior authorization request being submitted. El Dorado County will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for residential services.

Withdrawal Management Services

Withdrawal management services are separate from residential services and no longer require prior authorization.

Recovery Services

Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level. Recovery Services emphasize the beneficiary's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to beneficiaries. **Beneficiaries can now receive Recovery Services based on self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services.** Beneficiaries may receive Recovery Services while receiving MAT services, including NTP services. Beneficiaries may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD. Services may be provided in person, by telehealth, or by telephone. Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care

Medically Assisted Treatment (MAT) Services

Under CalAIM, El Dorado County will ensure that all network providers, at all levels of care,

demonstrate that they either directly offer or have an effective referral mechanism to the most clinically appropriate MAT services for beneficiaries with SUD diagnoses that are treatable with medications or biological products (**defined as facilitating access to MAT off-site for beneficiaries if not provided on-site. Providing a beneficiary, the contact information for a treatment program is insufficient**). An appropriate facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary is compliant whether or not that provider seeks reimbursement through DMC-ODS. DMC-ODS Counties shall monitor the referral process or provision of MAT services.

Telehealth Consent

If a visit, provided with the El Dorado network, is provided through telehealth (synchronous audio or video) or telephone, the network **provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a beneficiary.** The consent disclosure must include an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider. The provider must document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

Protected Health Information

Any verbal, written, recorded or electronic information that identifies or can identify a clientis considered Protected Health Information (PHI), Personally Identifiable Information (PII). All counselors must complete mandated training that covers Health Insurance Portability and Accountability Act (HIPAA) and 42 Code of Federal Regulations (CFR) Part 2 regulations upon employment and every year thereafter. **All credentialed and non-professional staff with access to**

PHI, PII, and PI must complete, at hire and annually, El Dorado County Security & Confidentiality Trainings, as well as submit signed security and confidentiality statements upon conclusion of training.

Best clinical practice regarding PHI, PII and PI requires that all authorizations, consents, and advisements be explained to clients in their preferred language and in a developmentally appropriate manner. **This explanatory process is called informed consent and is mandatory**.The process of informed consent ensures that clients understand "what" documents they are signing and "why" they are signing those documents. The signed authorizations and consents function as part of the legal record. All authorizations, advisements, and acknowledgements mustbe completely filled out, signed, and dated. Authorizations have various timelines; most require annual update.

There are specific state and federal required confidentiality laws for all clinical records thatcontain protected health information PHI, PII and PI. All providers, both at the program and at the individual level, are required to safeguard the record against loss, defacement, tampering, or use by any unauthorized persons. Records must be stored in a double locked location and if transported, must always be maintained in a locked unit. All electronic devices containing PHI must also be secured. Please refer to 45 CFR for completedetails.

https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html

HIPAA – Health Insurance Portability and Accountability Act

HIPAA Provides data privacy, and security provisions, for safeguarding medical information. A summary of the HIPAA privacy rule can be found here:

https://www.hhs.gov/hipaa/for-professionals/privacy/index.html

For more general information on HIPAA, please see:http://www.hhs.gov/ocr/privacy/index.html.

Note: These laws and regulations should not be used as barriers to providing coordinated and integrated care. Provided that the appropriate client releases and/or consents for treatment are obtained, every effort should be made to share clinical information with relevant providers across the continuum of care (including mental and physical health). Within the requirements of the laws and regulations governing confidentiality in the provision of health services, all providers within the SUD system must cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information for the purposes of improving the effectiveness, integration, and quality of

health services.

42 CFR PART 2-Confidentiality of Substance Use Disorder Patient Records.

All SUD treatment programs must operate in accordance with legal and ethical standards. Federal and state laws and regulations protect the confidentiality of client records maintained by all contracted providers. Maintaining appropriate confidentiality is of paramount importance. All providers are required by contract to establish policies and procedures regarding confidentiality and must ensure compliance with Title 42, Chapter I, Subchapter A, Part 2 of the Code of Federal Regulations, Part 2 (42 CFR Part 2), the Health Insurance Portability and Accountability Act (HIPAA) standards, and California State law regarding confidentiality for information disclosure of alcohol and drug use, and other medical records.

42 CFR Part 2 – Confidentiality of Alcohol and Drug Client Records Covers all records relating to the identity, diagnosis, and/or treatment of any client in a SUD program that is conducted, regulated, and/or assisted in any way by any federal agency.

For a summary of 42 CFR Part 2, please see:

https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2

- Subpart A includes an introduction to the statute (e.g., purpose, criminal penalty, reports of violations, etc.).
- Subpart B covers general provisions (e.g., definitions, confidentiality restrictions, and minor members, etc.).
- Subpart C covers disclosures allowed with the client's consent (e.g., prohibition on re-disclosure, disclosures permitted with written consent, disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs, etc.).
- Subpart D covers disclosures that do not require client consent (e.g., medical emergencies, research, evaluation and audit activities).
- Subpart E includes information on court orders around disclosure (e.g., legal effects of order confidential communications, etc.).

Unique Identifier Information that Must Be Protected

Personal Identifiable Information that identifies an individual is also referred to as Unique Identifier Information. Unique identifier information that must be protected includes:

- Names
- All subdivisions smaller than a State including street address, city, county, precinct, zip code, and their equivalent geocodes
- All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death, and age
- Telephone numbers
- Fax numbers
- Email addresses
- Social Security numbers
- Medical Record numbers
- Health plan client numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web URLs
- Internet protocol (IP) address numbers
- Biometric identifiers, including finger, iris, and voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic, or code

Client Problem Resolution Process

All clients are entitled to have access to the problem resolution process. The process allows clients to express any dissatisfaction they may have with their health care services, health care provider, or decisions made about their treatment services by their covering plan (in the case of a Medi-Cal client). A client may file a complaint verbally or in writing at any time during the course of their treatment. Both DMC insured clients and non-DMC clients may file a complaint

- With their primary case manager or counselor
- With any SUDS Tx staff person
- With any contracted provider treatment staff person
- By calling the 24/7 Access Line 1-800-929-1955

- By calling the office line 530-621-6290
- By walking into any County SUDS DMC Certified location
- By email to odsaccess@edcgov.us

County SUDS staff must inform clients of the problem resolution process at intake/assessment. All clients shall sign an "Acknowledgement of Receipt" that they have received a copy of the handbook and been informed of the problem resolution process. If a client wishes to file their complaint in writing, the provider shall offer the Grievance/ Appeal/Expedited Appeal form. County SUDS staff are to be available to help clients, if need be, to complete the form. This form should be made available at all EDC Plan sites.

County SUDS staff should familiarize themselves with the process in order to be able to explain the process to clients and treatment providers.

Notice of Adverse Benefit Determination (NOABD)

An NOABD is a form that is executed and sent from the County DMC-ODS Plan to the client when a decision is made for the following reasons:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting or effectiveness of a covered benefit.
- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner.
- The failure to act within the required timeframes for standard resolution of grievances and appeals.
- The denial of a client's request to dispute financial liability.

A Notice of Adverse Benefit Determination (NOABD) must explain the reason for the change in treatment services and then be mailed or hand-delivered to the client 10 days prior to any action taken by the provider. Providers of DMC services must also advise DMC clients of their State Fair Hearing Rights upon admission and *again* at any adverse change in treatment services.

The "Your Rights" form is distributed with the NOABD to the client; the "Your Rights" form explains the State Fair Hearing process to Medi-Cal clients. Additionally, providers will send

nondiscrimination notices and language assistance taglines as required by DHCS whenever distributing significant communication to clients, such as an NOABD, or Notice of Appeal Resolution (NAR). A NOA type letter must also be given to non-Medi-Cal clients along with an explanation of how to request an Internal Fair Hearing, which is an equitable problem resolution process for uninsured clients.

NOAs are kept in the client's record and clinical staff will document in the progress notes any attempts to contact the client about an adverse change in services and their client rights.

The NOABDs and written notices shall include:

- A statement of the action the provider intends to take.
- The reason for the intended action.
- A citation of the specific regulation(s) supporting the intended action.
- An explanation of the client's right to a State Fair Hearing or internal hearing for the purpose of appealing the intended action.
- An explanation, if all lower levels of problem resolution have been exhausted, that the client may request a Fair Hearing by submitting the request to:

  California Department of Social Services State Hearings Division, ACAB
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430 or Fax to: 1-916-651-2789
  call toll free: Call 1.800.952.5253 or TTY/TDD 1.800.952.8349

  - An explanation that the provider shall continue treatment services pending State and Internal Hearings decisions only if the client appeals in writing to DHCS for a hearing within ten (10) calendar days of the mailing or personal delivery of the notice of intended action.

  - This notification of Fair Hearing and Internal Hearing rights must be provided even if the client is being discharged for failure to attend the program. One good way to do thisis to include The Fair Hearing information on a last letter attempting to contact a client that has stopped attending a program.

- A copy of all NOABDs must be sent to the Quality Assurance Supervisor at sudsqualityassurance@edcgov.us

Grievances, Appeals and Expedited Appeals

Grievance means an expression of dissatisfaction about any matter. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships and failure to respect the client's rights regardless of whether remedial action is requested. Grievance includes a client's right to dispute an extension of time proposed by EDC SUDS investigators of the grievance to make an authorization decision. If a client is dissatisfied with the resolution of the grievance, the client may file another grievance.

The NOABD, the Notice of Title 22 Fair Hearing Rights, the Acknowledgement of receipt of both the client handbook and the problem resolution process and the client Problem Resolution Letter must be kept in the client's chart.

Please note: Copies of all grievances/appeals/expedited appeals are sent to the EDC SUDSto the Quality Assurance Supervisor at sudsqualityassurance@edcgov.us who monitors the resolution process and must report to the State.

If the complaint (problem) is resolved at the provider internal level, notification using the "Noticeof Grievance Resolution" is sent to the client by the provider and a copy is kept in the clinical chart.

The person investigating the grievance is responsible for sending a copy of the Notice of Grievance Resolution to the client and to the provider. If the provider believes a resolution has been achieved but the client chooses to address their concerns with the EDC SUDS, the EDC SUDS resolution process supersedes that of the provider.

Step by Step Process for Grievances

The process for Grievances involves the client making a decision to address what the client deems to be a problem with the treatment episode. The process is as follows:

- The client notifies the case manager that they wish to file a Grievance
- The case manager lets the client know that filing a Grievance is their right
- The case manager explains that the Grievance can be filed two ways:
  - The case manage can directly assist with the paperwork
  - The client can complete the paperwork on their own
- The case manager informs the client that they will provide any information, forms or

support needed

- The case manager then explains what will happen once the paperwork is complete:
  - The client can submit the paperwork directly to the EDC SUDS Quality Assurance email address- sudsqualityassurance@edcgov.us
  - The client can submit the paperwork via the case manager who will then forward the paperwork to the EDC SUDS Quality Assurance email address- sudsqualityassurance@edcgov.us
- The case manager will inform the client that the client will receive two letters:
  - The first letter will arrive within five business days acknowledging receipt of the Grievance.
  - The second letter will arrive within 90 days with the results of the Grievance investigation.
- The case manager will then inform the client:
  - The client has the right to file another Grievance if the client does not agree with the outcome of the investigation
  - The client has the right to speak with the EDC Director of Behavioral Health if the client does not agree with the outcome of the investigation

Cultural Competency

The inclusion of cultural perspectives and practices are critical components of assessments and treatment planning, to ensure perceived problems or issues are identified, and placed in the appropriate clinical context. Within assessments, SUDS staff will document evidence of:

- A discussion of the exploration of culturally significant topics with the client and/or significant support person(s).
- An exploration and discussion of relevant cultural issues that may pertain to the presenting substance use disorder related impairments and which can be used in the development of a culturally- appropriate treatment plan.
- How linguistic accommodations are made, either through a bilingual certified staff or interpreter service.

With growing diversity among clients and treatment providers in our County, it is essential for

SUDS treatment staff to capture the impact of beliefs, norms, culture and language when considering treatment planning and service delivery. At the initial assessment, in treatment planning, and throughout ongoing treatment, treatment staff should explore the following cultural elements in their interactions with clients:

- Racial factors.
- Linguistic factors.
- Religious/spiritual factors.
- Sexual orientation.
- Physical abilities or challenges.
- Socioeconomic factors, and
- Alternative or complementary healing practices.

Moreover, treatment planning must take into account any cultural considerations and how they may influence progress towards a client's treatment plan goals. By understanding and embracing a client's cultural background, staff is able to provide effective, personalized assessment and treatment strategies that elaborate on the client's natural resources and strengths. When talking about culture and health in shared decision making, consider the following:

- Client language preferences
    - What language does the client speak at home?
    - What language would the client like to speak here?
    - Does the client prefer to use an interpreter?
- Decision making in the client's life and family
    - How are decisions typically made in the client's family? In the client's community?
    - Are there particular family members that are consulted on important decisions?
- Beliefs about one's problem or situation
    - How does the client describe or understand their situation?
    - Is there a particular name or term used in the client's family or community to describe what they are experiencing?
    - Family or community beliefs associated with the client's decision making
    - Are the client's family members aware of their situation?
    - What are the client's family members' views about the decision the client is

weighing?

- Spiritual, religious, or family beliefs about the use of medication and other Western medicine treatments
    - How is using medication viewed within the client's family? Within the client's community?
    - How is Western medicine viewed within the client's family? Their faith community?
    - What alternatives are used instead of medication?
    - Are herbs, supplements, and other complementary or alternative medicine preferred?
    - Are there herbs, roots, or supplements that the client uses to promote healing?
- Customs or rituals the client is using or would like to use to promote health and healing
    - Are there customs or rituals that the client uses for health or healing?
    - Are these rituals rooted in religious or family traditions?
    - Are there customs, rituals, or remedies the client would like to try?
- Cross-cultural understanding
    - Are there other aspects of the client's culture or background that are important for the counselor to understand?
    - Are there areas of the client's culture or background that the counselor may have misunderstood?

Linguistic Requirements

Services are to be provided to clients in their preferred language. Language interpretation or translation services should be utilized as necessary. Contracted service providers are required to maintain, at Contractor's sole cost, access to bilingual interpreters, if needed.

For EDC SUDS employees, El Dorado County Health and Human Services Agency contracts for language support services through Language People.

In order to support the linguistic diversity in El Dorado County the following items must be completed, when applicable, based on client need:

Interpreter services must be offered and provided.

NOTE: FAMILY MEMBERS SHOULD NOT BE INTERPRETERS

- A refusal to accept interpreter services must be documented in the client's chart.
- Information must be provided to clients in an alternative format when needed, (e.g., large

font, audio, Braille).

- All related personal correspondence must be provided in the client's preferred language

Services Provided to Persons with Visual or Hearing Impairments

EDC SUDS will utilize the State TTY relay system, (7-1-1), as needed, for hearing impaired clients. Incoming TTY calls can also be accepted at (530) 295-2576, but 711 is preferred.

Client informational materials are to be made available in alternate forms for clients with a visual impairment (e.g., large print, audio format).

California Outcomes Measurements System (Cal-OMS)

What is the CalOMS? It stands for the California Outcomes Measurement System. The data domains gathered in CalOMS include admission information, client identifiers, substance use, employment status, legal status, medical status, mental health status, and social connections. CalOMS is also used to monitor treatment with the goals of improving treatment, being responsive to the service recipients and their families and communities.

CalOMS data are gathered for a variety of reasons:

- Analysis of changes in Treatment: Data collected at admission and discharge on the domains of substance use, legal status, mental status, and social connections.
- Reporting to SAMHSA (Substance Abuse Mental Health Services Administration): CalOMS data are fed into the Treatment Episode Data System (TED), which are used to study national substance use treatment trends.
- Reconciling admissions for Medi-Cal reimbursement: Although CalOMS and Medi-Cal maintain separate systems; Medi-Cal uses the CalOMS admissions record to corroborate that that a client was in fact in treatment during the period for which services were claimed.

CalOMS Reportable and Non-Reportable Modalities

EDC SUDS offers an array of services in the network of care. However, not all service modalities are required to collect and submit CalOMS data.

Reportable Modalities	Non-reportable Modalities
Outpatient	Case Management Programs
Intensive Outpatient	Recovery Residence
Partial Hospitalization	Recovery Services
Additional MAT	Psychiatric services
OTP/NTP	Screening & referral
Withdrawal Management (Detox)	DWI/DUI programs
Residential (all levels)	

County SUDS Programs and CalOMS

County SUDS staff who work at the Community Corrections Center and the South Lake Tahoe Outpatient Program are required to collect CalOMS data and submit according to state policies and procedures. This is because these two programs are offering outpatient treatment which is one of the modalities that is required to report.

County SUDS staff should collect the data at admission, at discharge and annually if the client is still in the program. CalOMS data collection forms are to be sent to the office assistant and uploaded to the client chart in AVATAR. Date of submission to the office assistant shall be noted in the client chart. The link to the DHCS CalOMS page can be found at the end of this manual.

Admission Questionnaire

Which clients should be administered a CalOMS admission questionnaire?

- All clients in a **CalOMS reportable treatment or service modality** (See above for list of reportable modalities) must be administered a CalOMS admission questionnaire, after the client has been formally admitted to treatment.

CalOMS is designed to be administered to program clients. A program participant should be administered a CalOMS admission form after it has been determined that the client has met the following criteria:

- A SUDS (substance use disorder) related problem
- Consented to treatment
- Completed the screening and admission process
- Been formally admitted to a SUD program facility for treatment (treatment services must have commenced).

CalOMS data must be gathered from all clients **irrespective of the payer** if they are receiving treatment in a facility that receives any DHCS funding (not just Medi-Cal):

- CalOMS data is also required for a private pay client who is receiving treatment in a facility that either completely or partially funded with DHCS dollars

Who should not be administered the CalOMS admission questionnaire?

CalOMS admission questions should NOT be administered to clients who:

- Have completed screening and/or the intake process but have not been admitted (seen a counselor)
- Have been placed on a waiting list
- Have received ONLY crisis counseling (such as at schools)
- Have been participating as an alumnus continuing involvement with the program
- Are attending self-help groups

Discharge Questionnaire

A CalOMS TX discharge data collection form must be submitted if an admission data collection form has been submitted for the client. Hint: All clients should have a CalOMSadmission completed if they are in OS, IOS, RES, MAT, and NTP.

The discharge questionnaire can be conducted either in person (face-to-face) or viatelephone. Treatment providers are advised to include a date to conduct a CalOMSdischarge questionnaire in the client's treatment plan. The earliest date the questionnaire can be administered is 2 weeks prior to a planned date of last service.

- Providers should try to conduct the CalOMS discharge questionnaire in a face-to- face session with a client.
- If a client is unable to appear for the scheduled discharge session, despite having made progress in treatment, then the client should be contactedby phone to complete the questionnaire.
- It should be noted that a telephone administration of the CalOMS discharge questionnaire does not constitute a clinical service by itself and cannot be billed.

How should the date of discharge be determined?

- For all modalities (except NTP/OTP):
    - For standard discharges, the discharge date is the last face-to-face or telephone session (service) date with the clinician.
    - If the standard discharge is conducted via telephone, then the discharge date is the date of the telephone interview. This is relatively rare for residential treatment services.
- For NTP/OTP:
    - The discharge date is the date of the client's last oral medication.
- For administrative discharges, the date of discharge depends on the treatment modality.

Administrative Discharges

The CalOMS Data Collection Guide (2014) states that:

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

CalOMS Data Dictionary provides additional details about the circumstances that lead to an administrative discharge for each modality of treatment. The rules are presented below.

Non-Residential/Outpatient Programs:

- Report an administrative discharge if s/he has not had at least one face to face visit (service) with a treatment counselor in 30 consecutive days.
- In this case, a client is deemed to have stopped treatment services without leave or notification to the program. The program cannot reach the client to complete the CalOMS discharge interview within 30 days. An administrative discharge is required in this instance.

- For an administrative discharge, the date of discharge is the date of the last face-to-face or telephone session.
- However, if the client can be located and s/he agrees to come in for additional treatment, the client will not need to be discharged.

Residential:

- Report an administrative discharge if s/he has been absent from the program without leave (from the program or treatment counselor) for seven consecutive days. If leave has been granted and the individual does not return by the date s/he is expected, begin counting from the day s/he was due back to the program.
- Clients who do not return from a leave (pass), the count of 7 days begin on the day the client was expected back. So, if a client was expected back on March 13th, but did not return to the program on the stipulated date, the client must be discharged administratively by March 20th.
- The date of discharge is the expected date of return.

Cal-OMS Admission and Cal-OMS Discharge Forms

The Cal-OMS Admission and Cal-OMS Discharge forms in Avatar are not only for collecting demographic data from each SUD service recipient. The forms also serve to collect treatment data which illustrates the positive influence SUD services has on SUD clients as well as facilitates the improvement of service delivery.

The forms contain questions about client demographics, substance use, social supports and other factors that can impact treatment.

CalOMS Data Collection Timelines

- CalOMS Tx Admission data is due to SUDS Office Assistant within 14 days of client's first service (which is the admission date).
- CalOMS Tx Discharge data is due to SUDS Office Assistant within 7 days of discharge date.
- CalOMS Tx Annual Update is due to SUDS Office Assistant within 14 days of the client's 1 year anniversary of admission date. **Annual Update date must be the one-year anniversary date.** For example: Admission is 4/25/17: Annual Update date is due 4/25/18

All CalOMS Tx data is protected Personal Health Information (PHI). At a minimum, when using

this data, use protection that complies with the privacy and security requirements defined in the rules of the Health Insurance Portability and Accountability Act (HIPAA) and Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2).

Monthly Tracking Reports

Medi-Cal Excel Timeliness Report and Medi-Cal Excel Level of Care Report

Each staff member is required to submit two Tracking Reports each month. These reports are contained in an Excel spreadsheet named:

- Medi-Cal Excel Timeliness Report
- Medi-Cal Excel Level of Care Report

These reports are due no later than 5th of each month and/or the first Monday after the 5th of each month. These reports shall be submitted via email to the SUDS Office Assistant.

Medi-Cal Excel Timeliness Report

Timeliness Reports track the time it takes for a beneficiary to receive services from the time they request those services. Due to DHCS Network Adequacy Requirements, beginning FY 22-23 El Dorado SUDS is implementing a new timeliness tracking report. EL Dorado County SUDS is working with to implement this form into Avatar system, until the new forms are complete the following excel sheet will be utilized. Timeliness report is due no later than the 5th day of the following month. For example, August 2022's tracking would be due by September 5, 2022.

DMC-ODS Timely Access Data Tool																		
DMC-ODS:			Outpatient Services - SUD															
Beneficiary Name	Age Group (Required)	County Client Number (CCN) (Required)	Referral Source (Required if applicable)	Date of First Contract to Request Services (Required)	Assessment Appointment First Offer Date (Required)	Assessment Appointment Second Offer Date (Required if applicable)	Assessment Appointment Third Offer Date (Required if applicable)	Assessment Appointment Accepted Date (Required)	Assessment Start Date (Required)	Assessment End Date (Required)	Treatment Appointment First Offer Date (Required)	Treatment Appointment Second Offer Date (Required if applicable)	Treatment Appointment Third Offer Date (Required if applicable)	Treatment Appointment Accepted Date (Required if Applicable)	Treatment Start Date (Required)	Close out Date (Required)	Closure Reason (Required if applicable)	Referred to (Required if applicable)	Description of Facts and Circumstance.

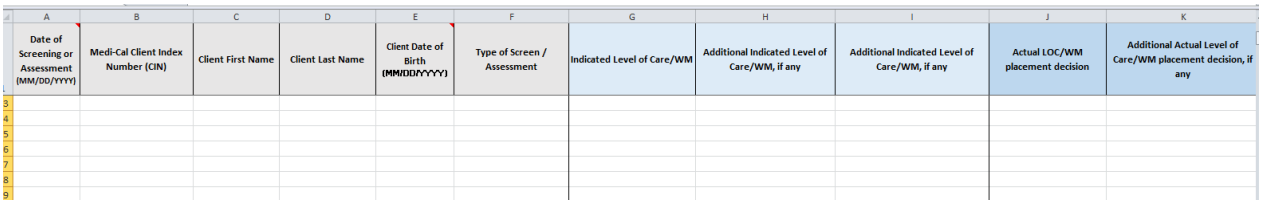
Timely Access Data Tool Columns

Column A	Beneficiary Name	Enter txt name.
Column B	Age Group (Required)	01 = Children/Youth: 0-17 02 = Adult: 18+
Column C	County Client Number (CCN) (Required if applicable)	
Column D	Referral Source (Required if applicable)	
Column E	Date of First Contract to Request Services (Required)	Use date format: MM/DD/YYYY
Column F	Assessment Appointment First Offer Date (Required)	Use date format: MM/DD/YYYY
Column G	Assessment Appointment Second Offer Date (Required if applicable)	Required if the first offer date is not accepted. Use date format: MM/DD/YYYY
Column H	Assessment Appointment Third Offer Date (Required if applicable)	Required if the first and second offer dates are not accepted. Use date format: MM/DD/YYYY
Column I	Assessment Appointment Accepted Date (Required)	Use date format: MM/DD/YYYY
Column J	Assessment Start Date (Required)	Use date format: MM/DD/YYYY
Column K	Assessment End Date (Required)	Use date format: MM/DD/YYYY
Column L	Treatment Appointment First Offer Date (Required)	Use date format: MM/DD/YYYY
Column M	Treatment Appointment Second Offer Date (Required if applicable)	Is required if the Treatment Appointment first offer date is not accepted. Use date format: MM/DD/YYYY
Column N	Treatment Appointment Third Offer Date (Required if applicable)	Is required if the first and second Treatment Appointment offer dates are not accepted. Use date format: MM/DD/YYYY
Column O	Treatment Appointment Accepted Date (Required if applicable)	Use date format: MM/DD/YYYY
Column P	Treatment Start Date (Required)	Use date format: MM/DD/YYYY. If a date is entered here, a date is not required for Column Q
Column Q	Close out Date (Required)	Use date format: MM/DD/YYYY

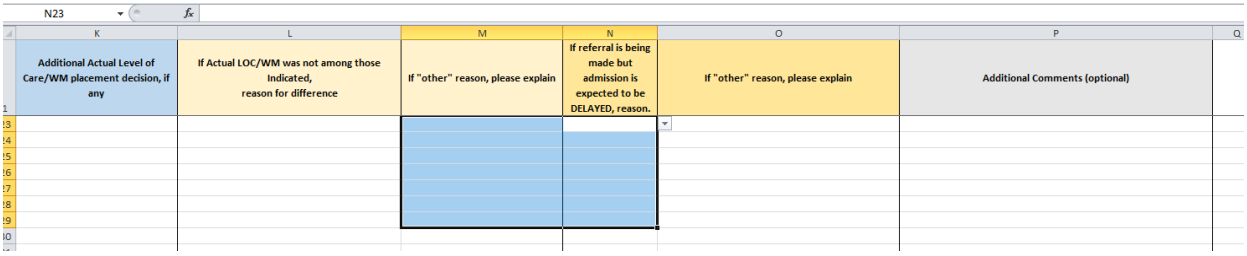
Column R	Referred to (Required if applicable)	Referred To: 01 = Managed Care Plan 02 = Fee-For-Service Provider 03 = Other (Specify) 04 = No Referral
Column T	Description of Facts and Circumstance.	Please use this field to provide description 'OTHER' selection. Referral Source: 23 = Other Closure Reason: 09 = Other

Medi-Cal Excel Level of Care Report

SUDS staff is required for tracking and reporting to DHCS the screenings/assessments we conduct and which level of care the beneficiaries are placed into based on said screenings/assessments. To do this we use the LOC spreadsheet pictured below.



A	B	C	D	E	F	G	H	I	J	K
Date of Screening or Assessment (MM/DD/YYYY)	Medi-Cal Client Index Number (CIN)	Client First Name	Client Last Name	Client Date of Birth (MM/DD/YYYY)	Type of Screen / Assessment	Indicated Level of Care/WM	Additional Indicated Level of Care/WM, if any	Additional Indicated Level of Care/WM, if any	Actual LOC/WM placement decision	Additional Actual Level of Care/WM placement decision, if any



N23

K	L	M	N	O	P	Q
Additional Actual Level of Care/WM placement decision, if any	If Actual LOC/WM was not among those Indicated, reason for difference	If "other" reason, please explain	If referral is being made but admission is expected to be DELAYED, reason.	If "other" reason, please explain	Additional Comments (optional)	

When a level of care is determined, the determination must be documented on the LOC Reporting sheet. This means that if a person is screened out to Intensive or Regular Outpatient Services that screening determination is placed in LOC sheet. If screening indicates a need for a more conclusive assessment, then level of care is not being determined and will not be filled out until full assessment is completed. For this hypothetical case let's imagine that the screening indicated that the client needed a full

assessment. Since a level of care determination was not made, we will not fill out the LOC spreadsheet until after the assessment.

Medi-Cal Excel Level of Care Report Columns

1. Date of Screening or Assessment (MM/DD/YYYY)
    a. This is the date that staff opens the client in AVATAR.
2. Medi-Cal Client Index Number (CIN)
    a. This is the client's Medi-Cal insurance number. When reporting on form only use the first 9 digits ending with the letter. For example, someone with a Medi-cal number that reads 90477179E06088 only record the 90477179E on the excel sheet.
3. Client First Name
4. Client Last Name
5. Client Date of Birth (MM/DD/YYYY)
6. Type of Screen / Assessment
    a. Three types to choose from the Drop down menu:
        i. Brief Initial -screening assessment, likely to lead to a referral to a contracted ASAM Level 1.0/2.1 provider
        ii. Initial Assessment=Placement into ASAM Level 3.1/3.2WM/3.5 or above program and/or placement into the SLT or CCC programs
        iii. Follow up Assessment-Continuing Care or if a major change in client's circumstance occurs, such as relapse
7. Indicated Level of Care/WM
    a. Specific to ASAM Levels of Care
    b. This is the service the client needs based on the assessment
        i. The Level of Care client assessed at regardless of availability
    c. Found in cell -Drop down menu
8. Additional Indicated Level of Care/WM, if any
    a. Specific to ASAM Levels of Care
    b. The secondary Level of Care regardless of availability such as:
        i. Indicated ASAM Level 3.2WM-Secondary ASAM Level 3.5
    c. Found in cell -Drop down menu
9. Additional Indicated Level of Care/WM, if any
    a. Specific to ASAM Levels of Care
    b. The tertiary Level of Care regardless of availability such as:
        i. Secondary ASAM Level 3.5/Tertiary ASAM Level 2.1 for aftercare
    c. Found in cell -Drop down menu
10. Actual LOC/WM placement decision
    a. Specific to ASAM Levels of Care
        i. This is the ASAM Level of Care that the client was placed in
    b. Found in cell -Drop down menu

11. Additional Actual Level of Care/WM placement decision, if any
    a. Specific to ASAM Levels of Care
        i. This is the secondary ASAM Level of Care that the client was placed in
    b. Found in cell -Drop down menu
12. If Actual LOC/WM was not among those Indicated, reason for difference
    a. Drop down menu choices:
        i. No applicable-No difference
        ii. Clinical Judgement
        iii. Lack of insurance / payment source
        iv. Legal Issues
        v. Level of care not available
        vi. Managed care refusal
        vii. Patient preference
        viii. Geographic accessibility
        ix. Family responsibility
        x. Language
        xi. Used two residential stays in a year already
        xii. Other
13. If "other" reason, please explain
    a. Connected to xii above. Explain why in this column.
14. If referral is being made but admission is expected to be DELAYED, reason.
    a. Drop down menu choices:
        i. Waiting for level of care availability
        ii. Waiting for language-specific services
        iii. Waiting for other special population-specific services
        iv. Hospitalized
        v. Incarcerated
        vi. Patient preference
        vii. Waiting for ADA accommodation
        viii. Other
15. If "other" reason, please explain
    a. Connected to xii above. Explain why in this column.
16. Additional Comments (optional)
    a. Any information that staff may feel is important will be placed

Appendix

DHCS Priority SDOH

The Appendix in the CalMHSA Documentation Guide is an abridged list that focuses on specific SDOH. The full list of Social Determinants of Health (SDOC) and ICD-10 codes (Z55-Z65) can be found on this website: https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z55-Z65

On the website, a red arrow means that "code" is a header whereas a green arrow is a usable, billable code. When using SDOH, be as specific as you're able. The full list of ICD-10 codes Z55-Z65 is below.

- Z55 Problems related to education and literacy
- Z55.0 Illiteracy and low-level literacy
- Z55.1 Schooling unavailable and unattainable
- Z55.2 Failed school examinations
- Z55.3 Underachievement in school
- Z55.4 Educational maladjustment and discord with teachers and classmates
- Z55.5 Less than a high school diploma
- Z55.8 Other problems related to education and literacy
- Z55.9 Problems related to education and literacy, unspecified
- Z56 Problems related to employment and unemployment
- Z56.0 Unemployment, unspecified
- Z56.1 Change of job
- Z56.2 Threat of job loss
- Z56.3 Stressful work schedule
- Z56.4 Discord with boss and workmates
- Z56.5 Uncongenial work environment
- Z56.6 Other physical and mental strain related to work
- Z56.8 Other problems related to employment
- Z56.81 Sexual harassment on the job
- Z56.82 Military deployment status
- Z56.89 Other problems related to employment
- Z56.9 Unspecified problems related to employment
- Z57 Occupational exposure to risk factors
- Z57.0 Occupational exposure to noise
- Z57.1 Occupational exposure to radiation
- Z57.2 Occupational exposure to dust
- Z57.3 Occupational exposure to other air contaminants
- Z57.31 Occupational exposure to environmental tobacco smoke
- Z57.39 Occupational exposure to other air contaminants
- Z57.4 Occupational exposure to toxic agents in agriculture
- Z57.5 Occupational exposure to toxic agents in other industries

- ☐ Z57.6 Occupational exposure to extreme temperature
- ☐ Z57.7 Occupational exposure to vibration
- ☐ Z57.8 Occupational exposure to other risk factors
- ☐ Z57.9 Occupational exposure to unspecified risk factor
- ☐ Z58 Problems related to physical environment
- ☐ Z58.6 Inadequate drinking-water supply
- ☐ Z59 Problems related to housing and economic circumstances
- ☐ Z59.0 Homelessness
- ☐ Z59.00 Homelessness, unspecified
- ☐ Z59.01 Sheltered homelessness
- ☐ Z59.02 Unsheltered homelessness
- ☐ Z59.1 Inadequate housing
- ☐ Z59.2 Discord with neighbors, lodgers, and landlord
- ☐ Z59.3 Problems related to living in residential institution
- ☐ Z59.4 Lack of adequate food
- ☐ Z59.41 Food insecurity
- ☐ Z59.48 Other specified lack of adequate food
- ☐ Z59.5 Extreme poverty
- ☐ Z59.6 Low income
- ☐ Z59.7 Insufficient social insurance and welfare support
- ☐ Z59.8 Other problems related to housing and economic circumstances
- ☐ Z59.81 Housing instability, housed
- ☐ Z59.811 Housing instability, housed with risk of homelessness
- ☐ Z59.812 Housing instability, homelessness in past 12 months
- ☐ Z59.819 Housing instability, unspecified
- ☐ Z59.89 Other problems related to housing and economic circumstances
- ☐ Z59.9 Problem related to housing and economic circumstances, unspecified
- ☐ Z60 Problems related to social environment
- ☐ Z60.0 Problems of adjustment to life-cycle transitions
- ☐ Z60.2 Problems related to living alone
- ☐ Z60.3 Acculturation difficulty
- ☐ Z60.4 Social exclusion and rejection
- ☐ Z60.5 Target of (perceived) adverse discrimination and persecution
- ☐ Z60.8 Other problems related to social environment
- ☐ Z60.9 Problem related to social environment, unspecified
- ☐ Z62 Problems related to upbringing
- ☐ Z62.0 Inadequate parental supervision and control
- ☐ Z62.1 Parental overprotection
- ☐ Z62.2 Upbringing away from parents
- ☐ Z62.21 Child in welfare custody
- ☐ Z62.22 Institutional upbringing
- ☐ Z62.29 Other upbringing away from parents

- ☐ Z62.3 Hostility towards and scapegoating of child
- ☐ Z62.6 Inappropriate (excessive) parental pressure
- ☐ Z62.8 Other specified problems related to upbringing
- ☐ Z62.81 Personal history of abuse in childhood
- ☐ Z62.810 Personal history of physical and sexual abuse in childhood
- ☐ Z62.811 Personal history of psychological abuse in childhood
- ☐ Z62.812 Personal history of neglect in childhood
- ☐ Z62.813 Personal history of forced labor or sexual exploitation in childhood
- ☐ Z62.819 Personal history of unspecified abuse in childhood
- ☐ Z62.82 Parent-child conflict
- ☐ Z62.820 Parent-biological child conflict
- ☐ Z62.821 Parent-adopted child conflict
- ☐ Z62.822 Parent-foster child conflict
- ☐ Z62.89 Other specified problems related to upbringing
- ☐ Z62.890 Parent-child estrangement NEC
- ☐ Z62.891 Sibling rivalry
- ☐ Z62.898 Other specified problems related to upbringing
- ☐ Z62.9 Problem related to upbringing, unspecified
- ☐ Z63 Other problems related to primary support group, including family circumstances
- ☐ Z63.0 Problems in relationship with spouse or partner
- ☐ Z63.1 Problems in relationship with in-laws
- ☐ Z63.3 Absence of family member…
- ☐ Z63.31 Absence of family member due to military deployment
- ☐ Z63.32 Other absence of family member
- ☐ Z63.4 Disappearance and death of family member
- ☐ Z63.5 Disruption of family by separation and divorce
- ☐ Z63.6 Dependent relative needing care at home
- ☐ Z63.7 Other stressful life events affecting family and household
- ☐ Z63.71 Stress on family due to return of family member from military deployment
- ☐ Z63.72 Alcoholism and drug addiction in family
- ☐ Z63.79 Other stressful life events affecting family and household
- ☐ Z63.8 Other specified problems related to primary support group
- ☐ Z63.9 Problem related to primary support group, unspecified
- ☐ Z64 Problems related to certain psychosocial circumstances
- ☐ Z64.0 Problems related to unwanted pregnancy
- ☐ Z64.1 Problems related to multiparity
- ☐ Z64.4 Discord with counselors
- ☐ Z65 Problems related to other psychosocial circumstances
- ☐ Z65.0 Conviction in civil and criminal proceedings without imprisonment
- ☐ Z65.1 Imprisonment and other incarceration
- ☐ Z65.2 Problems related to release from prison
- ☐ Z65.3 Problems related to other legal circumstances

- ☐ Z65.4 Victim of crime and terrorism
- ☐ Z65.5 Exposure to disaster, war, and other hostilities
- ☐ Z65.8 Other specified problems related to psychosocial circumstances
- ☐ Z65.9 Problem related to unspecified psychosocial circumstances