Hello everyone. Thanks for coming. We will be using a Start code and End code for today's training. You will need to use these on the survey that will be sent out to you after we are done. The link will be emailed only to those of you who registered for this training. You will need to complete the entire survey to receive CEUs or Certificates of attendance. Those of you in CCAPP who are registered will also be receiving an exam that also must be completed by CCAPP counselors/registrants to receive CEUs.

The Start Code is 3201

This presentation will be taped and posted to the EDC SUDS webpage under trainings and the PPT will be sent out later this week to anyone who requests a copy.

(Start recording)

Welcome to another El Dorado County Substance Use Disorder Services DMC-ODS Quality Assurance Training Series presentation. Today we will be discussing DMC-ODS Documentation Standards

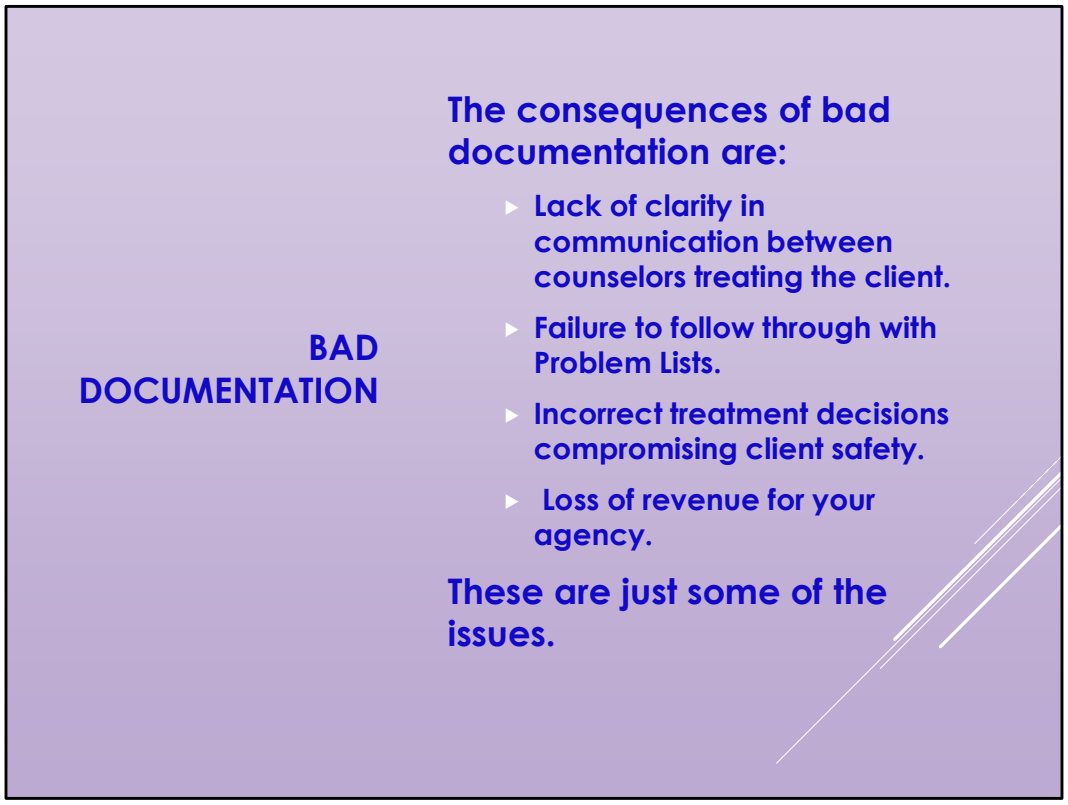
At the end of this 1.5 hour Continuing Education Training, participants will have the knowledge necessary to understand the following:

- The focus of documentation
- The importance of documentation within DMC-ODS
- Documentation responsibilities
- Documentation timeframes

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.

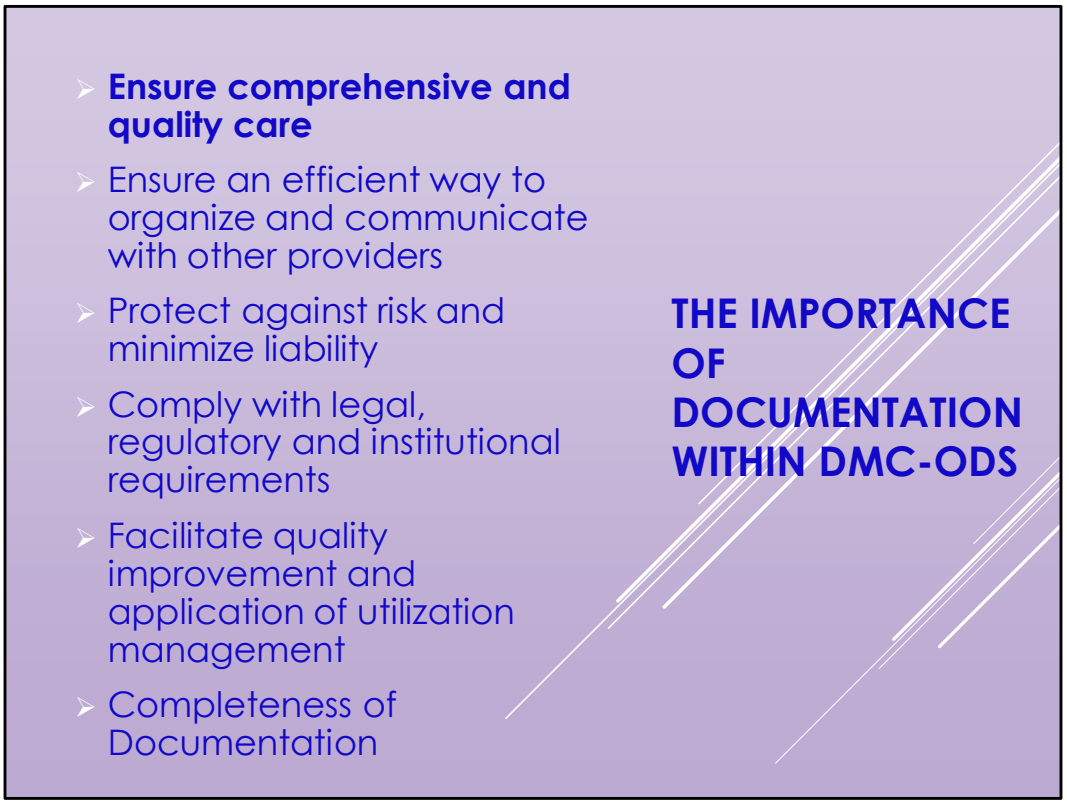
The phrase, "if it wasn't documented, it wasn't done", is something you have likely heard, said, and/or thought during your career. For those that aren't familiar with this phrase, it means that if there isn't a record of the care you delivered in the client's chart, (by way of your documentation), the activity was not done.

In other words, it did not happen.



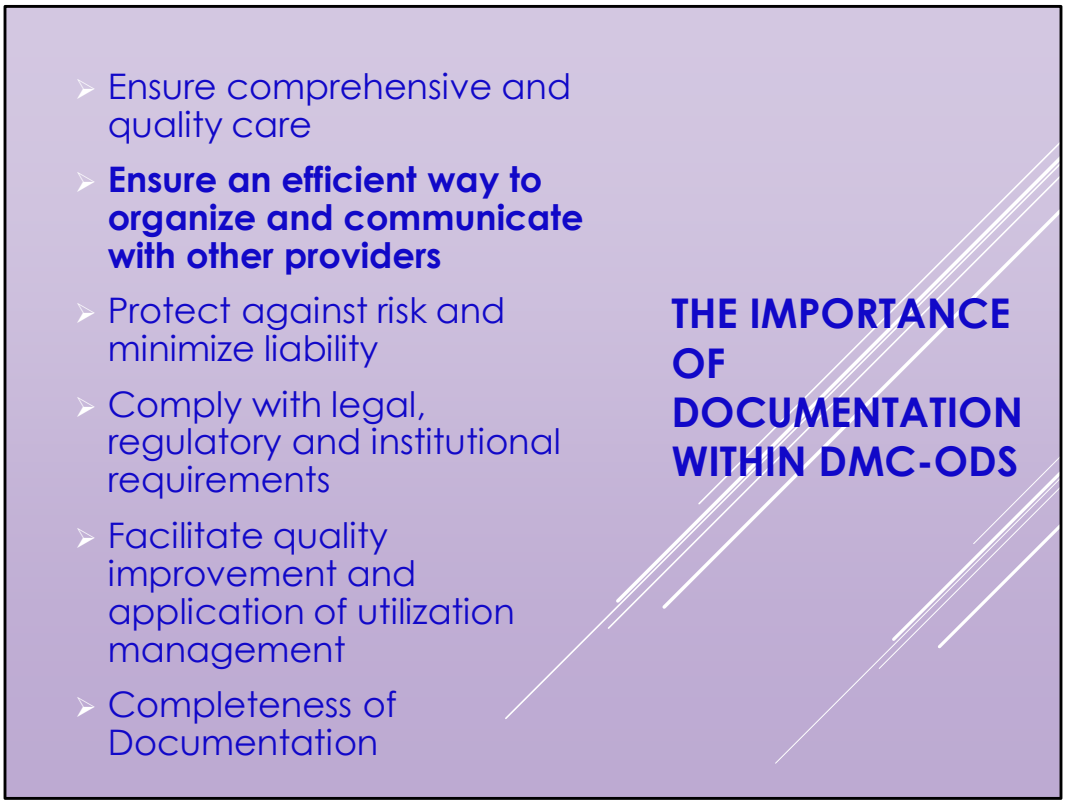
The importance of proper documentation in substance use disorder treatment cannot be overstated. Failure to document a client's impairments, progress, treatment plans or anything else related to client care can result in poor outcomes for clients, and liability issues for the facility, the client's counselor and EDC DMC-ODS.

Which brings us to documentation related disallowances. We bring this up because disallowances can severely impact revenue which has a direct impact on agency health and your well being.



Clinical documentation is a critical component of quality healthcare delivery and serves multiple purposes, helping to:

1) Ensure comprehensive and quality care – The process of writing initial assessments and proper progress notes requires thought and reflection. Preparing proper clinical documentation serves an important role of helping assure quality client care by giving practitioners an opportunity to think about their clients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work, and weigh alternative approaches to the care. Good clinical documentation helps one organize clinical details into a case formulation that can then be used for treatment planning and is an essential element of professional practice and of the provision of quality clinical services. It also helps to assure appropriate utilization of team members from multiple disciplines in order to leverage interdisciplinary competencies and maximize the quality of services provided.



Clinical documentation is a critical component of quality healthcare delivery and serves multiple purposes, helping to:

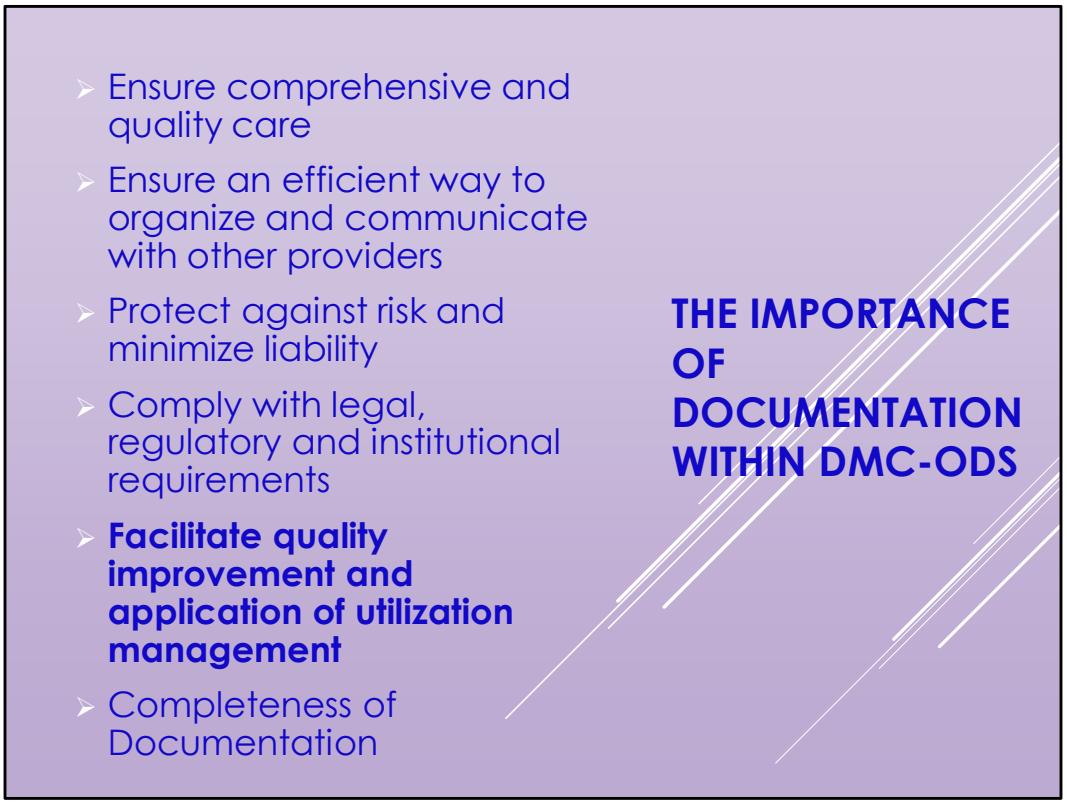
2) Ensure an efficient way to organize and communicate with other providers – The documentation of clinical care helps to provide structure and efficiency to clinical communications with other providers who may be involved in the care of shared clients. This assures coordinated rather than fragmented treatment/service delivery.

Clinical documentation is a critical component of quality healthcare delivery and serves multiple purposes, helping to:

3) Protect against risk and minimize liability – Accurate and comprehensive clinical documentation is not only important in terms of quality care, but is also essential in risk management. Detailing and justifying the thought processes that contributed to the clinical decision-making process helps to support the adequacy of the clinical assessment, the appropriateness of the treatment/service plan, and demonstrates the application of professional skills and knowledge toward the provision of professional services.

Clinical documentation is a critical component of quality healthcare delivery and serves multiple purposes, helping to:

4) Comply with legal, regulatory and institutional requirements – Good clinical documentation practices help to assure compliance with recordkeeping requirements imposed by federal and state (including licensing boards) laws, regulations, and rules. It also helps to ensure that documentation meets the standards set by CA DHCS, EDC DMC-ODS and your agencies



Clinical documentation is a critical component of quality healthcare delivery and serves multiple purposes, helping to:

5) Facilitate quality improvement and application of utilization management – Clinical documentation provides an opportunity to explain the process and substance of assessments, treatment and service planning, clinical decision-making, medical necessity, and the effectiveness of treatments and other services provided. As a result, it is essential for the quality assurance process because clinical documentation helps to substantiate the need for further assessment, testing, treatment and/or other services, or to support changes in or termination of treatment and/or services. From a quality perspective, clinical documentation facilitates supervision, consultation, and staff/professional development, and helps to improve the quality of services by identifying problems with service delivery by providing data based upon which effective preventative or corrective actions can be taken. Appropriate recordkeeping also provides data for use in planning educational and professional development activities, policy development, program planning and research in agency settings.

Clinical documentation is a critical component of quality healthcare delivery and serves multiple purposes, helping to:

6) Completeness of Documentation - Clinical documentation must be credible and complete, and is protected via HIPAA and 42 CFR Part 2. It encompasses every aspect of clinical care, including initial assessments, progress notes, and relevant encounters that occur outside of established appointments. Documentation of initial assessments follows the same format as the multidimensional ASAM assessment and reflects a comprehensive biopsychosocial approach. Progress notes are written during/after follow up appointments in order to gauge clinical progress and assess to determine if patient needs have changed and if modifications to the treatment approach/plan are required. The style of documentation is expected to be consistent and standardized throughout the agency/institution (e.g., everyone uses the same progress note format).

To achieve this aim, DHCS is streamlining and standardizing clinical documentation requirements across DMC-ODS services

This training will draw upon the BHINs for our direction and focus.

Behavioral Health Information Notice No: 23-001

Behavioral Health Information Notice No: 22-019 which Supersedes MHSUDS Information Notice No.: 17-040

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Behavioral Health Information Notice No: 23-001

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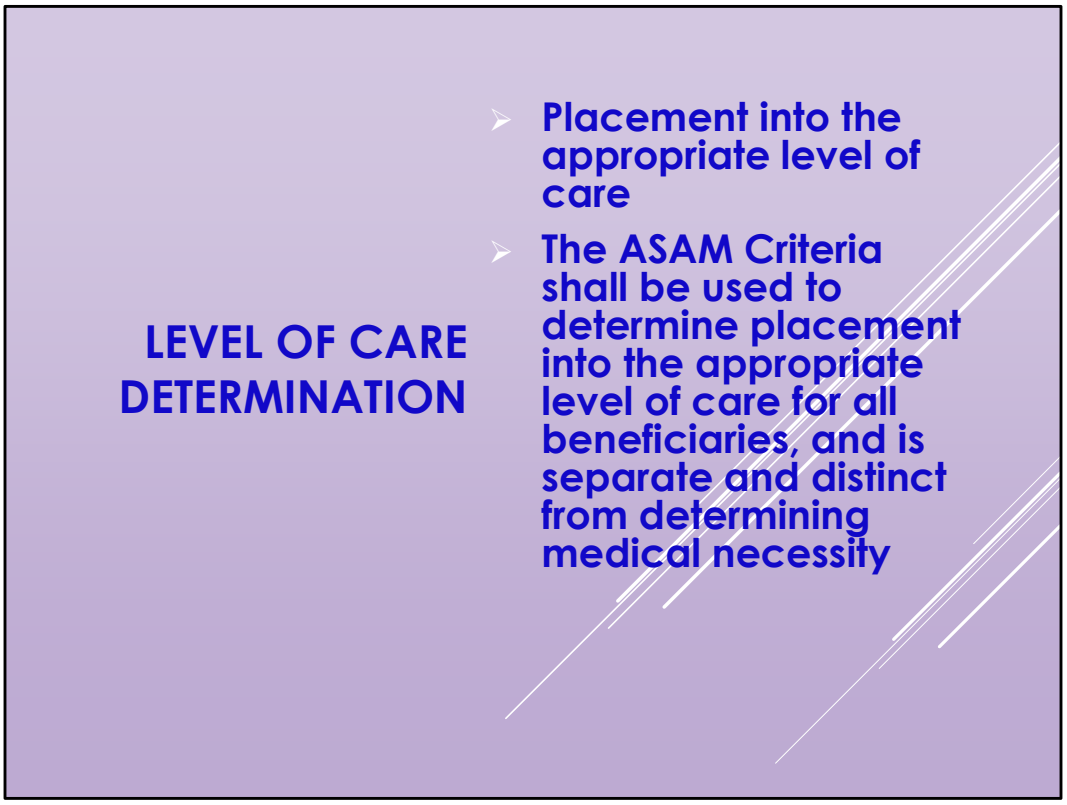
DEFINITION OF MEDICAL NECESSITY

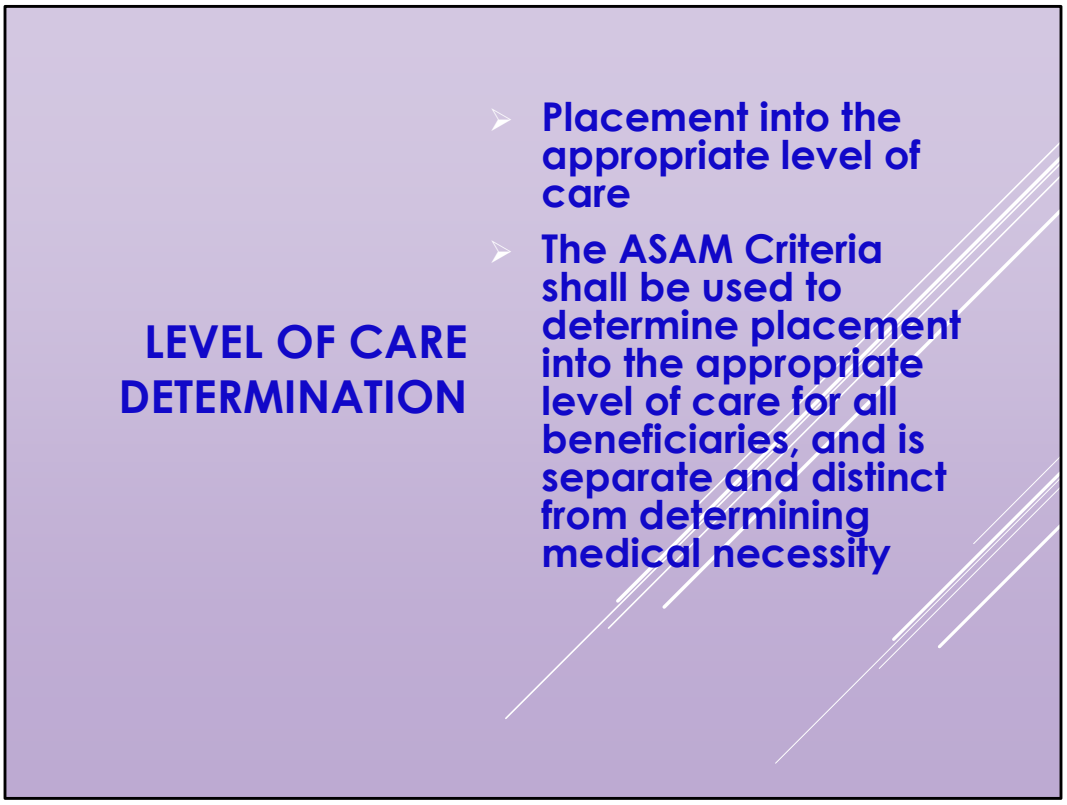
- All Medi-Cal services provided to persons in care need to meet the standard of being "medically necessary".

- For individuals aged 21 and older, an SUD service is considered "medically necessary" when it is "reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain."

This section requires provision of all Medicaid (Medi-Cal) coverable services necessary to correct or ameliorate substance misuse and SUDs
discovered by a screening service, whether or not the service is covered under the State Plan. These services need not be curative or completely restorative, and can be delivered to sustain, support, improve or make more tolerable substance misuse or an SUD condition.

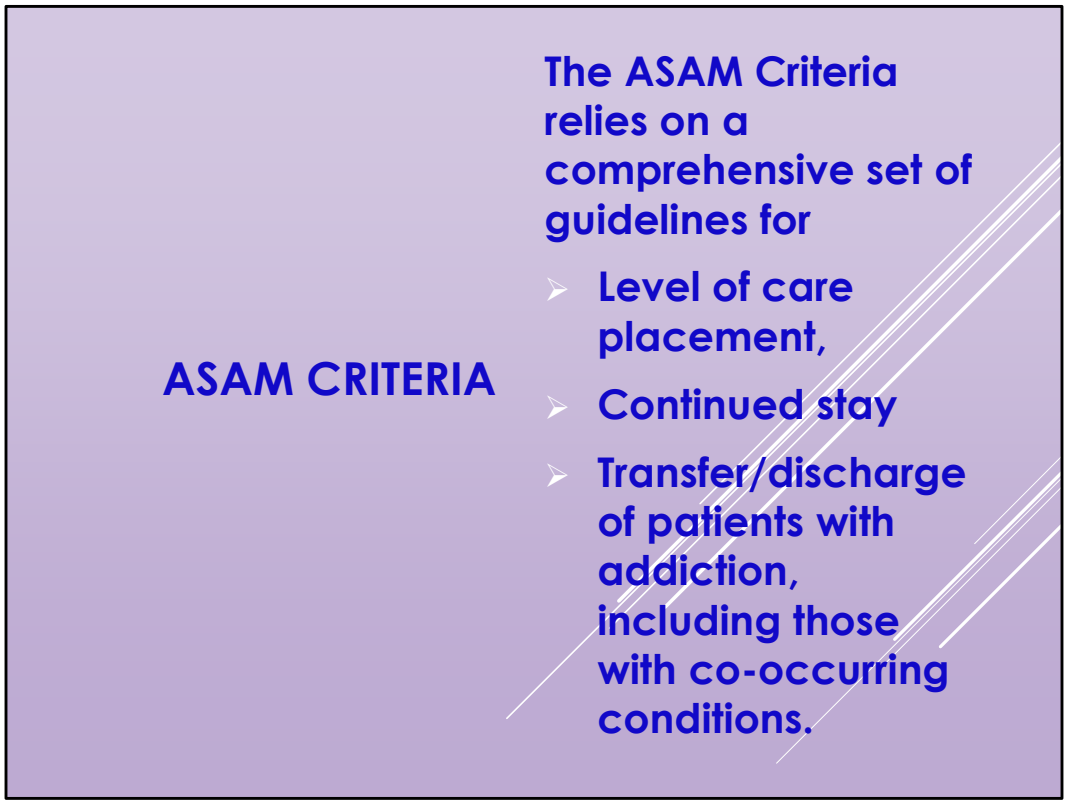


a. For beneficiaries 21 and over, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with an LPHA or registered/certified counselor.
b. For beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM Criteria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

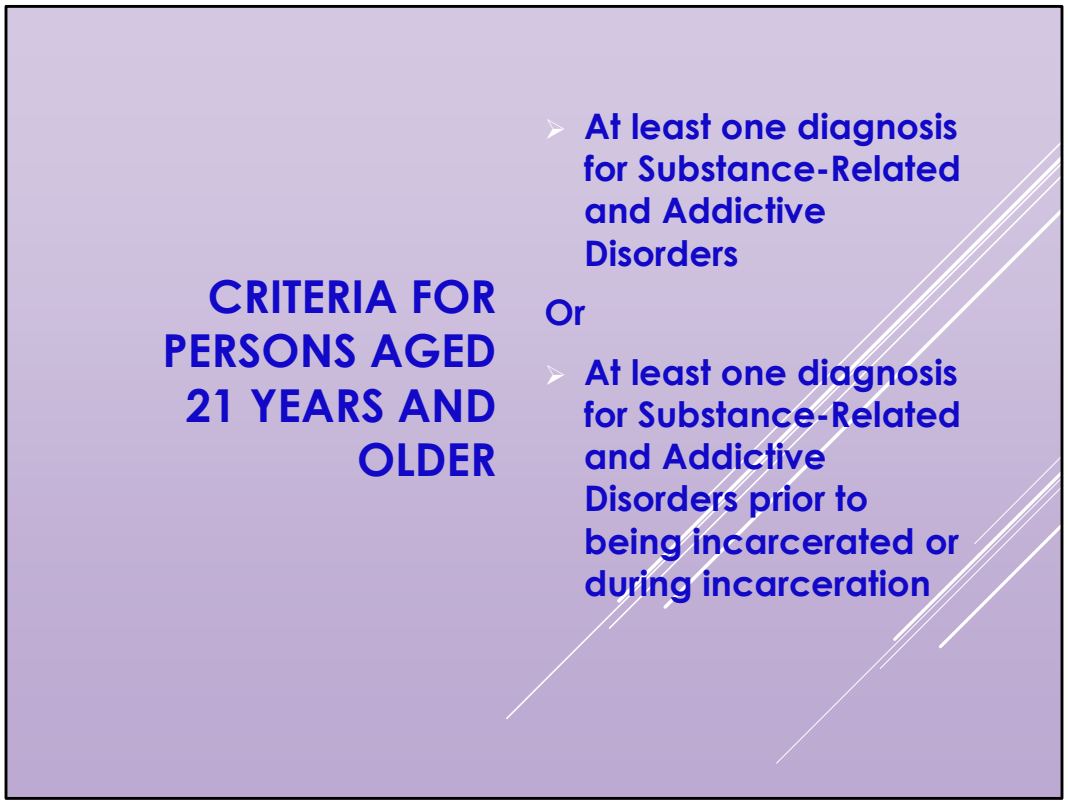


e. A full ASAM assessment, or initial provisional referral tool for preliminary level of care recommendations, shall not be required to begin receiving DMC-ODS services.
f. A full ASAM assessment does not need to be repeated unless the beneficiary's condition changes.
g. These requirements for ASAM Level of Care assessments apply to NTP clients and settings.

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.



The ASAM Criteria® uses a multidimensional patient assessment to direct medical management and the structure, safety, security, and intensity of treatment services.



At least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders for Substance-Related and Addictive Disorders, with the exception of Tobacco- Related Disorders and Non-Substance-Related Disorders.

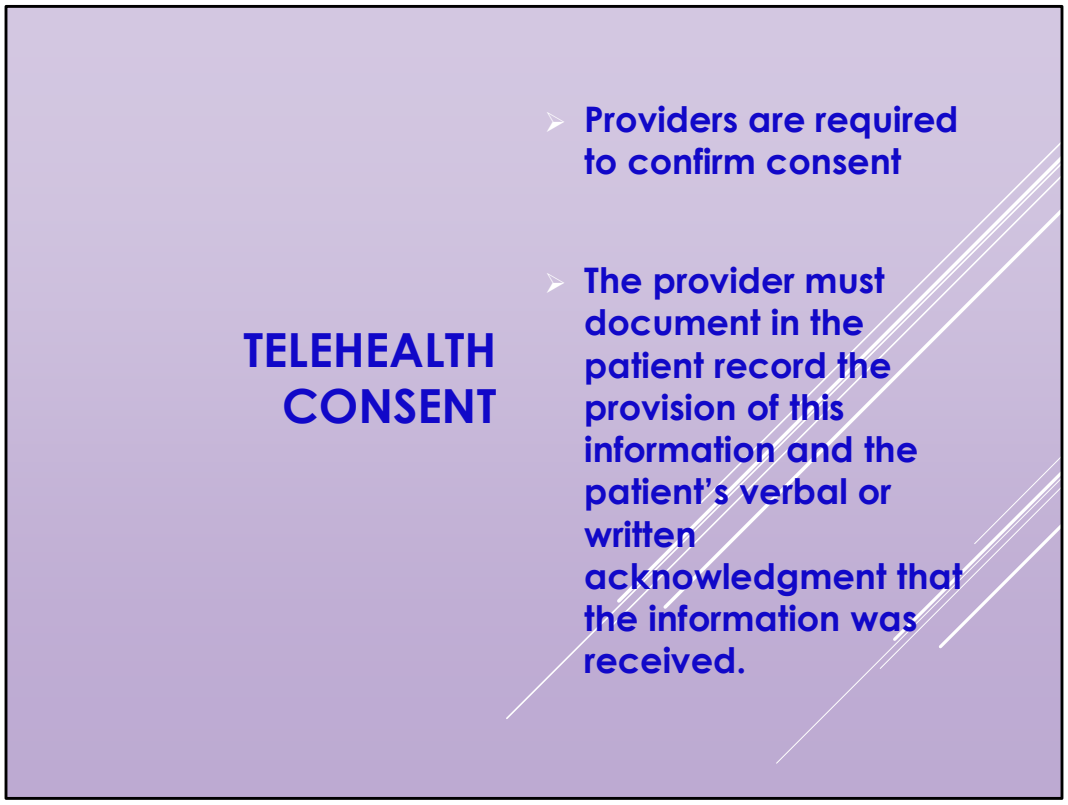
• OR at least one diagnosis from the Diagnostic and Statistical Manual of DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

CRITERIA FOR PERSONS UNDER 21 YEARS OF AGE

- Appropriate and medically necessary services needed to correct and ameliorate health conditions.
- Services need not be curative or completely restorative to ameliorate a condition.
- Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and thus covered as EPSDT

CRITERIA FOR ALL PERSONS SEEKING TREATMENT

- Access to medically necessary services, including all Food and Drug Administration (FDA)-approved medications for Opioid Use Disorder, cannot be denied to persons in care if they meet criteria for substance use services as per the ASAM criteria.
- DHCS has also alerted counties that individuals seeking substance use treatment cannot be placed on wait lists



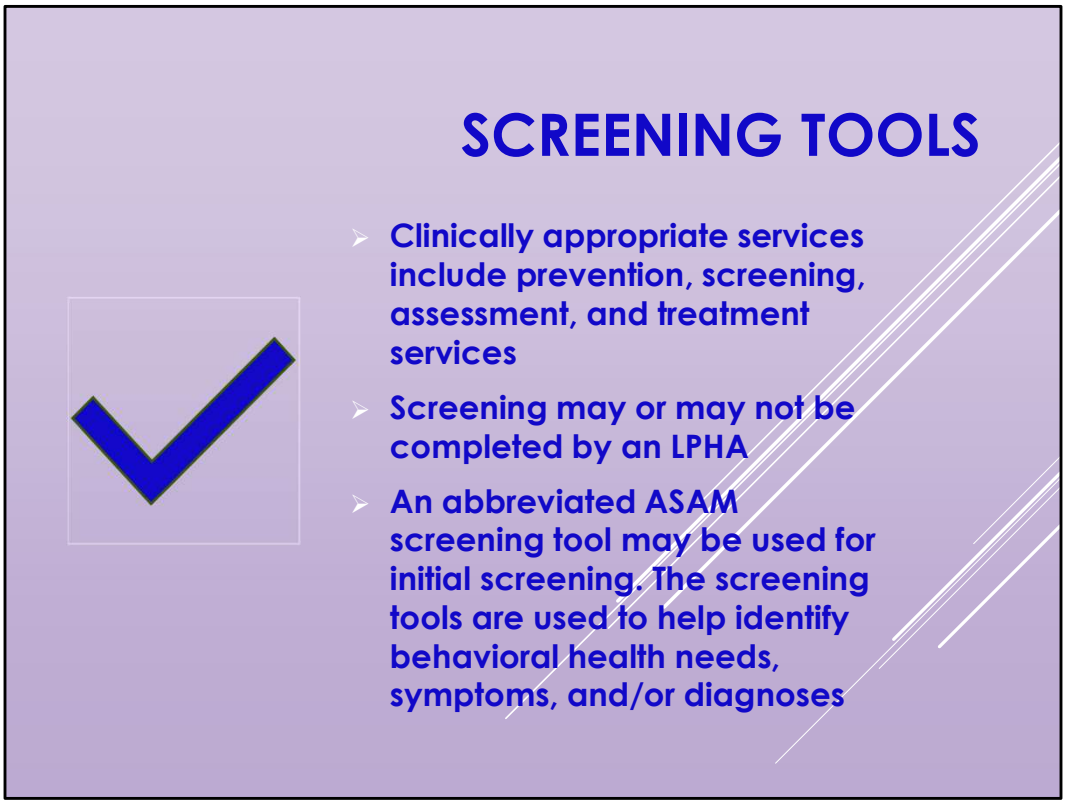
If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary:

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;

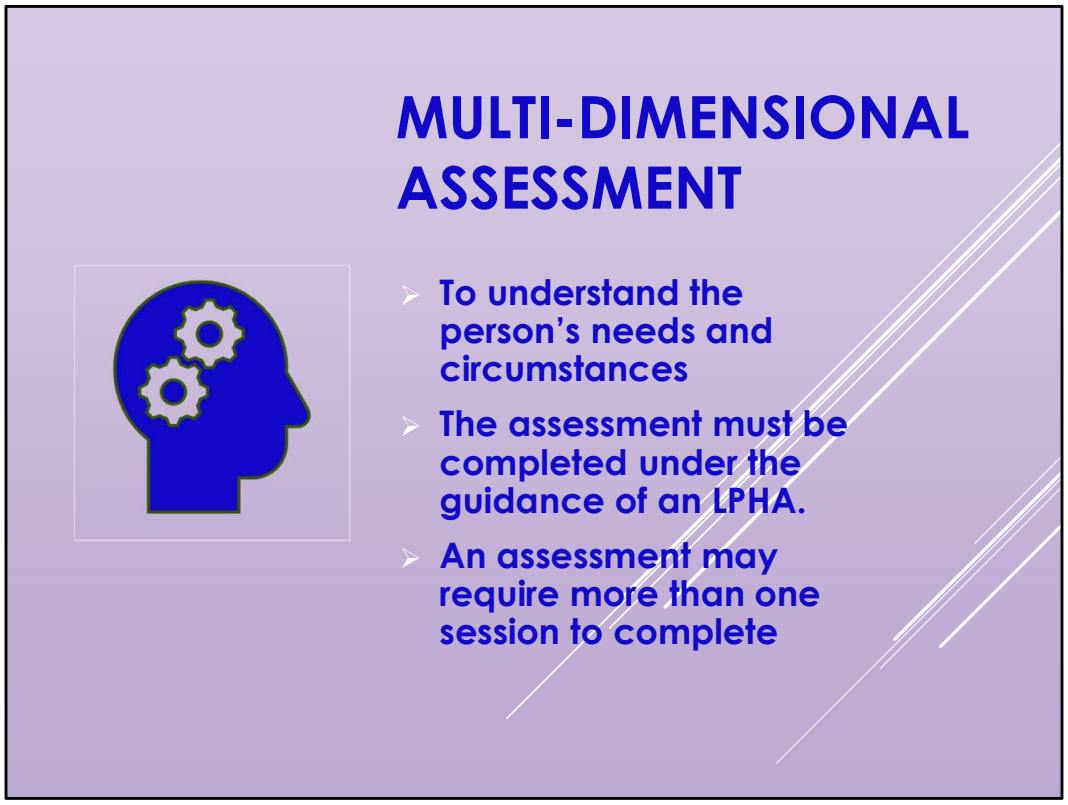
An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted;

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.



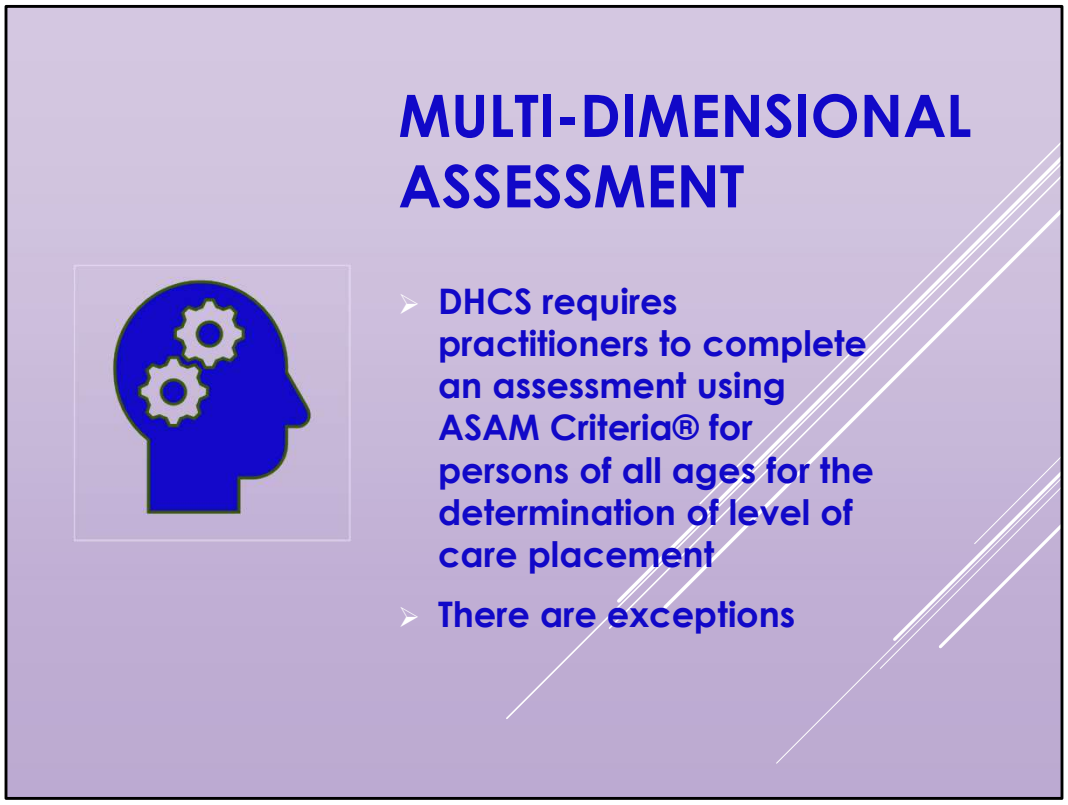
The aim of screening is to get the person the right care



The goal of a multi-dimensional assessment is to understand the person's needs and circumstances, in order to recommend the best care possible and help the person recover.

The assessment must be completed under the guidance of an LPHA. An assessment using the American Society of Addiction Medicine (ASAM) Criteria is used to evaluate the person's substance use and considers the person's needs, obstacles and liabilities, as well as their strengths, assets, resources, and support structure.

An assessment may require more than one session to complete and/or may require the practitioner to obtain information from other relevant sources, referred to as "collateral information", such as previous health records or information from the person's support system to gather a cohesive understanding of the person's care needs.

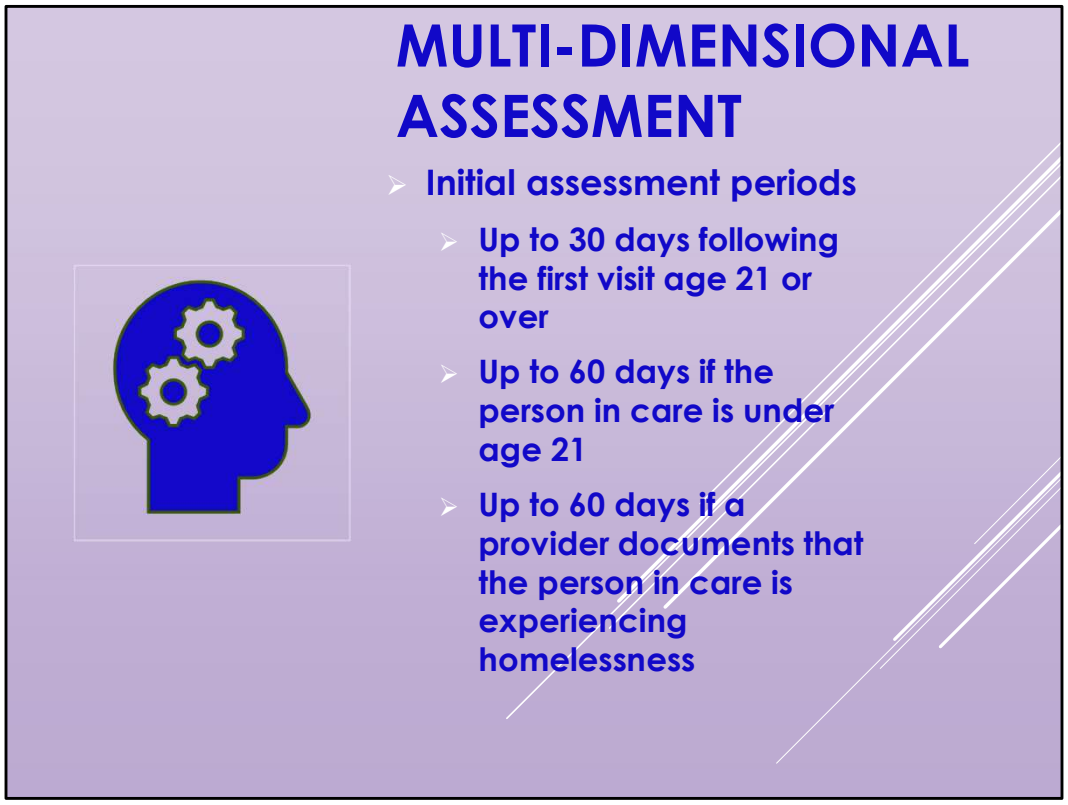


The delivery of prevention and early intervention services (ASAM Level 0.5) for persons under 21; a brief screening ASAM Criteria® tool is sufficient for these services. Assessments must include a typed or legibly printed name, and include the signature of the service provider, as well as the date of the signature.

The delivery of Withdrawal Management (WM) Level 1, Level 2, Level 3.2, Level 3.7, and Level 4.0 services provided as part of a continuum of care for persons experiencing withdrawal in outpatient, residential, and inpatient settings. These services are considered urgent and provided on a short-term basis. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing WM services.

For all levels of care except narcotic treatment programs, the assessment may be completed face to face (in an office, community location or at the person in care's home), by phone or by telehealth. A full ASAM assessment should be repeated when a person in care's condition changes.

Narcotic Treatment Programs (NTP), also referred to as Opioid Treatment Programs (OTP) is considered an outpatient program. NPT/OTP programs shall conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to an NTP qualifies for the purpose of determining medical necessity.



Initial assessment periods for non-residential services are as follows, with the first date of service counting as "day 1"

• 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 diagnosis for Substance-Related and Addictive Disorders from the current Diagnostic and Statistical Manual (DSM) is established

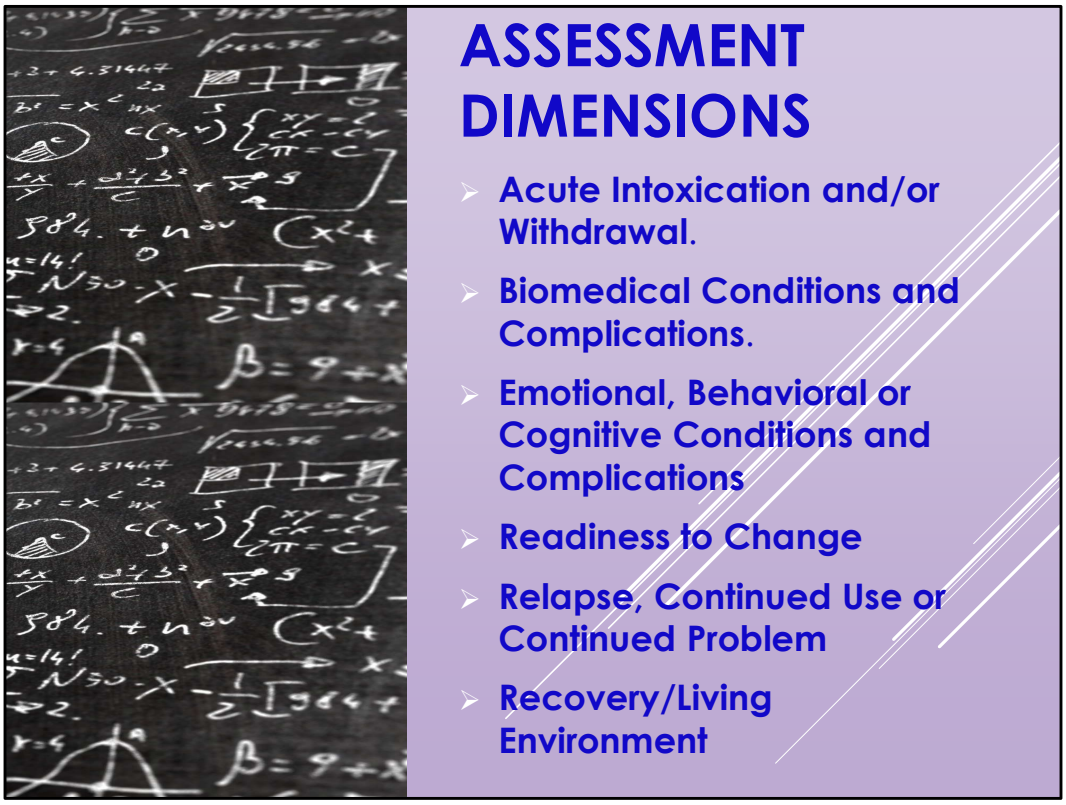
OR

• Up to 60 days if the person in care is under age 21

OR

• Up to 60 days if a provider documents that the person in care is experiencing homelessness and therefore requires additional time to complete the assessment

The assessment should be updated as clinically appropriate when the person's condition changes. If a person in care withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day or 60-day time period starts over.



Acute Intoxication and/or Withdrawal Potential-Dimension 1 assesses the need for stabilization of acute intoxication and the type and intensity of withdrawal management services that may be needed.

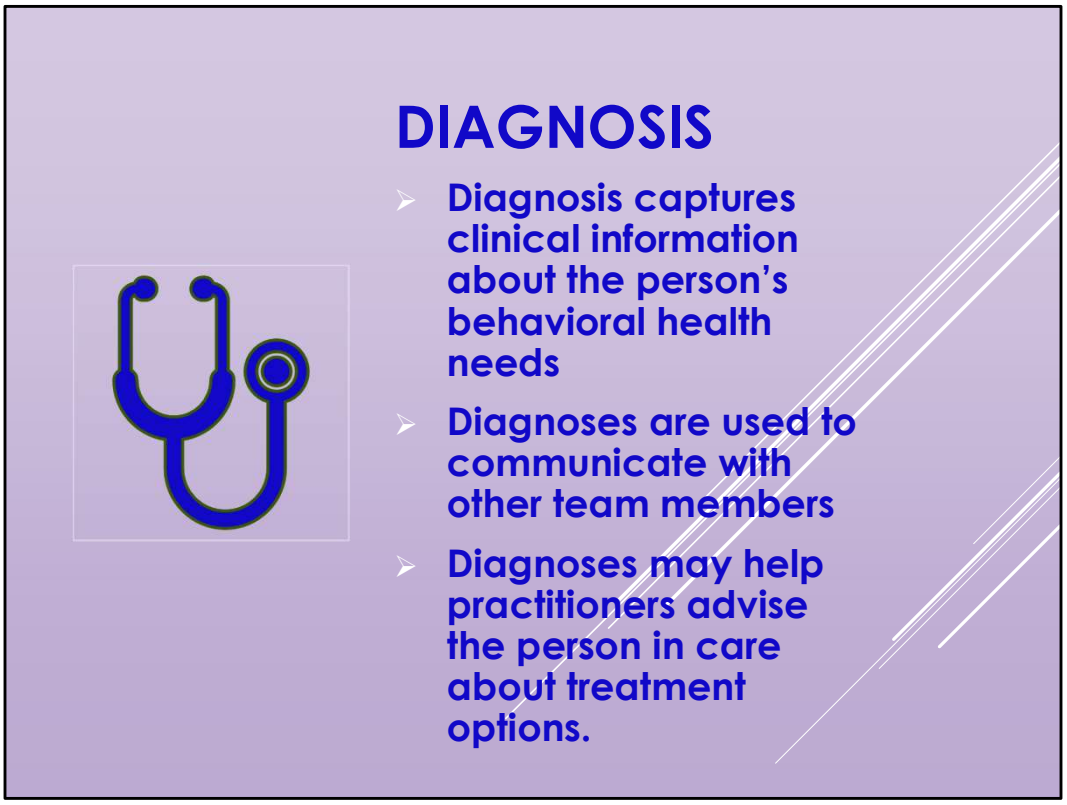
Biomedical Conditions and Complications-Dimension 2 involves information on medical and health factors that may complicate treatment.

Emotional, Behavioral or Cognitive Conditions and Complications-Dimension 3 focuses on history of mental health needs and the need for mental health treatment. Dimension 3 also includes a review of co-occurring disorders, the connection of mental health symptomology to substance use, risks and functioning.

Readiness to Change-Dimension 4 integrates the need for motivational interventions as part of the recovery process. Understanding where a person in care is related to the stages of change provides important context for understanding the needs of the people we serve and the interventions needed to assist them.

Relapse, Continued Use or Continued Problem Potential-Dimension 5 assesses the need for relapse prevention services and potential for continued use. It is important for providers to give equal weight to historical relapses and historical periods of sobriety to determine what works to help the person in care healthy.

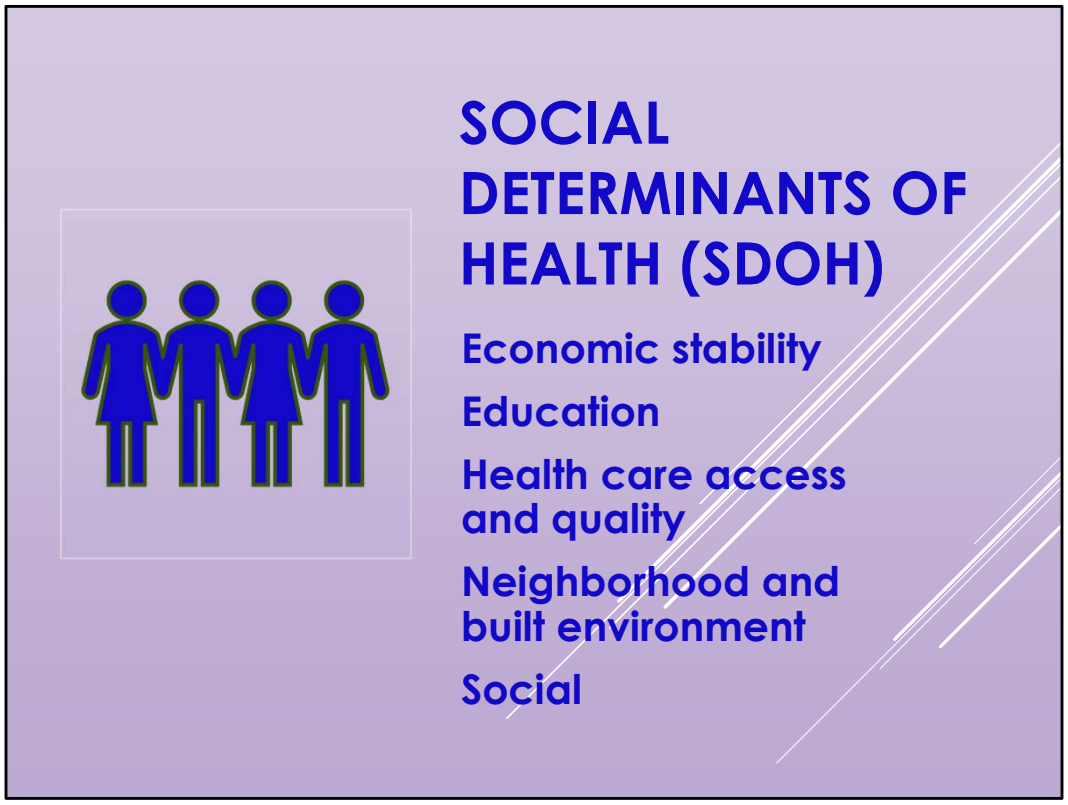
Recovery/Living Environment-Dimension 6 supports clinicians in understanding the environment in which the person in care is functioning. This environment can be on the micro-level (e.g., family) and on the macro-level (e.g., systemic racism and broad cultural factors).



Based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5).

Diagnoses are used to communicate with other team members about the person's substance use disorders, mental health symptoms, and other conditions and may inform level of distress/ impairment. Moreover, and most importantly, diagnoses may help practitioners advise the person in care about treatment options.

Providers may use the following options during the assessment phase of a person's treatment when a diagnosis has yet to be established:
• ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP). These are also known as Social determinants of health (SDOH)



A word on Social Determinants of Health (SDOH)

Play a huge part in people's health and wellness

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH are grouped into five domains (CDC)
1.Economic stability (ability to access and maintain food, clothing, shelter, and mobility as well as other basic needs within their community)
2.Education (opportunities to learn and build skills)
3.Health care access and quality (to prevent and treat illness and injury)
4.Neighborhood and built environment (safe, free from pollutants and access to nature)
5.Social and community context and connectedness

SDOH contribute to health disparities and inequities simply by limiting access to fundamental resources aimed at supporting health and wellness.

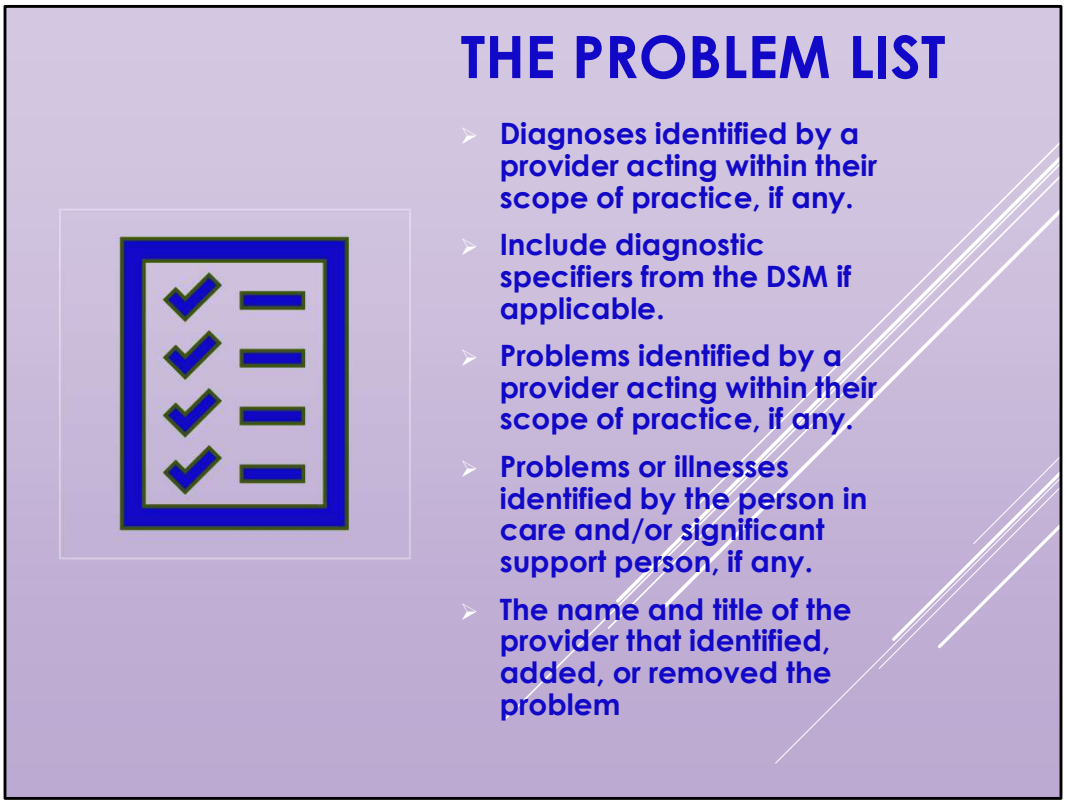
The use of a Problem List has largely replaced the use of treatment plans, except where federal requirements mandate a treatment plan be maintained (i.e., NTP treatment programs.)

The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

A problem identified during a service encounter may be addressed by the service provider during that service encounter, and subsequently added to the problem list.

The problem list includes clinician-identified diagnoses, identified concerns of the person in care, and issues identified by other service providers, including those by non-LPHA staff.

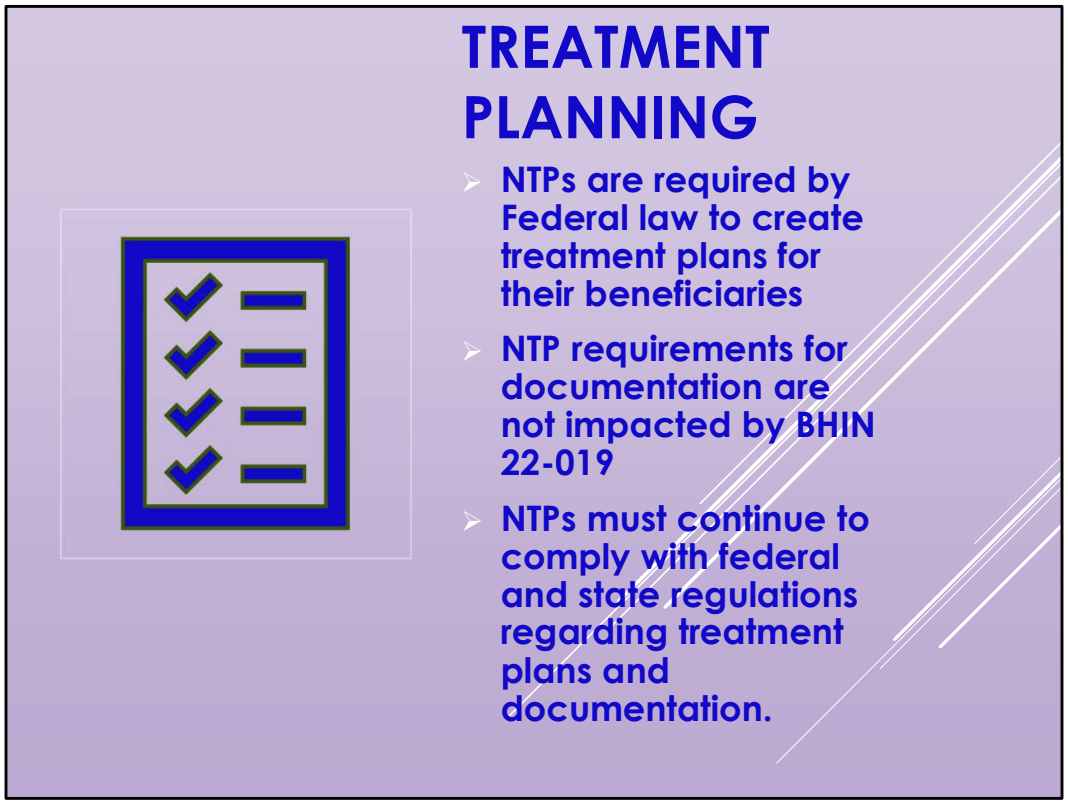
The problem list helps facilitate continuity of care by providing a comprehensive and accessible list of problems to quickly identify the person's care needs, including current diagnoses and key health and social issues.



The problem list shall include, but is not limited to, the following:
· Diagnoses identified by a provider acting within their scope of practice, if any.
Include diagnostic specifiers from the DSM if applicable.
· Problems identified by a provider acting within their scope of practice, if any.
· Problems or illnesses identified by the person in care and/or significant support person, if any.
· The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

Providers shall add to or remove problems from the problem list when there is a relevant change to a person's condition.

DHCS does not require the problem list to be updated within a specific time frame or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice. The problem list shall be updated on an ongoing basis to reflect the current needs of the person in care.



NTPs: As noted in BHIN 22-019, NTPs are required by Federal law to create treatment plans for their beneficiaries. NTP requirements for documentation are not impacted by BHIN 22-019 and NTPs must continue to comply with federal and state regulations regarding treatment plans and documentation.

There are two scenarios where treatment plans are required, or referenced, by state licensing and certification requirements, and DHCS will accept a problem list to identify the needs of the beneficiary and the reasons for service encounters:

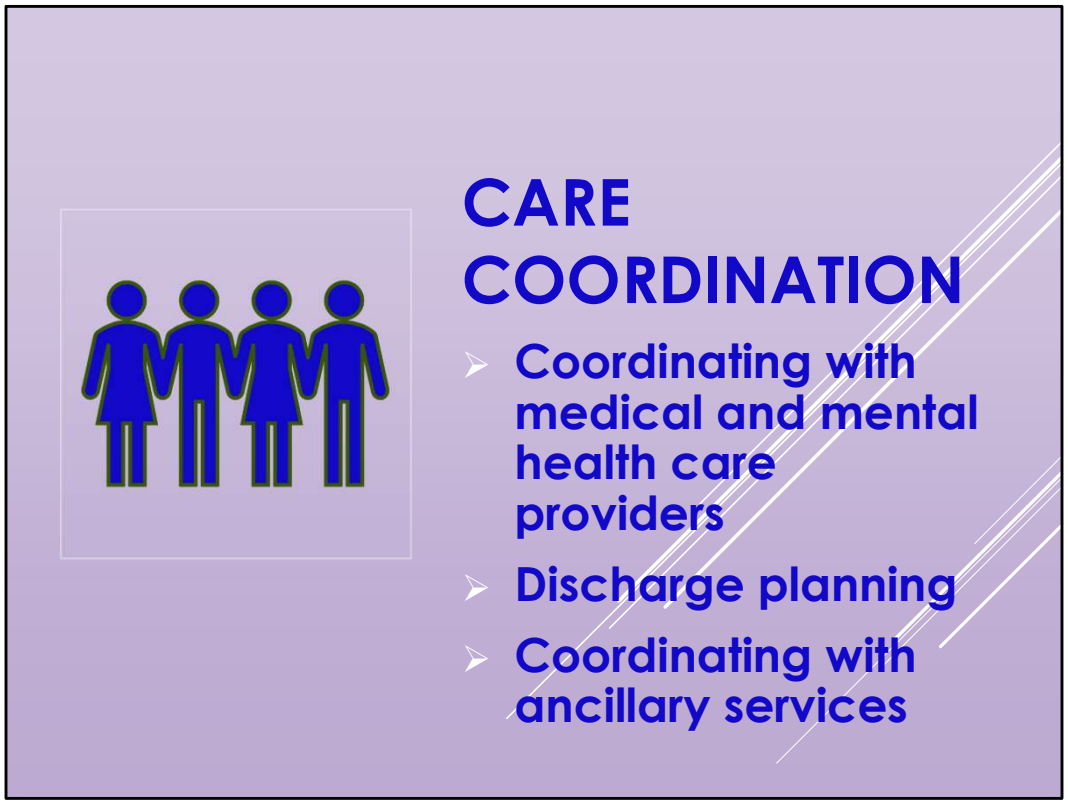
Alcohol and Other Drug (AOD) Certification Standards: DHCS is in the process of updating the AOD Certification Standards that pertain to treatment plans to align with BHIN 22-019. Until the AOD Certification Standards have been updated, BHIN 22-019DMC-ODS providers may use a problem list, as defined in , in lieu of a treatment plan for beneficiaries.

Adult Alcoholism or Drug Abuse Recovery or Treatment Facility Licensing Regulations: DMC-ODS providers may use a problem list, as defined in BHIN 22-019, in lieu of a treatment plan for beneficiaries to comport with adult alcoholism or drug abuse recovery or treatment facilities licensing regulations that pertain to treatment plans.

Access to health care requires services to be available and accessible at the time the person needs the services.

It also requires practitioners to work alongside the person in care throughout their health care journey and to take a stance of curiosity and ask meaningful questions aimed at understanding the person within the context of their culture, community, and help seeking behaviors.

Care coordination is necessary, requiring the practitioner to be intentional and informed about coordinating activities or services with other providers to best meet the person in care's needs. To ensure smooth coordination of care, practitioners should request authorization to share information (also known as releases of information) for all others involved in the care of the person in treatment during the intake process and throughout the course of treatment.



Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care coordination can be provided in clinical or non-clinical settings (including the community) and can be provided face-to-face, by telehealth, or by telephone. Care coordination includes one or more of the following components:

Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.

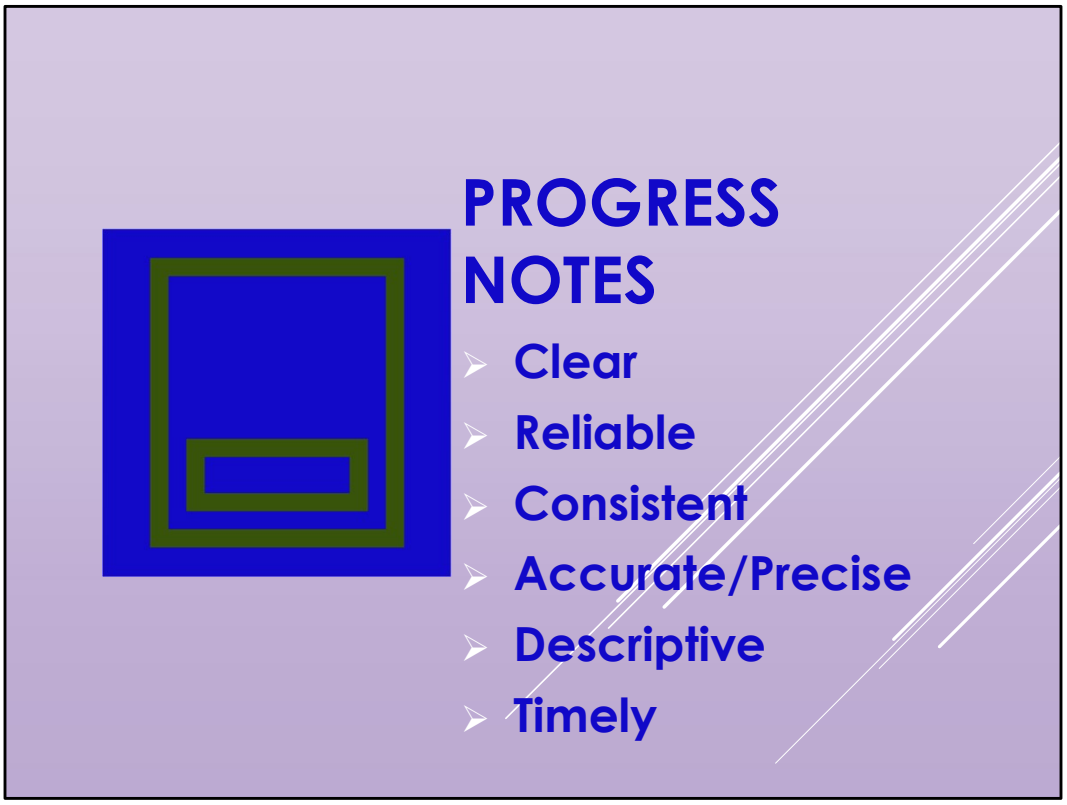
Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.

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.

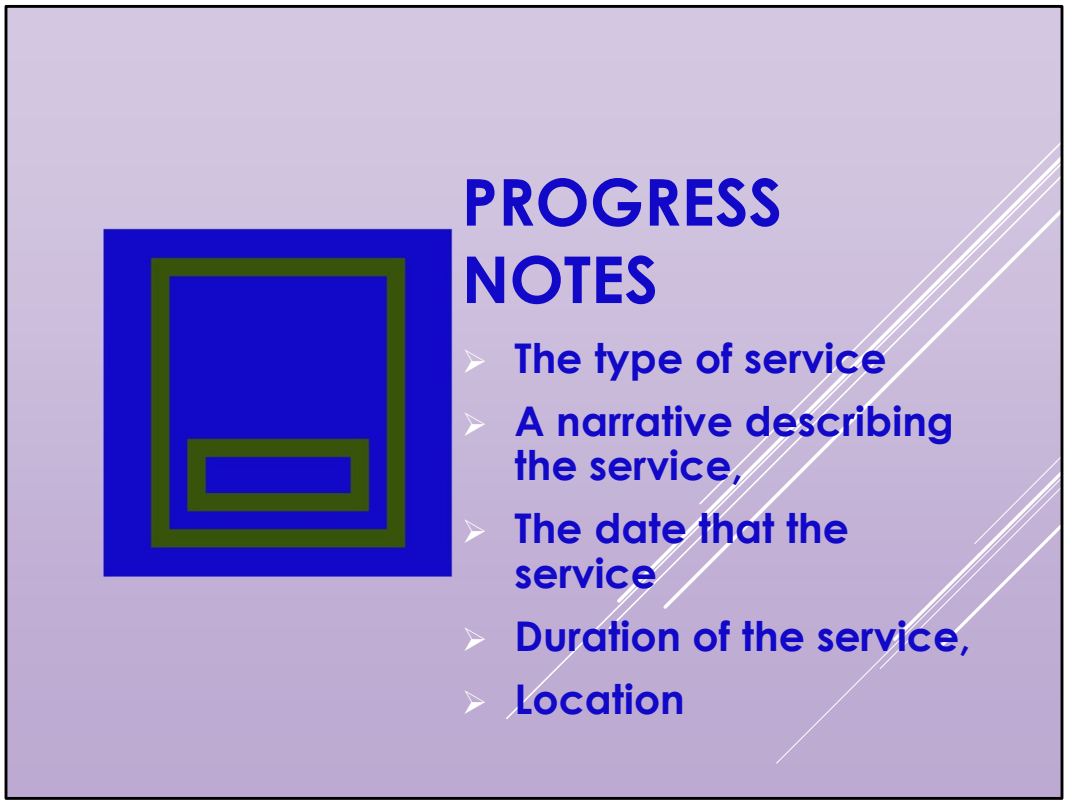
First, progress notes are used as a basis for planning care and treatment among practitioners and across programs. Progress notes are communication tools; therefore, each progress note should be understandable when read independent of other progress notes. This means, documentation should provide an accurate picture of the person's condition, treatment provided, and response to care at the time the service was provided.

Secondly, progress notes are considered a legal record describing treatment provided for reimbursement purposes. The progress note is used for verification of billed services for reimbursement. As such, there must be sufficient documentation of the intervention, what was provided to or with the person, to justify payment.

Third, progress notes are also used to communicate with other care providers. For these reasons, abbreviations should be avoided, unless universally recognized, to facilitate clear and accurate communication across providers and for when notes are used for legal or other reasons.



The following list are characteristics of a progress note that supports quality documentation.
Consider the following characteristics when documenting:
Clear
Reliable
Consistent
Accurate/Precise
Descriptive
Timely



Required Progress Note Service Information

The type of service rendered

A narrative describing the service, including how the service addressed the person's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors).

The date that the service was provided to the person in care.

Duration of the service, including travel and documentation time.

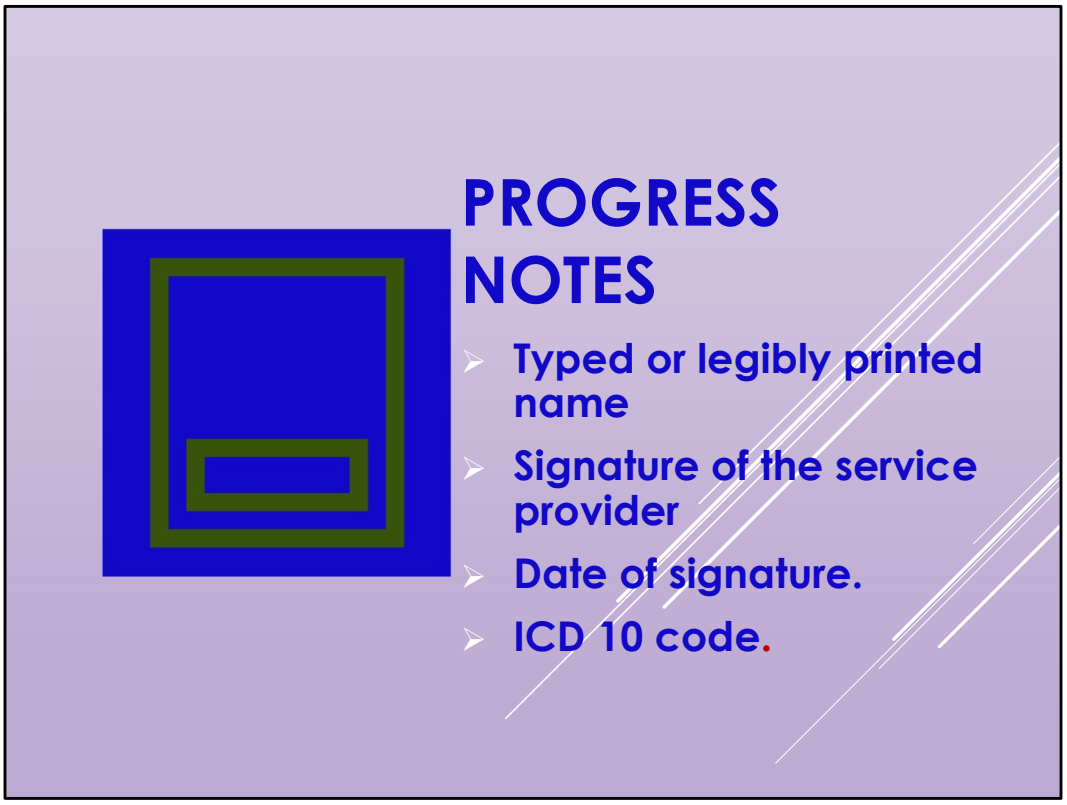
Location of the person in care at the time of receiving the service.

A typed or legibly printed name, signature of the service provider and date of signature.

ICD 10 code.

Current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.

Next steps including, but not limited to, planned action steps by the provider or by the person in care, collaboration with the person in care, collaboration with other provider(s) and any update to the problem list as appropriate.



Required Progress Note Service Information
The type of service rendered
A narrative describing the service, including how the service addressed the person's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors).
The date that the service was provided to the person in care.
Duration of the service, including travel and documentation time.
Location of the person in care at the time of receiving the service.
A typed or legibly printed name, signature of the service provider and date of signature.
ICD 10 code.
Current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
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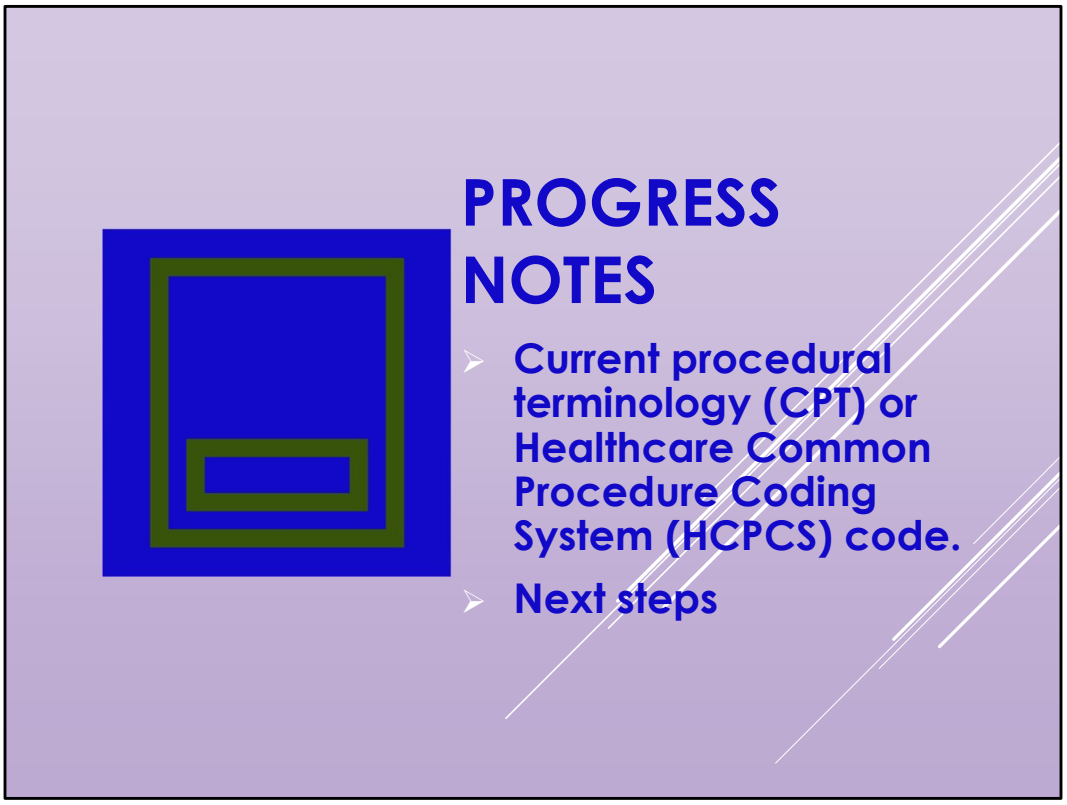

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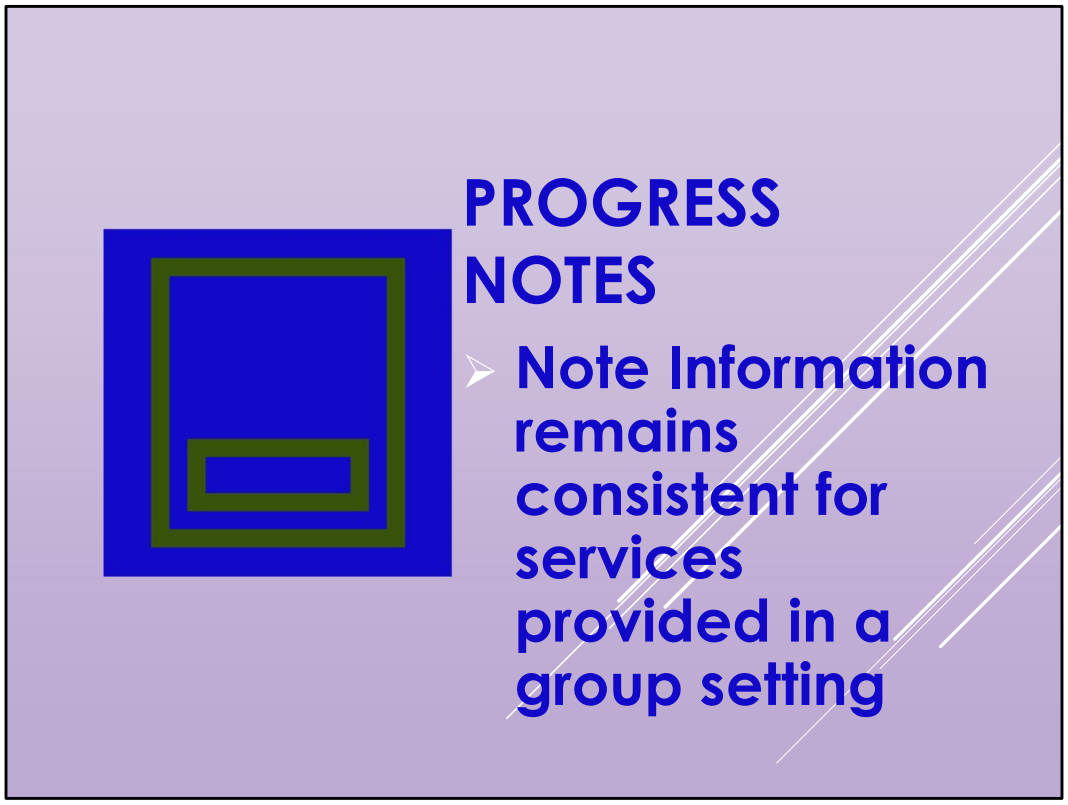


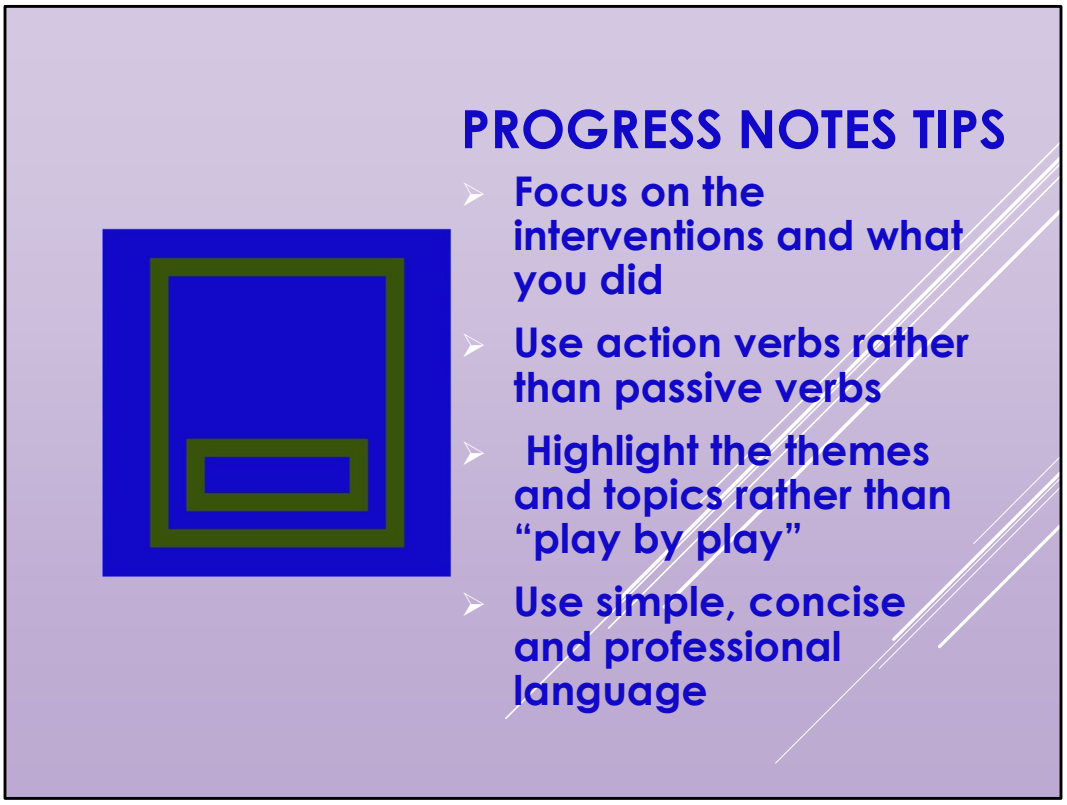
Required Group Note Service Information

The information from the previous slide remains consistent for services provided in a group setting, with the following additional requirements:

For groups facilitated by multiple practitioners, a single progress note signed by one of the practitioners shall be used to document the group service provided. Progress notes shall contain the information as noted above and modifications and additional information as noted below:

Information about the specific involvement and specific amount of time of involvement of each practitioner in the group activity, including time spent traveling to/from the service and documenting the service.

A list of group participant names shall be maintained. Please note, due to confidentiality standards, the full list of group participants must not be kept in any single participant's personal health records, instead the MHP or practitioner must maintain the full participant list outside of any participant's health records.



While rules vary regarding specific note content expectations, in general the below tips can assist you in writing high quality progress notes.

Focus on the interventions and what you did during the service as the provider

Use action verbs to describe your interventions rather than passive verbs

Highlight the themes and topics of a service rather than documenting a "play by play" of the service.

Use simple, concise and professional language with clear and specific examples.

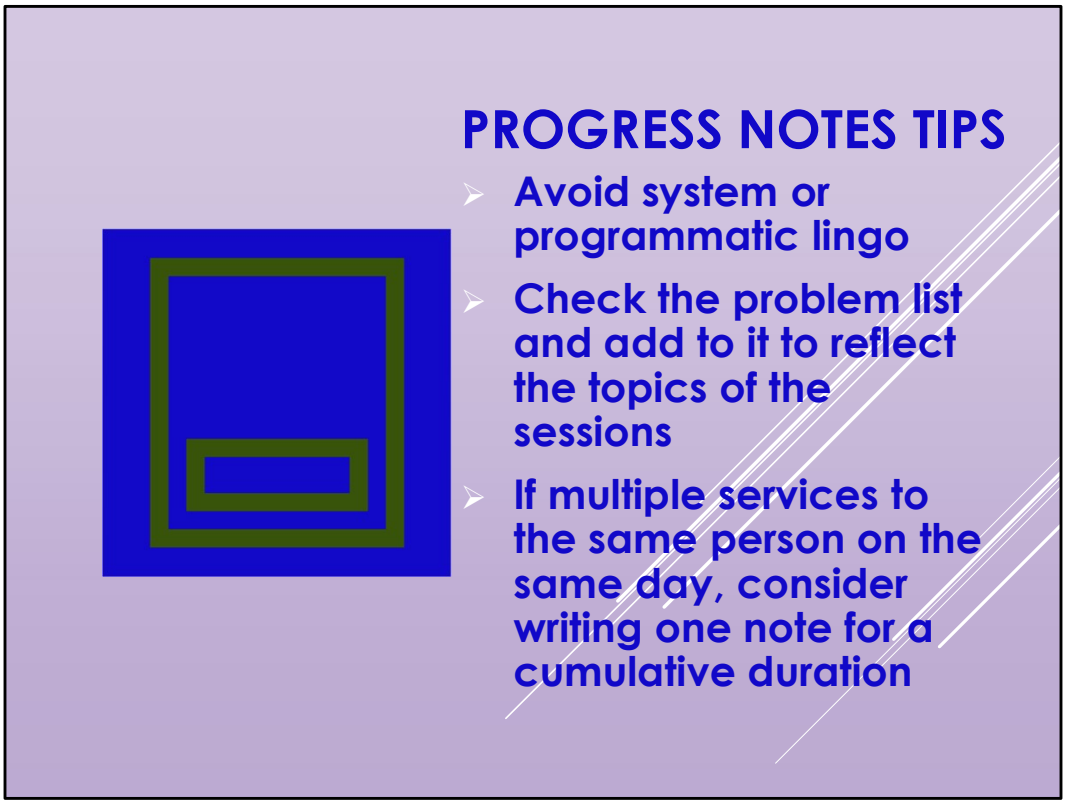
Avoid system or programmatic lingo to keep the notes person-friendly

Check the problem list and add to it to reflect the topics of the sessions as needed.

If multiple services of the same service type (e.g. care coordination) were provided to the same person on the same day, consider writing one note for a cumulative duration of time rather than separate notes.

Be precise in your service minutes – rounding is not permitted

Schedule time in your calendar to complete note writing each day and limit interruptions during those times



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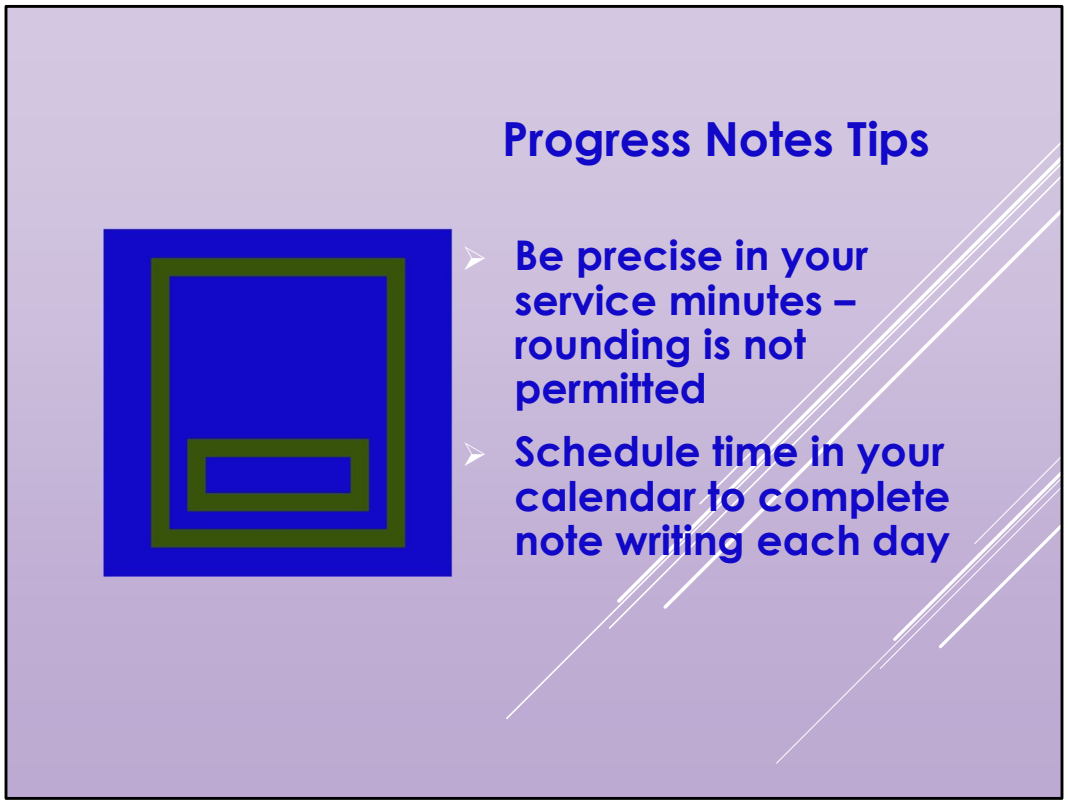
Check the problem list and add to it to reflect the topics of the sessions as needed.
If multiple services of the same service type (e.g. care coordination) were provided to the same person on the same day, consider writing one note for a cumulative duration of time rather than separate notes.
Be precise in your service minutes – rounding is not permitted
Schedule time in your calendar to complete note writing each day and limit interruptions during those times



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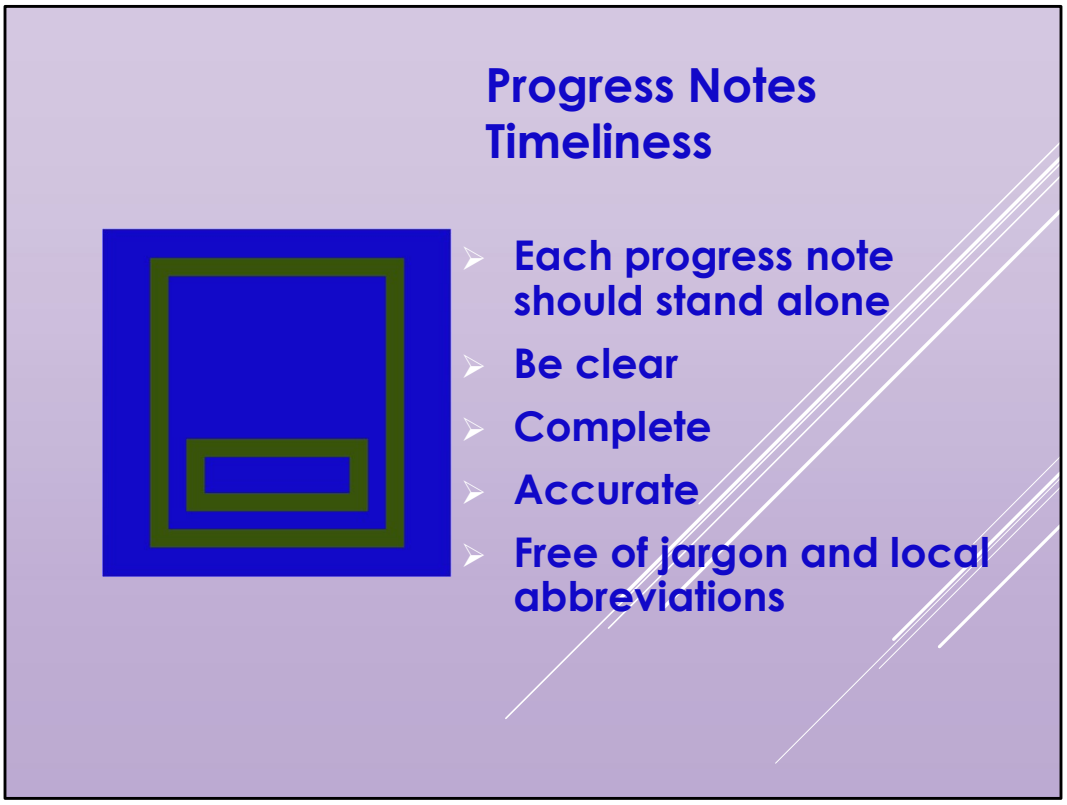
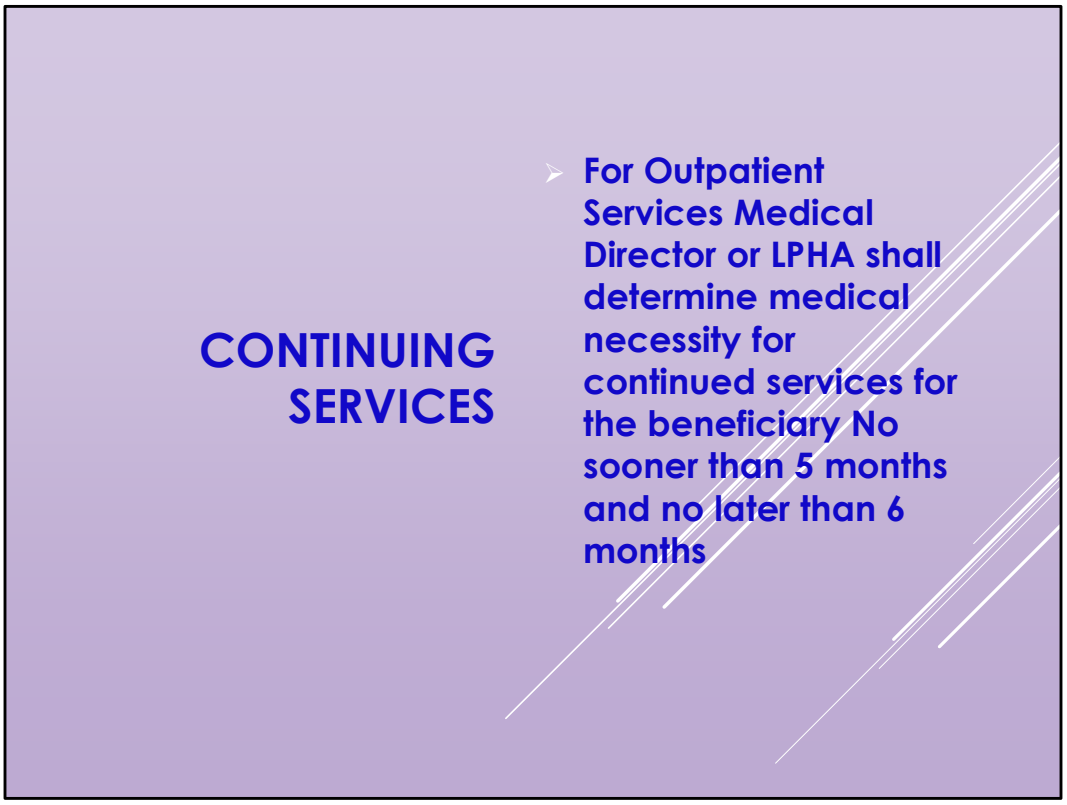


As noted above, each progress note should stand alone and be clear, complete, accurate, and free of jargon and local abbreviations. Documentation should be completed in a timely manner to support the practitioner's recall of the specifics of a service. Progress notes should never be completed in advance of a service. Below are timeliness expectations determined by DHCS:

Routine outpatient services: Documentation should be completed within three business days. If a note is submitted outside of the three business days, it is good practice to
document the reason the note is delayed. Late notes should not be withheld from the
claiming process. Based on the program/facility type (e.g., STRTP DHCS regulations), stricter note completion timelines may be required by state regulation.
Crisis services: Documentation should be completed within 24 hours.
Narcotic Treatment Programs: No changes to this requirement. Federal requirements remain in effect.
A daily note is required for documentation of some **residential services**, day treatment, and other similar settings that use a daily rate for billing. In these programs, weekly summaries are no longer required.

Must identify if service was in-person, by telephone, or telehealth & Must document location of service and how confidentiality was ensured if in community



For a beneficiary to receive ongoing DMC-ODS outpatient services, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary at least every six months through the continuing services justification process and document their determination that services are medically necessary.

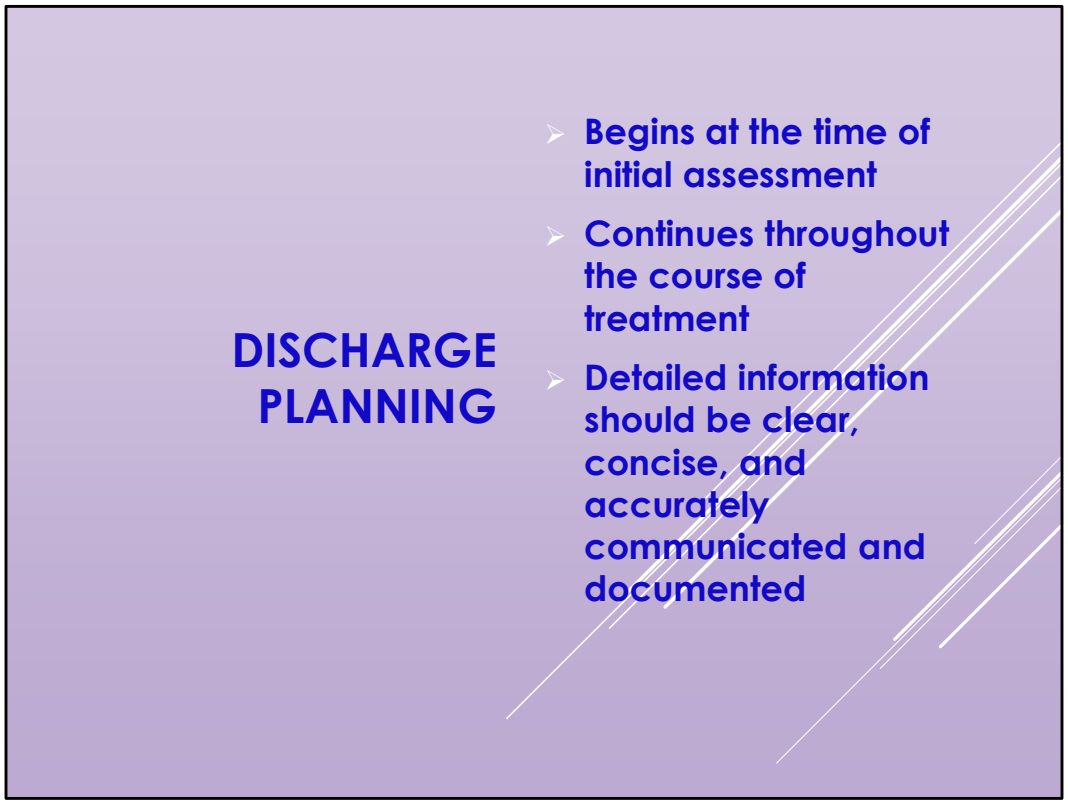
Timeframe

No sooner than 5 months and no later than 6 months

What must be documented?

Beneficiary's name
The purpose of the service
Description of how the service relates to the beneficiary's treatment plan
Date, start and end times of each service
Printed or typed & signed name of Medical Director or LPHA Adjacent to each other

Must identify if service was in-person, by telephone, or telehealth

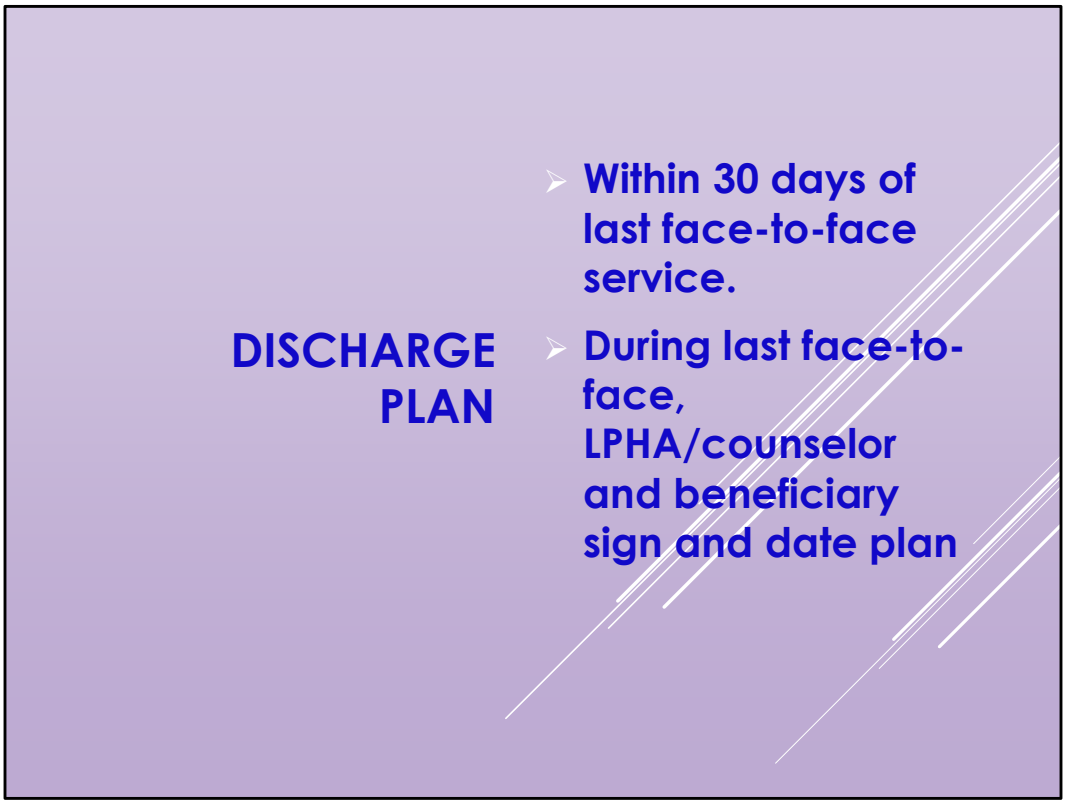


Discharge planning is the processes to prepare the client for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the client to essential community treatment, housing and human services.

The discussion about discharge planning begins at the time of initial assessment (as clinically appropriate) and continues throughout the course of treatment.

Discharge planning must include the person in care and their social supports as full partners in the planning process and should be done as far in advance as practical. Additionally, including other treatment providers, when applicable, paves the ways to successful transitions from one care setting to another. Detailed information on discharge planning should be clear, concise, and accurately communicated and documented.

A successful discharge discussion includes a review of how the person can continue to receive any necessary support and how those needs may be addressed post-discharge from the program. Information contained in discharge plans and shared with the person in care includes how the person's needs may be addressed, information on prescribed medications, the type of care the person is expected to receive and by whom, information on crisis supports, and available community services, to name a few.



Timeframe

Within 30 days of last face-to-face service.
During last face-to-face, LPHA/counselor and beneficiary sign and date plan

What must be documented

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

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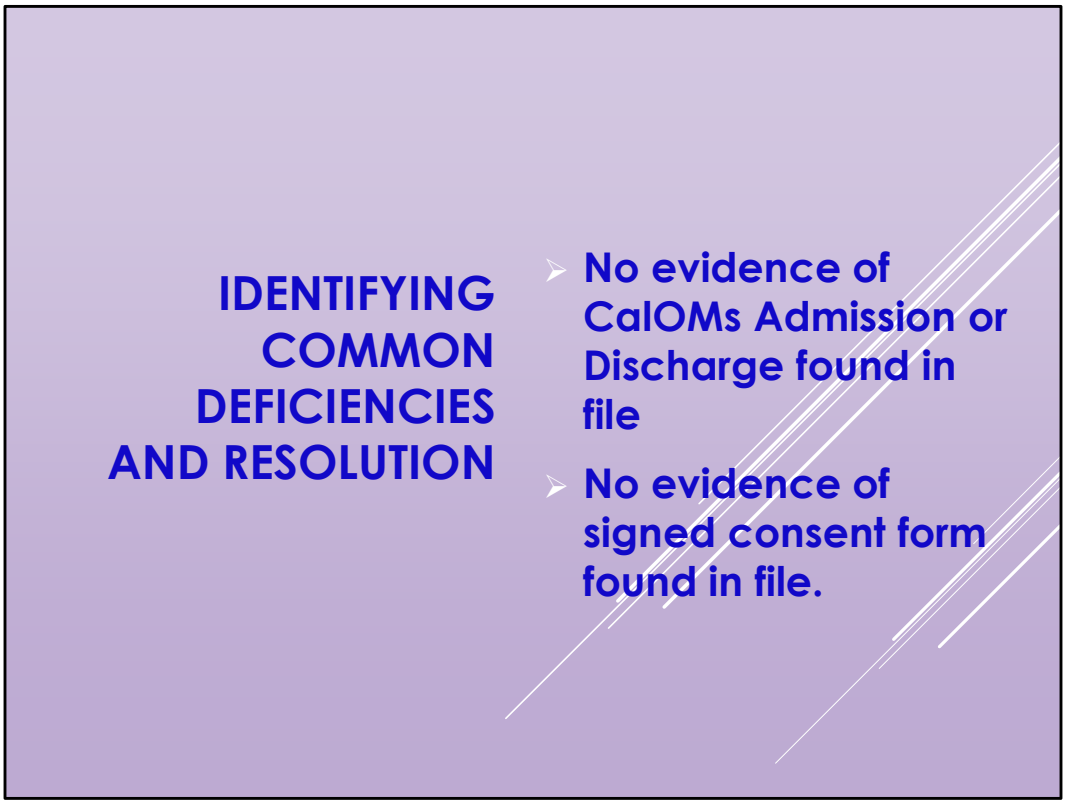
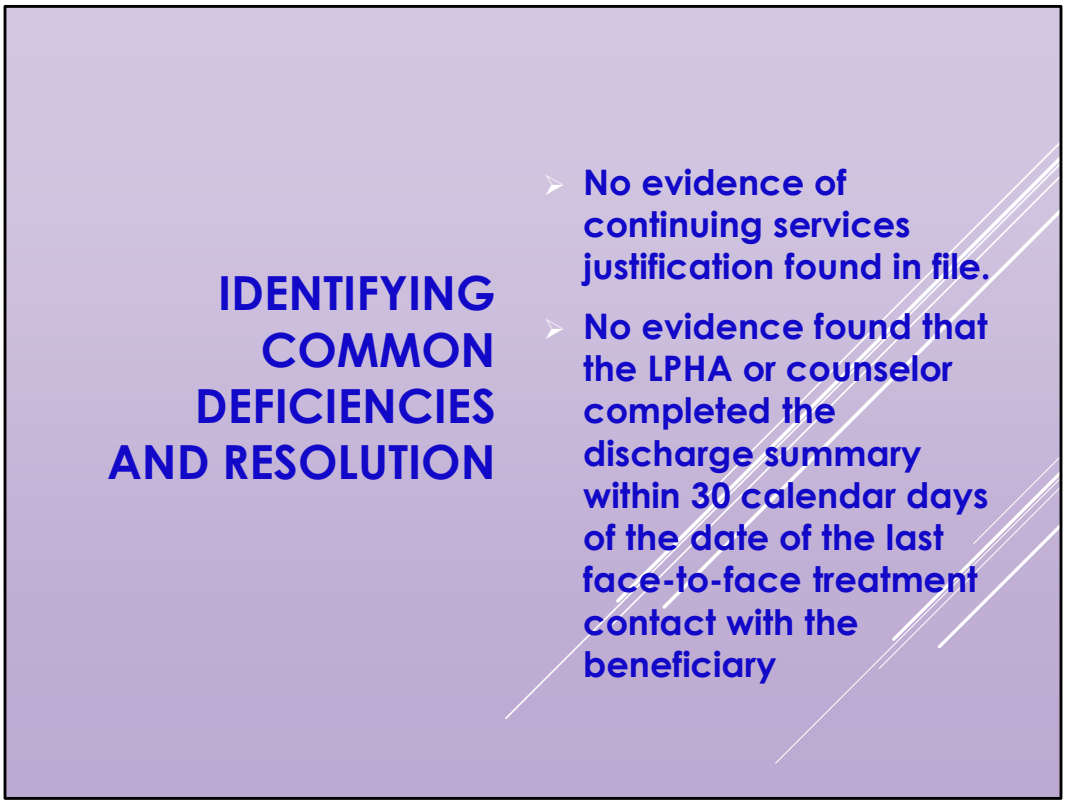


Just like EDC DMC-ODS Monitors your agency, DHCS monitors EDC DMC-ODS. Here is a list of Common Deficiencies and their Resolutions.

Files that are currently open contain a copy of admit CalOMS and annual update if episode year or longer. Discharged files shall contain admit, discharge or annual update as required.

The beneficiary shall sign a consent to treatment form. A copy of the consent to treatment shall be provided to the beneficiary upon admission.



For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.

For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary.

The LPHA or counselor shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:

The LPHA or counselor shall complete the discharge summary within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary.

The discharge summary shall include all of the following:

The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
The reason for discharge.
A narrative summary of the treatment episode.
The beneficiary's prognosis.

QUESTIONS

I want to thank everyone for attending today. Please feel free to contact Shaun or myself for any questions you may have.
(End Recording)

The End Code 4567

A survey will be sent out. Please use your start and end codes on the survey. For those with CADTP & CCAPP credentials, an exam will be sent out to you via email.

CUEs and Certificates of Attendance will be sent out soon for those who return Surveys and/or CADTP & CCAPP exams.

Our next Training is on Suicide Prevention is tentatively scheduled for Thursday September 14, 2023

Until next time, have a great rest of your day.