Behavioral Health Full Clinical Workflow

Request for Services Mental Health Services & Drug & Alcohol Services (DMC-ODS):

Request for services: Completed in Central Access

Managed Care AAs-(MH/DAS)

1. Launch Inquiry – Complete AA portions on Initial, Insurance, and Demographics tab – see Appendix A
    - Initial tab - Includes referring agency information if applicable.
    - Insurance tab - Verify Medi-Cal & enter.
    - Demographics tab - Basic Demo
2. Create a client ID (MR#) (Link/Create Client button)
3. Enroll into either SLO MC Authorization Adult/Youth Programs-***mark*** as "enrolled."

Managed Care BH Specialist:

MH Requests:

1. Complete Screening tool to determine which system of care the client will be served by
2. Complete disposition portion of Initial tab of Inquiry document, **end/complete inquiry, then save if moving on for assessment. (If referring to CenCal, assign inquiry to MC HIT for processing, and they will end/complete inquiry.)**
3. **Enrollment in the program-mark (without staff) as "requested" (Client programs; new; program assignment details) to accurately schedule the assessment appointment. (If intake program is not open before scheduling, the incorrect program will be in the service note and assessing clinician will need to change to correct program when completing service note.)**
4. Schedule assessment with the "Requested Program" marked (appt search: Service details)
5. **Assign staff to Program to complete the assessment (Client programs, program assignment details)**
6. **Close SLO MC Authorization Adult/Youth Program (Client programs; program assignment details)**
7. If an assessment appointment was offered and declined, launch the CSI Assessment Standalone. Begin and end the CSI Assessment Standalone entry with this closure reason.
8. Complete Service Note

DAS Requests:

1. Complete Service Note

Request for services: Coming from Central Access/Managed Care or Walk in-(MH/DAS) Clinic Administrative Assistant (AA) or Designee:

If client walks in:

1. Open client search and confirm they are not a current client – DAS only.
2. Use client search to create a new potential client – DAS only.

3. Create a client ID (MR#) (Link/Create Client button) – DAS only.
4. Begin the inquiry screen – DAS only.
    - Assessing clinicians will complete disposition portion of Initial tab of Inquiry document, **end/complete inquiry, then save.**
5. Verify Medi-Cal (Inquiry: insurance tab) & enter – DAS only.
6. Enroll the client in the DAS walk-in assessing program (Client programs, Program assignment details).
7. Complete electronic consents (Consent to Treat, Consent for Email Communication, Consent for Text Communication, Consent for Telehealth, Coordinated Care Consent-script AA is to use is in Onboarding a Client/DAS Walk-In How-To guides)-Both MH & DAS
8. Complete intake packet. -Both MH & DAS

Complete full demo (under client information) & any paper forms.

MH-Paper: Cost agreement, Advanced Beneficiary Notice (ABN), Health Questionnaire-Optional, Caregiver affidavit if applicable, Audio/Video consent-if applicable, Pediatric Symptom Checklist-if applicable, Consent to Photo if we are taking pics and uploading into SmartCare.

SUD-Paper: Cost agreement, Health Questionnaire, Audio/Video consent-if applicable, Multi-Party Consent-If applicable, Criminal Justice Consent, Consent to Photo if we are taking pics and uploading into SmartCare.

1. Complete client Information screen full demographics
2. Enter billing & insurance information in. Complete paper cost agreement, UMDAP Financial Assessment for non-UMDAP clients, and paper ABN (if applicable MH clients). If Medi-Cal enter in Medi-Cal for MH and Medi-Cal DAS. Go to Client Account screen and check financial information is complete box.

Intake/Assessment Mental Health Services & Drug & Alcohol Services (DMC-ODS):

If client is Mental Health scheduled assessment - Clinical Staff will:

1. If phone/zoom assessment-enroll client into program, complete consent forms and Client Information screen. Review Cost Agreement w/ non-UMDAP clients and ABN (if applicable) and any applicable form stated above and note in your service note.

   A. For youth mental health intakes: if phone/zoom assessment the AA will call or enter from paperwork dropped off and enroll client into program, complete consent forms and client information screens, review cost agreements w/non- UMDAP clients and any applicable forms stated above.

2. Complete CSI: CSI Standalone Collection (Client).
3. Complete Clinical Assessments for Adult: CalAIM Assessment (Client) + Mental Status Exam (Client)
4. Complete Clinical Assessments for Youth: CalAIM Assessment (Client) + California CANS + PSC 35 California Pediatric Symptom Checklist (Client) + Mental Status Exam (Client)
5. Complete assessment Service Note – Appendix D
6. Complete Diagnosis: Diagnosis Document (Client).
7. If Martha's Place, obtain Short Sensory Profile and CHADIS Report.
8. Make any needed referrals.
9. If not moving on complete NOABD.

a. Document any referrals.

If client is Mental Health scheduled assessment-Service Provider will:

1. If there is no funding source, Medicare only or self-pay, complete a paper UMDAP Financial Assessment (Client to sign/service provider to sign.) Service provider will meet with client and complete the UMDAP on paper. Once completed, the service provider will give AA to enter in the UMDAP Financial Assessment into SmartCare.

Site MH Program Supervisor will:

1. Review clinical assessment and make decisions of plan of care.

Site MH Health Information Technician (HIT) will:

1. If MH intake, ensure that the medical record elements are completed, clear completed notifications/flags, & add to SAT log treatment decision.
2. Add programs **(s) and Treatment Team** as needed.
3. Close any assessment or programs as needed.
4. Document the CSI Standalone Assessment (For Timeliness)

Verify the Administrative Assistant (AA) or Designee has:

1. Enrolled the client in the assessing program (Client programs, Program assignment details)
2. Completed Consents.
3. Completed intake packet.
    a. Completed full demo and Client Information screen is completed.
    b. Verify insurance information and enter in billing & insurance information in. Complete paper cost agreement & ABN (If applicable) If Medi-Cal enter in Medi-Cal for MH **and** Medi-Cal DAS. Verify financial information is complete box is checked in the Client Account screen.
    c. Enter UMDAP Financial Assessment (if done on paper) and check the "financial information is complete box" on the Client Account screen.

If client is Drug & Alcohol Walk-In, Clinical Staff Assessment Coordinators (AC) or Designee will:

1. Complete the DAS Screening to establish access criteria: BQuIP (Client).
    a. Scheduled for assessment or appropriate program(s) prior to assessment.
    b. Complete disposition portion on the initial tab of the Client Inquiries (Client). End/complete inquiry, then save.
    c. Complete a Provisional Diagnosis: Diagnosis Document (Client).
    d. Complete a Provisional Problem List: Client Clinical Problem Details (Client).
    e. Complete NOABD if needed.

When client shows up for Assessment, DAS Clinical or AC staff will:

1. Complete Assessments: CA ASAM (Client).
    a. Update Diagnosis as needed: Diagnosis Document (Client).
    b. Update Problem List as needed: Client Clinical Problem Details (Client).
    c. NOABD as needed.

2. If opening to treatment, email site HIT to report the program that must be opened for the client: treatment program, level of care, program start date, and assigned counselor. Assigned Counselor will be copied on this email. HIT will enroll client into the correct program and to the correct staff.
3. Complete CalOMS Admission: CalOMS Admission (Client).

When client shows up for Assessment, DAS Service Provider will:

1. If client is not FS Medi-Cal or grant funded, complete a paper UMDAP Financial Assessment (Client to sign/service provider to sign.) Service provider will meet with client and complete the UMDAP on paper. Once completed, the service provider will give to AA to enter in the UMDAP Financial Assessment into SmartCare.

If a client is already in treatment & is changing Level of Care (LOC) or changing sites (transfers):

1. CalOMS Discharge to be completed by the current clinical lead to close the CalOMS Admission for that level of care or site.
2. A new CalOMS Admission needs to be completed for the new LOC or site. Lead completes if transferring or level of care change CalOMS Discharge and the new lead completes the CalOMS Admission (should not be future dated.)

DAS-Site Health Information Technician (HIT) will:

1. If DAS Intake, ensure opening to correct level of treatment & ensure medical record elements are complete.
2. Add program(s) **and Treatment Team** as needed.
3. Close any assessment or programs as needed.
4. Ensure any CalOMS are completed.

Verify the Administrative Assistant (AA) or Designee has:

1. Open client search and confirm they are not a current client.
    a. Use client search to create a new potential client/started inquiry.
2. Enroll the client in the assessing program (Client programs, Program assignment details)
3. Complete Consents.
4. Complete intake packet.
    a. Complete full demo and Client Information screen is completed.
    b. Verify insurance information and enter in billing & insurance information in. Complete paper cost agreement. If Medi-Cal enter in Medi-Cal for MH **<u>and</u>** Medi-Cal DAS. Verify financial information is complete box is checked in the Client Account screen.
    c. Enter UMDAP Financial Assessment (if done on paper) and check the "financial information is complete box" on the Client Account screen.
5. If the screening is completed and assessment is determined, assist with scheduling the next available intake or other program needs from the outcome of the screening per the assessment coordinator.

Continuing Services Documentation Mental Health Services:

1. Complete new CalAIM Assessment (LPHA provider) or complete treatment summary progress note (non-LPHA provider - See Appendix E)
2. Complete new CANS: CA CANS
3. Complete Pediatric Symptom Checklist for Youth (ages 3-17) Every 6-Months: 35 California Pediatric Symptom Checklist (Client)
4. Annual Mental Status Exam: Mental Status Exam (Client) must be completed annually for all clients being served by a LPHA.
5. CSI as needed: CSI Standalone Collection (Client)
6. Update Diagnosis as needed: Diagnosis Document (Client).
7. Update Problem List as needed: Client Clinical Problem Details (Client).

Continuing Services Documentation Drug & Alcohol Services (DMC-ODS):

1. CalOMS Updates: CalOMS Standalone Discharge/Update (Client).
    a. Completed by clinical lead and will only be completed when the client is still open to treatment at the same level of care & same site a year after the admission. Done each year on the "anniversary" date of admission for each year they remain open.
2. Update Diagnosis as needed: Diagnosis Document (Client).
3. Update Problem List as needed: Client Clinical Problem Details (Client).
4. Update ASAM as needed: CA ASAM (Client).

Discharge Documentation Mental Health Services:

1. CSI: CSI Standalone Collection (Client)
2. For Youth: California CANS + 35 California Pediatric Symptom Checklist (Client)
3. Update Diagnosis as needed: Diagnosis Document (Client).
4. Update Problem List as needed: Client Clinical Problem Details (Client).
5. NOABD: NOABD Termination

Discharge Documentation Drug & Alcohol Services (DMC-ODS):

1. Discharge Plan Session: Use Discharge Planning Service Note as Discharge Plan (Client to sign Discharge Plan Progress Note and Clinical Lead to offer a copy of the Discharge Plan Note to Client). Follow appropriate template in Appendix. Assign site HIT as co-signer for the Discharge Planning Progress Note. The HIT will discharge the client from the program(s). Clinical Lead will close Drug Testing program and email AdminOps Team to update Sentry.
2. Discharge Summary: Use Client Non-Billable Srvc Must Document Service Note as Discharge Summary.
3. Because writing the discharge summary is not tied to a service provided to the client, a service cannot be billed, however the summary is still required. Assign site HIT as co-signer for the Non-Billable Discharge Summary Progress Note. The HIT will discharge the client from the program(s). Clinical Lead will close Drug Testing program and email AdminOps Team to update Sentry.
4. CalOMS Discharge: CalOMS Standalone Discharge/Update (Client)
    a. Completed by clinical lead.

5. Update Diagnosis as needed: Diagnosis Document (Client).
6. Update Problem List as needed: Client Clinical Problem Details (Client).

Appendix:

Consent/Authorization Form Client Signature Information

Form	Is Client Verbal Authorization Permitted	Client Signature (Electronic or Hardcopy Required)
Consent for Treatment	Yes	Ideal/Best Practice
Coordinated Care Consent	No	Required
Authorizations to Release Information (Release of Information)	No	Required
Informed Medication Consent	Yes	Ideal/Best Practice

Appendix: Templates

DMC-ODS Discharge Plan Progress Note Template

Description of the treatment episode (duration of treatment with admission date and discharge date, narrative summary of the treatment episode, description of recovery services completed):

Current alcohol and/or other drug use:

Current medications prescribed by Behavioral Health (including dosage and response, plan for continued medication, and list other medical issues/medications prescribed by other providers):

Vocational and educational achievements (achievements, scheduled time, structured time, activities such as volunteering, caring for family, or note no change since admission):

Legal status and comments:

Current living situation (status at discharge, recovery environment support):

Reason for discharge (indicate one of the following: Client not appropriate for treatment, Discharged against medical advice, Disengaged from services/Non-compliant with treatment, Involuntary discharge, Moved out of area, Services no longer needed, Successful completion, Transfer to a higher level of care, Tranfer to a lower level of care, or Transferred to a different program):

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

Client's relapse triggers and plan to assist client to avoid relapse when confronted with each trigger:

Client's Discharge/Support Plan for Continued Recovery (people, organizations, Recovery Support Services) and comments at the close of treatment:

Was client offered/provided a copy of their Discharge Support Plan (yes, no, explanation if necessary):

DMC-ODS Discharge Summary Progress Note Template

Description of the treatment episode (duration of treatment with admission date and discharge date, narrative summary of the treatment episode, description of recovery services completed):

Current alcohol and/or other drug use:

Current medications prescribed by Behavioral Health (including dosage and response, plan for continued medication, and list other medical issues):

Vocational and educational achievements (achievements, scheduled time, structured time, activities such as volunteering, caring for family, or note no change since admission):

Legal status and comments:

Current living situation (status at discharge, recovery environment support):

Reason for discharge (indicate one of the following: Administrative discharge, Client not appropriate for treatment, Deceased, Discharged against medical advice, Disengaged from services/Non-compliant with treatment, Incarcerated, Involuntary dicharge, Moved out of area, Services no longer needed, Transfer to a higher level of care, Tranfer to a lower level of care, or Transferred to a different program):

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

Was an NOABD Termination Notice sent to the client (N/A, yes, no, explanation if necessary):