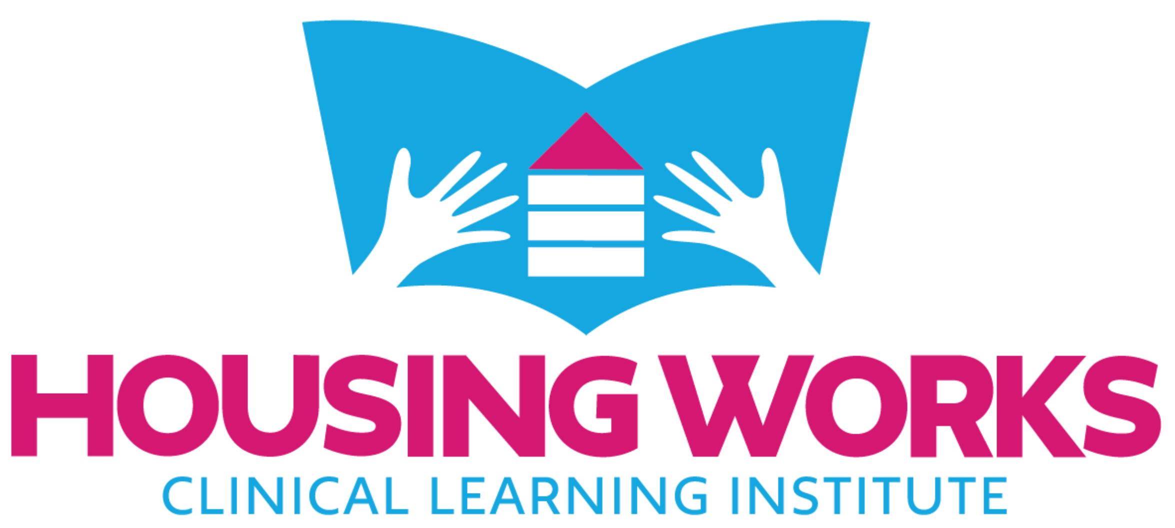


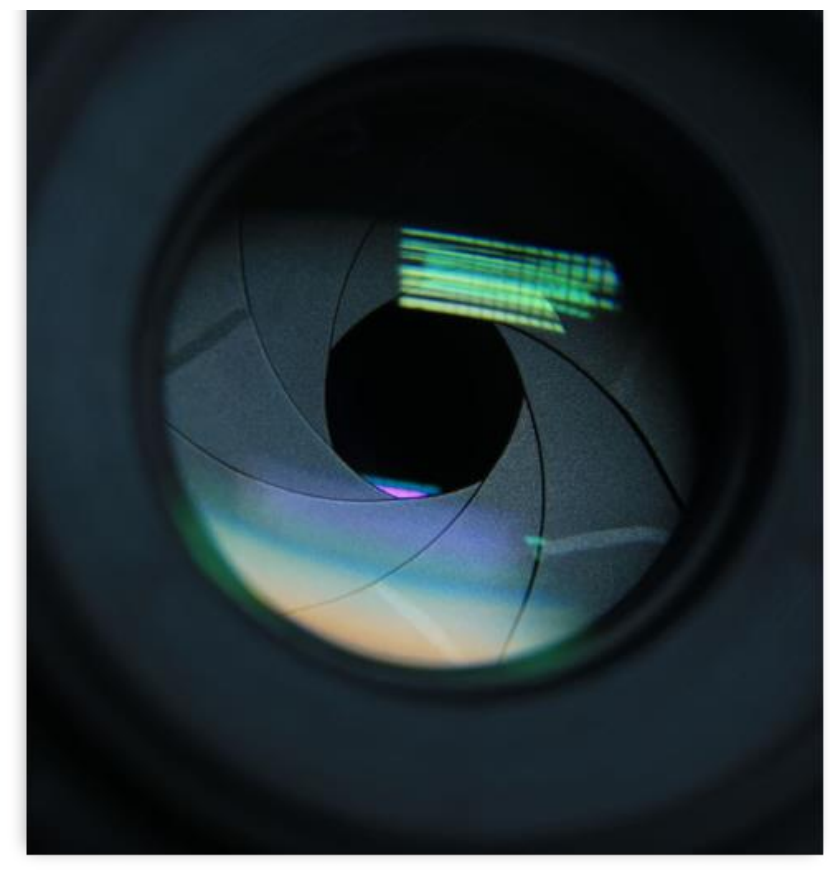
OASAS Compliance Training

Deena Smith, LCSW, SIFI

Behavioral Health Compliance Manager

Objectives

- Understand documentation best practices at Housing Works, particularly for OASAS programs
- Understand the purpose of documentation
- Familiarize you with the electronic health records (EHR) utilized to document client encounters
- Identify and use the essential elements required in a treatment plan, including client information, goals, interventions, and progress monitoring
- Describe the documentation process for effective progress notes
- To create effective discharge plans to support clients as they transition out of therapy
- Review workflows utilized to provide quality clinical care



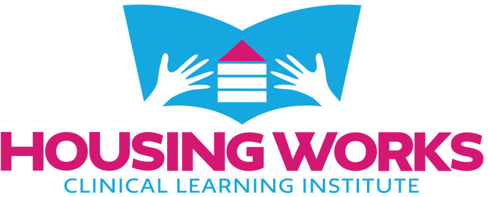
Documentation is mandatory for all client contacts, assessments, and the delivery of services.

Documentation should be completed in eiCare and locked in eCW within 48 hours after the encounter.

All documentation should be entered in the respective electronic health record (E.H.R)

Documentation should be clear, concise, and organized

Good documentation ensures accountability, service improvement, and reimbursement for services rendered.



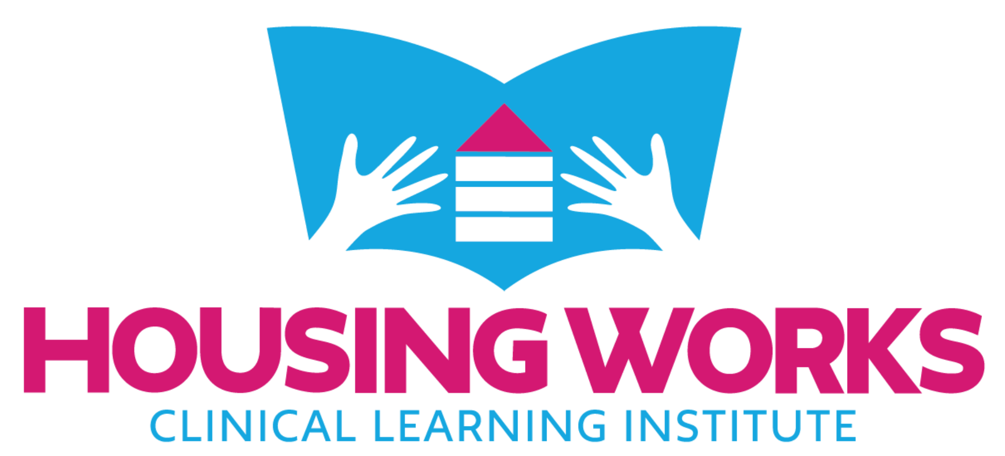
E-Clinical Works (ECW) and E-ICARE used to document scheduling of services & billing

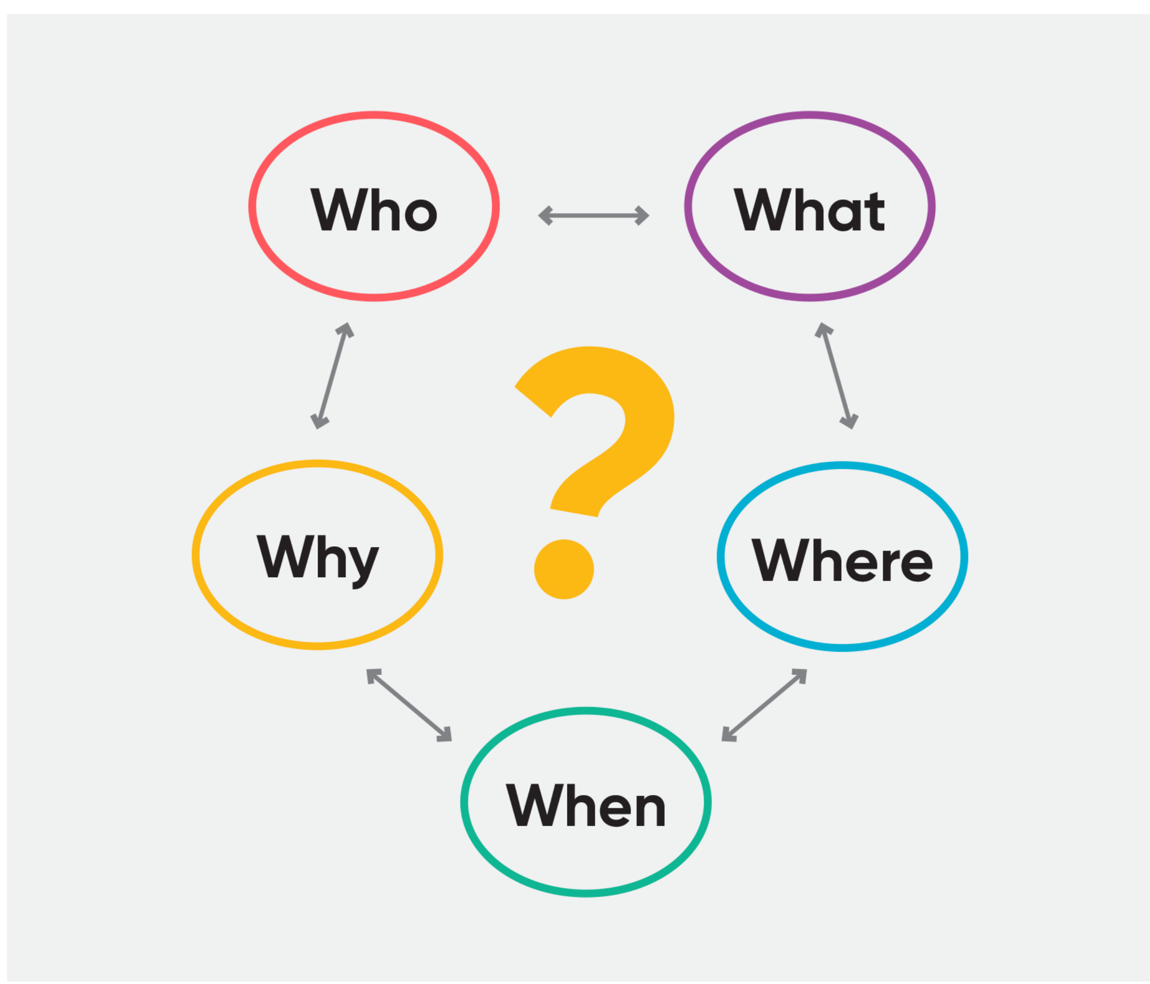
Not every program uses the same EHR.; OMH – e-icare; CONNECT – e-icare; OASAS – e-icare; Article 28/IOS - ECW

Documentation in the Client Record/EHR

Electronic Health Records

- OASAS uses electronic health records (EHR) e-clinical works (ECW) and ei-Care to document services delivery with clients.
- The program services determine which EHR progress note is documented.
  - Article 28 & IOS documents encounters in ECW
  - OASAS, OMH, RAD, Health Home & other programs document encounters in ei-Care.
- Services can be rendered via in-person, televisit or telephone (in special circumstances)
- All documentation must be completed and locked within 48 hours.

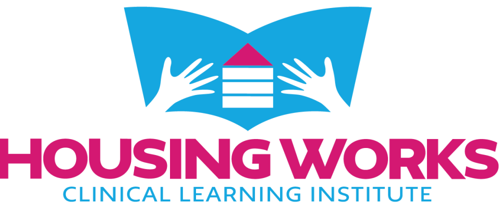


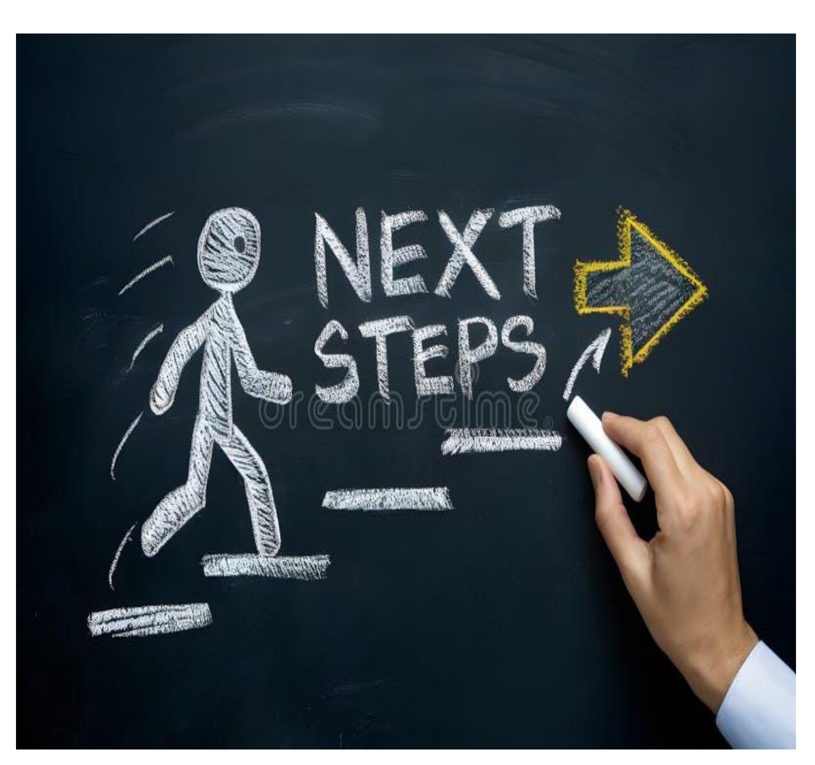


Documentation in the Client Record/E.H.R

- Documentation should address:
  - Who,
  - what,
  - when,
  - where,
  - how
  - And next steps

- **Who:** client; the social worker; any additional individuals present
- **What/Why:** issue/concern, reason for visit, task to be addressed, purpose; describe the service being provided
- **Where:** location of service, client, clinician/provider, esp. *telehealth
- **When:** date of service, time of visit, length/duration





- **How:** intervention, modality and frequency
- **Next Steps:** plan of action next visit

Telephone Encounters (TE) in eCW

Telephone Encounter

- Telephone encounters are a way to have conversation between providers within the EHR & can also be used to capture administrative info that needs to be documented in the client record.
- For OASAS, we use eiCare for our admin documentation but may still receive TEs from other HW providers so should still be checked

Test, Salina,(Sakina) 32Y, F INFO Connect
SOGI
57 WILLOUGHBY ST,LOWER LEVEL, BROOKLYN,NY-11201-...
929-431-8897 (P) | 929-431-8897 |
s.nejumi@housingworks.org | 11/22/1991
Account No: 34567 | Messenger Enabled: Yes
Web Enabled: Yes | healow Tracker Data: No |

Advanced Directive :
Insurance : TEST
Last vMsg : 03/22/2023 , 12:42:16
PCP : Werner, Jennifer
Rendering Pr : Werner, Jennifer
Default Facility : Westside Health Ce...

Billing
Patient Balance : $0.00
Account Balance : $0.00
Collection Status :
Assigned to :
Billing Alert | Guarantor Balance
Account Inquiry | Billing Logs

Appointments
Last Appt: 04/04/2024 09:30 AM EDT at WHC:...
Next Appt:
Bumped Appt: NONE Case Manager Hx:
New Appointment

Structured Data	
Homeless	No
Migrant	No
Seasonal	No
Veteran	No
Public Housing	No
Date of HIV Diagnosis	
Referral Source	N/A
Communication	no barriers

0 Labs | 0 DI | 0 Referrals
0 Actions | 0 Tel Enc | 0 Web Enc
0 Docs | 0 P2P

Progress Notes | Patient Docs | Action | New Tel Enc
Medical Summary | Devices | Logs | New Web Enc
Medical Record | Consult Notes | Letters >> | Send Message
Problem List | Flowsheets | Print Labels | Messenger
eCliniForms >> | PHM Hub | eEHX
BH Hub

TEST, Salina "Sakina" Nov 22, 1991 (32 yo F) Acc No. 34567
healow Insights 2
Overview | Enc | DRTLA | History | CDSS | OS

Global Alerts
- Request insurance card
- Request insurance card

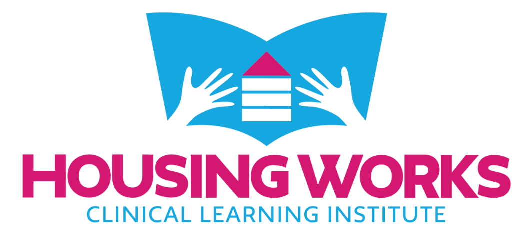
Advance Directive
Problem List SNOMED All
- F33.2 Severe episode of recurrent major depressive disorder, without psychotic features

Allergies
Medication Summary
Group By: Medication Medication: -- Select --
Select a Medication to view the medication details.
Immunizations
...peutic Injections
Circle Of Care

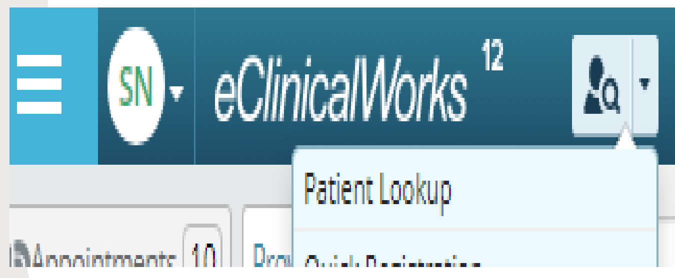
Components of a TE

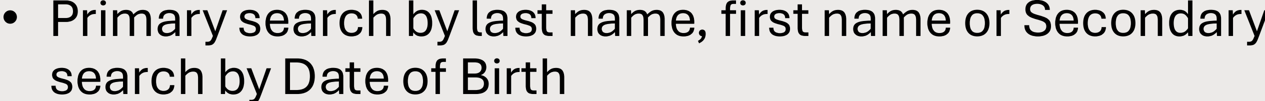
- **Reason:** This should be a succinct statement of the purpose/content of the TE e.g. "IOS care coordination"
- **High priority:** you can select this box, located under reason, if this is an urgent communication
- **Assigned:** This is selecting the person who will be following-up on the identified issue or to whom you are wanting to communicate with
- **Provider line:** Change the provider to the behavioral health supervisor (e.g. remove the current provider and then add BH "supervisor's name)
- **Facility:** Best practice is to change this to the facility you are operating in but is not required for most TEs
- **Messages:** In this area is where you will have the meat of your message. Should include summary of conversation/the issue you are addressing
- **Action taken:** In the initial message, you are simply going to select *Time stamp* to indicate when you are sending this message. Further conversation between providers would continue within this action taken section, with a time stamp for each time that you make an entry

Documenting a Telephone Encounter

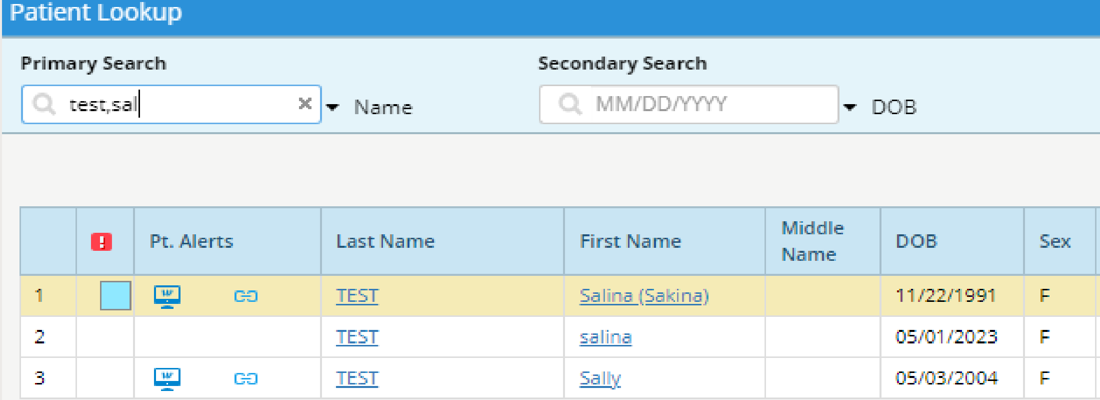


- From the patient hub, select New Tel Enc
- Select patient look up





- Primary search by last name, first name or Secondary search by Date of Birth
    - If you know the Medical Record Number (MRN) you can also use that to search directly



Telephone Encounter

- Select *New Tel Enc*

TEST, Salina "Sakina" Nov 22, 1991 (32 yo F) Acc No. 34567

Test, Salina,(Sakina) 32Y, F INFO Connect
SOGI
57 WILLOUGHBY ST,LOWER LEVEL, BROOKLYN,NY-11201-...
929-431-8897 (P) | 929-431-8897 |
s.nejumi@housingworks.org | 11/22/1991
Account No: 34567 | Messenger Enabled: Yes
Web Enabled: Yes | healow Tracker Data: No |

Advanced Directive :
Insurance : TEST
Last vMsg : 03/22/2023 , 12:42:16
PCP : Werner, Jennifer
Rendering Pr : Werner, Jennifer
Default Facility : Westside Health Ce...

Billing
Patient Balance : $0.00
Account Balance : $0.00
Collection Status :
Assigned to :
Billing Alert | Guarantor Balance
Account Inquiry | Billing Logs

Appointments
Last Appt: 04/04/2024 09:30 AM EDT at WHC:...
Next Appt:
Bumped Appt: NONE Case Manager Hx:
New Appointment

Structured Data	
Homeless	No
Migrant	No
Seasonal	No
Veteran	No
Public Housing	No
Date of HIV Diagnosis	
Referral Source	N/A
Communication	no barriers

0 Labs | 0 DI | 0 Referrals
0 Actions | 0 Tel Enc | 0 Web Enc
0 Docs | 0 P2P

Progress Notes | Patient Docs | Action | New Tel Enc
Medical Summary | Devices | Logs | New Web Enc
Medical Record | Consult Notes | Letters >> | Send Message
Problem List | Flowsheets | Print Labels | Messenger
eCliniForms >> | PHM Hub | eEHX
BH Hub

TEST, Salina "Sakina" Nov 22, 1991 (32 yo F) Acc No. 34567
healow Insights 2
Overview | Enc | DRTLA | History | CDSS | OS
Global Alerts
- Request insurance card
- Request insurance card

Advance Directive
Problem List SNOMED All
- F33.2 Severe episode of recurrent major depressive disorder, without psychotic features

Allergies
Medication Summary
Group By: Medication Medication: -- Select --
Select a Medication to view the medication details.
Immunizations
...eutic Injections
Circle Of Care

Telephone Encounter TEST, Salina "Sakina" Nov 22, 1991 (32 yo F) Acc No. 34567

Test, Salina ,(Sakina) , 32 Y , F INFO HUB ASK EVA ? Connect SOGI

57 WILLOUGHBY ST , BROOKLYN, NY 11201-5257

11/22/1991 | 929-431-8897 | 929-431-8897

s.nejumi@housingworks.org | Yes

Allergies Billing Alerts

Appt(L): 04/04/24 (A.K.)
PCP: Werner, Jennifer
Lang: English
Translator: No

Ins: TEST
Acc Bal:$ 0.00
Guar: Test, Salina
Gr Bal: $0.00
Ren: Werner, Jennifer

Medical Summary | CDSS | Rx | Labs | DI | Procedures | Growth Chart | Imm | T.Inj | Encounters | Patient Docs | Flowsheets | Notes

Answered By: Nejumi, Sakina
Caller:
Reason: IOS care coordination
High Priority

Date/Time*: 06/11/2024 02:28 PM
Assigned To*: Nejumi, Sakina
Provider*: Douglas, Jeremy
Perform Eligibility Check

Facility*: Westside Health Cent
Pharmacy: Salaam Pharmac

Addressed

If TE will be shared with provider, change *assigned to* to provider name

Ensure Provider is a BH supervisor

Messages | Rx | Labs/DI Hx | Notes | Addendum | Log History | Virtual Visit

Messages

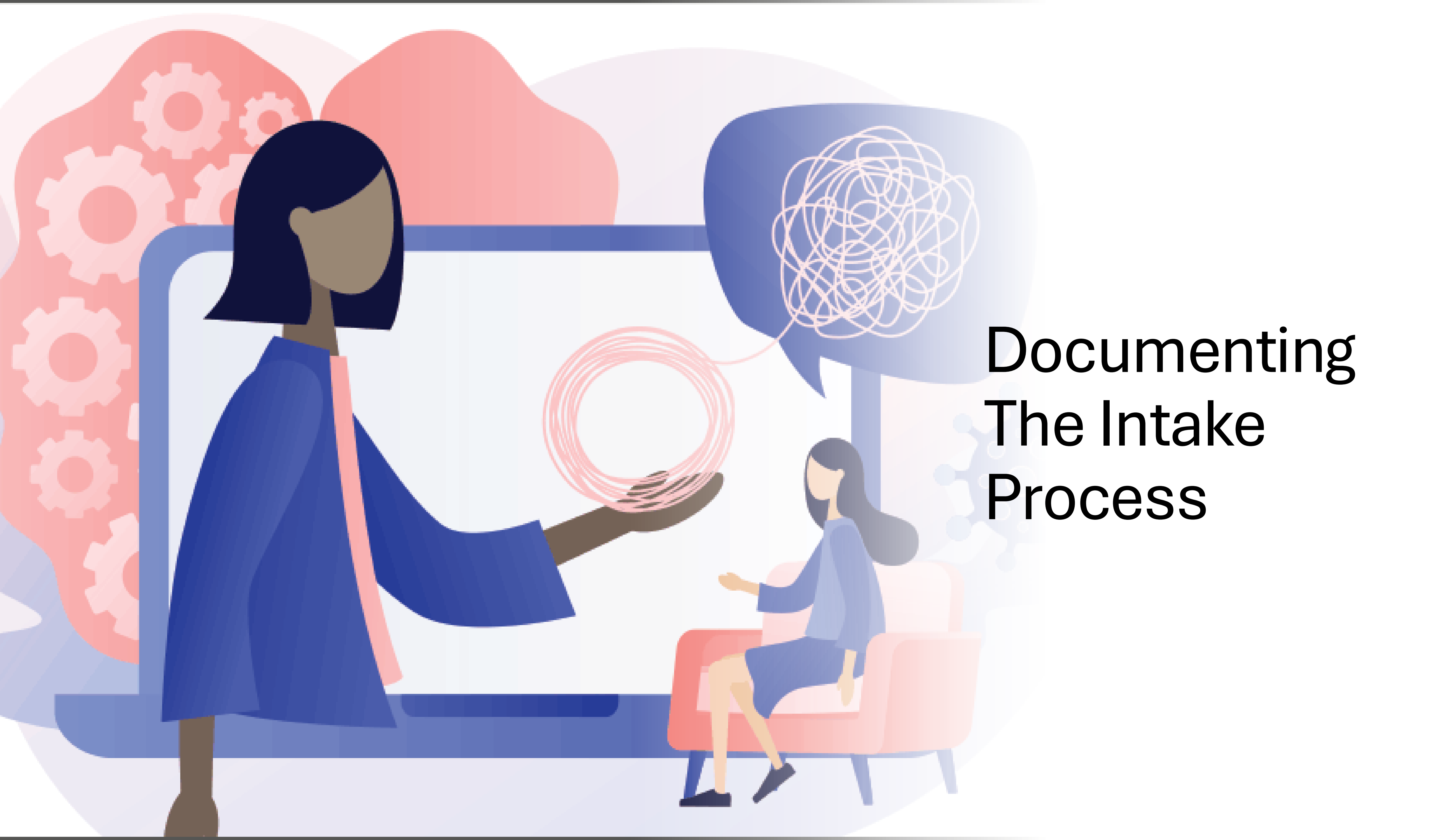
Therapist met with clients psych provider Mr. Ruiz to discuss his recent psychiatric hospitalization at Gracie Square Hospital. Client was admitted on 5/24/2024. Client was admitted due to erratic behavior on the subway. It's suspected client was experiencing a manic episode. His assigned social worker Rebecca Smith indicated he is responding well to abilify medication and has shown improvement. If improvement continues he may be discharged within a week.

Action Taken — Messenger | Reply to Patient | Time Stamp | Action Taken

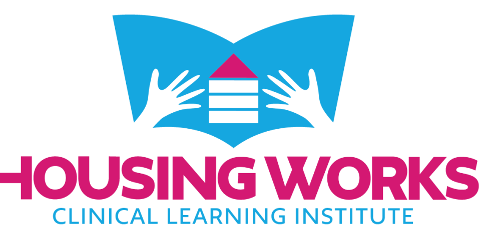
Nejumi, Sakina 06/11/2024 02:37:27 PM EDT > Transition In Care Management appointment will be scheduled within 7-14 days of discharge. Therapist will coordinate with Ms. Smith appointment date a time once discharge is confirmed.

Document next step and remember to time stamp

Print Script | Send Rx | Print Report | Progress Note | Document | Save as Template | Apply Template | Close


Documenting
The Intake
Process

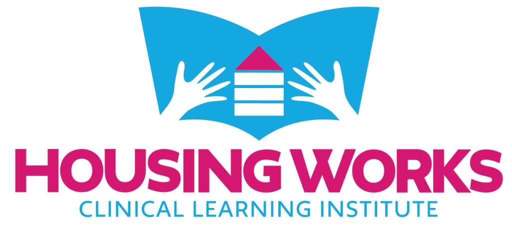
The Intake Process: Setting the stage



- Through the intake and engagement process, the clinician strives to develop a rapport with the client that will help to facilitate the client's commitment to work together on their identified goals
- When first meeting the client....
  - Provide a short description of your role and function within the organization setting
  - Share information about confidentiality [including being a mandated reporter], the helping process, the type of treatment services offered and expectations for entering services and during treatment
  - Discuss release of information for collaterals and treatment providers or a referral if they don't meet program requirements or are no longer interested.

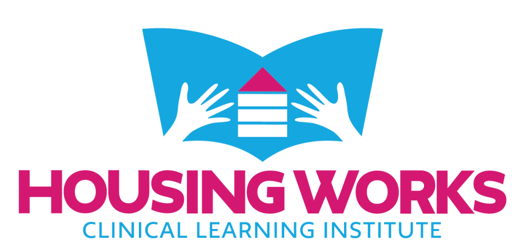
Intake Process cont.

- The information obtained during the intake process will help to formulate the assessment
- The process is a collaborative relationship to engage & build rapport with the client
- It's important to be respectful, thoughtful, genuine & non-judgmental
- Help the client understand the next step in the overall treatment process and /or help with an identified referral

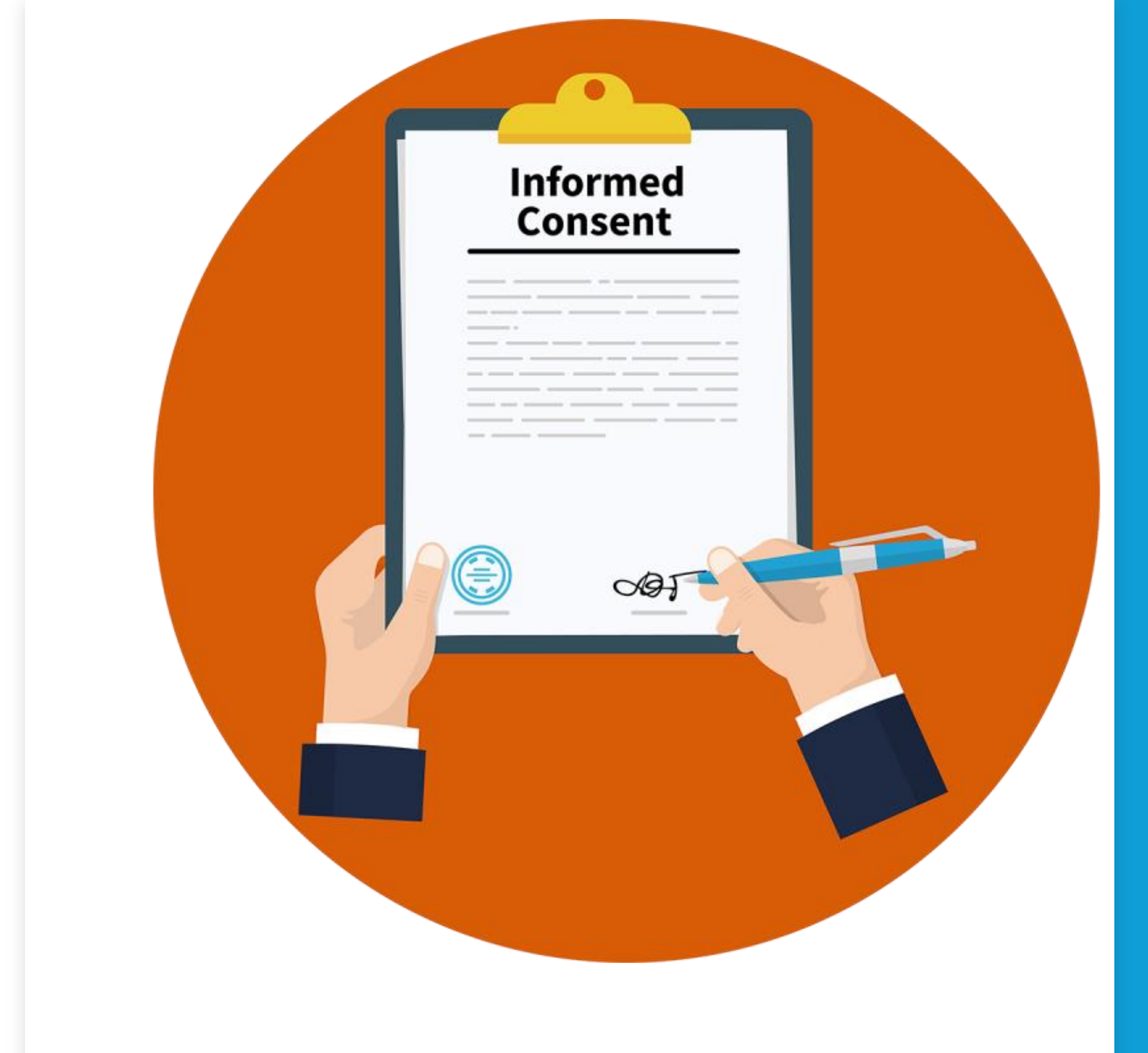


Intake Process cont.

- As part of initiating treatment, you will also want to
  - Review consents/intake packet & document in the progress note that consents were "reviewed and understood" by the client
- Obtain and review Release of Information (ROI) to collaborate with collaterals
- Remind client that engagement in services is voluntary



Consents



Consents

See mock intake packet for clear example of how should be completed

- In the first session, review all consents with client to ensure all forms are correct
- For consents to be valid, the following must be present:
  - Client has signed & dated, where indicated
  - Staff/witness signature & dated, where indicated
  - At least 2 forms of identifying info (combo of name, DOB, or MRN/**eiCare #**)
- Intake packet should be absent of any blank/unsigned consent forms
  - If not signed, clinician should write "void" across the consent & still have it uploaded as part of the packet
- Intake packet should be uploaded by front desk staff within 24 hours & no more than a week of submitting

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[A litigation version of this form has been approved by the New York State Department of Health]

Patient Name John Doe	Date of Birth 01/01/1990	Social Security Number NA or MRN
Patient Address 123 ABC Street, New York, NY 10030		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

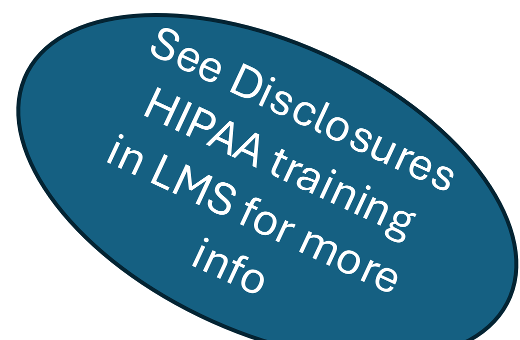
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item

Third Party Authorization to Disclose PHI form

- Also known as:
- Release of Information (ROI)
- Or HIPAA form



Authorization to Disclose PHI

PHI Release of Information (ROI) requests must be responded to **within 5 and no more than 10 calendar days**.

- Patient must complete the Authorization for ROI Form
- **If authorizing disclosure, EACH section must be completed**. The patient must:
  - **indicate** exactly which records are being requested.
  - **initial** the ALCOHOL/DRUG section, as applicable.
  - **initial** the MENTAL HEALTH, as applicable
  - **initial** the HIV-RELATED section, as applicable

  Redact any Alcohol/Drug, Mental Health, or HIV-Related information if these boxes are NOT initialed
- Expiration (item #11) must be indicated, or the form is **INVALID**
- Patient information should only be released by the Patient Care Coordinator, Med Record Coord, or Health Center Director by hard copy, PDF file transmittal, or electronic fax, adhering to the records request workflow.

7. Name and address of the provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:
☐ Medical Record from (insert date) __________ to (insert date) __________
☐ Entire Medical Record, including histories, notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
☐ Other: __________

Include: (*Indicate by Initialing*)
__________ **Alcohol/Drug Treatment**
__________ **Mental Health Information**
__________ **HIV-Related Information**

Authorization to Discuss Health Information
(b) ☐ By initialing here __________ I authorize __________
Name of individual health care provider
to discuss my health information with the person or agency listed here:
____
(Person or Entity Name)

10. Reason for release of information:
☐ At request of individual
☐ Other: __________

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

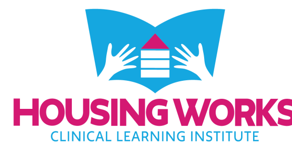
13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

__________ Date: __________
Signature of patient or representative authorized by law.

Part 2 Consents

- Clients who are engaged in services under Part 2 (OASAS licensed programs) have consent forms that are unique
- It can be helpful to share with clients that though these forms are specific, they are meant to make sharing of information during an episode of care more manageable and therefore more beneficial for the client
- Categories of consents:
  - Substance use treatment
  - SU counseling
  - Treatment, payment & healthcare operations (TPO)
  - Preventing multiple enrollments
  - Civil, criminal, legal, & administrative proceedings



Consent for release of SU information

8. Name or other specific identification of the person(s), or calls of persons, authorized to release this information:

9. Name and address of person(s), or class of persons, to whom this information will be sent:

10(a). Specific information to be released:

- ☐ Record from (insert date) ___________ to (insert date) ________________________
- ☐ Entire Record, including histories, notes (except substance use disorder counseling notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care and substance use disorder treatment providers.
- ☐ Other: __________________________ Include: (*Indicate by Initialing*)

  __________________________ _______________ **Mental Health Information**

  _______________ **HIV-Related Information**

10(b). **Authorization to Discuss Information**

☐ By initialing here ________________ I authorize ____

Name of individual provider

to discuss my information with the person or agency listed here:

____

(Person or Entity Name)

11. Reason for release of information:
- ☐ At request of individual
- ☐ Other: ___________________

12. Date or event on which this authorization will expire:

13. If not the patient, name of person signing form:

14. Authority to sign on behalf of patient:

Consent for SU counseling records

7. THIS CONSENT DOES NOT AUTHORIZE YOU TO DISCUSS MY INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL OR ENTITY SPECIFIED IN ITEM 10(B).

8. Name or other specific identification of the person(s), or calls of persons, authorized to release this information:

9. Name and address of person(s), or class of persons, to whom this information will be sent:

10(a). Specific information to be released:

- ☐ Substance Use Disorder Counseling Records from (insert date) _________ to (insert date) ______
- ☐ Entire Record of Substance Use Disorder Counseling Records.
- ☐ Other: ________________________ ________________________

Include: (*Indicate by Initialing*)

______________ **Mental Health Information**

______________ **HIV-Related Information**

10(b). **Authorization to Discuss Information**

☐ By initialing here _______________ I authorize ______________________________________
Name of individual provider

to discuss my information with the person or agency listed here:

____
(Person or Entity Name)

11. Reason for release of information:
- ☐ At request of individual
- ☐ Other: _________________

12. Date or event on which this authorization will expire:

13. If not the patient, name of person signing form:

14. Authority to sign on behalf of patient:

Consent for SU and treatment, payment, or healthcare operations

7. THIS CONSENT DOES NOT AUTHORIZE YOU TO DISCUSS MY INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL OR ENTITY SPECIFIED IN ITEM 10(B).

8. Name or other specific identification of the person(s), or calls of persons, authorized to release this information:

9. Name and address of person(s), or class of persons, to whom this information will be sent:
- ☐ My treating providers, health plans, third party payers, and people helping to operate this program
- ☐ Other: ____

10(a). Specific information to be released:

- ☐ Record from (insert date) _________ to (insert date) ____________________
- ☐ Entire Record, including histories, notes (except substance use disorder counseling notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care and substance use disorder treatment providers.
- ☐ Other: ______________________ ______________________

Include: (*Indicate by Initialing*)

______________ **Mental Health Information**

______________ **HIV-Related Information**

10(b). **Authorization to Discuss Information**

☐ By initialing here _______________ I authorize ______________________________________
Name of individual provider

to discuss my information with the person or agency listed here:

____
(Person or Entity Name)

11. Reason for release of information:
- ☐ For treatment, payment, and health care operations
- ☐ Other: _________________

12. Date or event on which this authorization will expire:

13. If not the patient, name of person signing form:

14. Authority to sign on behalf of patient:

Consent for SU to prevent multiple enrollments

7. THIS CONSENT DOES NOT AUTHORIZE YOU TO DISCUSS MY INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL OR ENTITY SPECIFIED IN ITEM 10(B).

8. Name or other specific identification of the person(s), or calls of persons, authorized to release this information:

9. Name and address of person(s), or class of persons, to whom this information will be sent:

☐ To the following central registries and withdrawal management or maintenance treatment programs:

[List name and address of each]

☐ To any withdrawal management or maintenance treatment program established within 200 miles of ______________________ (name of provider)

☐ Other: ______________________

10(a). Specific information to be released:

☐ Patient identifying information, type and dosage of drug, and relevant dates.

☐ Other: ______________ ______________

Include: (*Indicate by Initialing*)

______ **Mental Health Information**

______ **HIV-Related Information**

10(b). **Authorization to Discuss Information**

☐ By initialing here ________ I authorize ______________________

Name of individual provider

to discuss my information with the persons or agencies listed in Section 10(a) above.

11. Reason for release of information:

☐ To prevent multiple program enrollments

☐ Other: ____________

12. Date or event on which this authorization will expire:

13. If not the patient, name of person signing form:

14. Authority to sign on behalf of patient:

Consent for SU for legal proceedings

7. THIS CONSENT DOES NOT AUTHORIZE YOU TO DISCUSS MY INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL OR ENTITY SPECIFIED IN ITEM 10(B).

8. Name or other specific identification of the person(s), or calls of persons, authorized to release this information:

9. Name and address of person(s), or class of persons, to whom this information will be sent:

10(a). Specific information to be released:

☐ Record from (insert date) __________ to (insert date) ______________

☐ Entire Record, including histories, notes (except substance use disorder counseling notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care and substance use disorder treatment providers.

☐ Testimony relaying information contained in my record from (insert date) __________ to (insert date) ______________

☐ Testimony relay information contained in my entire record.

☐ Other: ______________ ______________

Include: (*Indicate by Initialing*)

______ **Mental Health Information**

______ **HIV-Related Information**

10(b). **Authorization to Discuss Information**

☐ By initialing here ________ I authorize ______________________

Name of individual provider

to discuss my information with the person or agency listed here:

____

(Person or Entity Name)

11. Reason for release of information:

☐ At request of individual

☐ Other: ____________

12. Date or event on which this authorization will expire:

13. If not the patient, name of person signing form:

14. Authority to sign on behalf of patient:

HW OASAS Consent form

- This is a consent only used in OASAS programs.
- Any additional providers who the client identifies on this form, best practice to also have the client complete a ROI for that provider
- Staff only sign the bottom if/when a client revokes consent
- This form will be phased out with the new TPO Part 2 Consent

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL SUBSTANCE USE DISORDER PATIENT RECORDS

I, Jane Doe ______________________, authorize Housing Works Health Services III,
[Patient's Name]
Inc. to disclose my medical record, as reasonably necessary, for purposes of continuity of care, treatment (including treatment plans and recommendations), payment activities, and health care operations (including but not limited to quality assurance activities and audits), to the following (list name of recipient):

JD My Insurance Company: Name of Client's insurance company

JD My Pharmacy: Needs to be as specific as possible (name, address, phone # of pharmacy), but can put N/A if they do not have a pharmacy

✓ Other Treatment Providers: these should be providers who client identifies as part of client's OASAS tx; separate HIPAA stil required to share info

✓ Healthix Health Information Exchange (to opt out, please ask to complete a Healthix Authorization Form).

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

if 30 days from discharge is the agreed upon date, should be written in - not typed

[Date, event, or condition upon which consent will expire]

I understand that I may be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or healthcare operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

Jane Doe ______________ 4/14/22 ______________

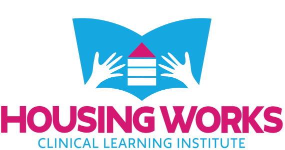
Signature Date

____

Signature of Person Signing Form if Not Patient

Describe Authority to Sign on Behalf of Patient: ______________________

Date Revoked: ______________ **Staff Initials:** ________



TRS-61 consent

- This consent authorizes client data to be entered into the OASAS portal/central registry
- Clients are prompted to authorize whether they consent to sharing of info related to HIV status
  - If not initialed, cannot enter anything related to HIV on the PAS 44, 45 and 26N

NYS Office of Alcoholism and Substance Abuse Services
Authorization for Release of Behavioral Health Information

Patient Name **Sean Carter**	Date of Birth **12/4/1980**	Patient Identification Number **123456**
Patient Address **555 Marcy Ave, Brooklyn, NY 11303**		

I, or my authorized representative, request that health information regarding my care and treatment may be released and exchanged as set forth on this form. I understand that:

1. This authorization may include disclosure of all of my health information, including where applicable, my federal social security number (for record matching purposes only), any and all information relating to ALCOHOL and DRUG TREATMENT and HIV/AIDS-RELATED information. In the event the health information described below includes any of these types of information I specifically authorize release of such information to the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

SC If you initial this line, HIV-AIDS RELATED information can also be released to OASAS. You do not have to initial this line.

SC ______If you initial this line, your Social Security Number can also be released to OASAS. You do not have to initial this line.

2. With some exceptions, health information once disclosed may be redisclosed by the receiving entity. If I am authorizing the release of my federal social security number, HIV/AIDS-related, alcohol or drug treatment, the receiving entity is prohibited from redisclosing such information or using the disclosed information for any purpose other than the purpose indicated by this authorization without my further authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity Releasing and Exchanging this Information: **Housing Works OASAS East New York, 2640 Pitkin Ave, Brooklyn, NY 11208**
6. Name and Address of Entities to whom this Information will be Disclosed and Exchanged: **NYS Office of Alcoholism and Substance Abuse Services, 1450 Western Avenue, Albany, New York 12203**

OASAS Intake Process

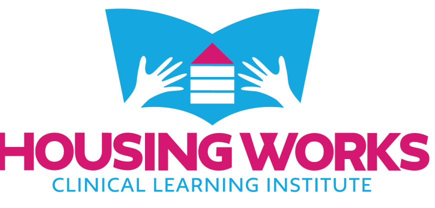
Priority admissions

See OASAS admissions policy & priority admission training for more details

- OASAS has defined subsets of the population who are more at risk of overdose & lethal consequences of engagement in use, therefore benefit from connection with treatment ASAP
- Categories:
  - Person who is pregnant & uses substances intravenously
  - Person who is pregnant
  - Person who uses substances intravenously
  - Recently released from incarceration
  - Person who is at risk of/engaged in ACS
- This information should be documented on referral form & scanned into the record
- Clients must be **admitted within 5-14 business days from date of referral**

HOUSING WORKS
CLINICAL LEARNING INSTITUTE

OASAS Intake Procedure



- Intake assessment is captured in eiCare through the Pre-admission extended assessment & typically requires at least 2 visits to complete
  - For billing purposes note that the 90791 initial assessment code can only be used once
  - Note that **no more than 3 pre-admission sessions** can be billed for an episode of treatment
  - Services completed by the CRPA do not fall into this pre-admission limit
- The purpose of the intake is to identify the individual's goals, strengths & needs through the evaluation of their mental, physical, social condition, and history – specifically exploring substance use patterns & impacts – to guide treatment
- This is also a great time to explore what their initial goals of tx are, discuss how they can be supported within the OASAS program and/or discuss what other supports, referrals may be beneficial in helping the client to accomplish their stated goals

Key dates & factors

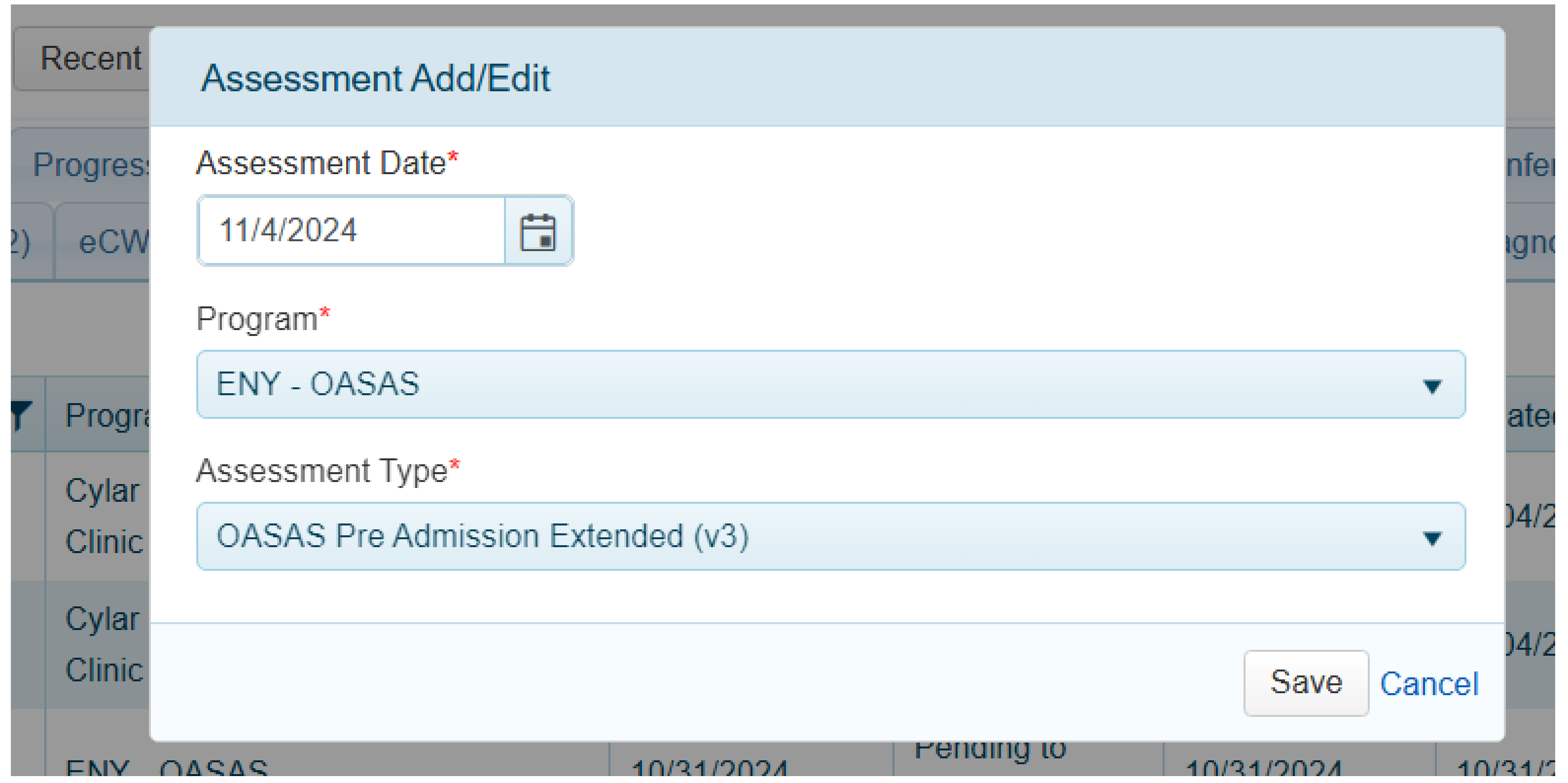
- Generally intakes will take place over 2 sessions; a **pre-admission note should be entered for each encounter**, providing overview of what content from intake was completed & any other relevant info
  - Completed intake assessments **must be submitted** to supervisor **prior to or on DOA**
  - Supervisors have 3 days from submission to review/approve assessment
  - Keep in mind that your supervisor may submit edits for you to make & these must be done timely
- Toxicology testing should be offered to assess baseline use of identified substance(s) in pre-admission and/or admission note
  - If client is not interested in providing a toxicology, the chart should include it was offered & any barriers, reasons client did not want to provide. If toxes are mandated, should also include discussion of risks/challenges for mandating agency.
- Client is scheduled an **Admission session** after intake assessment is complete to confirm tx schedule, complete PAS44
  - **PAS44 must be submitted on the DOA**
- An **admission note should be completed on the same date** (found in progress notes) usually noting reason for admission, diagnosis(es) & treatment frequency, date of next scheduled session

Intake Assessment

- All intake assessments must be comprehensive and include the following information:
  - Presenting Problem (reason for seeking services), ideally includes quotes from client
  - Referral info (referral form should be uploaded in attachments in eiCare)
  - Substance use assessment
  - Criminal justice involvement
  - Vocation, education, employment history & needs
  - Risk Assessment based on Housing Works risk categories
  - Current Family and Social situation (patient/family current strengths, supports, and stressors; family and significant others social function, housing, culture, and language)
  - Parenting Needs and ACS/APS issues
  - Mental Status Evaluation
  - Brief Medical History
  - Psychiatric History (including history of past mental health treatment, psychiatric hospitalizations and current prescribed psychotropic medication)
  - Collateral Information when appropriate
  - All assessed DSM-5 substance use diagnosis(es), including Nicotine use disorder, if relevant
    - If a client endorses substance but does not meet diagnostic criteria, this should be specified within the assessment.

Intake assessment

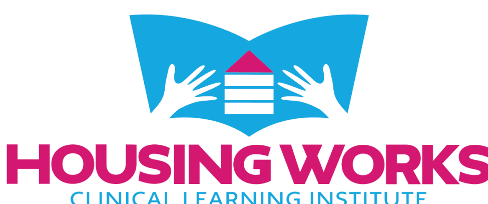
- In eiCare > Assessments tab > select *ENY-OASAS site* > *OASAS Pre Admission Extended v3*



Referral and Chief Complaint

- Document the presenting problem in client's own words.
  - Ask the client their reason for seeking treatment
- Example:
  - "I'm looking for consistent mental health treatment and monthly psychiatric medication."
  - "I'm trying to just get things right…I wanna see or understand what has me going through what I'm going through."
  - "Belinda referred me for therapy." Brief description of problem substance use and needs for treatment
  - This may also include quotes from the client but is focused on summary of SU and identified issues
- Referral source
  - Answer all the prompts including whether the client is mandated for tx
  - If mandated, prompted to ask for ROI for the mandating party the client authorizes you to share info with

OASAS Intake Assessment



- Approval History
- Basic Information
- Referral Information
- Substance Use
- Criminal Justice Involvement
- Vocational, Education and Employment
- Family and Housing
- Ancillary
- Modified Mini Screen (MMS)
- PTSD Checklist
- Mental and Medical Health Service History
- Mental Status Exam (MSE)
- DSM-5 Diagnosis
- Admission Decision

Presenting Problems

Presenting Problems: (Priority Issue(s) and any other patient-identified priority issues that include any emergencies or issues that may impact the individual's ability to participate in outpatient treatment):*	Mandated "i have to come here - i dont have a problem but I need to work on whatever i need to do to get my life back in order"
Brief description of Substance Use and needs for treatment at this time	I was arredsted for Drinking nad rivking and got in an accidnet; this was in early 2024 january - not the first itme.that is family culture of gathering and party to celbrate.

Referral Information

Referral source contact information:

Were you ever a Housing Works client before?	○ Yes ◉ No
Name of referring agency	same day walk in self referral
Name of referring worker	
Telephone	
Email	
Program Referral Source	Another HW Client

Substance Use

- *Does the client have a history of drug/alcohol use? Y/N*
  - This should only be no if someone identifies as a SO
- *Are you enrolling in tx as a significant other of someone who uses substances? Y/N*
  - This can be a partner, parent, close family member of someone who uses substances and seeking tx with stressors related to this person's use
- Add info about the *primary drugs of choice*
  - Specify the substance
  - Amount of days of use in the past 30 days
  - Lifetime use calculated in years
  - Route of administration
  - Frequency of use
  - Age of first use
  - Age of last use

Substance use

Question	Response
Does client have a history of drug/alcohol use?	(•) Yes ( ) No
Are you enrolling in treatment as a significant other of someone who uses substances? *	( ) Yes (•) No
Enter primary substance below	
Primary substance	(•) Alcohol ( ) Amphetamines/Crystal meth/Speed ( ) Barbiturates ( ) Benzodiazepine ( ) Cannabis ( ) Cocaine/crack ( ) Hallucinogens ( ) Heroin ( ) Inhalants ( ) Opioids ( ) Other opiates ( ) Other sed/hyp/tranq ( ) Over the counter drugs ( ) PCP ( ) Sedative/hypnotics (Special K) ( ) Synthetic cannabis (K2 or Spice)
Substance use In past 30 days(# of days)	25
Lifetime Years(# of years)	15
Route of Administration	(•) Oral ( ) Nasal ( ) Smoking ( ) Non IV/Non injection ( ) Iv/Inj
Frequency of Use	(•) None in the past month ( ) 1-3 times/month ( ) 1-2 times/week ( ) 3-6 times/week ( ) Every day

Nicotine

- *Does the client have a history of nicotine use?* Y/N
- *Nicotine type:* vaping, smoking, chewing
- *At what age did you first begin nicotine use?*
- *Nicotine use in past 30 days*
- *Frequency of use* in past month: none, 1-3x/mo, 1-2x/week, 3-6x/week, every day
- *Lifetime use in number of years*
- *Have you ever tried to stop nicotine use?* Y/N
- *What is the longest period that you have gone without nicotine use since you first started?* Identifying longest period of abstinence
- *How interested are you in stopping nicotine use:* strongly, very, somewhat, a little, not at all
- *Are you interested in addressing your nicotine use while in the program?* Y/N
  - If yes, should be a goal of the treatment plan & addressed throughout tx

Nicotine

- If a client identifies as an active smoker, you must complete a Fagerstrom screening every 6 months post admission
- Screening located in eiCare on assessments tab > *"Tobacco assessment"*
- Include that they include diagnosis if appropriate

Nicotine

Does client have a history of nicotine use?* — (•) Yes ( ) No

Nicotine type* — [x] Vaping [ ] Smoking [ ] Chewing

At what age did you first began nicotine use?* — 15

Nicotine use In past 30 days(# of days)* — 25

Frequency of Use* — ( ) None in the past month ( ) 1-3 times/month ( ) 1-2 times/week ( ) 3-6 times/week (•) Every day

Lifetime Years(# of years)* — 20

Have you ever tried to stop Nicotine Use?* — ( ) Yes (•) No

What is the longest period that you have gone without nicotine use since you first started* — test

How interested are you in stopping nicotine use?* — ( ) Strongly ( ) Very (•) Somewhat ( ) A little ( ) Not at all

Are you interested in addressing your nicotine use while in the program?* — (•) Yes ( ) No

Previous treatment history

- *Has the client ever sought treatment for alcohol or drug use in the past?* Y/N
- *Last treatment episode.* Provide the estimated date of most recent tx
- *Program name*, if able to recall
- *Type of setting:* inpatient detox, rehab, residential tx, outpatient tx
- *Complete?* Y/N
- *Additional tx history.* This is an open box to type in any additional info related to forms of tx history.

12 Step recovery meetings or other self-help groups

- *Are you attending any self-help groups?* Y/N NA, AA, SMART recovery
- *Did you attend any of the above meetings in the last 30 days?* Y/N
- *Are you interested in attending any self meetings?* Y/N

Previous treatment history & peer work

Previous Treatment History: Please update with any information in addition to the admissions assessment

Has the client ever sought treatment for alcohol or drug use in the past? ○ Yes ● No ○ N/A ○ Refused

Last treatment episode:

Program name:

Type of setting:

Complete? ○ Yes ○ No

Additional treatment history:

12 Step recovery Meetings or other Self help Groups (A/A,N/A,C/A,G/A,Other)

Are you attending any Self Help Groups (NA, AA, SMART Recovery, Etc) ● Yes ○ No

Did you attend any of the above meetings in the last 30 days? ● Yes ○ No

Are you interested in attending any self meetings? ● Yes ○ No

Overdose screening

- In your lifetime have you ever overdosed on alcohol or drugs unintentionally? Y/N If *yes*, an overdose screening will be added
- Past hx of drug overdose, recent use of specific substance(s), any exacerbating stressors, specifics on patterns of use

For on-site safety measures & processes, check out the Drug Overdose & Prevention response policy

Overdose Risk Screening

Past History of Drug Overdose

- [ ] Accidental drug overdose
- [x] More than one accidental drug overdose
- [ ] Intentional use of drugs to overdose

Recent Use of Opioids or Substances With Increased Risk of Accidental Overdose

- [x] Opioids such as pain medication, fentanyl, methadone or heroin, etc, even if rarely or prescribed
- [ ] Non-opioid substances / medications bought illicitly such as Xanax, cocaine, MDNA, etc., even if occasionally

Health and Stressors

- [x] Health issues which increase risk (eg breathing, liver, immune, or vision)
- [x] Life stressors which impact your risk (eg loss of a loved one, housing, money, relationship, treatment)
- [ ] Are there any other factors which you think could increase your risk of overdose? Please describe below

What, How, and When You Use Substances

- [x] Using different strengths or quality of substances
- [ ] Using when rushed, afraid or in unfamiliar places
- [x] Using while you are alone
- [ ] Using while having thoughts of suicide, or not caring if you wake up
- [ ] Using substances with an IV / needle
- [ ] Switching how you use substances (eg snorting, smoking, swallowing)
- [ ] Using more than one substance together
- [x] Using substances while under influence of alcohol

Overdose safety plan

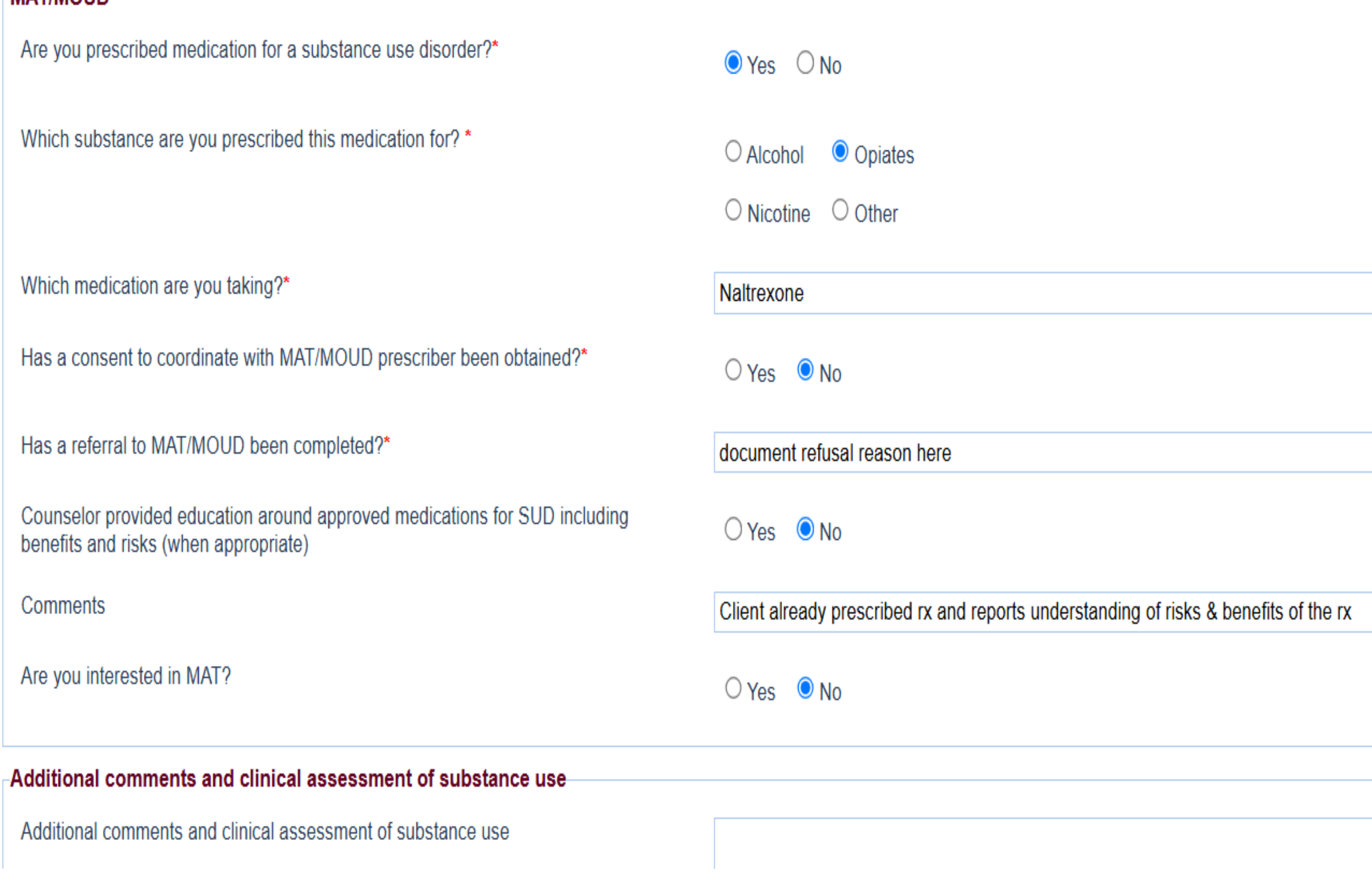
- Similar to any type of risk safety plan, you are partnering with the client to identify triggers, coping strategies & supports that they can engage with to reduce harm/risk of an overdose

My Safety Plan

Step One: Things which put me at risk of accidental overdose (Risks are often use of medications or illicit drugs, methods of use, history, and health factors)	drinking alcohol, "going to my friend's apt in the Bronx because they like to mix a lot", having severe asthma
Step Two: Actions I can take to reduce my risk of overdose (Consider steps that address the risks found in step one, example: Changing method of use)	"only drinking one beer when I'm out if I feel I have to drink at all" going to party with his friend in Brooklyn instead of the Bronx making sure he has inhaler and Narcan kit when he is planning to use
Step Three: Things I do regularly (or want to do more) to stay well (Consider ways you take care of your physical and mental health)	exercise, make sure attends visits to see kids, doing asthma treatments consistently
Step Four: People who support my wellness and I can ask for help	"my cousin. my girlfriend, my neighbor
Name 1	Cousin John
Phone 1	917-123-4567
Name 2	Layla Ali
Phone 2	347-567-8970
Step Five: Professionals and agencies I can call in a crisis	Housing Works therapist 988 Never use alone
Professional Name	
Professional Phone	718-277-0386

MAT/MOUD

- Goal is to provide an opportunity at intake for psychoed around MAT/MOUD/NRT if client is engaged in use of a substance that would benefit from these supports
- If they are already engaged, it's an opportunity to request ROI for prescribing provider, if not already obtained
    - Note that it is a requirement for OASAS to attempt to have collaboration with prescribing provider for these rx


MAT/MOUD

Are you prescribed medication for a substance use disorder?* — (•) Yes ( ) No

Which substance are you prescribed this medication for? * — ( ) Alcohol (•) Opiates ( ) Nicotine ( ) Other

Which medication are you taking?* — Naltrexone

Has a consent to coordinate with MAT/MOUD prescriber been obtained?* — ( ) Yes (•) No

Has a referral to MAT/MOUD been completed?* — document refusal reason here

Counselor provided education around approved medications for SUD including benefits and risks (when appropriate) — ( ) Yes (•) No

Comments — Client already prescribed rx and reports understanding of risks & benefits of the rx

Are you interested in MAT? — ( ) Yes (•) No

Additional comments and clinical assessment of substance use

Additional comments and clinical assessment of substance use

Criminal Justice involvement

- If on probation/parole. Entering the person's info, including if there are specific legal stipulations. Should also request an ROI or indicate reason why if not obtained.
- Criminal justice status: parole, probation, in jail, work release, charges pending, any treatment or specialty court.
- Arrests/incarceration. Enter # of arrests at 30 days, last 6 months. # of days incarcerated in last 6 mo.
- Have you ever spent time in jail, prison, or detention center?
- Any continuing legal issues to address prior to tx?
- Important to note that there is a comment box at the bottom of the page that allows for any additional info, context that expands on the answers provided above and/or info that is relevant to the client's hx or tx but is not captured by the provided questions

Criminal justice involvement

P.O. phone:

P.O. email:

Lawyer name

Agency name

Agency contact number:

Agency email

Date Parole/Probation Ends?

Lifetime Parole ☐

Mandate Verified? ◉ Yes ○ No

What legal stipulations were confirmed?* stipulations

Was a consent obtained for mandating source?* ○ Yes ◉ No

Criminal Justice Information

Criminal Justice Status (check all that apply)*

- ☐ None
- ☐ Probation
- ☑ Parole
- ☐ Work Release
- ☐ In Prison/Jail
- ☐ In OCFS Facility
- ☐ Charges Pending
- ☐ Any Treatment or Specialty Court
- ☐ Other

Arrests/Incarceration

Is this admission a result of an alternative to incarceration?* ○ Yes ◉ No

No. of Arrests in Prior 30 Days* 0

Vocational/Educational

- Literacy assessment. Client responds to 3 statements on a likert scale that varies based on the question. If needs are assessed here, this may be a focus of resources/referrals in care.
- Educational history. Select client's highest level of education that was completed. There is an option for no formal education completed.
- Did client have an IEP when they were in school? Y/N
- What did you struggle with in school? This includes grades, learning ability, learning style, and any other relevant barriers.
- What part of your educational experience made you feel good or proud? This is totally up to the client to identify.

Vocational/Educational

Question	Response
On scale of 1 to 5 with 1 being "never" and 5 being "always", how often do you have someone help you read important material or documents?	3
On a scale of 1 to 5 with 1 being "not at all" and 5 being "extremely", how confident are you filling out important forms yourself?	3
On a scale of 1 to 5 with 1 being "never" and 5 being "always", how often do you have problem learnig about important information because of difficulty understanding written material?	3

Education History: (Check all that apply)

Item	Response
Some high school	☐
High School Diploma	☑
GED	☐
College	○ Yes ○ No
Vocational School	☐
Other Education?	○ Yes ○ No
Highest Level or # of years Completed	12
No formal education	☐
Did client have an individualized education plan (IEP) when they were in school?*	○ Yes ● No
What did you struggle with in school (include grades, learning ability, learning style and any other relevant barriers)?	Client identifies struggling with peers in school - often getting into fights with others that led to suspensions. Client identifies struggles with grades due to these frequent suspensions.
What part of your educational experience made you feel good or proud?	"I liked the friends who I did have who helped me with school work when I was out. I liked my history teacher in 10th grade - I felt like they really cared about my learning." Client identified feeling proud of being able to reduce number of suspensions for certain years in school, primarily in 8th grade and last 2 years of high school.

Employment/Military

- Employment status. Answer all provided questions.
  - If client is currently engaged in educational programming or employment, a box will appear to add more details.
  - How has your drug or alcohol use affected your employment? Ask client directly but clinician may also provide any clinical assessment that is identified through inquiry.
  - Identifying if there is any further help or discussion that the client would like in their treatment in regards to vocation, education, or employment. Reminder these goals should be specified in the initial treatment plan.
- Military. Asking if they have ever served in military and if so, were they involved in direct combat. These are both Y/N questions.
- Reminder that the comment box on this page can provide any additional context or goals that are not captured above.

Employment/Military

Employment Status

Are you currently employed or in any educational programming?

(•) Yes ( ) No

Please provide detail about current occupation or educational programming

Client is currently enrolled in the peer training program at Housing Works and hopes to find long-term employment with completion of the program.

Are you currently on disability?

( ) Yes (•) No

How has your drug or alcohol use affected your employment?

Client identifies previous issues with job performance and being able to focus due to coming to the job site under the influence of ETOH. In client's last job, was referred to inpatient treatment prior to being let go after returning with job performance issues after treatment.

Does the individual want help with or desire further discussion of the following?

- [ ] Vocational
- [ ] Educational
- [x] Employment

Military

Have you every served in the Military?

( ) Yes (•) No

Were you ever in direct combat?

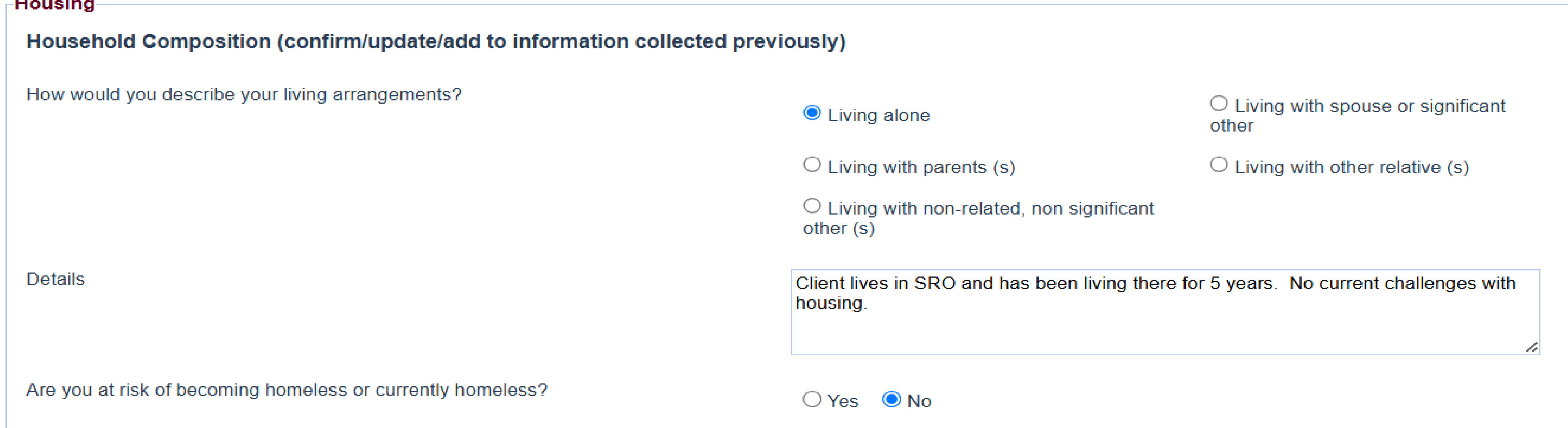
( ) Yes (•) No

Comment

Clinician's findings and patient's identified needs in this functional area and level of motivation

Housing

- How would you describe your living arrangements? Select the option that best describes who client lives with. There is a details box that provides space to expand on housing needs, challenges.
- Are you at risk of becoming homeless or currently homeless? Y/N. If yes, comment box pops up that allows for expand on needs, challenges, & goal identification related to housing.


Housing

Household Composition (confirm/update/add to information collected previously)

How would you describe your living arrangements?

- (selected) Living alone
- Living with spouse or significant other
- Living with parents (s)
- Living with other relative (s)
- Living with non-related, non significant other (s)

Details

Client lives in SRO and has been living there for 5 years. No current challenges with housing.

Are you at risk of becoming homeless or currently homeless?

- Yes
- (selected) No

Minor children

- Does the client have parenting responsibilites for any children under the age of 18? Y/N This does not specify biological children so keep that in mind when exploring with the client.
- How do you describe the relationship with your children?
- What do you well as a parent?
- What do you struggle with as a parent?
- Will parenting responsiblities impact ability to attend treatment? Y/N
- Is CPS/ACS invovled? Y/N If *yes*, a box to expand pops up. Also prompts to request a consent.
  - If client has a hx of CPS/ACS, that is helpful to add in the comment box at the bottom of the page

Minor children

Minor Children

Question	Response
Does the client have parenting responsibilities for any Children under the age of 18?	○ Yes ◉ No
How many children who are under 18 are living with you?	0
Number of children total	9
Number of children living with client	0
Number of children in foster care	0
How do you describe the relationship with your children?	"Distant, non-existent. Except my step-daughter, me and her are very close."
What do you do well as a parent?	"take care of her and my grandkids, be there for moral support, care, and love."
What do you struggle with as a parent?	"not being there for my family, losing contact with them"

To the Interviewer

If the client has no minor children and no parenting responsibility for a minor child, Skip to next section.

Is there a need for the following services?

Question	Response
Will parenting responsibilities impact ability to attend treatment?	○ Yes ◉ No
Is CPS/ACS involved?	○ Yes ◉ No ○ Not Asked ○ Refused

Family assessment

- This section focuses on the client's family of origin.
- Describe growing up in your family. Description box that allows for free text to provide direct quotes and/or clinical summary of what client shares.
- Child of Alcohol/Substance user. Select relevant choice. Note that AOD = Alcohol and drugs
- Would anyone in your family be intersted in participating in tx? Y/N If *yes*, be sure to request ROI & explore with client how they would like the person to be involved.
- Relationship status section explores whether the client is currently engaged in a relationship; what role substances have played in the current relationship and previous relationships?
- This section also assesses if the client has ever been involved in physical abuse in their relationships – as the victim or the offender

Family assessment

Family of Origin: (please fill in the following information)

Describe growing up in your family	"my family was a good family. I was sexually abused and molested after my mother was murdered. thats probably what got me in the addiction, trying to numb myself from all I been through. But I surrendered to God and Im redeemed and delivered. I had to stop chasing feelings."
Child of Alcohol/Substance Abuser	○ No ◉ Yes to AOD ○ Yes to Alchohol only ○ Yes to Substance only
Would anyone in your family be interested in participating in your treatment?	○ Yes ◉ No

Relationship Status (confirm/update/add to information collected previously)

Does the client have a main or primary partner that she/he would call a boyfriend, girlfriend, lover, or significant other?	○ Yes ◉ No ○ Not Asked ○ Refused
What role do drugs or alcohol play in your current relationship? What role did they plan in your past relationship(s)?	"a bad part. it didnt work out. you cant be getting high together and stay together."
Have you ever hit, pushed, kicked or otherwise struck your partner in a relationship?	◉ Yes ○ No
Have you ever been hit, pushed, kicked or otherwise struck your partner in a relationship?	◉ Yes ○ No
Are you in need of order of protection	○ Yes ◉ No

Comment

Clinician's findings and patient's identified needs in this functional area and level of motivation	Tx needs will include working through trauma and distress tolerance skills. She states she is single and celibate." Pt states her IPV incidents were over 20 years ago.

Anciallary

- This section covers an array of areas that impact client's free time.
- SOGS scale is embedded as the Problem Gambling Severity index
    - If client responds *no* to the fist 2 questions, no further assessment is needed
    - If they respond *yes* to one of the first 2, additional questions will be prompted to assess impact of gambling
    - If client scores an 8 or more, you need to pause the intake & explore referral to an 822 that offers an additional layer of treatment for gambling services
    - This treatment requires a specialty certification from OASAS.
    - If a client expresses that they would not engage in care or are not interested in addressing gambling, move forward with intake and then discuss with your supervisor on best next steps.
- Do you see your culture or ethnicity have an impact on your substance use or tx? Open text box to provide any details the client provides.

SOGS

If patient answers yes to either of these questions complete SOGS as part of Comprehensive Evaluation

Have you ever felt the need to bet more and more money?	○ Yes ◉ No
Have you ever had to lie to people important to you about how much you gambled?	◉ Yes ○ No
Problem Gambling Treatment History:	

IF YES TO EITHER OF THE FIRST TWO QUESTIONS, PLEASE ANSWER THE PROBLEM GAMBLING SEVERITY INDEX

IF THE PATIENT ANSWERED YES TO EITHER OF THE TWO LIE-BET QUESTIONS FROM THE ADMISSIONS ASSESSMENT THEN A SOUTH OAKS GAMBLING SCREEN SHOULD BE GIVEN TO DETERMINE THE NEED FOR FURTHER PROBLEM GAMBLING TREATMENT SERVICES.

Problem Gambling Severity Index

Thinking about the last 12 months

Have you bet more than you could really afford to lose?	○ 0 Never ◉ 2 Most of the time	○ 1 Sometimes ○ 3 Almost always
Still thinking about the last 12 months, have you needed to gamble with larger amounts of money to get the same feeling of excitement?	○ 0 Never ◉ 2 Most of the time	○ 1 Sometimes ○ 3 Almost always
When you gambled, did you go back another day to try to win back the money you lost?	◉ 0 Never ○ 2 Most of the time	○ 1 Sometimes ○ 3 Almost always
Have you borrowed money or sold anything to get money to gamble?	◉ 0 Never ○ 2 Most of the time	○ 1 Sometimes ○ 3 Almost always

Anciallary ctd...

- Assessment of Adult Daily Living Skills (ADLs). Series of 5 questions where client self-reports any challenges in a range of daily tasks on a likert scale of 1 to 5, 1 being "very difficult" & 5 being "very easy" & rate how well they complete the tasks
- Social/leisure activities
  - Each question has an open text box to provide responses from the client.
  - What do you for fun & relaxation?
  - Which of these activities have involved drugs or alcohol?
  - Who do you go to when you need to talk things through?
  - What would you say are your strengths as a person?
  - What would you say are your challenges as a person?

ADLs

Assessment of Adult Daily Living Skills (ADLS)

On a scale of 1 to 5 with 1 being "very difficult" and 5 being "very easy" rate how well you complete the following tasks:

How able are you to manage your finances each month?

○ 1 ○ 2
○ 3 ○ 4
◉ 5

How easy is it for you to keep you living space clean?

○ 1 ○ 2
○ 3 ○ 4
◉ 5

How able are you to get around on transportation?

○ 1 ○ 2
○ 3 ○ 4
◉ 5

How easy is it for you to take medication as prescribed?

○ 1 ○ 2
○ 3 ○ 4
◉ 5

How well are you able to take care of your personal hygiene? (Shower, deodorant, brushing teeth, etc).

○ 1 ○ 2
○ 3 ○ 4
◉ 5

Social/leisure activities

Social/Leisure Activities

Question	Response
What do you do for fun and relaxation?	"listen to gospel music, watch tv, go out to eat, go shopping."
Which of these activities have involved drugs or alcohol?	"none. Sometimes when I eat Ill have a couple mix drinks at the restaurant."
Who do you go to when you need to talk things through?	"my daughter Stacey."
What would you say are your strengths as a person?	"caring, loving, honest, loyal"
What would you say are your challenges as a person?	"i have a temper"

Comment

Question	Response
Clinician's findings and patient's identified needs in this functional area and level of motivation	Tx needs may include exploring social supports, but pt reports a rich social life.

Modified Mini Screen (MMS)

- This is an evidenced-based screening tool that helps to identify a range of mental health sx including anxiety, depression, trauma, & SI
  - Mood symptoms
  - Anxiety symptoms
  - Psychotic symptoms
- If a client indicates *yes* to question 4 about SI, the CSSRS is an embedded suicidality screener that will be added
- If the client scores a 9 or above on the MMS, indicates *yes* to #4, or *yes* to both #14 & #15, a referral for mental health assessment must be made. This can be accomplished through referral to a psychiatrist and/or mental health therapy

MMS

Mood symptoms

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past 2 weeks?* — ○ Yes ◉ No

2. In the past 2 weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?* — ○ Yes ◉ No

3. Have you felt sad, low or depressed most of the time for the last two years?* — ○ Yes ◉ No

4. In the past month, did you think that you would be better off dead or wish you were dead?* — ◉ Yes ○ No

COLUMBIA SUICIDE SEVERITY RATING SCALE

These next questions will focus on the last month

A. Have you wished you were dead or wished you could go to sleep and not wake up? * — ◉ Yes ○ No

B. Have you actually had any thoughts of killing yourself?* — ◉ Yes ○ No

C. Have you been thinking about how you might do this? (E.g. "I thought about taking an overdose but I never made a specific plan as to when, where or how i would actually do it...and I would never go through with it.")* — ○ Yes ◉ No

D. Have you had these thoughts and had some intention of acting on them? (As opposed to "I have the thoughts but I definitely will not do anything about them.")* — ○ Yes ◉ No

E. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?* — ○ Yes ◉ No

F. Have you ever done anything, started to do anything, or prepared to do anything to end your life? (ex: collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.)* — ○ Yes ◉ No

5. Have you ever had period of time when you were feeling up, hyper or so full of energy or full of yourself that you got into trouble or that other people thought that you were not your usual self? (Do not consider times when you were intoxicated on drugs — ○ Yes ◉ No

Risk assessment

See OASAS High Risk policy for further guidance

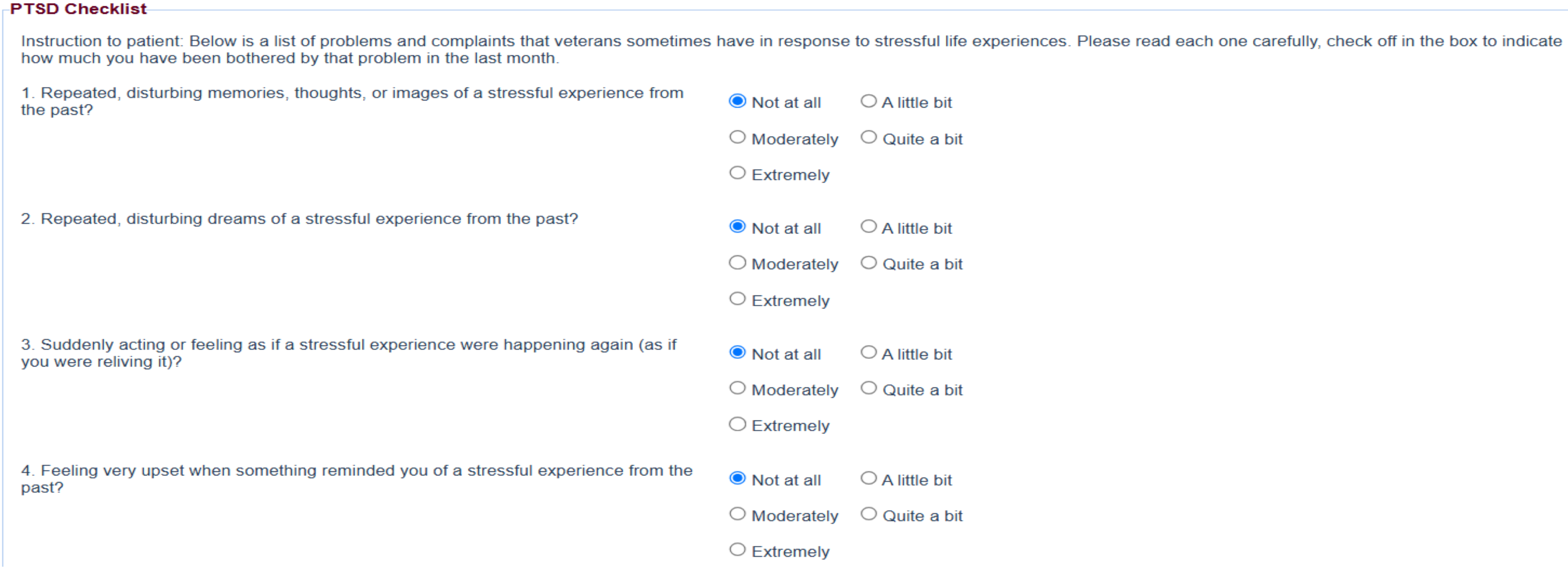
- This area assess any current or history of SI/HI
- This is broken down to assess when these thoughts last occurred, details of the last thought, assessment of any intent & action
- If client indicates any active intent or planning for either, a safety plan should be considered
    - Stanley Brown safety plan could be uploaded to attachments in eiCare if completed on paper
    - Safety plan is available in assessments under "patient safety plan"

Risk assessment

Question	Response
Have you ever thought about killing someone?	(•) Yes ( ) No
When?*	"a long time ago"
Details of last thought	"I just was angry because they hurt one of my friends and i wanted to kill their ass too. I didnt want to do 25 so I didnt do it even though I wanted to."
Assessment of any intent and action	pt lacks intent/action at this time she states, "God is the one who takes use out, not us."
Has client ever had thoughts of hurting her/himself?	(•) Yes ( ) No ( ) Refused
Details of last thought	"I just wanted to kill myself because I was in pain and experiencing loss." "I attempted suicide last month. I aint doing it again though."
Assessment of any intent and action	Pt states she has no intention at all of killing or hurting herself at this time. Pt states she got rid of the medication she took to attempt to kill herself.
Has client ever had thoughts of committing suicide?	(•) Yes ( ) No ( ) Refused
Does client have a current plan to hurt her/himself?*	( ) Yes (•) No ( ) Refused
Have you ever engaged in self harm behaviour? such as cutting	(•) Yes ( ) No

PTSD checklist

- This is a version of the PCL-C and assessing impact of trauma
- If someone scores positively on this screener, another trigger for referral to mental health &/or including trauma care into tx



PTSD Checklist

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, check off in the box to indicate how much you have been bothered by that problem in the last month.

1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?

   (●) Not at all ( ) A little bit ( ) Moderately ( ) Quite a bit ( ) Extremely

2. Repeated, disturbing dreams of a stressful experience from the past?

   (●) Not at all ( ) A little bit ( ) Moderately ( ) Quite a bit ( ) Extremely

3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?

   (●) Not at all ( ) A little bit ( ) Moderately ( ) Quite a bit ( ) Extremely

4. Feeling very upset when something reminded you of a stressful experience from the past?

   (●) Not at all ( ) A little bit ( ) Moderately ( ) Quite a bit ( ) Extremely

Mental & Medical health service history

- This section provides an overview of client's history of engagement in mental health tx & medical hx
- On this page you will have a range of questions that are identifying...
  - Whether the client has ever been in mental health counseling?
  - Whether they've been prescribed psychotropics – including adherence
  - If they have been engaged, prompts to ask if the client authorizes ROI for the previous provider
  - Note that if a client is **currently engaged with a provider who is prescribing MAT/MOUD/NRTs, a consent must be requested & some collaboration with this provider is required,** if authorization is provided
    - Refusal should be clearly documented & should be revisited at different points in tx

Mental health section

Mental and Medical Health Service History

Question	Response
Has the client ever received mental health counseling?	(●) Yes ( ) No ( ) Refused
When were services received?	(●) During the last 6 months ( ) Between 6 and 12 months ago ( ) More than 12 months ago
Has the client ever been prescribed medication for a psychiatric/emotional condition?	(●) Yes ( ) No ( ) Not Asked ( ) Refused
Medication Type	abilify
In the last 7 days, how many days did you take this medication as prescribed?	7
Medication Status	(●) Current ( ) Within the last 6 months ( ) Within the last 12 months
Adherence	100%
Have you been to the ER or hospital in the last 6 months for medical, mental health, or substance use needs?	(●) Yes ( ) No
Does the client is currently receiving mental health services?	(●) Yes ( ) No
Name of clinician (List if multiple)	Dr. Arty

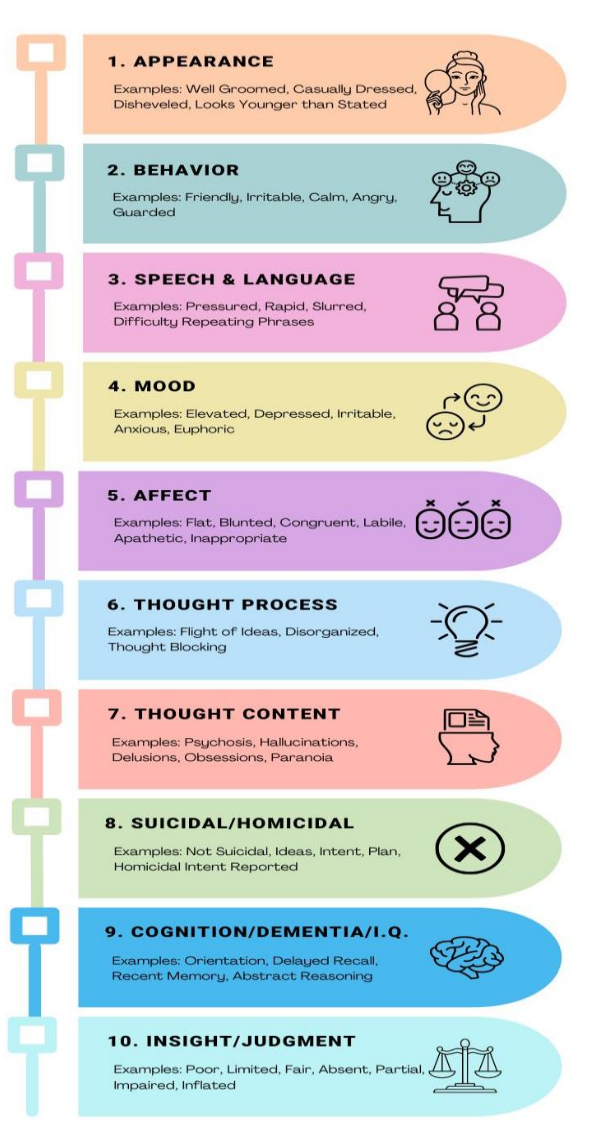
Medical section

Current/Past Medical

Does the client have an ongoing medical challenges and do they receive treatment for those challenges? (Ask about HIV, Hep C, STIs, Pregnancy, TB, and any other major medical issues)	Pt HIV+
Does the patient receive primary care?	(●) Yes ( ) No
Where does the patient receive primary care?	Housing Works
Has the patient been scheduled for an OASAS medical assessment?	( ) Yes (●) No

Comment

Clinician's findings and patient's identified needs in this functional area and level of motivation	Pt is highly motivated. She is starting mental health therapy soon.
Information all past hospitalizations for mental health	"about 30." pt states she was in the state hospital for about a year at one time, which is when she did not smoke cigarettes.



Mental Status Exam

- On this page, you are documenting your assessment of the client's presentation in the pre-admission session(s)
- If the client's presentation is different across multiple pre-admission sessions, indicate the discrepancies in the comment box
- This may be a page that you do outside of your face-to-face time with the client

DSM-5 Diagnosis

- This page should include all assessed SU diagnoses, including the supporting criteria that was assessed
  - Mild = 2-3 sx
  - Moderate 4-5 sx
  - Severe = 6+ sx
- Nicotine is most commonly forgotten – be sure to add this as a diagnosis if the client meets diagnositic criteria
- Reminder that just because someone indicates use of a substance, does not mean that they should automatically receive a diagnosis for that substance

DSM-5 Diagnosis

Please select all substances of use patient reports and the corresponding symptoms for each substance of use below.

- [ ] Alcohol
- [x] Amphetamines/Crystal meth/Speed
- [ ] Barbiturates
- [ ] Benzodiazepines
- [ ] Cannabis
- [x] Cocaine/crack
- [ ] Hallucinogens
- [ ] Heroin
- [ ] Inhalants
- [ ] Opioids
- [ ] Other opiates
- [ ] Other sed/hyp/tranq
- [ ] Over the counter drugs
- [ ] PCP
- [ ] Sedative/hypnotics (Special K)
- [ ] Synthetic cannabis (K2 or Spice)
- [x] Nicotine

Amphetamines/Crystal meth/speed (Please select all that apply)

- [x] Continued substance use despite social or interpersonal problems
- [x] Craving/extensive thoughts and/or emotions driving desire to use substance
- [ ] Desire to control use or unsuccessful attempt to limit use
- [ ] Extensive time spent on getting and using substance
- [x] Failure to fulfill major role obligations at work, school or home
- [x] Loss of control over use after starting
- [x] Pattern of use in physically hazardous situation
- [x] Physiological tolerance
- [x] Substance use is continued despite awareness of problems created by use
- [x] Use interferes with other important activities
- [x] Withdrawal symptoms

Cocaine/crack (Please select all that apply)

- [ ] Continued substance use despite social or interpersonal problems
- [x] Craving/extensive thoughts and/or emotions driving desire to use substance
- [ ] Desire to control use or unsuccessful attempt to limit use
- [x] Extensive time spent on getting and using substance

Treatment modality

- This serves as the initial txp that you are developing with the client
- Clarifying if they are exploring their goal specificially with SU as well as any other life areas that they would like to be addressed in session
  - Physical health
  - Vocational/educational
  - Social/leisure
  - Family
  - Daily living skills
  - Legal
  - Housing
  - DV
- Best to capture the identified goals in the client's own words
- If you do not use quotes, make sure to use language that indicates that the client was the person who identified the goal
  - e.g. "Client expresses desire to find employment before the end of the year"
- The comment box should reaffirm the assessed diagnosis(es) and specify if there were substances previously identified but client does not meet diagnostic criteria for

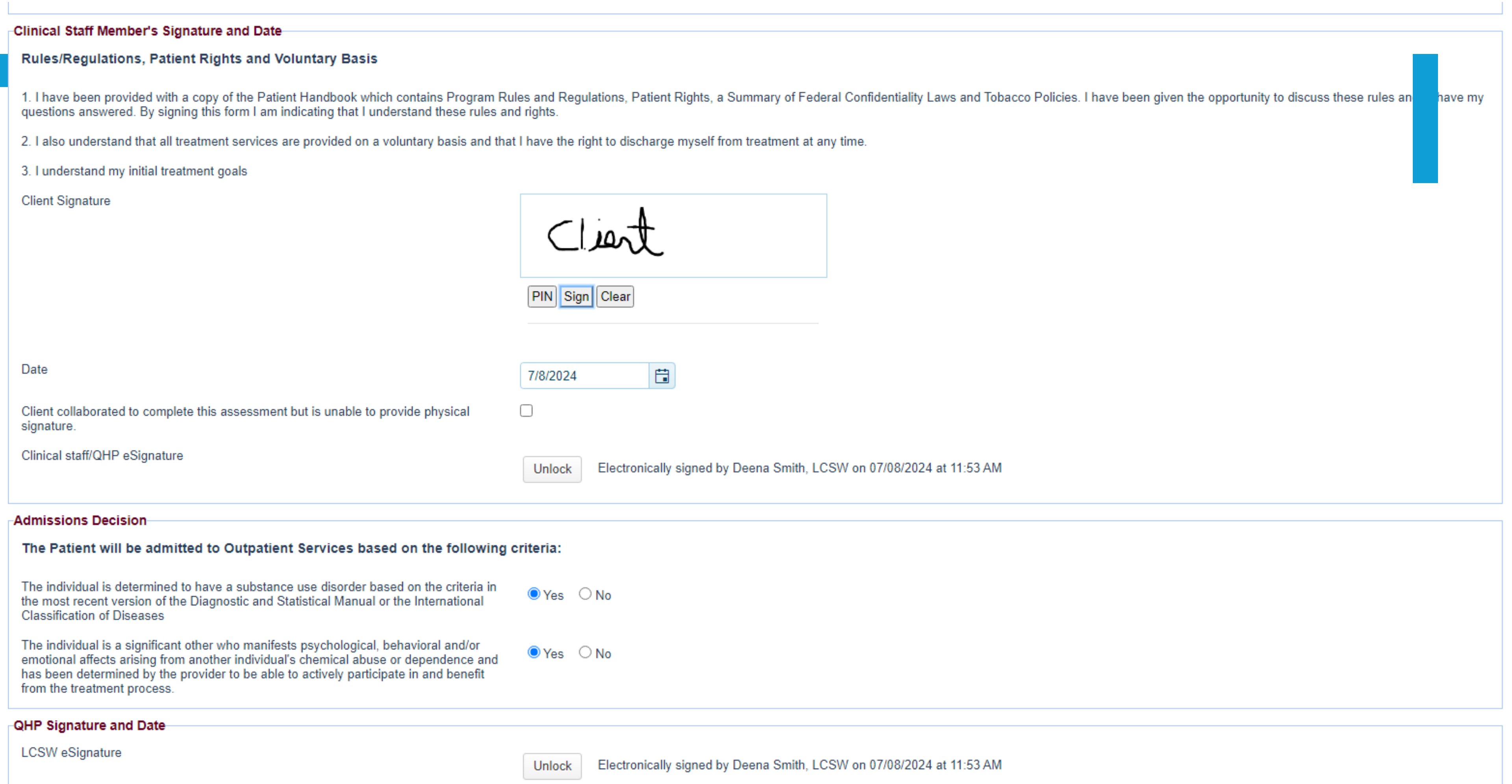
Treatment modality

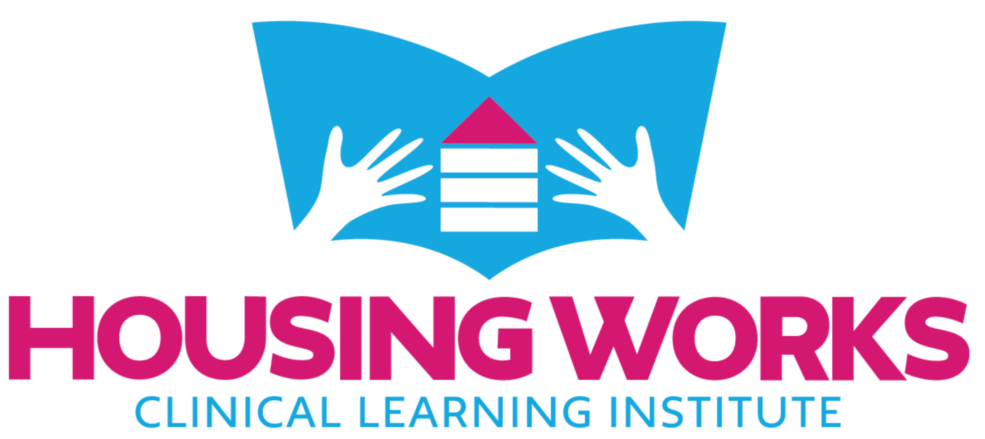
Treatment Modality

Does the client have the ability to develop or assist in the development of the treatment plan?	(•) Yes ( ) No
Is your ultimate substance use goal abstinence?	(•) Yes ( ) No
Initial Treatment Goals	[ ] Physical Health [x] Mental Health [x] Vocational/Educational [ ] Employment [ ] Social/leisure (community recovery supports, etc) [ ] Daily Living Skills [ ] Family [ ] Legal [ ] Problem Gambling [x] Housing [ ] Spirituality [ ] Domestic Violence [x] Substance Use
Mental Health - Goal*	Pt wishes to enter mental health therapy and remain current with her appointments with Dr. Arty.
Vocational/Educational - Goal*	Pt wishes to "get a career." She wishes to obtain her peer certification or her CASAC.
Substance Use - Goal*	Pt wishes to maintain abstinence from crack and crystal meth.
Housing - Goal*	Pt wishes to obtain permanent housing.

Signature of Intake

- Clinician & LCSW/supervisor must electronically sign to be in compliance





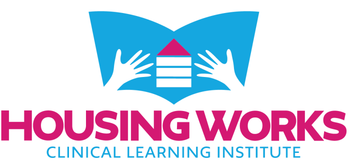
OASAS Compliance training Part II

Deena Smith, LCSW

Behavioral Health Compliance Manager

Documenting the intake

- All intake assessments **must be signed & approved by supervisor on or before DOA**
  - Best practice to submit the intake to your supervisor at least 24 hours before scheduled admission session
- In addition to completing the intake assessment itself, you will also need to complete a pre-admission progress note to document the service encounter



Sample Pre-admission note

The client met with SW to complete an OASAS intake, He was referred to treatment services by ATI Program to receive Tx for his alcohol usage. client is currently mandated to treatment for the next 6 months. He presented as oriented x3, and cooperative. The client and clinician completed the entire intake assessment, LOCADTR, and consent package. The clinician was able to review and provide an understanding of consent. The client acknowledged and verbalized understanding of consent and had no questions regarding any of the consents. the client agreed to the following: program expectations, client code of conduct, client's rights, a notice of privacy practices, TRS-61, TRS AN, consent for Justice center, consent for LOCADTR, consent for treatment, telehealth consent, Trs62, outreach agreement, client handbook acknowledged, HW substance use consent, Healthix, Toxicology FAQ. After signing, A copy of the consent was offered and given to the client, he elected not to need a copy. The consent was uploaded to the chart in EICARE. the client will provide documentation for OASAS medical clearance through an external PC. A LOCADTR was completed and uploaded to the client charts. The client is deemed appropriate for outpatient treatment.

Baseline toxicology was requested from client and completed; results will be reviewed with client when returned.

The client and SW completed the entire intake assessment.

His goal is to refrain from alcohol usage and comply with and complete the mandate.

The client is scheduled for admission on 8/29/23 at 11 a.m. with the Clinician.

Timeline

- Pre-admission/intake appts may be scheduled for 15, 45, 75 minutes
- You are only able to use the intake assessment billing code once for each treatment cycle
- Intakes must be completed in no more than 3 sessions
- The intake assessment must be completed within 60 days
  - This gives flexibility for a population that we recognize may have difficulty with initiating & remaining consistent with tx
- Once complete, the assessment must be submitted to supervisor at least 24 hours prior to the DOA; supervisor must review/approve prior to DOA

HOUSING WORKS
CLINICAL LEARNING INSTITUTE

OASAS Intake + Admission

- All intake assessments will be submitted to the Director, Assistant Director, or appointed LCSW and **must be reviewed/approved by the supervisor on/or day of the DOA**
- In addition to the Pre-admission extended assessment, you must also complete the PAS44/OASAS admission report
  - Should be completed during the admission session with client
  - This form **MUST be submitted on DOA**
- An admission progress note must be utilized to indicate client's official enrollment into 822 services

PAS 44

- AKA OASAS Admission report
- Completed during admission session with client
- All areas with red asteriks are required fields
- Must be submitted on day of admission
- Supervisor approves within 2 business days
- These forms are used to enter client data into the OASAS central registry

Approval History
Demographics
Basic Information
Admission Details
No. of Assessment Visit/Days
LOCADTR Information
TSR-61- Identifying Information (ID)
TRS-49- Criminal Justice (CJ)
Veteran Status and Military Status
Type of Residence and Living Arrangements
Referral/Education/Employment/Criminal Justice/Family History/Gambling Details
Alcohol and Substance Use
Physical Health-Related Conditions and Mental Health-Related Conditions
Gambling
Trauma
Orientation to Change

Admission Details

Provider Number : ENY 48960*
Select Provider Number* — PA Provider number: 1738 / ENY Provider number: 48960
Program Number: ENY 52958*
Select Program Number* — PA program number: 52933 / ENY program number: 52958
Client ID* — 123456
Special Project (See instructions):
Sex (at birth)* — Male / Female
Last Name First 2 Letters (Birth Name)* — Da
Last Name First 2 Letters (Current Name)* — Da
First Name* — Darth
Medicaid Client ID
Admission date* — 9/9/2024

<< Save & Previous | Save | Save & Next >>

Admission note

- Must be completed to indicate enrollment into active treatment
- Content should include general overview of the session, goals for treatment, & finalized treatment schedule
- Should specify that consents were reviewed with & understood by the client
- Include whether tox results from intake being reviewed or baseline tox being requested
- Should indicate discussion of referral/f/u for medical assessment

Add/Update Note

Program * PA - OASAS
OASAS (selected) | OASAS/ATI
Date 9/9/2024
Duration 30 Mins

Note Type * Admission
Interventions --None--

Mandated: Yes | No (selected)
Change in Level of Use: Yes | No (selected)
Change in Level of Functioning: Yes | No (selected)

MAT: Yes (selected) | No — Suboxone
Medical: Diabetes

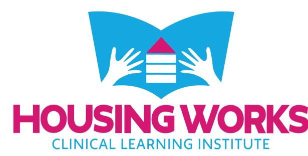
DSM-5 Diagnoses and ICD-10-CM Codes
F10.20 Alcohol use disorder, moderate
F11.20 Opioid use disorder, severe

Content of the Session *
General overview of the session
Should also indicate solidified treatment schedule, including any identified groups

Result of the Service *
next appt date and any other identified next steps

Save | Close

Sample Admission note



The client met with SW for an admission session. The client presented as well-dressed and alert, with normal affect. The client is currently presenting with an alcohol, marijuana, and nicotine Dx. He is mandated to TX by ATI to receive support around his alcohol consumption.

His goals are to comply with the program rules and protocols, comply with ATI for the next six months, and be sober from alcohol.

He is deemed appropriate for admission into the OASAS program. He is mandated to attend the Stages of Change group and IC with the Clinician on Fridays as well as provided weekly urine screening.

A PAS44 admission report was completed with the client.

The client was officially admitted into the HW ENY OASAS program on 8/29/23

Next IC Friday, 9/8/23 at 12:00pm

LOCADTR

- Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) is a specific assessment tool developed by OASAS to assess the appropriate level of care that matches the client's assessed needs based on a set of questions
- This must be completed prior to or on DOA
- For poly substance users, the substance that has the potential to cause the most harm should be utilized for the assessment
- If the LOCADTR identifies anything other than "outpatient services," the clinician must discuss further with the supervisor before admitting into the 822
- If supervisor agrees/supports admission, justification for clinical override of the determination must be added to the LOCADTR
  - o See next slide for more info
- LOCADTR is scanned & added to attachments in eiCare

LOCADTR Overrides

As a supervisor, when reviewing admissions, you should also review the LOCADTR

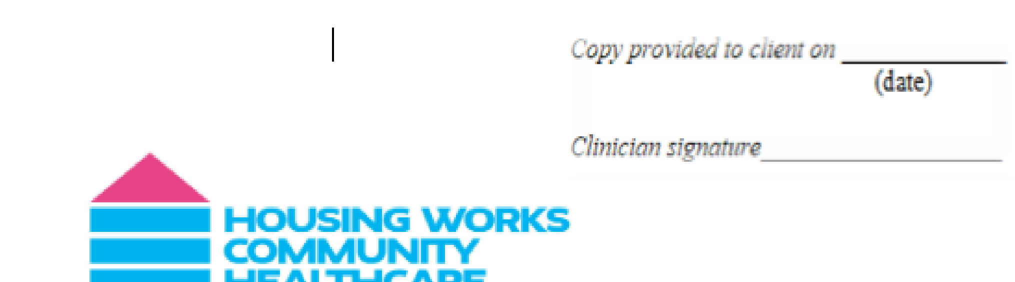
- If LOCADTR identifies any LOC other than "outpatient services" before moving forward with admission, clinician ***must*** discuss with supervisor if 822 is the appropriate LOC
- After discussion with the supervisor, the staff or supervisor should indicate in the LOCADTR which of the options follows the need to have an override to admit the client at this level of care. Options are:
  - The recommended level of care is not available
  - There are additional clinical factors documented below
  - There is an external mandate documented below
- No matter which option is selected, there should be a clear rationale that states the decision to override and that a supervisor was consulted if being documented by the therapist
- There has to be a specific reason to support the override. Some examples of how it could be documented:
  - They are mandated to our clinic by parole
  - Client refuses to engage in the recommended level of care and these are the additional support services that will be offered towards having a higher level of support...
  - Client is able to engage with MOUD treatment options with clinic provider and has appointment on X date

Medical assessment

- To support overall wellness & to comply with regulations, physical health info is equally important as part of the assessment process
- All incoming OASAS clients should be offered linkage to a Primary Care Provider, if they are not already engaged with one
  - This is verified at intake by providing the client a copy of the medical clearance form
  - If necessary, the relevant health information will be provided to HW from an external provider by the client. If an individual refuses to provide access to such information about their health assessments conducted by outside providers, it must be documented in the case record.
- OASAS requires that we request their most **recent physical evaluation within the last 12 months since DOA**, with Tuberculosis (TB) screening included
  - If client is going to participate in groups in person, TB clearance is a requirement
- Discussion of medical clearance **should be documented in the pre-admission or admission session note**. If follow up is required, should be captured in ongoing progress notes.
- Those clients with chronic illness(es) or who identify a physical health need will be offered frequent monitoring of their conditions as defined in their treatment plan.

Medical clearance form

- This is a form within the intake packet.
- If completing form in person, the clinician should sign the top right of the form as verification that this requested of and provided to the client.
- If completing electronically, the electronic time stamp of the consents will serve as verification


Copy provided to client on ____________
(date)

Clinician signature ________________

HOUSING WORKS COMMUNITY HEALTHCARE

East New York Health Center • Ph#: 718-277-0836 **• Fax:** 929-480-9136

Medical Clearance Form

Dear Primary Care Provider:

I am referring_ / DOB:_ to Housing Works' OASAS Program. I believe my patient can benefit from the program in one or more of the areas outlined below, which will enhance the quality of my patient's life.

Please check services that apply to your patient:

O Case Management O Mental Health Services O Substance Use/Harm Reduction Services

Please list medical condition (s) / History: (*Please attach all recent labs for patient as may pertain to treatment)

Risk Assessment

Risk Factors: Suicide

- **Distal Risk Factors – Chronic and longstanding risk factors**
  - Demographic factors- death by suicide, previous suicide attempts (past year, past 3 months), psychiatric hospitalizations
  - Family hx of suicide or violence
  - Adverse childhood experiences
  - HX of Psychiatric Illness & symptoms – Major Depressive Disorder, Bipolar Disorder, Schizophrenia, Substance Use Disorders, Eating Disorders, Posttraumatic Stress Disorder, Borderline Personality Disorder) (Suicide Prevention Resource Center, 2018)
  - Chronic Pain

Proximal Risk Factors- acute or current factors that identify more imminent risk
  - Current and active psychiatric sxs
  - Current substance use
  - Stressful life conditions
    - COVID -19 Pandemic
    - Job loss, etc
  - Direct access to lethal means
  - Exposure to suicide in community, social circles or the media

- Other Risk factors
  - Some cultural or religious beliefs

Mental health risk factors

See the Behavioral Health Orientation training for more info on Suicide risk & safety planning

Routine Follow-Up to continually assess MH Risk Factors

Identify any discrepancies in assessments , for e.g. PHQ 9- rendorse SI but denies in general intake

Risk Areas should include NSSI, SI, HI, IPV/DV

Safety Plan Creation and Reassessment

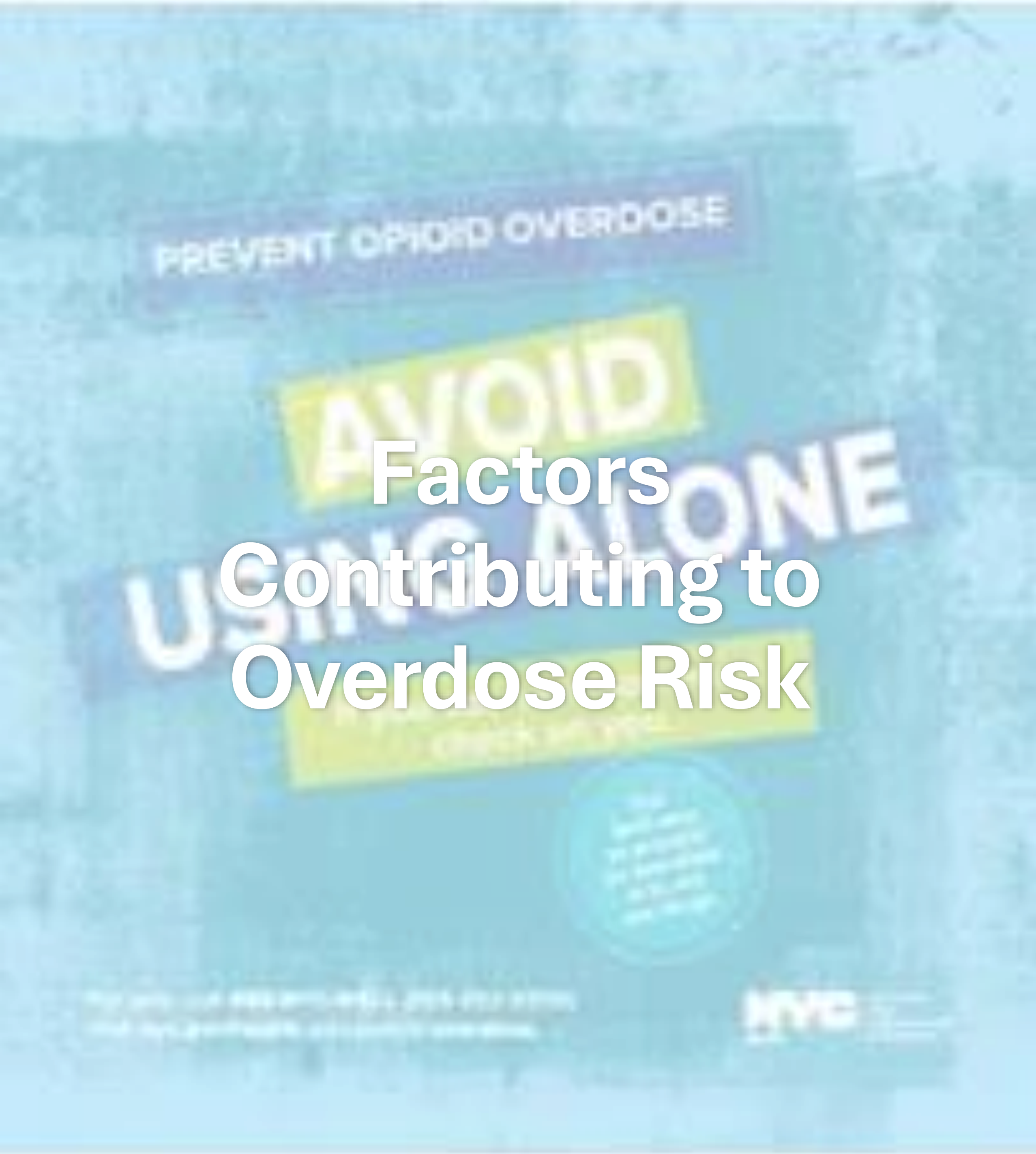
Documentation in EHR and also shared with patient (i.e. also note in documentation if patient declined copy)

Warning Signs & Protective Factors

- *Warning Signs – changes in behavior and new behavior that highlight imminent risk*
  - Threatening to hurt or kill self or talking of/wanting to kill oneself
  - Recent increase in suicidal thinking/planning
  - Making preparations
  - Feeling burdensome
  - Hopelessness, no reason to live, feeling trapped or being in unbearable pain
  - Increase in social isolation/social withdrawal
  - Increase in substance use or differing behaviors as it relates to substance(s) and types of use
  - Insomnia/sleep disturbance
  - Rage/revenge seeking behavior
  - Verbalizing "not being around"
  - Recent and intensive changes in mood

Protective Factors

- Coping strategies
- Problem Solving skills
- Help-seeking behavior
- Family (close, supportive, sense of responsibility)
- Spirituality
- Fear of consequences
- Fear of death
- Minimize access to Lethal Means
- Social Support/Sense of Belonging
- Strong therapeutic relationship with a trusted provider

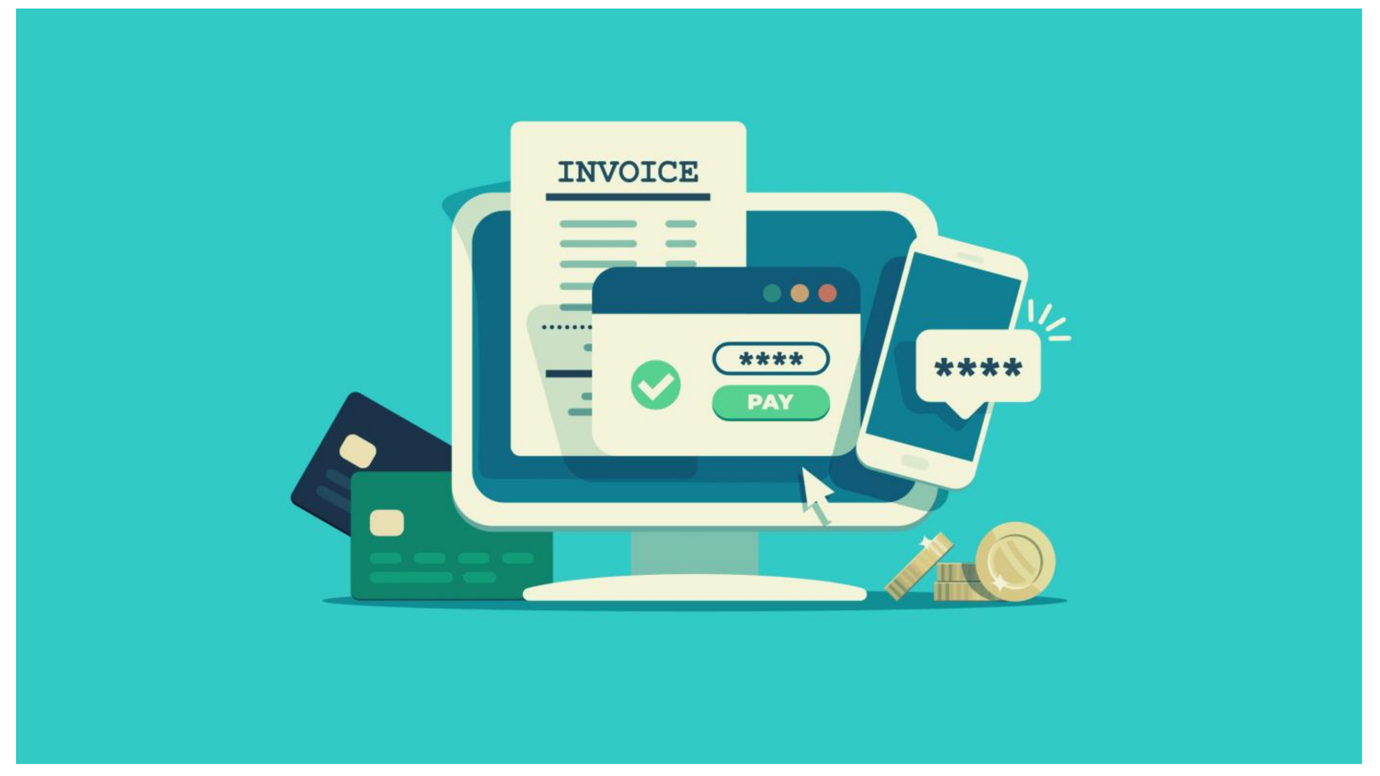


Factors Contributing to Overdose Risk

- Recent Use of Opioids/Other substances high potential for overdose (Within past 12 month period)
- Past Hx of overdose
- Health and Life Stressors:
- Any personal factors : explore and solicit from the individual
- Process of Substance use: (the what, how and when)

See the Behavioral Health Orientation training for more info on Harm reduction & overdose prevention

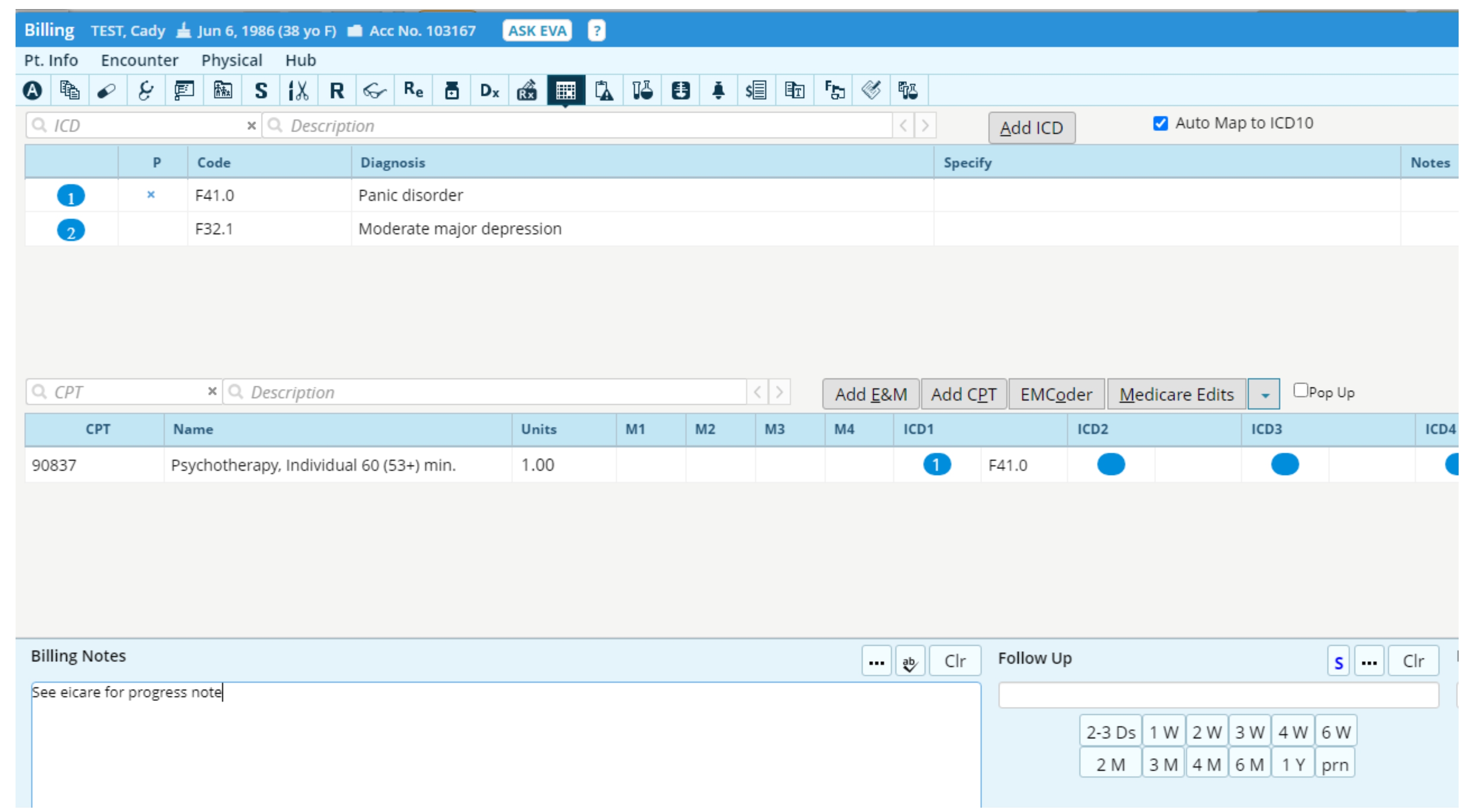
Billing in eCW



Billing

- Billing is captured in a separate EHR than the clinical documentation: eCW
- What's included:
  - All assessed SU diagnoses
  - Telehealth questionnaire for telehealth visits
  - CPT/billing code
  - Additional modifiers
  - Billing note to "See eiCare for progress note"
  - Signature of clinician providing services

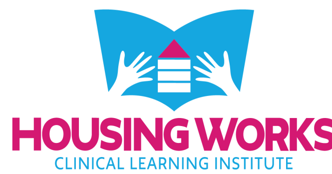
Example of billing



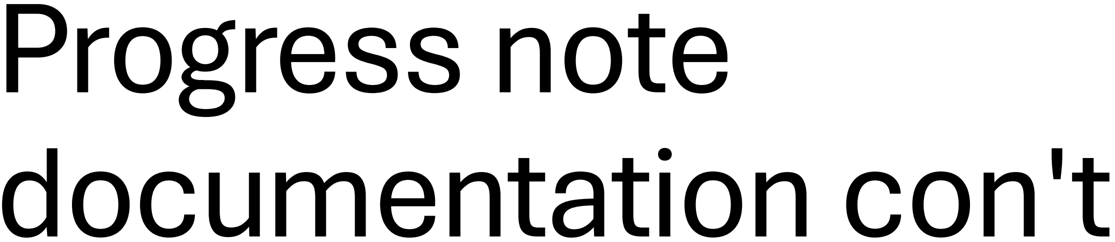
Review further with your supervisor

Progress Notes

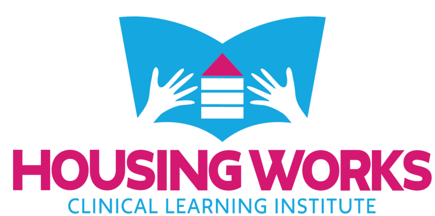
Progress notes



- Progress notes are a key element to recovery. Each individual's record must contain progress notes that are reflective of the individual's progress and provide an overview of what is covered in each session.
- Progress notes must:
  - Report advancement toward goals, identified barriers to progress
  - symptom reduction
  - functional improvement
  - Identify the services provided (consistent with the Individualized Treatment Plan
  - Create the informational framework for the program and the individual to review and update the assessments and especially the Individualized Treatment Plan
  - Provide documentation to demonstrate that services are delivered as defined in the treatment plan, so that Medicaid billing is supported.
  - Include duration/time of services rendered
  - Dated and signed by a clinical member of the clinical program staff
  - Dually signed by supervisor



Progress note documentation con't

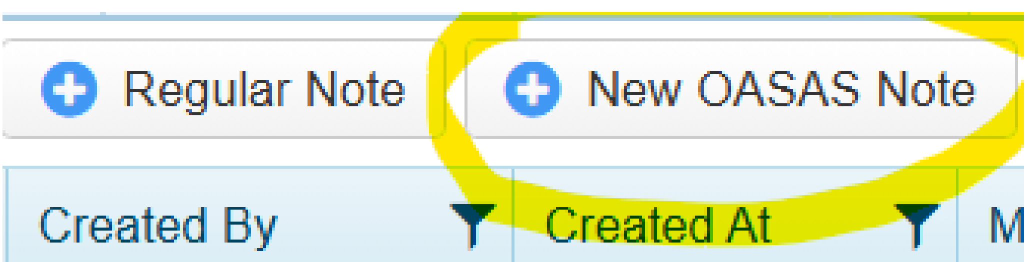


- Progress notes should also include identification of any necessary changes to the treatment plan and services related to such changes.
  - Goals should be captured in a manner that reflects a person-centered perspective and the SMART goal framework
- If other people are present in the session, this should be documented in the note (i.e. case manager is present or interpreter)
- Interventions that you are using in session should be captured in the progress note
- The assessed Stage of Change (SOC) should be assessed & captured at each visit
- Progress notes are expected to be completed within 48 hours of the DOS
- **Note that encounters should not be locked in eCW for billing until a progress note capturing the content of the session is completed in eiCare**

See OASAS Case records policy for more information

How to create a progress note

- In top right, select *New OASAS note* > Select type of note > Enter all header info
- Note that required fields must be entered before a note can be saved
- It is recommended to **periodically save your note** as you enter the data so as to not lose information



Content of the note

- Every check box in the header (i.e .note type, date of service, duration, modality, mandated, MAT, medical goals/needs, assessed stage of change, diagnosis) should be filled in at the top of the note
- Notes need to include the **type of session** (i.e., intake vs follow up) and **how it was conducted** (in person or telehealth)
  - If you do the session by **telehealth**, you need to include:
    - The **type** of telehealth (i.e., doxy, zoom, telephone)
    - Where the **patient is located** for the session (i.e., their specific location and the state they're in)
    - If the patient is in a potentially public space (like a park), document the conversation you have around **potential risks to privacy** and patient's consent, if they consent, to proceed with the session
- Who was present in the session
- The progress note should overall contain 3-5/7 sentences that discuss the overview of main content/goals discussed in session. The patient's **treatment goal that is being addressed** and any progress or barriers that have contributed
  - **Example**: Addressed patient's goal to reduce harm by reducing alcohol use
  - Please note that you should **periodically circle back to goals** in the following domains: **substance use, medical, mental health, areas of assessed risk, as well as any other client-identified goals**
  - This should also include identification, incorporation of client's **strengths and resources** that they are able to utilize to support them in addressing goals

Content of the session (cont)

- The **therapeutic modality you're using and what you're using it to address**
  - **Example:** Writer used CBT to assess triggers for substance use and coping skills to address triggers. Writer introduced the ABC model to assist pt in identifying situational and emotional triggers; pt reported triggers are getting into arguments with others and feeling disrespected. Writer and pt practiced deep breathing coping skill in session.
- The **patient's perception/response**
  - **Example:** Pt reported the deep breathing skill was helpful in this moment and expressed concerns about utilizing it in the moment. Writer and pt discussed practicing skill when pt feels calm so that it is easier to use when pt is activated
- *Plan:* Their **next appointment date** and any other next steps that may need follow up on

Progress note example

Add/Update Note

Program*: PA - OASAS
(•) OASAS ( ) OASAS/ATI

Date: 8/8/2024

Duration: 45 Mins

Note Type*: Individual

Interventions: Coping Skills

Mandated: ( ) Yes (•) No

Change in Level of Use: ( ) Yes (•) No

Change in Level of Functioning: ( ) Yes (•) No

MAT: (•) Yes ( ) No — Naltrexone

Medical: Diabetes

DSM-5 Diagnoses and ICD-10-CM Codes: F10.20 Alcohol use disorder, moderate; F11.20 Opioid use disorder, severe

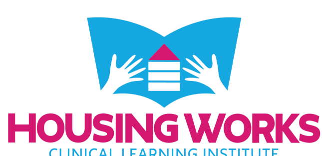
Content of the Session*

This is where you would provide an overview of the content of the session. Must include discussion of client's self-identified goals and speak to progress or lack thereof that is being reported/observed.

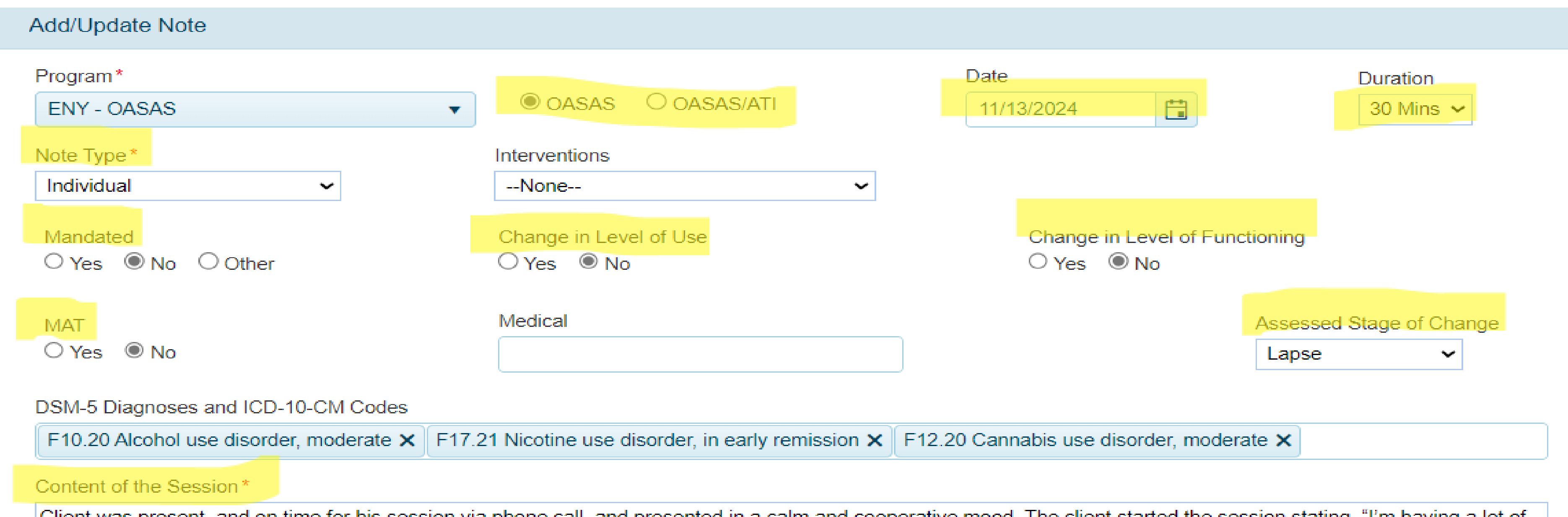
Result of the Service*

Client indicates progress in ability to take Naltrexone oral pill more consistently and has noticed a decrease in eTOH consumption.
Next appt is 8/15/24 9:00am

Save Close



Note example



Add/Update Note

Program*: ENY - OASAS
(•) OASAS ( ) OASAS/ATI
Date: 11/13/2024
Duration: 30 Mins

Note Type*: Individual
Interventions: --None--

Mandated: ( ) Yes (•) No ( ) Other
Change in Level of Use: ( ) Yes (•) No
Change in Level of Functioning: ( ) Yes (•) No

MAT: ( ) Yes (•) No
Medical:
Assessed Stage of Change: Lapse

DSM-5 Diagnoses and ICD-10-CM Codes
F10.20 Alcohol use disorder, moderate ✕ F17.21 Nicotine use disorder, in early remission ✕ F12.20 Cannabis use disorder, moderate ✕

Content of the Session*

Client was present, and on time for his session via phone call, and presented in a calm and cooperative mood. The client started the session stating, "I'm having a lot of pain this morning." The client then added that he did receive the DOXY link but had no phone data to log on to the link, so he decided to stop by the office. Clinician reminded the client that today was a remote day. The client then requested to engage in the session over the phone and would make efforts to engage via telehealth next week. As the session continued the client engaged in a conversation regarding his use of alcohol and marijuana stating, "I use alcohol and marijuana as a way of helping me with the pain and sleeping issues. I have nightmares and occurrences from my previous job. I use it to calm myself down." The client continued by stating, "I don't think I have an alcohol issue. I am seeking advice and help with the decisions regarding my current life circumstances. I'm not seeking help with alcohol use." The client continued and reported no plans of quitting. The client then reiterated, "I want solutions with my pain and the psychological issues regarding my situation with the shelter."

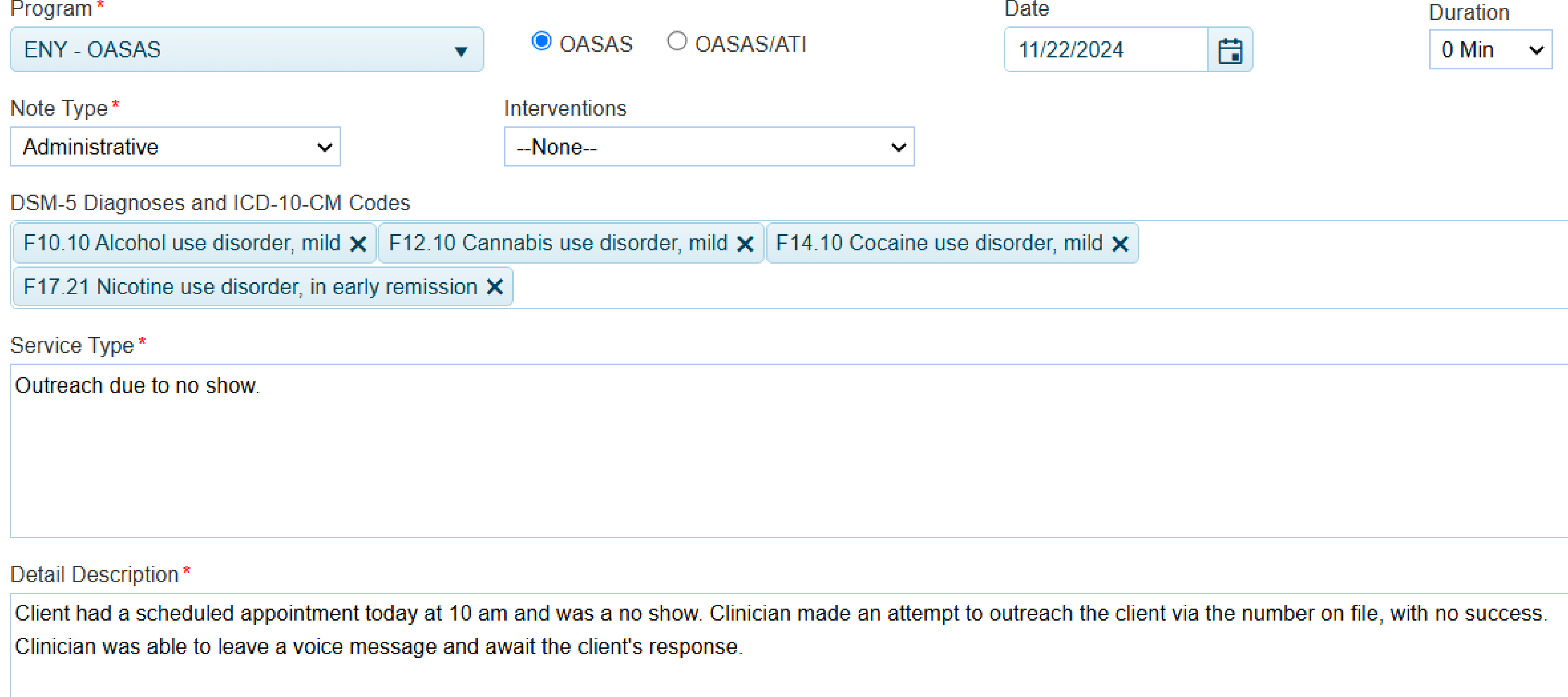
Result of the Service*

As a result of the service the clinician was able to utilize open-ended questions, reflective listening, affirmation, and rapport building for supportive counseling. As the session proceeded the client shared an update after calling 311 stating, "I received a number to contact a Legal Aid lawyer." For further assistance the client was provided with the contact information for the office of the Ombudsman (800-994-6494 and ombudsman@dss.nyc.gov) to report his complaints. The clinician commended the client for his efforts in attending today's session.

Admin notes

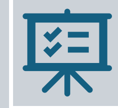
- Similar to telephone encounters (TEs) in eCW
- These notes are meant to capture any non-billable encounter or important information or event that is relevant to client's care and/or goals
- This may include:
  - Outreach for a missed session
  - Outreach to a collateral
  - Compliance issues that have been identified and indicated to include a note in the record
    - This is typically completed by the supervisor
- It is best practice to document any time you review records in eCW for a psych or medical provider- could be added as a care coordination note (selected under *Note type*) or integrated into the next progress note with client
- Though not billable, these notes should still be completed in a timely manner, signed, & locked by the writer

Admin note for outreach

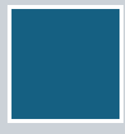


Documenting Treatment Plans

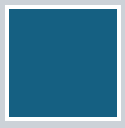
Treatment Planning: The Process



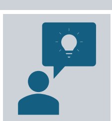
A collaborative process between therapist and the client and includes client feedback



Addresses the client’s presenting problems via goals and actionable objectives.



The treatment plan includes a statement of the clinical problem, the interventions and room to measure client’s progress.



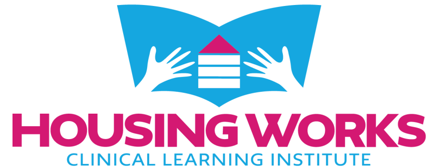
Considers the client’s strengths and barriers along with their circumstances

Treatment planning

- This is captured uniquely in OASAS, as there are no formal txps
- The initial txp is captured within the intake assessment on the DSM5 diagnosis page. This sets the foundation for tx & identifying initial goals the client would like to address
- Subsequent reviews/updates for these goals should be captured within progress notes throughout treatment
- Goals should be person-centered & directed by the client
    - Goals can be captured by using direct quotes from clients
- New goals can also be added as a focus of tx as you progress. These are also captured within progress notes
- Goals should be written in a clear, concise manner
- Goals should still follow SMART goal framework

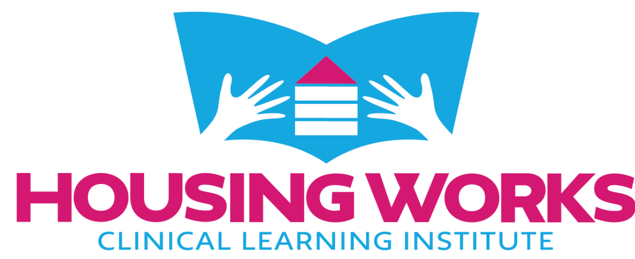
SMART GOALS:

Use SMART goals to identify the plan to address the presenting problem or need. SMART stands for Specific, Measurable, Attainable, Realistic, and Time



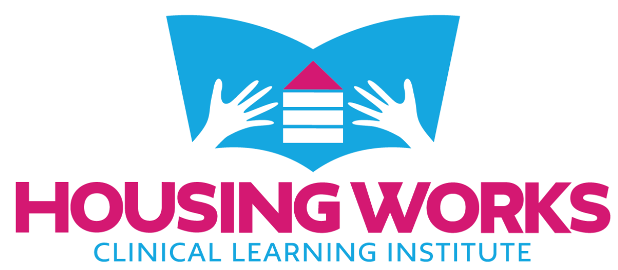
Make objectives	
Specific	Goals and objectives are more easily accomplished when they are clearly stated. Answering the 5 “W” questions (who, what, when, where, and why) is helpful in setting specific goals
Measurable	Establishing concrete criteria for measuring progress can help motivate continued effort to achieving the goal. How will we know when the goal is accomplished?
Attainable	Goals should be reasonable and achievable. Trying to do too much in too little time is not the best way to succeed.
Realistic	A goals is probably realistic if the person believes that it can be accomplished. To be realistic, a goal must represent something a person is willing and able to do.
Timely	Goals are more grounded when there is a time frame attached to them. Identifying short-term steps within a longer term goal can help to create hope and momentum.

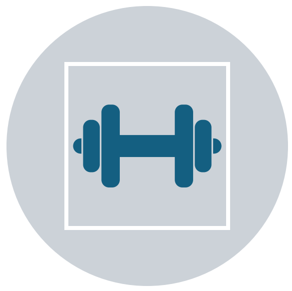
Creating a goal



- Clinical statement of the condition you expect to change
- The goal is tied to the assessment and problem statement
- The goals are reasonable and achievable
- Goals and objectives are often confused in treatment plans so keep in mind there is a difference.
- If you can see the client do something (i.e.-complete a journal entry, attend AA, etc.) then it is an objective.
- If you can't see a client do something (i.e.-reduce anxiety, accept powerlessness) it is a goal.

Understanding the Client





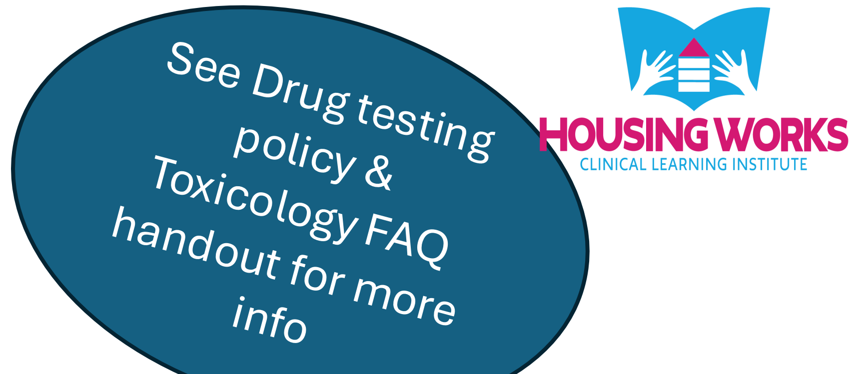
Consider the client's strengths, emotional and physical circumstances, and what they're trying to achieve.

Select services: Use the client's strengths when choosing services.

Create measurable goals: Set goals that can be measured as the client progresses.

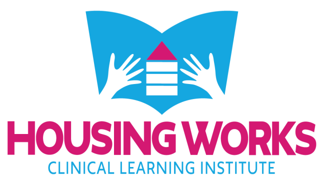
Choose interventions: Interventions are techniques, tools, and exercises that help the client meet their goals. Some examples include counseling, crisis intervention, advocacy, safety plans, behavior plans, and crisis plans.

Toxicologies



Toxicology

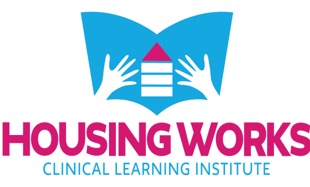
- Toxicologies are ALWAYS voluntary
- Even if someone is involved with a 3rd party who is mandating
- Requested at intake & toxicologies conducted throughout treatment as a clinical tool
  - If client is not interested in providing a toxicology, the chart should include it was offered & any barriers, reasons client did not want to provide. If toxes are mandated, should also include discussion of risks/challenges for mandating agency.
- Should never be used as a punitive tool & instead should be used as a tool to assist clients & their stated goals, not as a punitive, judgmental or stigmatizing aspect of care
- These should be conducted in a trauma-informed manner
- At the State level still requires request of 8 toxicology screenings at minimum every year and these screening and information about them are noted in the intake package and consents for client awareness
- Any substance that shows up on the tox but was not identified should be discussed with client – can also speak with them prior to results for them to self-disclose what may show on the tox
- Results should always be reviewed with client once available & documented in the progress note
- Any results that are unexpected and/or high risk should be discussed with the supervisor and Medical Director for review



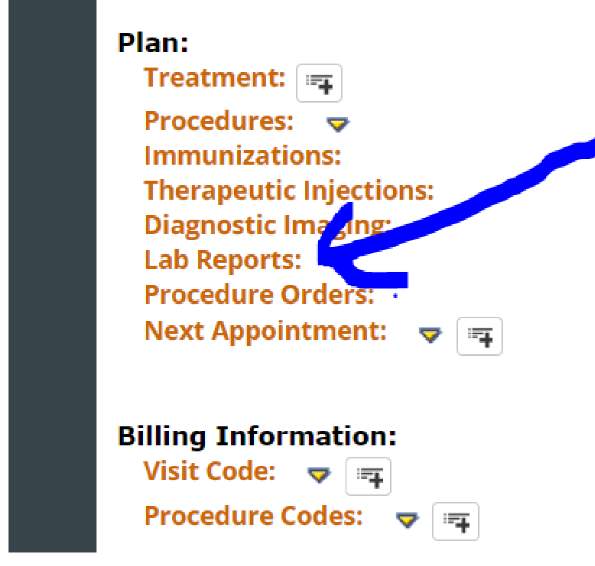
Criteria to request toxicology

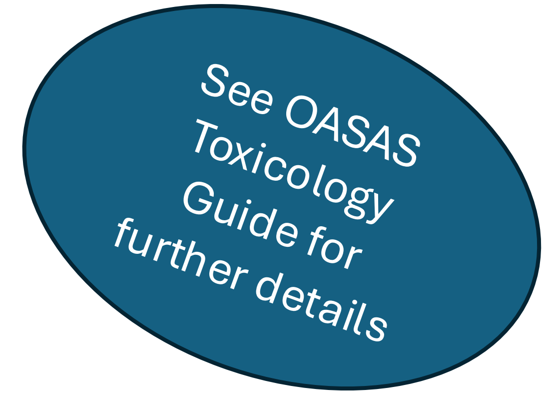
- Criteria to consider
    1. upon observation of the signs & symptoms of acute intoxication or clinically significant changes in behavior; or
    2. on a random basis, administered at the discretion of clinical staff;
    3. or in alignment of request of an outside mandating agency.
    4. Drug and alcohol screens are incorporated into the intake and assessment process and each patient's individual treatment plan according to clinical necessity.
- Drug testing is not used as a punitive tool & should be used to support client awareness & to make informed decisions around their treatment goals, harm reduction, or recovery efforts

How to order toxicology tests



- Are completed within eCW
- Can be captured within billable encounter or not connected to a visit
- Only identifying substances that are endorsed by the client



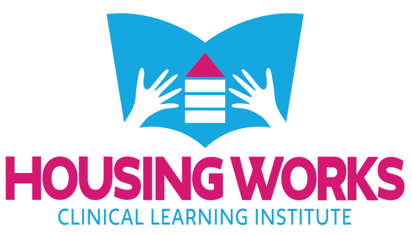


Outreach & Collaboration

Outreach

- It's important that we support clients who may have difficulty with consistent engagement
- If a client is 5-10 minutes late for scheduled appointment time, it's best practice to outreach the client. Appointment can be rescheduled, if needed, or converted to a telehealth session if client is not able to attend in person but can participate remotely
- For each scheduled encounter, there should be documentation in the record
- Support staff may also engage in outreach for missed appointments

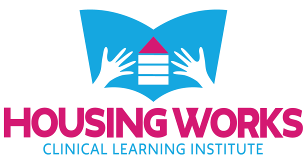
Collaboration with Collaterals



- The state agency and insurance providers are looking for **collaboration with other providers**, specifically medical and mental health professionals
  - It's best practice to have at least one conference/collaboration per treatment window/year
- OASAS has a specific regulation that persons who are engaged with MAT/MOUD should have collaboration with the prescribing provider, if authorization is provided
  - The record should reflect that this was requested if client denies authorization
- These can often be billed as Complex Care Management (CCM) services
  - CCM may involve coordination with any service provider or housing, employment or government entity
  - Can be billed in 5 min increments with a max unit of 4 per day (20 minutes); max units in a week 12 (60 mins)
  - The collaboration must be "non-routine," with "routine" defined as any specific activty that applies to the majority of clinic patients or majority of circumstances

Discharges

DISCHARGE PLANNING



Discharge summary

- Before completing a discharge from the program, ensure that there is documented outreach in client's chart. At least 3 outreach notes are expected for someone who is seen weekly or bi-weekly.
- A discharge summary is required to be completed & submitted to supervisor within 10 days of discharge from the program
- Complete discharge summary including the following:

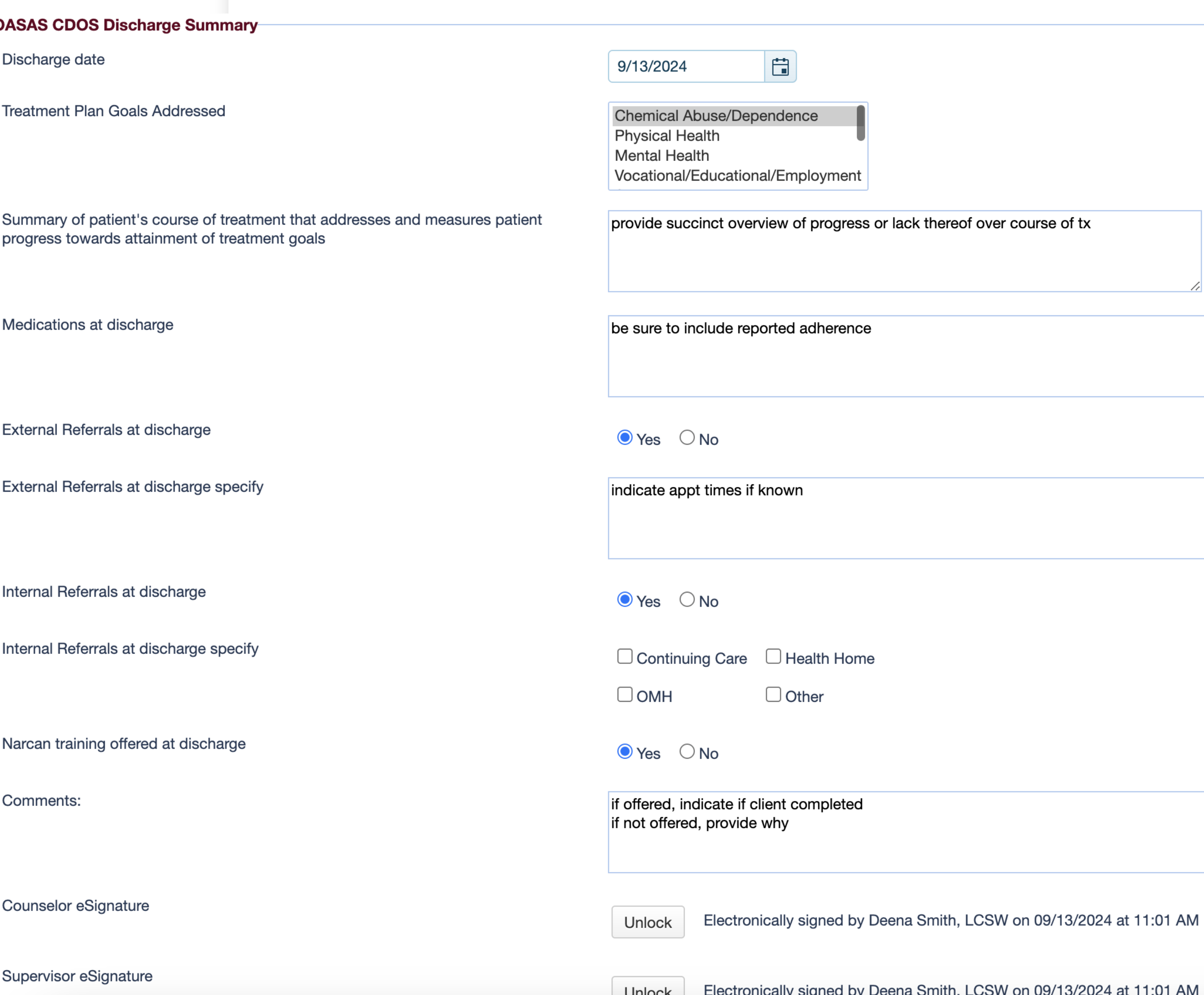
  a) Client's progress or barriers towards progress of identified goals

  b) Client's updated prescriptions (if any) and reported adherence

  c) Client's referrals including appointment dates (if applicable) to any internal or external referrals

  d) Whether overdose prevention training was offered at discharge
    - If offered, comment box should specify if client completed training
    - If not offered, must provide reason as this is a state requirement
- You must electronically sign & submit to supervisor for review/approval
  - Supervisors have 3 business days to approve

Discharge summary


OASAS CDOS Discharge Summary

Discharge date: 9/13/2024

Treatment Plan Goals Addressed:
- Chemical Abuse/Dependence
- Physical Health
- Mental Health
- Vocational/Educational/Employment

Summary of patient's course of treatment that addresses and measures patient progress towards attainment of treatment goals: provide succinct overview of progress or lack thereof over course of tx

Medications at discharge: be sure to include reported adherence

External Referrals at discharge: (x) Yes ( ) No

External Referrals at discharge specify: indicate appt times if known

Internal Referrals at discharge: (x) Yes ( ) No

Internal Referrals at discharge specify: [ ] Continuing Care [ ] Health Home [ ] OMH [ ] Other

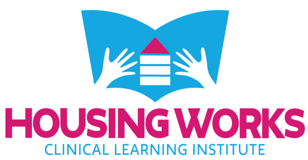
Narcan training offered at discharge: (x) Yes ( ) No

Comments:
if offered, indicate if client completed
if not offered, provide why

Counselor eSignature: Unlock — Electronically signed by Deena Smith, LCSW on 09/13/2024 at 11:01 AM

Supervisor eSignature: Unlock — Electronically signed by Deena Smith, LCSW on 09/13/2024 at 11:01 AM

Discharge Plans



- If client is being discharged for any reason outside of being lost to follow up, a discharge plan/discussion should be completed with the client & documented within their chart
- Can be helpful to also include the names & phone numbers of people that the member can call for help, including local crisis services & toll-free hotlines
- If DC plan is completed, MUST be reviewed & signed by supervisor prior to client's discharge date
- A copy should be provided to client
  - Best practice is to complete DC plan with client in session & then ask them to return for one additional close out session & provide copy then
- A discharge summary is also required within 10 days of discharge from the program

Discharge plan

Approval History

Basic Information

Individualized Relapse Prevention Plan

Provider(s) Need and Initial Appointments

Individualized Relapse Prevention Plan

Client's self-identified Relapse issues: (e.g. triggers, stressors, emotional state, situations)

Client's self-identified plan to address Relapse Issues

PAS 45

- AKA OASAS Discharge report
- Completed to indicate disenrollment of client in 822, regardless of type of discharge
- All areas with red asteriks are required fields
- Supervisor approves within 2 business days

Approval History
Basic Information
Admission Details
Mental Health, Gambling & Nicotine Goal Achievements
Total Treatment Visits and Recent History
Status of Alcohol and Other Drug Use at Discharge
Status of Different Problem Substances Used and Not Reported at Admission (if any)
Tobacco and Physical Health-Related Conditions
Discharge Reason & Referral Information
Evaluation of Client's Goal Achievement
Medication Assisted for Addiction Treatment (MAT):9
Addiction Medications Used During Treatment and Trauma
Provider Signature

Discharge Status

Note: Completed Treatment: half or more can ONLY be selected if 4+ goals are completely achieved. 'Completed Treatment' cannot be selected if there are any goals noted as partially achieved

PLEASE SELECT AT LEASE ONE

- [ ] Completed Treatment: All Goals Met
- [x] Completed Treatment: Half or More Goals Met
- [ ] Treatment Not Completed: Maximum Benefit/Clinical Discharge
- [ ] Treatment Not Completed: Some Goals Met
- [ ] Treatment Not Completed: No Goals Met

Discharge Disposition

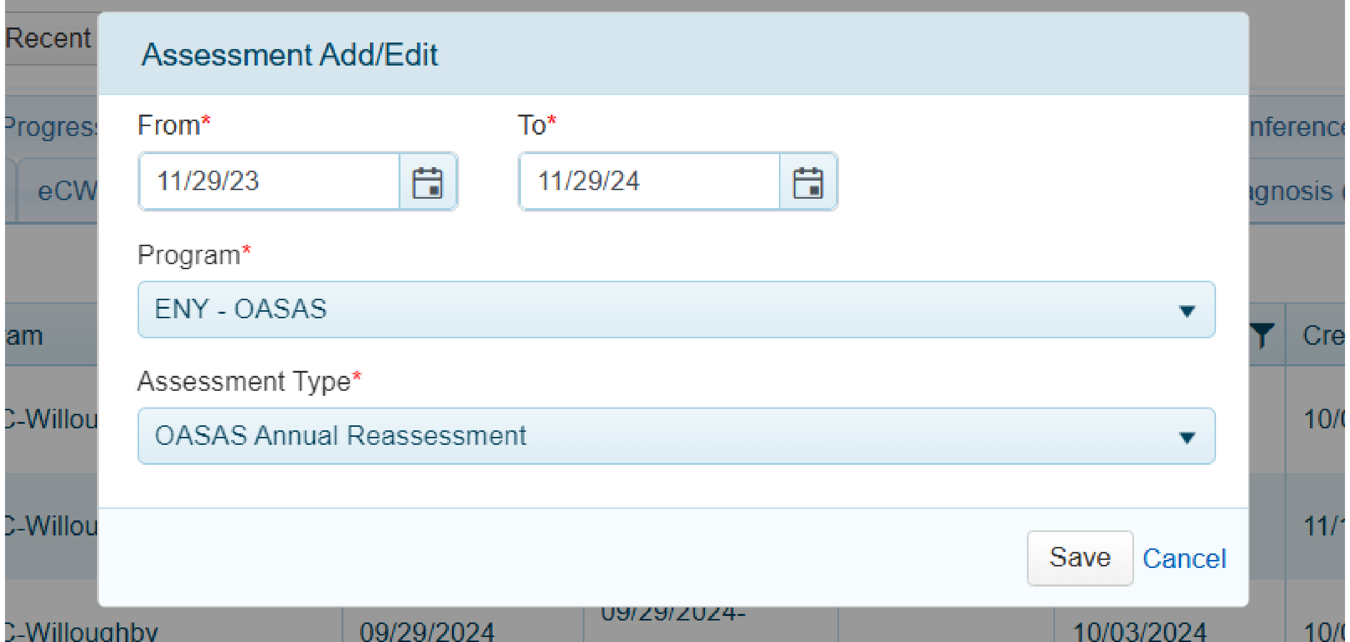
Please Note: 'Additional treatment at this level of care no longer necessary' can ONLY be selected if Achieved or Not applicable are selected in the Goal Achievement section

Discharge Disposition*

- ○ Additional treatment at this level of care no longer necessary
- ○ Further treatment at this level unlikely to yield added clinical gains
- ○ Left against clinical advice: Formal referral made/offered
- ● Left against clinical advice: Lost to contact (no referral possible)
- ○ Left against clinical advice: Termination of third party funds
- ○ Discharged due to non-compliance: program rules
- ○ Discharged due to non-compliance: violence
- ○ Discharged due to non-compliance: substance use
- ○ Discharged due to non-compliance: possession of contraband
- ○ Client arrested/incarcerated

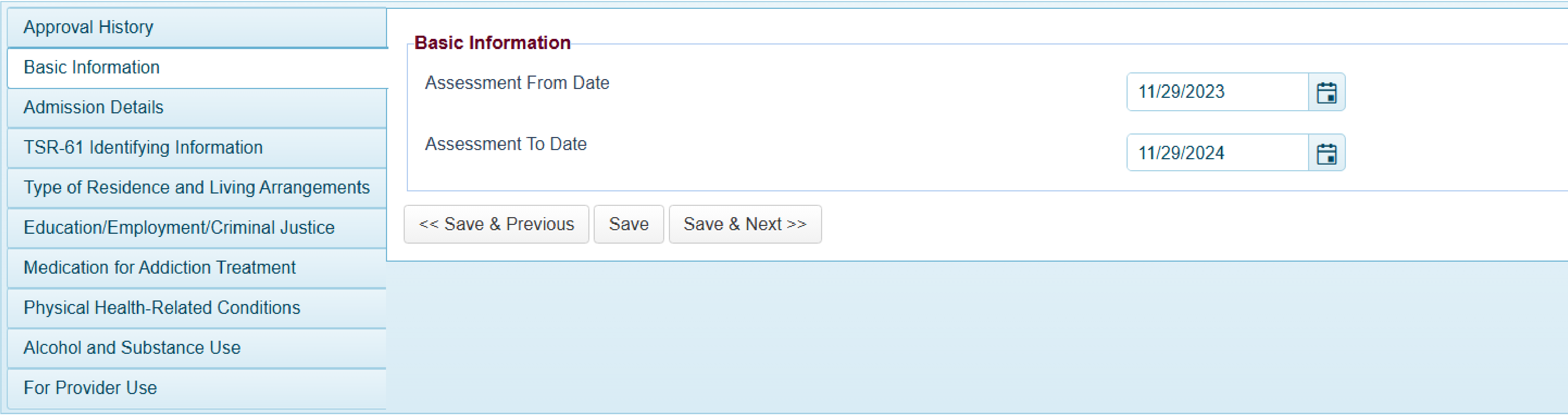
PAS 26N OASAS Annual Reassessment

- This is a new requirement under OASAS as of August 2024
- To access: go to reassessment tab > enter date range of year being reviewed > *ENY OASAS* program > select *OASAS Annual* Reassessment



OASAS annual reassessment

- This is completed annually as client is enrolled in care& is requesting updates on most areas that are identified at intake



Continuing Care

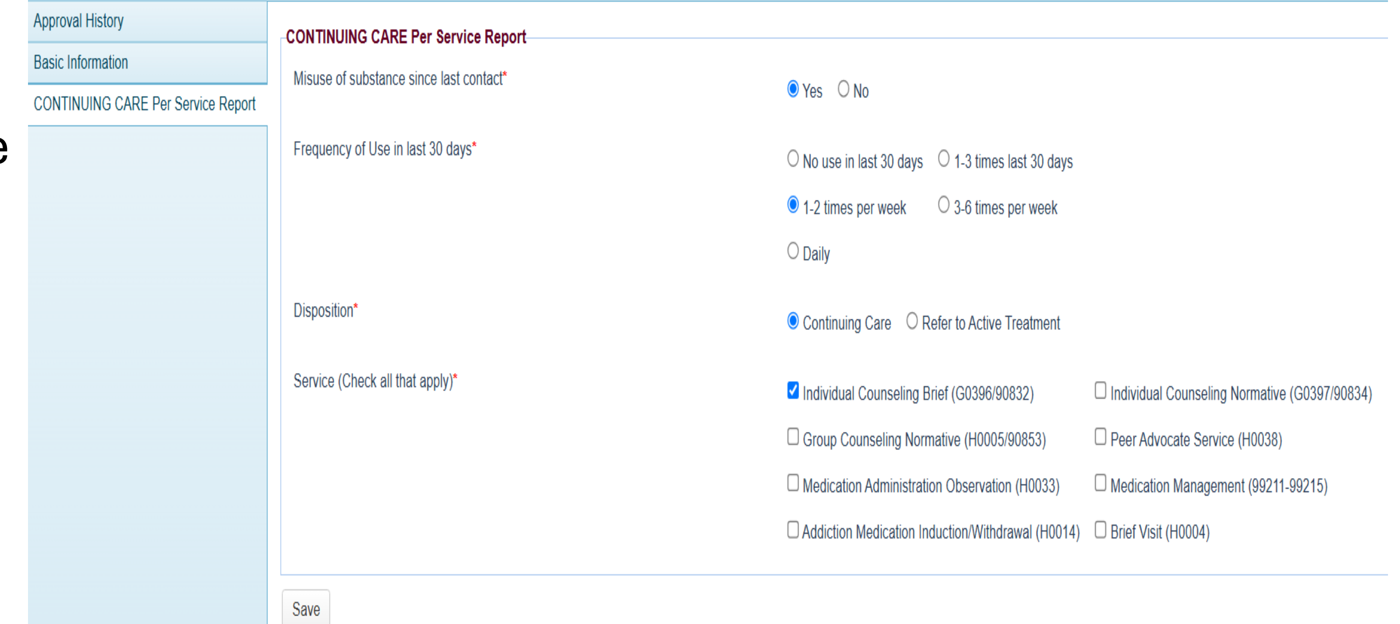
Continuing care

See Continuing Care Guidance for more details & case examples

- Continuing care is an opportunity to provide additional support outside of active treatment. I.e. someone who has graduated/completed tx; someone who is struggling with consistent engagement in active tx
- This should be indicated when completing the PAS45 when discharging client from active tx.
- Must identify goals of continuing care & expected frequency of visits
  - Recommended treatment schedule is 1x month
  - Peer services & groups can also be a part of continuing care & provided in the same month as counseling
- If tx schedule starts to mirror active treatment, consider re-enrolling into active care
- There is no time limit on continuing care; however, the plan should be reviewed annually and updated, as needed
- Cases will be administratively closed after 3 months of no contact with a minimum of 3 diligent outreach efforts documented
  - This review can be captured in the progress note
- Clients can return to re-engage in continuing care if at any point they have been an active tx client

PAS 126

- In addition to the progress note for the session, this assessment must be completed after each encounter with a client who is enrolled in Continuing Care
- Once approved, sent to the data coordinator to be entered into the OASAS central registry/portal



Questions? Comments?