SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

AOD Clinical Monitoring Tool –Instructions	
Question on Tool	**Instructions/Guidelines (This is what clinical reviewers look for when reading each document)**
1. Is there a complete MH assessment including medical & psychiatric co-morbidity, psychosocial status, medications, inpatient history, suicidal ideation and substance abuse involvement?	Does the evaluation contain all the elements required by Clinical Coverage Policy 8C? Is there sufficient information documented within each domain to justify medical necessity of treatment? Could another clinician "Get the full picture" of your patient based on the information provided in each domain?
2. Has an ASAM screening been completed, and appropriate level assigned?	Dimensions 1-6 should be fully assessed to determine intensity of treatment needed. The ASAM score should be directly connected to the level of services recommended in the CCA. If provider does not offer services at the level needed; documentation should reflect referral sources provided to patient
3. Has possibility of co-morbidity been examined throughout course of treatment? (Mood or anxiety disorders, etc.)	Pre-existing mood, anxiety disorders, etc. may be an underlining factor in AOD as alcohol may lessen symptoms (anxiety, psychosis). APA clinical guidelines state, "Identifying co-occurring conditions can aid treatment planning and help in providing integrated care for AUD and other psychiatric conditions." Alcohol may worsen depressed mood during periods of use or. "Problematic alcohol use may also occur in the context of certain disorders that result in impaired impulse control (e.g., bipolar disorder, borderline personality disorder) or may itself lead to worsening behavioral disinhibition." (APA)
4. If there is a dual diagnosis, is patient being treated for both MH and AOD? 5. If **YES,** is there evidence of coordination of care between MH and AOD providers?	Treatment plan should contain specific interventions for both substance use and mental health symptomologies. Coordination of care between all treatment and service providers is
6. Was a recommendation made to a primary care physician to screen for non-psychiatric medical conditions? a. Is there evidence of follow-up on recommendation status?	Evidence of coordination of care **could** include: • consent form for prescribing provider • Non-billable coordination of care note (separate from billable note) • Email, fax, or letter between therapist and prescribing provider

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7. Were barriers to sobriety identified?	Barriers to sobriety can be identified during the initial CCA and treatment planning, as well as throughout treatment process. Identification with a recovery community, sponsorship, step work, time constraints and their implications on treatment should be discussed and documented in the patient record.
8. Has an initial risk assessment been completed for suicidal and/or aggressive behaviors? 9. Is assessment for risk of harm to self or others done each visit?	Documentation to support if ongoing assessment would be appropriate **could** be found in the CCA, treatment plan, or service notes. If ongoing assessment is found to be appropriate, evidence to support that a risk assessment is completed each visit should be documented in service notes.
10. Is there documentation to support a discussion of risks to self (physical health, legal involvement), and others (impaired driving, impact on loved ones)	This information should be documented in the service notes.
11. Is there documentation of medication management? 12. If YES, is there evidence of coordination with prescribing physician?	If medication management is not appropriate, NA should be marked Evidence of coordination of care **could** include: • consent form for prescribing provider • Non-billable coordination of care note (separate from billable note) • Email, fax, or letter between therapist and prescribing provider Was medication management indicated as a possible need during intake evaluation? Evidence of follow-up **could** include: • Consent form for prescribing provider • Discussion of follow-up/results documented in service note • Discussion of barriers to medication evaluation if identified documented in service note; as well as how barriers addressed

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13. Does documentation include level of patient compliance with therapy & medication?	Service notes should clearly state if patient has attended sessions regularly, or missed appointments. Additionally, service notes should reflect dialog regarding medication adherence. For example, asking patient if they are taking their medications as prescribed, if medications have changed, if they are having any adverse side effects, if they feel the medication is effective, etc.. Clinician should recommend patient see their prescribing physician if there are any medication questions. Clinician should also notify prescriber of issue (can be by fax, email, phone, letter). Follow-up with patient at next session would be expected as well.
14. Is there evidence that patient is also involved in a Community 12-Step program?	Evidence-based practices endorse concurrent involvement in a 12-step program such as AA/NA, etc. Documentation of involvement may be found in the CCA, notes, and/or plan. If patient is not involved in a program, documentation of a discussion of the benefits, and a list of resources provided, should be found in the patient record.
15. If alcohol is an identified abused substance, is there evidence of screening for Tobacco Use Disorder?	Completed and documented during the CCA. Smoking cessation resources should be provided and documented. (Ex., NAMI website, QUITNC)
16. Is there documentation of client agreement to initial goals, (ex: abstinence versus reduction of use)?	Discussion of goals specific to reduction and abstinence should be in notes relating to initial treatment plan, and/or signature on service plan should be documented in patient record
17. Does the treatment plan include steps for addressing factors such as acute intoxication, ongoing monitoring, and behavioral health and pharmacological interventions, as indicated?	This information would be found in a crisis plan
18. Has there been a change in patient's treatment needs leading to revision/addition of goals? a. If YES, has an addendum to the assessment been completed? 19. Has there been a change in patient's behaviors leading to revision/addition of diagnosis? a. If YES, has an addendum to the assessment been completed?	If goals on the treatment plan, or a change of a diagnosis is required, an addendum to the current CCA or a new CCA (if it has been more than one year from the date of the current CCA) is needed. CCA/Addendum, along with the revised, or new plan (plans must be completed annually as well) must be in the patient record.
20. Is an assessment for risk of harm to self or others done each visit?	Documentation to support if ongoing assessment would be appropriate **could** be found in the CCA, treatment plan, or service notes.
21. What types of therapies utilized in treatment recommended in the CCA (Individual, Group, Family, etc.)?	Types of therapy should be documented in the CCA as recommendations, and should also be documented in the treatment plan.

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22. Is psychoeducation included as part of treatment plan?	Best-practice standards, and CCP 8C, call for psychoeducation to be included in treatment for patient, as well as patient's involved family members. Evidence to support psychoeducation is taking place should be in service notes.
23. Does the treatment plan include relevant evidence-based modalities for each goal?	All goals in treatment plan should include the modality to be utilized to assist patient in reaching that goal. Examples of EBP modalities **could** include CBT, DBT, Psychodynamic Therapy, and Interpersonal Therapy. The expectation is that the initial treatment plan would have more generalized modalities, but would be revised throughout course of treatment to be more specific to what works with that patient.
24. Do the service notes reflect interventions from the modality specified in the plan? 25. Are interventions utilized in the session easily identified in the notes?	Specific goal must be identified in each service note Specific interventions for the appropriate modality documented in the plan must be clearly documented in the service note for each day of service.
26. Do notes contain details of patient's response to treatment?	Found in service notes. Patient's response to the specific interventions utilized **during the session** must be detailed, and clearly documented. Would another clinician be able to assess which interventions were successful for this patient based on this write-up?
27. Has client shown progressive improvement throughout course of treatment? a. If NO, has patient been re-assessed to determine a more effective modality? b. Was the treatment plan updated with patient to reflect changes made?	Progress/lack of progress should be clearly documented in client response section of the service notes. If minimal progress has been made within a clinically appropriate period of time, or within time-limited enhanced service; patient should be reassessed to determine if new interventions are needed, or diagnosed needs to be revised. All changes to the treatment plan must be clearly documented, dated, and signed by therapist and patient.
28. Does the treatment plan include discharge plan?	For Enhanced Services: Discharge plan must follow Corresponding Clinical Coverage Policy For OPT: Discharge plan should outline level of functioning patient could expect to achieve from course of treatment. Schedule for titration of services should be outlined based on patient's realistic level of functioning. **Please remember that North Carolina is a rehabilitative state. Services are in place to assist the patient in attaining a maintainable **BASELINE** level of functioning.