# SA Outpatient & Case Management

1. 01 (65D 30.0042(1)(b)) Pertaining to Screening; Does the chart include documented informed consent for a drug screen when screening is required by the component or circumstances?

2. 02 (65D-30.0042(1)(c)) Pertaining to Screening; Does the chart contain a complete and signed consent for release of information form that meets 42 CFR Part 2 requirements?

3. 03 (65D-30.0042(1)(d)) Pertaining to Screening; Does the chart include a signed consent for services form obtained prior to or upon placement (unless it was an involuntary placement)?

4. 04 (65D-30.0042(2)) Does the chart show evidence of a comprehensive assessment (including physical health and psychosocial assessment) as required for the component at placement?

5. 05 (65D-30.0042(2)(a)(2.c)) For day/night with community housing, day or night treatment, IOP or outpatient: Does the chart include a medical history completed within 30 calendar days prior to or upon placement?

6. 06 (65D-30.0042(1)) If screening was not completed by a qualified professional, does the chart include a countersignature and date by a qualified professional?

7. 07 (65D-30.0042(1)(a)) Does the screening documentation demonstrate determination of need and eligibility for placement: using a validated tool, documenting rationale, and noting if assessment at admission prevents screening?

8. 08 (65D-30.0042(2)(b)(1.a)) Does the psychosocial assessment include the individual's history of emotional or mental health conditions?

9. 09 (65D-30.0042.(2)(b)(1.b) & (1.d)) Does the psychosocial assessment include the individual's history of substance use impairment (level, choice of drugs, patterns, consequences, treatment history)?

10. 10 (65D-30.004(2)(b)(1.c)) Does the psychosocial assessment include the individual's family history, including substance use by other family members?

11. 11 (65D-30.0042(2) (b) (1.e)) Does the psychosocial assessment include educational level, vocational status, employment history, and financial status?

12. 12 (65D-30.0042(2)(b)(1.f)) Does the psychosocial assessment include social history and functioning (support network, family/peer relationships, current living conditions)?

13. 13 (65D-30.0042(2)(b)(1.g)) Does the psychosocial assessment include past or current sexual, psychological, or physical abuse or trauma?

14. 14 (65D-30.0042(2)(b)(1.h)) Does the psychosocial assessment include the individual's involvement in leisure and recreational activities?

15. 15 (65D-30.0042(2)(b)(1.i)) Does the psychosocial assessment include cultural influences?

16. 16 (65D-30.0042(2)(b)(1.j)) Does the psychosocial assessment include spiritual or values orientation?

17. 17 (65D-30.0042(2)(b)(1.k)) Does the psychosocial assessment include legal history and status?

18. 18 (65D-30.0042(2)(b)(1.l)) Does the psychosocial assessment include the individual's perception of strengths and recovery potential?

19. 19 (65D-30.0042(2)(b)(1.m)) Does the psychosocial assessment include a clinical summary (analysis/interpretation) of the psychosocial assessment results?

20. 20 (65D-30.0042(2)(b)(1.n)) Does the psychosocial assessment include documentation of placement determination using a validated tool for service determination?

21. 21 (65D-30.0042(2)(b)(1.o)) Does the psychosocial assessment include documentation of appropriateness of level of care, countersigned by qualified professional or clinical supervisor?

22. 22 (65D-30.0042(2)(b)(2.e)) For intensive outpatient treatment and outpatient treatment: does the psychosocial assessment show it was completed within 30 calendar days of placement (or accepted if completed within 30 days prior)?

23. 23 (65D-30.0042(2)(b)(3)) Was the psychosocial assessment signed and dated by clinical staff, and if not completed by a qualified professional, was it reviewed, countersigned and dated by a qualified professional within 10 calendar days of completion?

24. 24 (65D-30.0042(2)(b)(4)) If an individual is readmitted to the same provider within 180 days of discharge, is there a psychosocial assessment update if clinically indicated, and is a new assessment completed for readmission after 180 days? Also, if continuous treatment >1 year, is there an annual update?

25. 25 (65D-30.0042(2)(b)(5)(a)&(5)(b)) For referrals or transfers from one provider to another: if a psychosocial assessment is forwarded, does the receiving provider evaluate if it complies; if not, do they update or complete a new one? If the individual is placed within 7 days, is update limited; if placed after 7 but within 180 days, does the receiving provider determine extent of update; if placed >180 days, is a new assessment completed?

26. 26 (65D-30.0044.1. a (8,b,4)) For methadone medication-assisted treatment for opioid addiction and long-term outpatient methadone detoxification are treatment plan reviews completed every 90 calendar days for the first year and every 6 months thereafter?

27. 27 (65D-30.0042(2)(c)) Does the assessment process include identification of individuals with co-occurring mental illness and other needs, and is there documentation of direct provision or referral with records of services/referrals maintained?

28. 28 (65D-30.0043(1)) Does the provider have written operating procedures that clearly state criteria for admitting, retaining, transferring and discharging individuals?

29. 29 (65D-30.0043(2)) Does the chart show that an assessment was completed prior to admission to determine level of service need and client choice, and if the provider doesn't offer the service needed, did they refer to appropriate level of care?

30. 30 (65D-30.0043(3)(a)) Was a primary counselor assigned to the individual (except detoxification and addictions receiving facilities)?

31. 31 (65D-30.0043(3)(b)(1)-(10)) Pertaining to Orientation; Did the chart document orientation to the program at admission (and upon request) in a language the individual or their representative understands? Did it include the required items 1. A description of services to be provided; 2. A copy of the individual's rights pursuant to chapter 397, part III, F.S.; 3. A summary of the facility's admission and discharge policies; 4. A copy of the service fee schedule, financial responsibility policy, and applicable fees; 5. Written rules of conduct for individual's served which shall be reviewed, signed, and dated; 6. A copy of the grievance process and procedure; 7. General information about infection control policies and procedures; 8. Limits of confidentiality; 9. Information on parental or legal guardian's access to information and participation in treatment; and 10. Information regarding advance directives which delineate the facility's position with respect to the state law and rules relative to advance directives?

32. 32 (65D-30.0043(4)) Does the provider ensure safe and orderly transfers and discharges in accordance with facility policy and compliance with 42 CFR? (Transfer/discharge summary filed; 42 CFR compliance considered (SUD records); documentation of notice given if required.)

33. 33 (65D-30.0044(1)(a)) Does the chart show that a written treatment plan was completed and signed by the individual and staff, including measurable goals, tasks, type/frequency of services, expected dates? (If the treatment plan is completed by other than a qualified professional, was the treatment plan reviewed, countersigned, and dated by a qualified professional within 10 calendar days of completion?) a. Goals and related measurable behavioral objectives to be achieved by the individual.
b. The tasks involved in achieving those objectives.
c. The type and frequency of services to be provided, and the expected dates of completion.

34. 34 (65D-30.0044(1)(a)(1)) For long-term outpatient methadone detoxification and methadone medication-assisted treatment for opioid addiction: Was the treatment plan completed prior to or within 30 calendar days of placement?

35. 35 (65D-30.0044.(1)(a)(6)) For outpatient or intensive outpatient treatment: Was the treatment plan completed prior to or within 30 calendar days of placement?

36. 36 (65D-30.0044(1)(a)(8)) For providers licensed for multiple program components delivering a continuum of care: Was a treatment plan review or update conducted when any change in level of care occurred?

37. 37 (65D-30.0044(1)(a)(8.b)) Are outpatient treatment plan reviews completed within 30 days of completion of the initial treatment plan and signed and dated by the individual and a qualified professional or co-signed by a qualified professional within 5 calendar days

38. 38 (65D-30.0044(1)(a)(8)(c)) For outpatient treatment: Are progress notes entered in the clinical record documenting progress or lack of progress toward treatment plan goals and objectives, signed/dated with credentials?

39. 39 (65D-30.0044(1)(a)(8)(c)(3);) For intensive outpatient treatment and outpatient treatment: Are progress notes recorded at least weekly or in accordance with session frequency if less than weekly?

40. 40 (65D-30.0044(2)) Does the chart/documentation show that ancillary services (provided directly or through referral) were linked to the treatment plan; that referrals were initiated and followed up; and that linkage efforts are documented?

41. 41 (65D-30.0044(3)(a)) For indicated prevention services: Was a prevention plan completed within 45 calendar days (if component applies)?

42. 42 (65D-30.0044(3)(b)) 42. 65D-30.0044(3)(b); For intervention services: Was an intervention plan completed within 45 calendar days?

43. 43 (65D-30.0044(4)(c)) For prevention or intervention services: Are summary notes completed and signed weekly (for weeks with scheduled services)?

44. 44 (65D-30.0044(4)(a)) Does the chart include a written discharge summary for individuals who complete services or leave prior to completion, including involvement summary, reason for discharge, referral/aftercare services provided?

45. 45 (65D-30.0044(2)(b)) For transfers from one provider to another: If within same provider, was a transfer summary completed immediately? If from one provider to another, was the transfer summary completed within 5 calendar days?

46. 46 (65D-30.0044.4) Does the discharge summary include a summary of the individual's involvement in services, the reasons for discharge, and the provision of and referral to other services needed by the individual following discharge, including aftercare?

47. 47 (65D-30.0044.4) Is the discharge summary completed within 15 business days of discharge and signed and dated by a primary counselor?

48. 48 (65D-30.0044(3)(c)) Are summary notes signed and dated by the staff delivering the service and include information regarding the individuals' progress or lack thereof in meeting the conditions of the prevention or intervention plan?

49. 49 (65D-30.0044(3)) Does the prevention plan include goals and objectives designed to reduce risk factors and enhance protective factors and is it signed and dated by the staff who developed the plan and the individual? (This question pertains to those receiving indicated prevention services)

50. 50 (65D-30.0044.3, b) Is the intervention plan signed by both staff and the individual?

51. 51 (65D-30.0044.3, b) Is the intervention plan reviewed and updated every 60 days?

52. 52 (65D-30.0044.3, c) Are summary notes entered weekly during weeks when services occur?

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53. 53 (65D-30.0044.2) Is a clinical record entry documenting transfer circumstances completed and signed within 15 days?

54. 54 (65D-30.0044(3)) Was the prevention plan reviewed and updated every 60 calendar days from the date of completion of the plan?

55. 55 (65D-30.0044.3, b, I) Do Intervention plans include goals and objectives designed to reduce the severity and intensity of factors associated with the onset or progression of substance use?

56. 56 (65D-30) Does the provider maintain an overdose prevention plan and ensure staff are trained on it?

57. 57 (65D-30) Is overdose prevention information including overdose risk education and Naloxone information (use and access) shared with individuals upon intake or offered to individuals placed on a waitlist to receive treatment services?

58. 58 (65D-30.0044.1. a (8,b,5)) For outpatient treatment are treatment plan reviews completed every 90 calendar days for the first year and every six (6) months thereafter?

59. 59 01-CM (65D-30.012(4)(a)) For individuals engaged in case management services, does the provider designate an individual or individuals responsible for carrying out case management functions, as required by policy and staffing plan?

60. 60 02-CM (65D-30.012(4)(b)) For case management services, is there evidence that priority individuals (those with multiple problems, needs, and requiring multiple services or resources) are identified and prioritized for case management?

61. 61 03-CM (65D-30.012(4)(c)1) For individuals engaged in case management services, is there documentation of ongoing assessment and monitoring of the individual's condition, progress, and continued service needs?

62. 62 04-CM (65D-30.012(4)(c)2) For individuals engaged in case management services, is there documentation that the case manager facilitated linkage to internal or external services as dictated by individual needs?

63. 63 05-CM (65D-30.012(4)(c)3) Referral Follow-Up; For individuals engaged in case management services, is there documentation that the case manager conducted follow-up on all referrals for other services to confirm connection or outcome?

64. 65 06-CM (65D-30.012(4)(c)4) For individuals engaged in case management services, is there evidence in documentation that the case manager acted as an advocate on behalf of the individual when accessing or coordinating services?

65. 66 07-CM (65D-30.012(4)(d)) For individuals engaged in case management services, does documentation show that the case manager met face-to-face with the individual at least monthly, unless otherwise clinically justified and documented in the record?