Work First New Jersey

Substance Abuse Initiative And Behavioral Health Initiative

Care Coordination Services Manual

January 2020

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WFNJ SAI/BHI Glossary of Terms

ASAM Dimensions - The *ASAM Dimensions* are the six areas in which individual client functioning is evaluated for symptom severity according to the American Society of Addiction Medicine, 3rd Edition, in order to determine appropriate level of care placement. The six dimensions are acute intoxication/withdrawal potential, biomedical conditions and complications emotional, behavioral or cognitive conditions and complications, readiness to change, relapse, continued use or continued problem potential, and recovery/living environment.

ASI - The *Addiction Severity Index (ASI)* is a structured assessment interview tool designed to address seven potential problem areas in substance abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status. The database *ASI* module is used to conduct assessments with all clients.

Assessing CC - The *Assessing Care Coordinator* conducts the initial assessment interview with the client. The *Assessing CC* may or may not be assigned as the Managing CC.

Assessment Level of Care (LOC) - The *Assessment LOC* is the ASAM LOC dimensional review type to be selected and documented in the database when a client is being evaluated for

treatment during the initial assessment interview with the CC. There are 10 ASAM levels of care and five ASAM levels of withdrawal management (see Level of Care).

DCP&P- The *Division of Child Protection and Permanency (DCP&P)* within the Department of Children and Families (DCF) is New Jersey's child protection/child-welfare agency. Its mission is to protect children, support families, ensure permanency for children and prevent violence and family disruption. *DCP&P* is responsible for investigating allegations of child abuse and neglect and if necessary arranging for the child's protection and the family's treatment.

Division of Family Development (DFD) – Within the Department of Human Services (DHS), DFD provides leadership and supervision to the public and non-profit agencies that deliver many services to community. These include financial assistance and critical safety net services to individuals and families in New Jersey. Among the programs within this agency are Work First New Jersey/Temporary Assistance for Needy Families (TANF) and General Assistance (GA) – the two programs that make up the state's welfare program; NJ Supported Nutritional Assistance Program (SNAP, formerly Food Stamps); New Jersey FamilyCare (Medicaid); the Domestic Violence Initiative; Supportive Assistance to Individuals and Families (SAIF); Child Care services; and Emergency Services for housing. DFD holds the contract for the WFNJ SAI/BHI.

Eligibility – Client *eligibility* refers to the client's status in the on-line Medicaid Management Information System (MMIS) operated by Molina Medicaid Solutions. If a client does not have an active NJ FamilyCare (Medicaid) number in MMIS, the SAI/BHI cannot approve payment for treatment services and the client cannot be placed in treatment. Clients who do not have an active Medicaid number are usually not *eligible* for WFNJ SAI/BHI services. An active Medicaid number must be accompanied by a Program Status Code (PSC) in MMIS that is within the approved WFNJ SAI/BHI program status code range in order for a client to be *eligible* for the WFNJ SAI/BHI. The eligible PSC for GA is 762, and the eligible PSCs for TANF are 295, 310-470, 490, and 491.

Employment Case Manager - *Employment Case Managers* are responsible for coordinating work activities for welfare recipients. They are typically based at the county one-stop agencies and are employees of the county Department of Labor (DOL) system.

Episode of Care - An *Episode of Care (EOC)* begins when a client is referred for assessment and ends when the client has been discharged from all treatment services and a Case Closure Summary has been completed in the database (currently, Atlantis). Because the WFNJ SAI/BHI provides services across the treatment continuum, Case Closure status at the end of an Episode of Care indicates the outcome of the entire Episode of Care, and not the outcome of a single level of care placement.

Follow-up – A *follow-up* is a face-to-face or phone contact with a client ten minutes or longer in duration. All *follow-ups* must be documented in the Service Log. Some follow-ups may require an ASAM Reassessment if a client is not in treatment and a dimensional review is conducted.

GA – A *General Assistance* (GA) client is a single adult with no children who receives cash assistance and may receive other services, including Emergency Assistance, from the county welfare agency. GA recipients are eligible for WFNJ SAI/BHI services. All GA clients are subject to the 60-month lifetime cap on welfare benefits regardless of employment status, unless they have been granted an extension.

GA Employable – A *GA Employable* client is a GA client who has a work activity requirement. *GA Employable* clients typically receive a cash grant of $150 per month.

GA Unemployable - A *GA Unemployable* client is a GA client who is deferred from a work activity requirement due to a medical or psychiatric condition. *GA Unemployable* clients typically receive a cash grant of $220 per month.

Good Cause Exception - A *Good Cause Exception* may be granted to certain individuals with a drug distribution charge who would otherwise be ineligible for GA benefits. This exception may be granted based on the client's assessment result and willingness to follow treatment recommendations or because the client is enrolled in a licensed residential treatment program. Clients who have been identified as subject to the exception receive the same services as other SAI/BHI clients. The welfare agencies are responsible for eligibility determinations and referring clients as appropriate to the SAI/BHI. Further information on the *Good Cause Exception* can be found in the most recent DFD instruction regarding *Good Cause Exceptions*.

IRP – The *Individual Responsibility Plan (IRP)* is the welfare client's welfare-to-work service plan. It is completed by the welfare caseworker with the client and should include participation in SAI/BHI services, if indicated, based on the CC's recommendations for treatment participation and/or work activity.

Level of Care (LOC) - *The ASAM Criteria* provides guidelines for the different Levels of Care (LOCs) according to standardized criteria for intensity of services at each level. Each *LOC* offers a standardized intensity of services as outlined in the SAI/BHI Service Description for each LOC.

There are 10 ASAM levels of care:

Level 0.5: Early Intervention
Level 1: Outpatient (OP), 1-9 outpatient hours per week
Level 2.1: Intensive Outpatient Program (IOP), 9-20 hours per week
Level 2.5: Partial Care (PC), 20 + hours per week
Level 3.1: Clinically Managed Low Intensity Residential Services, such as Halfway House (HH), 3-6 months
Level 3.3: Clinically Managed Population Specific High Intensity Residential Services (New Jersey does not offer 3.3 level of care)
Level 3.5: Clinically Managed High Intensity Residential Services or Long-term treatment services, 3-12 months.
Level 3.7: Medically Monitored Intensive Inpatient Services, or Short Term Residential Treatment, 14-21 days
Level 4: Medically Managed Intensive Inpatient/Hospital Based, 3-5 days (may be longer for benzodiazepine or alcohol use disorder or medical complications)

MAT/OMT: Medication Assisted Treatment/Opioid Maintenance Therapy (also known as OTS, Opioid Treatment Service)

There are five ASAM levels of withdrawal management:

Level 1-WM: Ambulatory Withdrawal Management without Extended On-site Monitoring
Level 2-WM: Ambulatory Withdrawal Management with Extended On-site Monitoring
Level 3.2-WM: Clinically Managed Residential Withdrawal Management
Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management
Level 4-WM: Medically Managed Intensive Inpatient Withdrawal Management

Managing CC – The *Managing Care Coordinator or Case Manager (Managing CC)* is assigned to manage the client's case after the initial assessment. The *Managing CC* may or may not be assigned as the Assessing CC. The managing CC is responsible for ensuring their name is assigned to the case in the database on the ASI Screen.

Mental Health Treatment Provider A *Mental Health Treatment Provider* is a licensed mental health provider agency that is not in the SAI/BHI provider network. *Mental health Providers* are not approved for reimbursed for treatment services; as a result, they may or may not agree to adhere with all program requirements regarding reporting client treatment participation and progress. The CCs must reach out to them to obtain updated client information. Clients with a substance use disorder should not be referred to mental health providers.

Network Treatment Provider – A *Network Treatment Provider* is a licensed substance use disorder or co-occurring Treatment Provider that has applied for, and been accepted, into the SAI/BHI Treatment Provider network. *Network Treatment Providers* are approved to be reimbursed for treatment services within specific levels of care as specified in the electronic Provider Directory in the database. These providers have agreed to adhere to all SAI/BHI program requirements regarding reporting on client treatment participation and progress. All *Network Treatment Providers* are assigned a unique identifier in MMIS that is used for service authorization and claims submission.

New Jersey FamilyCare Number (AKA Medicaid number) – the NJ FamilyCare number is a unique client identifier assigned to GA and TANF clients in MMIS that is used to determine eligibility for SAI/BHI services. This number is also used for processing claims for SAI/BHI services. If a client does not have an active number in MMIS, the WFNJ SAI/BHI cannot approve payment for treatment services and the client cannot be placed in treatment. The Assistant Care Coordinator (ACC) enters the FamilyCare number in the database at the time of referral. An active FamilyCare number must be accompanied by a program status code in MMIS that is within the approved SAI/BHI program status code range.

NJ Spirit Number – The *NJ Spirit Number* is the unique client identifier assigned to DCP&P clients. All clients with a current or previous open DCP&P case have a unique *NJ Spirit Number*. The SAI/BHI enters the *NJ Spirit Number* in the referral screen for all clients with a known current or previous open DCP&P case.

Non-network Treatment Provider – A *Non-network Treatment Provider* is an addictions Treatment Provider agency that has not applied for and/or has not been accepted into the SAI/BHI Treatment Provider network. *Non-network Treatment Providers* are not approved to be reimbursed for treatment services; however, they have agreed to comply with all program requirements regarding reporting on client treatment participation and progress.

Patient Placement Log – The *Patient Placement Log (PPL)* screen in the database captures critical information regarding patient placement, including level of care assessed, LOC placed, the reason for difference in LOC assessed and placed, projected treatment start date, treatment admission date, treatment discharge date, and treatment provider.

Payment Authorization – A *Payment Authorization (PA)* is a standardized form issued to treatment providers that includes client and treatment provider identifiers, the service date range, and service codes for which a treatment provider may submit a claim for services. *PAs* are created in the database and issued to treatment providers based on adherence to SAI/BHI program reporting requirements. Each *PA* is assigned a unique identifier that is entered into MMIS along with the client name, treatment provider, and service information so that a provider can submit a claim against the PA via MMIS for payment.

Preauthorization – A *Preauthorization* is standardized documentation of the LOC with associated service codes and designated service period maximums that a treatment provider is expected to provide to a client. The *Preauthorization* is created in the ASAM LOC screen and is linked to a PPL for a specific provider. All treatment services, for all levels of care in a network provider must have preauthorization. No services can be reimbursed without documented preauthorization issued to the provider.

Referral – A *Referral* is required to open a client's case, or episode of care, with the SAI/BHI. *Referrals* can be made from various sources, e.g., CWA/MWA, One Stop, DCP&P, etc. All referrals are sent to the SAI/BHI regional offices by the completion and faxed submission of a referral packet. Once the referral has been faxed, the referring agent will call the regional office to obtain an assessment appointment for the client. All information in the referral packet is entered in the database referral information screens. An assessment cannot be conducted until a referral has been completely entered.

Sanction – A *Sanction* may be imposed by County or Municipal Welfare Agencies on a welfare-to-work clients for failure to participate in a work activity, or in treatment as an alternative work activity. The imposition of a sanction results in the incremental reduction of a client's cash grant depending upon the level (the number) of sanctions previously imposed. In some cases, a sanction may be lifted if the client completes a 10-day "intent to comply" period by participating in an approved work activity, such as treatment through the SAI/BHI.

Severity Ratings - The ASI *Severity Ratings* are the subjective ratings of the client's need for treatment, derived by the interviewer according to a standard method for calculating these scores, in each of the seven life areas assessed by the ASI.

TANF - A *Temporary Assistance to Needy Families (TANF)* client is an adult with dependent children whose family receives cash assistance and may receive other services, including Emergency Assistance, from the county welfare agency. *TANF* recipients are eligible for SAI/BHI services. All *TANF* clients are subject to the 60-month lifetime cap on welfare benefits regardless of employment deferral status unless they have been granted an extension.

UDS – A *Urine Drug Screen (UDS)* is both a test, and the report of a test, to detect evidence of recent drug use as measured in a client's urine drug sample. The SAI/BHI records weekly *UDS* results in the database for all clients who receive weekly testing.

Welfare Case Number –The *Welfare Case Number* is a unique client identifier assigned to GA and TANF recipients by the county welfare agencies that is used to track the client's case in the welfare data systems.

Work Activity – A *Work Activity* is a CWA/MWA-approved employment-directed activity, including participation in the SAI/BHI, which satisfies the Work First New Jersey requirement. Clients may be deferred or exempt from a *Work Activity* by welfare if they meet specific criteria for deferral or exemption. Clients may be placed in certain structured *Work Activities* by Employment Case Managers based at the county One-Stop or other Department of Labor (DOL) offices. GA clients are expected to participate in a work activity for 30 hours a week (state requirement) and TANF clients are expected to participate in a work activity for 35 hours a week (federal requirement).

Staff Safety Guidelines

The following guidelines are intended to help provide for the care, safety, and security of SAI/BHI staff and the clients they serve. All staff who have direct contact with SAI/BHI clients are expected to complete at least one full day of the *Nonviolent Crisis Intervention Training Program* via the Crisis Prevention Institute, Inc. (CPI) or through the SAI/BHI Certified Instructor. All SAI/BHI staff are required to be aware of security procedures at their specific county/office location.

The need for safe, effective, techniques to manage potentially aggressive and assaultive clients are essential in promoting a safe work environment. It is important that staff understand what to do and what is expected of them during each level of a crisis. Expectations of the appropriate staff responses, or staff attitudes to each of the four levels of crisis development, are outlined below.

The Anxiety Level

The first behavior observed in the crisis development sequence is the Anxiety Level. According to CPI, "A*nxiety behavior is defined as a noticeable increase or change in behavior that is manifested by a no-directed expenditure of energy."* An example of escalating anxiety occurs when a client has to sit in the waiting room for an extended period and becomes visibly impatient and upset. You can clearly observe that something is causing the client to become anxious. Clinical and administrative staff are expected to use a supportive approach with anxious clients. Staff should use an empathic, non-judgmental, approach to alleviate the client's anxiety. That is,

the client who is anxious and upset does not need to be judged, the client simply needs someone to listen to them. Note: this is where most potentially explosive situations are diffused. Your supportive response is instrumental in de-escalating the situation.

The Defensive Level

Occasionally, the client may escalate to the second level of crisis development, the defensive stage. At this point, the client begins to give you clues verbally and nonverbally indicating that he/she is beginning to lose control and he /she begins to challenge your authority. The client may begin to test you and your limits by "pushing your buttons," by using abusive language alluding to your race, weight, sex or any other sensitive area. Since this is a very critical time during crisis development, it is crucial that staff maintain their professionalism and control of their own behavior. Staff are expected to call upon their supervisor for assistance. If the supervisor is not on site, a phone call is in order. All staff should respond to the defensive client by using a very direct, yet calm, approach. Simply clarify instructions and set clear behavioral limits for the client. For example, the SAI/BHI staff person would instruct the client to sit in the waiting room until he/she regains their composer. This gives the staff person time to call the Supervisor to obtain further instruction and to alert security. If the Supervisor is on site, then he/she might explain to the client that if they do not calm down the Supervisor may need to call Security and have the client removed. Limits should be set objectively and in a non-threatening, but firm, manner. The goal is to maintain professionalism, to avoid being caught in a power struggle, and to make the client realize that the consequences of his/her behavior are up to them. In other words, make the client feel like he/she has a choice. The client can calm down and receive SAI/BHI assistance or schedule the appointment on another day when the defensive behavior has subsided.

The Acting-Out-Person

The acting-out-person stage is defined as loss of emotional control resulting in a physical episode where the person becomes a danger to him/herself and/or others. If the client's voice becomes more aggressive and the client invades staff's space, staff should call Security/911 immediately. The client may no longer be responding to reason and may not be able to control himself/herself. In such instances, if co-workers become aware of an escalating client, they should make their presence known to offer support as appropriate for the situation. If a client's verbal aggression becomes physical, the client may assault staff, other clients, or even attempt to harm himself/herself. Staff should avoid physical intervention. The SAI/BHI staff should call Security and/or 911 for assistance immediately. If the office is equipped with a panic button, this is the time to push the panic button.

Nonviolent physical crisis intervention should only be used if the client strikes you, grabs you, or pulls your hair.

Tension Reduction

Most likely, a hostile or violent client will be removed from the welfare office by Security or medical staff; therefore, SAI/BHI staff will not have the opportunity to assist the person in "coming down" from the crisis situation via therapeutic rapport. The SAI/BHI team should process the experience with their Supervisor by talking through the event and identifying their feelings, as well as what worked and what did not work with the client.

Note! If security or other emergency services are called, the SAI/BHI staff person must be certain that the incident is well documented in the Service Log of the client's file; further, an Incident Report must be completed every time police and/or rescue emergency are called to your office location.

Section Two – Assessment and Clinical Procedures

Assessment Script

Hello, _____. My name is _____. I am a Care Coordinator for a program called the Work First New Jersey Substance Abuse and Behavioral Health Initiative. I am a (certified/licensed/masters level, etc.) or (counselor/social worker/clinician, intern, etc.), not a welfare caseworker, and I am very glad to see you here today. Our mission is to assist GA and TANF recipients who may be having difficulty seeking or keeping a job because substance use or mental health issues may be a barrier to their employment. I see from your referral you were referred to us due to suspicion or knowledge of substance use or mental health concerns by your (**choose one below**):

- ✓ **Welfare Caseworker** – today we are going to assist you with obtaining or maintaining your benefits or to help you prevent (or lift) a sanction.
- ✓ **Housing /EA Caseworker**- today we are going to assist you with keeping your housing.
- ✓ **Employment services-** today we are going to assist you with being able to obtain, and keep, a job.
- ✓ **DCP&P**- our organization works closely with DCP&P to assist you with keeping your family together and to reunify families.

We are going to do an assessment to determine if treatment is recommended for you. If it is, we have a statewide network of all types of outpatient and inpatient treatment programs. We will work together to find the treatment that best meets your needs. There is no financial costs for you to attend treatment it is completely free.

(Review of Assessment)
The assessment will take about 90 minutes. If at any time you want to stop and take a break or ask questions, please let me know. Some of the questions are very sensitive and you have the right to refuse to answer any question, but please know that the more information I have, the better I will be able to assist you.

We will cover 7 areas of your life including your medical history and any current medical needs; your education and employment history including your employable skills, and current barriers to employment; your drug and alcohol history and current patterns of substance use; your family history; current family/social relationships; your legal history and any current legal problems; and finally, your mental health history, including any past psychiatric hospitalizations, traumatic events, and any past or current mental health symptoms. All of this information will be used to

help us find the most appropriate treatment setting for you and to ensure all of your needs will be met.

(Review HIPAA Privacy Notice and confidentiality guidelines)
Federal and State confidentiality laws protect the information you share with me and with whom I can share that information. Our organization complies with those laws and we have a document that describes how medical information about you may be used. (At this time review the Notice of Privacy Practices/Statement of Client Rights and then have the client sign the consent and give them their copy). I will request that you sign releases in order for me to share information with your welfare caseworkers, the treatment providers, and (the referral source). I will only be able to share the minimum necessary information to have your needs met.

There are 3 ways that I am allowed to break confidentiality without your consent: (1) if I suspect you are having suicidal thoughts and are at risk of hurting yourself, (2) if you tell me you are having homicidal thoughts or are going to hurt someone else, or (3) if I suspect a case of child abuse or neglect, then I have the duty to warn and protect.

(DCP&P review if client has an open DCP&P case)
One part of a multi-agency release that I am going to ask you to sign is for DCP&P. We work very closely with DCP&P and we communicate with the workers regularly. DCP&P has required that you attend a substance abuse treatment program. We will be in contact with your DCP&P worker monthly to report on your progress. We will also contact your DCP&P worker if your treatment attendance is poor, if you have positive urine screens, or for any other event that would be associated with your children being in immediate danger.
(If TANF and no open DCP&P case) – In the event that I feel that your children may be at risk of abuse or neglect due to your poor attendance in treatment or positive drug screens, I am mandated to inform DCP&P of the possible risk to your children.

(Review the WFNJ SAI/BHI work requirement)
As a WFNJ TANF recipient, you are required to participate in a 35-hour per week work activity or 30 hours per week if you are receiving GA benefits. Your participation in a full-time substance abuse treatment program will count as your work activity. Just like any other work activity, your participation becomes mandatory. If at any time you stop participating in treatment, you are at risk of a welfare sanction.

If a client has a Med-1 medical deferral form, the CC must engage the client in a discussion about the reason they are deferred. The CC must also inform the client that the SAI/BHI is a welfare-to-work initiative, and that at any time the CC believes the client may be able to participate in part-time or full-time work activity that a recommendation will be made to re-evaluate the client's employability.
(Review the benefits of the program)
There are many benefits for participating in the WFNJ SAI/BHI. We can assist you with getting connected to housing, childcare, legal services for Social Security benefits, psychiatric care, family services, education and employment services, and transportation services. So, as you can see, there can be many positive rewards but you must attend and participate in your treatment program in order to receive the benefits of our program.

The CC should also ask the following questions:

1. Are currently participating in the Drug Court or MAP programs? If yes, are you receiving a cash grant from GA or TANF?
2. Are you a new applicant for GA or TANF? If so, are you required to bring in any additional information in order to obtain cash assistance?
3. Are you currently in treatment? If yes, how are you paying for it?
4. Do you have questions before we begin?

Steps to Follow for a WFNJ SAI/BHI Assessment

1. Prior to beginning the assessment, the CC must read all previous episodes of care to ensure an understanding of the client's history.
2. Review all HIPAA policies and procedures with the client and have client sign the HIPAA Notice and Acknowledgement and offer HIPAA notice. If "SAI" or DCP&P-referred, inform the client that a UDS will be required as part of completing the assessment. The UDS should be conducted within 48 hours of the assessment. (Please note - If a client is not eligible for Medicaid at the time of the assessment, the client should NOT be referred for treatment and/or an assessment UDS until Medicaid is active.)
3. Review the client's current address and phone number in Atlantis and obtain their preferred method of contact. Enter this information into Atlantis. If a client has provided you with a collateral contact, add that collateral contact information in Atlantis under collateral contact and obtain a signed general release for that person.
4. Just before saving the ASI and discussing the treatment recommendations, make sure there are comments on ALL positive responses. Currently, all comments to the red questions will be pulled through to the ASAM Assessment Summary.
5. Save the ASI and begin to discuss your treatment recommendation/LOC and service plan, including substance use, mental health, medical, DCP&P, dental, etc.
6. Have client sign releases (Multi-Agency, General Release, Health Release, etc.). Once the releases are signed by the client, the CC must go into the Status section in Atlantis and select "signed" for each release that was generated and signed by the client.
7. Have client initial and sign the "Treatment Agreement" and give a copy to the client. Contact the agreed upon treatment provider(s) to obtain intake date (s) for client.
8. Discuss any emerging medical needs or other services that client may need (e.g., probation, DCP&P, LSNJ referral) and assist with making connections to those services. Give the client a copy of their "Treatment Service Form" with all of their scheduled appointments.
9. If the CC has a Care Coordinator Support Specialist that may assist with client needs, please inform the client of this person and coordinate necessary services with the CCSS.
10. Staff in Newark and Camden with TANF and/or DCP&P-involved clients must complete the "Care Coordination Plan" at the time of assessment with the client. All other Care

Coordination may use the Care Coordination Plan module but are not required to use it at this time. Give the client a copy of their Care Coordination Plan.

11. Complete the ASI page in Atlantis, select "Managing CC," and "Diagnostic Category." (The Diagnostic Category should be congruent with information in the ASI, ASAM Assessment Note and the DSM-5 diagnostic impression. For example, if you have chosen a diagnostic category of SA2 for a client, the client should be referred to a treatment program that offers co-occurring services for both substance use and mental health disorders.)
12. Make a referral to the appropriate treatment provider while the client is present. If in a network or non-network provider, inform the provider that the documents are available on the web portal and that the ASAM Note with preauthorization will be available within 24 hours. If the client will be referred to a MH provider, fax the required paperwork as soon as possible.
13. Complete the ASAM Assessment Summary. Dimensions 1-6 should all have clinically sound problem statements. If there are no issues within that dimension, DO NOT leave it blank. Document "Not Clinically Indicated" in that space.
14. Your DSM-5 Diagnostic Impression must be in the order of clinical severity and match the Diagnostic Category.
15. Enter the initial service log with the following information: "Client came in for his/her scheduled assessment. Assessment was completed. Client was referred for an assessment UDS at (*name of the treatment provider(s) on (date/time*). Client signed releases for (*DFD, DCP&P, mother,* etc.). Client's preferred method of contact is (*cell, home phone or through mail*). Client was referred to LOC and (*state your recommended discharge plan for the client's next LOC in their continuum of care*)."
16. If the client has current DCP&P involvement and a release was signed by the client, contact the County's Systems Coordinator to request the NJC Spirit number and other DCP&P information so that it can be entered into Atlantis, if it was not already entered. If your county does not have a System's Coordinator, the client may know their NJ Spirit number and other information or the CC can ask the DCP&P worker for the number when they make initial contact.
17. A Referral Response Letter (RRL) must be generated and faxed to the DCP&P worker indicating the results of assessment and treatment placement recommendations. The ASAM Assessment Summary must be faxed along with the RRL.
18. Call the DCP&P hotline if a negative event was reported during the assessment and child safety is at risk.
19. Complete the initial assessment Case Worker Referral Response Form (CWRRF) and fax it to the referring working. The CWRRF must include the number of episodes of care, the name of the program and the days/hours the person is in, or scheduled for, treatment.
20. All faxes, interactions with client, follow-up calls made on the client's behalf should be documented in the service log.

IF A TANF OR NON-GA PROTOCOL CLIENT DOES NOT SHOW FOR THE ASSESSMENT

1. Inform the ACCs/SCs that the client did not show, within 30 minutes to allow for walk-in or standby assessments.
2. The ACC/SC will complete a Caseworker Referral Response Form (CWRRF) to inform the referring worker and outreach attempts will begin, the case will remain open for 30 days to reschedule.
3. If the case is not rescheduled in 30 days, the case will be closed with the closure of **Refused Assessment**.

GA Protocol Policy

All CCs must ask their GA clients who are not receiving cash assistance if they are new applicants for GA, meaning they are required to adhere to all recommendations set forth by the County Welfare Agency for the GA Protocol for cash assistance. CCs would identify if a client is not receiving cash assistance in the database, but must be careful not to confuse this status with sanctioned clients. It is strongly recommended that the ACCs/SCs determine if the client is a new GA applicant and indicate the information in the comment section of the referral screen in the database.

The following policy is enforced for GA applicants only who must adhere to the GA Protocol.

In the event a GA protocol client fails to show for the assessment or assessment UDS (if DCP&P or "SAI"), **the client will not be rescheduled, and the SAI/BHI case will be closed.** They will be closed as either "Refused Assessment" if they did not show for the assessment at all, or "Failed to Complete Assessment," if the client did not show for the assessment UDS. The Care Coordinator (CC) must indicate in the comments on the Caseworker Referral Response Form (CWRRF) that the client did not show for the assessment or failed to complete the assessment (if the client did not go for the assessment urine screen). The client's GA case will likely be denied once the Caseworker receives your CWRRF for failing to complete this requirement of the GA protocol.

If the CC has referred the client for treatment at the time of the assessment, and the SAI/DCP&P client fails to show for the assessment UDS, then:

- The CC must call the treatment provider to inform them that the client failed to complete the assessment and the SAI/BHI case will close.
- The CC must cancel the intake appointment with the treatment provider.
- The CC must call the client or ask an Outreach Assistant Care Coordinator to send a letter to the client informing them that their case is closed and that the SAI/BHI will not authorize the scheduled treatment services.

- If the client wants to attend treatment, they must be instructed to contact their welfare worker to obtain a re-referral to the SAI/BHI for services.

Treatment Refusal Policy

All GA and TANF recipients who are not temporarily exempt or deferred from a Work First New Jersey (WFNJ) activity must participate in employment-directed work activities. Substance use and/or mental health treatment may count towards all or part of their work requirement. If a client is referred to the SAI/BHI, the County/Municipal Welfare Agency (CWA/MWA) Caseworker must put the referral recommendation on the client's Individual Responsibility Plan (IRP) and the client is then required to attend the assessment. If a client is utilizing Emergency Assistance (EA) for housing and is referred to the SAI/BHI, the referral is placed on the client's EA Plan and the client is required to attend the assessment.

If a client refuses to attend treatment, the Care Coordinator must explain to the client that failure to participate in a WFNJ work activity, which may include treatment, may result in sanctioning or loss of their benefits. Clients who are deferred or exempt from a work activity may still receive a mandatory referral to the SAI/BHI for treatment and failure to engage in the recommended level of services may result in loss of emergency assistance, temporary rental assistance, childcare, or other ancillary services.

All clients who refuse to attend any level of care following the assessment must sign a Treatment Refusal Form in the database and the county should be informed, see below.

At the time of assessment, if a client refuses to attend any level of care, with the exception of withdrawal management services, the client must be given 30 calendar days to change their mind before the case is closed. The CC must use Motivational Interviewing techniques with the clients to engage them in treatment. **At least one outreach attempt by phone or mail should be provided by the CC, ACC Outreach Specialist, or CCSS to encourage the client to reconsider their decision during that time**. If the client does not respond to the outreach efforts, the case would be closed as "Refused Treatment."

At the time of assessment, if a client refuses clinically recommended residential withdrawal management services (i.e., 3.2-WM, 3.7-WM, or 4-WM) the client must be given 10 business days to allow them to reconsider their decision. **At least one outreach attempt by phone or mail should be provided by the CC to encourage the client to reconsider their decision**. If the client does not have a phone, a letter may be sent by the ACC. If the client does not respond to the outreach efforts, the case is closed as "Refused Treatment."

WFNJ SAI/BHI

Refusal Of Treatment Recommendations

I, _____, have been assessed by the WFNJ SAI/BHI Care Coordinator, who has recommended that I participate in the following:
(Describe the recommended level of care and service provider below.)

_____
_____
_____

I hereby acknowledge that I do not wish to accept a referral for these services at this time. I understand that the Care Coordinator will inform my welfare caseworker and DCP&P worker, if appropriate, that he/she has recommended these services and that I have declined.

I understand that refusal to accept and follow through with WFNJ SAI/BHI treatment recommendations may be cause for a welfare sanction, possible loss of my welfare benefits, and further action by DCP&P (if applicable).

_____ _____
Client Date

_____ _____
Care Coordinator Date

If You Assess a SUD Client and Treatment is Not Indicated

1. Assign managing CC, Diagnostic Category, and Releases
2. Clients referred to the SAI, not BHI, and all DCP&P referred clients should be sent for an assessment urine drug screen. DCP&P may request a 4-week Extended Evaluation on clients who deny substance use but there is suspicion of use.
3. Complete the ASAM Admission LOC Service Note
4. Complete and fax the CWRRF

5. Document all events in the Service Log

CONTACT ANY OTHER AGENCIES INVOLVED WITH THE CLIENT, TO SUPPORT AND VERIFY YOUR CLINICAL JUDGEMENT THAT TREATMENT IS NOT INDICATED. ONCE VERIFIED, AND THE CLIENT SUCCESSFULLY COMPLETES THE UDS, or DCP&P- EE , THE CASE CAN BE CLOSED IN **30 DAYS** WITH A CLOSURE CHOICE OF **TREATMENT NOT INDICATED, **see below for guidelines.**

If You Assess A BHI - MH Client And Treatment Is Not Indicated

1. Assign managing CC, Diagnostic Category, and Releases
3. Complete ASAM Admission LOC Service Note
4. Complete and fax the CWRRF
5. Document all events in the Service Log

CONTACT ANY OTHER AGENCIES INVOLVED WITH THE CLIENT, TO SUPPORT AND VERIFY YOUR CLINICAL JUDGEMENT THAT TREATMENT IS NOT INDICATED. ONCE VERIFIED, THE CASE CAN BE CLOSED WITH A CLOSURE CHOICE OF **TREATMENT NOT INDICATED**, ****see below for guidelines.**

****Before any client is closed as "treatment not indicated,"** the case must be reviewed by a Regional Manager, the Clinical Director, the Quality Assurance Supervisor, or the Director of Care Coordination. The case information must be completed in the database for the senior manager to review (ASI, ASAM Admission Service Note, relevant service log entries). Following the case review, the supervisor must indicate in service log they have reviewed the case and either approved or denied the case closure

A case may be closed as "treatment not indicated" after review if:

- The client reported no history of, or current substance use and/or mental health symptoms and no reported SUD/COD/MH treatment history;
- The client had no previous episodes of care for SUD/COD/MH services with the SAI/BHI;
- Collateral information supports case closure.

There should be very few case closures with treatment not indicated (less than 3%). A SAI/BHI client **should be placed in treatment and not be closed** if:

- There is at least one previous episode of care that had an identified SUD, COD, and/or mental health disorder with a treatment recommendation.
- There are allegations of SUD and referred by DCP&P.
- The client admits to sporadic and/or continued substance use.
- By self-report, a client meets the criteria for sustained remission (12 months and no less) for any substance, but there is no supportive collateral confirmation.
- A client reports prescribed medication by a general practitioner that has resulted in physiological dependence.
- Supportive allegations of substance use by the referring agent.
- The client needs mental health treatment.

There are some clients who may have had a history of substance use or mental health symptoms many years ago, but they deny current symptoms within the last few years. These cases must be reviewed and investigated before they are closed.

- The CC must contact the referring County Welfare or DCP&P caseworker by phone or email to obtain collateral information and the reason for the referral because the client is denying symptoms.

*The clinical staff person must document in the service log why the client was referred for a SAI/BHI evaluation and the findings. This must be documented **BEFORE** a senior manager reviews the case.*

Steps in Making a Referral for Treatment

1. Call the treatment provider with the client present to schedule an intake
2. Instruct the treatment provider to obtain the referral packet from the SAI/BHI web portal which includes: **(1) Client Information Summary**, **(2) the most recent ASAM LOC Note with pre-authorizations, (3) signed releases**, **(4) Universal Treatment Agreement**, **(5) Admission Letter**, and **(6) ASI.**
3. Every client must also receive a copy of the Treatment Service Form, with all of their appointments you have linked them with, and their Treatment Agreement.
4. Complete and fax the CWRRF
5. Document all steps in the Service Log

ASI Considerations

Medical

If the client was hospitalized for a serious illness or injury in the past, or if the client has had surgery, ask:

- Have there been any remaining effects? Example, if the client broke his/her foot and had surgery three years ago, does he/she still experience any pain there? Difficulty walking?

After going through all the items on the **M3** section:

- Specifically, ask about problems with chronic pain to determine a connection with opiate abuse.

If you are assessing a client that will most likely be referred for withdrawal management or residential treatment, and the client has medical diagnoses, instruct them that they will need a letter from their doctor documenting that they are medically stable to participate in treatment, and that they are receiving the proper treatment for the reported condition. Examples of such conditions would be past or present heart problems, hypertension with no medication, any chronic pain problems/injuries that pose a problem for walking/standing long periods of time that may interfere with treatment.

Employment/Support

E7: When was the last time you worked? What type of work were you doing? What led to that job ending?

On **E15a**, when asking if the client has ever applied for SSI, ask:

- About his/her employment goals.
- If the client has not applied for SSI, is that because he/she has a goal of returning to work? School?
- Since the major goal of the WFNJ SAI/BHI is to help remove the barriers of substance use disorder/mental illness for employment, find out the client's goals for employment/education/SSI.

E19: If the client is "employable" and has been looking for work ask:

- What type of job search have you been doing?
- Have you had any calls back? Interviews?

Alcohol/Drugs

Questions you should ask for each substance:

- First use?
- Last use?
- When did it start?
- How much did you start with?
- Frequency?
- Amount?
- How long has this level of use been going on? Tell me about your highest level of use. When did that occur? How long did that go on?
- Do you believe that this substance is a problem? What makes you say so? / Why not?
- Are you experiencing any withdrawal symptoms?
- Are you aware of what triggers your use?
- *For alcohol and benzodiazepines*: Do you have any history of withdrawal seizures?
- What were you doing when you were clean?
- What made you start using again?
- What did you notice in your behavior? Or drug seeking behavior?
- When was the first time you were in treatment?
- What previous treatment experiences have you had? When? Where? What happened?
- Did you successfully complete them?
- If involved in current treatment, who is the counselor? Days and hours of treatment? OMT dose?
- AA/NA reason not to go?
- Alcohol problems, do you have cravings, withdrawal, disturbing effects of use, wanting to stop and being unable to.

D15: What types of things did you do, or places you went, that helped you to stay sober? What was working for you at the time that is different now?
D19/20: If the client is reporting treatment history, ask how long they remained sober after treatment and what may have caused the relapse.
D30/31: What is the motivation for treatment/sobriety now? What would they like to see happen now at this point in their life? Do they know what step they can begin to take to get what they want?

Additional question for clients who live with their children: There are several questions in the drug/alcohol section for TANF clients, regarding their drug use and their children. It's important to ask additional questions, because if they are using, and refusing treatment, you may have to contact the DCP&P hotline

- Do you use in front of your child?
- Do you use when your child is in the home?
- Where exactly is the child when you use? Maybe in a different room? A relative's house? School?
- Maybe you have never used in front of your child, but has your child ever been with you when you are under the influence? Have you taken your child with you to buy drugs?

Legal Status
Many of our clients have an extensive legal history. Sometimes it can be overwhelming to gather all of that information. Focus on things that stand out, rather than collecting every detail. For example, if the client tells you that he/she was arrested, five times, for assault, you are going to want to find out more information about those charges because this could be an indicator of behavioral or psychiatric conditions that may require treatment. Whenever a client reports multiple arrests of any crime, ask when they were last arrested and charged.

Family History
If the client discloses that a family member is using drugs or alcohol ask:

- Is the person actively using? Do they live in your household? Or, do you see them regularly?
- Has the person ever sought help?
- If deceased, did that person die because of a drug/alcohol-related reason?

If the client discloses that a family member has a mental health problem:

- Is the person in treatment, or did he/she ever get a diagnosis? Is the person on medication? If yes, do you know what medication?
- Who were you raised by?
- Where is your mother or your father?
- If any of your immediate family has passed away, was it substance related?
- How many brothers and sisters do you have?
- Are your close friends drug free?
- Is your family supportive of your getting help?
- If there were conflicts with your family; specifically, what were they?
- What are the family issues that you need to work on in treatment?

- Do you have a sober support system?

Family/Social
F7/8a: If the client admits to living with someone who has a substance use disorder or if his/her significant other has a substance use disorder, ask:

- How does this affect your sobriety?
- Do you plan to change your environment?
- Do you believe you will be able to stay sober if you continue to live with this person/stay in a relationship with this person?
- Is your family member clean and for how long?

F27, 28, 29A: These questions are, perhaps, the most difficult and sensitive on the ASI for many CCs. Do not be afraid to ask! A large percentage of our population has a history of trauma and the CC must help the clients to understand that treatment is available for them to heal. If a client discloses abuse, but not occurring within the last 30 days, find out:

- Are they currently living in a safe environment? Are they currently in danger?
- When did the abuse occur. Childhood? Two months ago?
- Was it someone the client knows? Was it an unknown perpetrator? You can say something like, "It's not something we have to talk about in detail today, but have you ever addressed the abuse in counseling before?"

F31A: Who are the people in your support system? How do they help you? Have you been willing to ask for help?

Psychiatric Status
P1: When did the hospitalization(s) occur? What were the reasons for admission?
P2A: Who diagnosed you?
P4 through P7: You are asking the client:

- If they have had these problems *separate from drug and alcohol use.* Usually I will say something like, "There is an expected amount of depression and anxiety that can go along with addiction and with the stressful situations that you are in right now. However, I'm asking you if you have experienced any of these difficulties separate from your addiction; as in, these problems significantly interfered with your functioning."
- For each of the problems in this section, ask when they first occurred, what the symptoms are, and how the problems are interfering with the client's ability to function.

P4: There is not a specific question for mania/hypomania on the ASI, so you may want to assess for it in this section, especially, if the client is reporting a diagnosis of Bipolar Disorder.
P6: If the client is reporting hallucinations, also assess for paranoia in this section.
P9: If the client reports a history of suicidal thoughts, but none within the last 30 days:

- Ask *when is the last time you had any thought of suicide?* And of course, do the usual suicide assessment: Any plan? Means? Intent?

- What stopped you from following through? History of suicide attempts? (which you will be prompted to ask in P10)

P99: This is similar to the abuse questions—

- Let the client know that you are not there to explore the details of the event, but you are asking if the client can please let you know the nature of the event, and when it occurred so that you can determine his/her treatment needs.
- Follow it up with P99a, to find out about possible PTSD symptoms. You may want to ask if the client repeatedly avoids stimuli that may remind him/her of the traumatic situation.
- Are you using alcohol when feeling depressed? Do you feel that your feelings of depression are related to your drug and or alcohol use? Do you have difficulty sleeping and or eating?
- Have you ever experienced a panic attack? How often do you experience this? Do you feel that using drugs/alcohol helps you deal with your anxiety? What are the symptoms that you experience when you feel anxious?
- Do you hear voices? What are the voices saying? Do you recognize the voice? Are you under the influence or experiencing withdrawal symptoms when you are hearing voices or seeing things? What are the things that you are seeing? How often do you experience this? When is the last time this occurred?
- If they report they have problems understanding, concentrating, remembering it should be gaps in their memory, losing their way, things out of the ordinary not just basic things that we will all sometimes forget. Does their memory affect their daily functioning?
- If they have episodes of rage or violence, is it verbal / physical against self, others or objects? Are they usually intoxicated? When was the last time? Briefly explore their coping skills with anger.
- If they have experienced serious thoughts of suicide, inquire about a plan/method and availability of acting it out. When was the last time? What kept you from acting out your plan? Ask if they are feeling that way right now.
- If they have a history of suicide attempts obtain history of all attempts. Determine whether it was a gesture or a serious attempt.
- If they have a history of medication, try to get the names of the medications. Were they prescribed or illicit? Do they take the prescribed amount? If from a doctor, is he/she a psychiatrist or a general medical doctor? If they were prescribed medication in the past how long were they taking it, and why did they stop?

Key to ASI Severity Ratings

Severity *– defined as the need for new or additional treatment based on the amount, duration, and intensity of symptoms within each area.*

All ratings are based on objective and subjective data within each area.

A systematic method has been developed for Severity Ratings. Reliability is increased if this method is used.

2-Step Method:

1. Consider the objective data with particular attention to critical items. (Why are these critical? – Because over time they have been found to be the most relevant to a valid estimate of Severity.)

   At this point, the interviewer makes a preliminary rating: a 2-3 point range based only on objective items.

2. Interviewer looks at subjective items and fine-tunes his/her rating to a single score.

REMEMBER: We are not rating *potential* benefit but the extent to which the treatment is needed (regardless of availability or potential efficacy.)

Interviewer Rating Scale:		**Patient Rating Scale:**
0-1	No real problem, treatment not indicated	0-None, Not at all
2-3	Slight problem, treatment probably not indicated	1-Slightly
4-5	Moderate problem, some treatment indicated	2-Moderately
6-7	Considerable problem, treatment necessary	3-Considerably
8-9	Extreme problem, treatment absolutely necessary	4-Extremely

SAI/BHI Diagnostic Categories

The purpose of the Diagnostic Categories is to identify treatment NEED, not treatment PLACEMENT. Treatment placement is based on The ASAM Criteria and severity in each dimension. The Diagnostic Category does not drive treatment placement or whether the client is referred to a SAI/BHI network or MH-Only provider. The Diagnostic Categories assist the CC with ensuring all of the client's symptoms will be addressed in the most appropriate treatment placement, regardless of the program's designation of SAI or MH-only.
Accurate assignment of the Diagnostic Categories also assists management with observing how many clients are "substance use only," "mental health only," and how many are "co-occurring" to inform programmatic decision-making. The Diagnostic Category may change during an

episode of care; in these instances, the CC must update the Diagnostic Category (in the database, this will be on all CSRs).

SA1. Substance Use Disorder Only SA2. Substance Use Disorder (primary) with Low to High Mental Disorder	SAI
BH3. Mental Disorder Only BH4. Mental Disorder (primary) with Low to High Substance Use Disorder	BHI

Category 1 – SA1 (SAI): This category includes individuals with any severity substance use disorders (SUD) and no current mental health symptoms. Psychiatric symptoms are no longer present or are non-existent. The primary diagnosis is a substance use disorder. **These are not considered co-occurring clients.**

Category 2-SA2 (SAI): These clients have substance use disorders as the primary diagnosis with presenting low to high mental health symptoms. These individuals can be accommodated in treatment settings of either co-occurring mental health or co-occurring chemical dependency programs, with consultation or collaboration between settings if needed. The primary diagnosis is a substance use disorder. **These clients are considered co-occurring clients.**

Category 3- BH3 (BHI): This category includes individuals with any severity mental health symptoms that are usually identified as priority clients within the mental health system. The primary diagnosis is a mental health disorder. **These are not considered co-occurring clients. (These clients do not have current symptoms of substance use disorders.)**

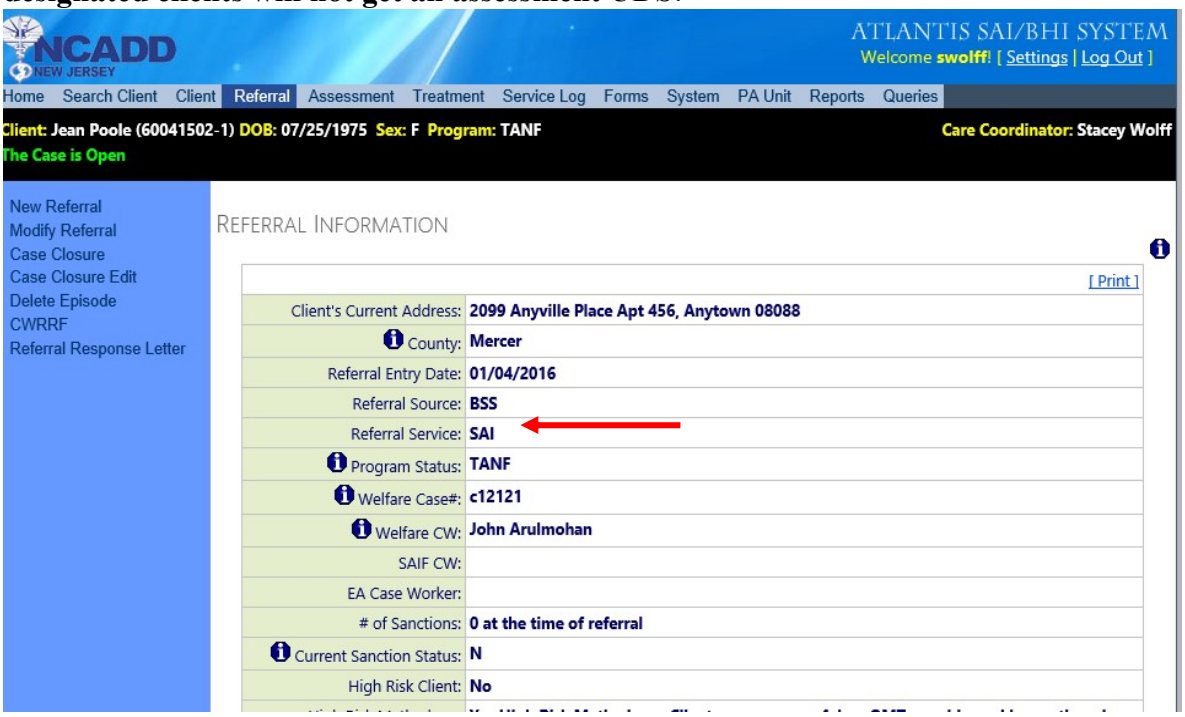
Category 4- BH4 (BHI): Includes individuals with any severity of mental health symptoms as the primary diagnosis who also have any severity of substance use disorders. These individuals require comprehensive and integrated services for both their mental health symptoms and substance use symptoms, or relapse prevention for their SUD in remission. The primary diagnosis is a mental health disorder. **These clients are considered co-occurring clients and substance use should be addressed in treatment with random urine drug screening.**

WFNJ SAI/DCP&P Urine Drug Screen Policy

All SAI (not BHI) and all DCP&P-referred clients must receive a urine drug screen (UDS) as an integral part of the assessment process. All SAI and DCP&P clients must be sent for a UDS within 24 hours of the assessment. In the event that there are no providers available to conduct the UDS within 24 hours, all efforts must be made to obtain the first available UDS appointment.

The ACC must adhere to the selection (substance abuse=SAI or mental health=BHI) on the WFNJ-125 Referral form that is sent by the County. The ACC will enter either SAI or BHI based on the referral only.

Only DCP&P-involved clients and those clients who are referred by the counties who are designated as <u>"SAI"</u> can be sent for an assessment urine drug screen (UDS). "BHI" designated clients will not get an assessment UDS.



If a BHI-referred client has current substance use or a history of substance use, they can and should be sent for co-occurring treatment and begin weekly urine screens as part of their treatment.

If DCP&P requests an extended evaluation, this is the only time it will be permitted. Per policy, all extended evaluations requested by DCP&P must be documented in the service log.
As always, a client must have an active Medicaid number before he or she is sent for an assessment UDS or treatment.

<u>Assessment UDS and EE for DCP&P clients:</u>

Clients who are referred by DCP&P who deny substance use at the time of the assessment may be referred for an extended evaluation upon request from DCP&P. If a client does not attend the first UDS, they may be rescheduled; however, the client must complete all four UDS within a 4-week period.

If the client fails to show for the first UDS and is rescheduled, and does not attend the second UDS, he or she must be outreached to attend SUD treatment. If no contact occurs after outreach attempts, or if the client refuses SUD treatment, the case should be closed as 'failed to complete assessment' at 30 days from the date of assessment with a referral to sanction.

All SUD clients who are sent for an EE must simultaneously be referred for a full-time work activity. In the event the client has a Med-1 deferral form, and the CC believes the client can participate in a

work activity, the CC must indicate that the client should be reassessed for employability on the Caseworker Referral Response Form.

Assessment Urine Drug Screens, EE/OEE UDS Module

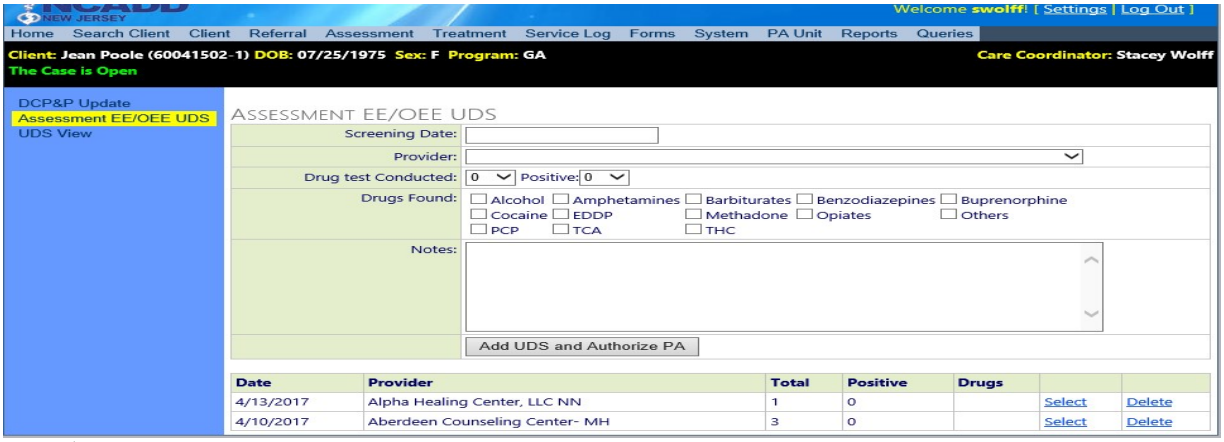
As mentioned above, Assessment Urine Drug Screen (UDS) referrals are mandatory for all SAI and DCP&P- referred clients.

UDS results and payment authorizations are entered in the database by the Care Coordinator upon receipt of the result. The PA unit generates the PA in the next batch print cycle, enters the PA into MMIS, and sends the active PA to the provider.

To enter the UDS result and create the Payment Authorizations follow these steps:
Go to **ASSESSMENT EE/OEE UDS MODULE**

This module will be used for all Assessment urine drug screens and UA Extended Evaluations when a PPL will not be created. The CC is responsible for entering all Assessment UDS and EE UDS-only results and creating the Payment Authorization.

- ✓ Search for a client and verify that you are in the client's current EOC.
- ✓ Select "Treatment" from the main menu bar.
- ✓ Select the "Assessment EE/OEE UDS" option from the side menu.



- ✓ Enter the screening date (the date that the urine specimen was COLLECTED by the provider, not received by you).
- ✓ Select the treatment provider who provided the UDS from the "Provider" dropdown.
- ✓ Enter the number of tests conducted (this is how many substances the client was tested for; it is often 7-10). This number is automatically defaulted to "0."
- ✓ Then enter the number of substances the client tested positive for (up to 10). If you choose a number for "positive" you must check off which substances the client tested positive for. This number is automatically defaulted to "0." Do not change this number if the client was negative.
- ✓ You can write any additional information that is significant in the "notes" section.
- ✓ Then click "Add UDS and Authorize PA" to save the results.

- ✓ Your Assessment UDS or EE/OEE Payment Authorization is automatically created.
- ✓ In the event a mistake is made, and "Add UDS and Authorize PA" has been selected, the CC must contact IT or Laura Abramowitz to make the correction to the UDS and PA.

WFNJ SAI/BHI

ASAM Admission Assessment Summary

Client Name: **Jean Poole** WFNJ SAI/BHI # **6122313**

Date Assessed: 6/28/17 **Date of Next Service Review** 7/30/17

DSM 5 Diagnostic Impression: Alcohol Use Disorder, Severe, F10.20; Major Depressive Disorder Recurrent episode, Moderate, F33.1

ASAM LOC: D1) High D2) Low D3) Low D4) High D5) Moderate D6) Low

Immediate Need Profile and Mental Status Exam:

1. Acute Intoxication and/or Withdrawal Potential- Currently having severe, life threatening and/or similar withdrawal symptom? No
2. Biomedical Conditions/Complications - Any current severe physical health problems that require emergency services (e.g., recent severe pain in head, chest, abdomen, or excessive bleeding from mouth or rectum, unstable hypertension) No
3. Emotional/Behavioral/Cognitive Conditions/Complications- (A.) Imminent danger of harming self or someone else? (e.g., suicidal ideation with intent, plan, and means to succeed; homicidal or violent ideation; impulses and uncertainty about ability to control impulses, with means to act on.) No
   (B.) Unable to function in activities of daily living, care for self with imminent, dangerous consequences (e.g., unable to bathe, feed groom, and care for self due to psychosis, organicity, or uncontrolled intoxication with threat to imminent safety of self or others as regards death or self injury.) No

Appearance: Unkempt
Speech: Slurred
Thought Process: Tangential
Mood: Depressed
Affect: Flat
Behavior: Withdrawn
Impairment of Cognition: Memory (short-term), Attention/Concentration
Client was a poor historian and could not recall events from last year.

Current ASAM Dimensional Issues:

D1) Acute Intoxication and/or Withdrawal Potential

Client reported daily alcohol consumption with tolerance and withdrawal symptoms. Client will require medically managed residential withdrawal management for safe detoxification.

D2) Biomedical Conditions and Complications

In the last twelve months, client has been diagnosed with Type 2 Diabetes, does not remember when she was diagnosed and is not currently on medication. Client remembers having asthma since childhood. Client has been prescribed Albuterol inhaler as needed up to four times per day; is not currently prescribed medications for diabetes.
Client has experienced medical problems in the past 30 days, difficulty breathing related to having a cold with a lingering cough, and her asthma has been exacerbated.

D3) Emotional, Behavioral or Cognitive Conditions and Complications

Client reported a history of physical abuse, last boyfriend was very violent, and they had physical fights regularly when they were both drinking. Client was also charged with assault during this relationship. No contact with this man in four years.
Client reported treatment in an outpatient setting for psychiatric care for anger management four years ago.
Client reported symptoms of depression, including that she feels depressed every day. She stated that she cries daily and often does not want to get out of bed. She has periods when this can last for up to two weeks at a time. These episodes started in her late twenties, which also coincided with her alcohol use increasing.
Client reported symptoms of anxiety, including that she often feels anxious, mostly related to her life situation. She stated that she worries about her future, not having a steady job, and not having a permanent place to live. Client can verbalize the source of her anxiety, she has not had significant periods of anxiety/tension throughout her lifetime.
Client reported trouble controlling violent behavior, including episodes of rage or violence, this occurred only during an abusive relationship with her ex-boyfriend. She stated that when they were both drinking they would have violent fights. This lasted for approximately 2 years but no outbursts in the last four years. Client stated that anger management counseling helped her.
Client will need a psychiatric evaluation.

● **Client needs a psychiatric evaluation**

D4) Readiness to Change

Client recognizes her tolerance and inability to stop drinking on her own but is reluctant to stop drinking completely. Client is motivated for WFNF SAI/BHI services to keep benefits and regain custody of her children.

History and Related Treatment)

Client reported that she began to drink alcohol at age 14, she would drink socially with friends after school and on weekends, rarely to intoxication. Client stated that she occasionally drank during pregnancy at age 18. She drank sporadically until approximately 10 years ago, at age 28 her drinking progressed to daily use. She stated that she would currently drink up to 1/5 of vodka by herself daily, she stated that she has significant tolerance and if she stops drinking, she "feels shaky and sick." She stated that she has been drinking daily for the last year.
Client stated she smoked marijuana 1-3 times per week with friends from age 15 to approximately age 20, no use in the past 18 years.
Client stated she smoked PCP in her late teens, no regular use but smoked occasionally for approximately one year when it was available with her friends.
Client reported that that she does not remember any significant length of time when she did not drink alcohol.

D6) Recovery/Living Environment

The family is estranged; there is some social sober support, her children are placed in kinship care with client's aunt through DCP&P.

ASAM LOC: D1) 3.7 WM D2) I D3) I D4) High D5) 2.1 D6) 1

ASAM level Assessed:__3.7WM__ ASAM Level #1 Placed:_3.7WM_

ASAM Level #2 Placed: _____

Reason why client was not placed at assessed level: N/A

☐ **EE** ☐ **OEE**

Medical justification is required for Level 3.7 only. At least two of the six Dimensions meet 3.7 criteria, and at least one must be in Dimension 1, 2, or 3:

List medical justification in comment section: (This will not print if 3.7 is not selected.)

Recommended Service Plan and linkages / Discharge Plan: (medical, psychiatric, dental, prenatal, housing, DV, trauma, etc. Include discharge plan)

Client requires withdrawal management followed by short-term residential treatment. Client will need ongoing treatment, which may include intensive outpatient patient services following residential placement. Client will require a psychiatric evaluation once her alcohol detoxification is complete and her alcohol use disorder has stabilized. Client to continue with her primary care physician for asthma and diabetes treatment. Recommend that client receive tobacco cessation treatment.

Pre-authorization information will be generated here.

WFNJ Substance Abuse And Behavioral Health Initiative (WFNJ SAI/BHI) Treatment Provider Admission Letter

Date: _____(autofill)_____

Treatment Provider: _____(autofill from PPL, there may be more than one PPL, must be able to create an admission letter for each PPL with a scheduled start date)_____

Thank you for facilitating the admission of _____(autofill)_____ who is scheduled for admission to your program on __(autofill from PPL)_____. The client should be placed in the following level of care (autofill from PPL)_____.

A signed consent form that allows communication about this client between the NCADD-NJ WFNJ SAI/BHI and your program is enclosed along with a copy of this client's ASI and ASAM Assessment Summary.

The WFNJ SAI/BAI is required to report all clients' treatment attendance to the County Welfare Agencies (CWA) every week. Please contact us to let us know when the client has begun treatment at your agency. We ask that you assist the client by completing the **Weekly Attendance Form** so that we can report the client's attendance to the CWA. If you require a copy of this form, please contact Laura Abramowitz (labramowitz@ncaddnj.org):

- Please fax or email the completed **Weekly Attendance Form** to the WFNJ SAI/BHI Payment Authorization (PA) Unit at (609) 259-1458 or email to paunit@ncaddnj.org within two working days of the end of the week in which the services are provided.
- WFNJ SAI/BHI **contracted** treatment providers must conduct weekly urine drug screens. The completed **Urine Drug Screen Reporting Form** (please contact Laura for this form) **or Lab results** must be mailed, sent Fed Ex, or emailed to the WFNJ SAI/BHI PA Unit within two working days of the end of the week in which the UDS was collected.

YOUR ASSISTANCE WITH THIS WILL HELP TO ENSURE THAT THE CLIENT CONTINUES TO RECEIVE BENEFITS AND WILL PREVENT THE CLIENT FROM INCURRING A SANCTION DUE TO NON-ATTENDANCE AT TREATMENT.

If the client needs services other than what has been pre-approved, the treatment provider must contact the WFNJ SAI/BHI Care Coordinator for pre-authorization in order to receive payment authorization for other services. It is the treatment provider's responsibility to contact the WFNJ SAI/BHI CC for a service review by the service review date indicated on the ASAM note; otherwise, this will affect payment authorization for services.

For **non-contracted** mental health treatment providers, the WFNJ SAI/BHI CC will contact the program counseling staff once per month to obtain information on client progress, participation, and attendance. If the client needs services other than what he/she has been referred to your program to receive, you may contact the CC at any time for assistance with referring the client to the most appropriate treatment or level of care.

If you have any questions or concerns about this client's placement, or if there is an emergency (including unscheduled discharge) regarding this client, please contact the CC as follows:

- Monday through Friday, 8:00 AM-4:30 PM, by phone: _____, or, after business hours and on the weekends, you may call the CC's telephone number and leave a message on the voicemail. If there is a clinical emergency and you need to

speak with someone in the WFNJ SAI/BHI immediately, then call: (800) 396-6646 and follow the instructions to reach the Regional Manager.

Thank you for your assistance and cooperation.

Sincerely,

WFNJ SAI/BHI Care Coordinator

WORK FIRST NEW JERSEY
SUBSTANCE ABUSE/BEHAVIORAL HEALTH INITIATIVE (SAI/BHI)

Client Responsibility And Treatment Agreement

The Work First New Jersey Substance Abuse Initiative/Behavioral Health Initiative (WFNJ SAI/BHI) is a welfare-to-work program intended to remove substance abuse and mental health disorders as barriers to participation in work activities. WFNJ SAI/BHI participants attend treatment as an alternative work activity. WFNJ SAI/BHI participants may fulfill some or all of their work activity requirements through the WFNJ SAI/BHI by attending treatment as recommended by the WFNJ SAI/BHI Care Coordinator (CC). Treatment attendance of 75% or more and negative urine drug screens are key indicators of treatment participation and progress.

Recommended Service Plan:
Treatment Provider 1: (drop down of providers with auto populate for address and phone number)
Assessed Level of Care: (typed in services by CC)
Scheduled Treatment Start Date and Time: (typed in by CC)

Treatment Provider 2: (drop down of providers with auto populate for address and phone number)
Assessed Level of Care: (typed in services by CC)
Scheduled Treatment Start Date and Time: (typed in by CC)
Additional WFNJ SAI/BHI service plan requirements such as a psychiatric evaluation, medical services, housing, prescription documentation, or application/redetermination for welfare benefits:

Care Coordinator to develop a new service plan. I also understand that once I agree to the treatment plan outlined above, I must attend at least 75% of the recommended treatment as scheduled and

provide negative urine drug screens or risk having my benefits sanctioned, a DCP&P investigation or possible WFNJ SAI/BHI case closure.
(Client initial one of the following:)
_____ I agree to attend the level of care recommended by my WFNJ SAI/BHI Care Coordinator.
_____ I agree to attend a level of care other than the level of care recommended by my WFNJ SAI/BHI Care Coordinator. I understand that if I am unsuccessful, it will be **mandatory** for me to attend the level of care recommended by my WFNJ SAI/BHI Care Coordinator.
_____ I refuse to attend treatment through the WFNJ SAI/BHI and understand that this refusal may affect my welfare benefits and/or DCP&P case and my WFNJ SAI/BHI case will be closed.
_____ If on OMT, I understand that if I continue to test positive for substances other than methadone and valid, prescribed, medications, I must participate in additional or other treatment services, which may involve detoxification from methadone and residential services.

The WFNJ SAI/BHI treatment providers will report weekly treatment attendance and random Urine Drug Screen (UDS) that will be collected at least one time per week. I am responsible for providing the WFNJ SAI/BHI and the treatment provider(s) with a current copy of all prescribed medications that may be detected by the UDS.

I understand that if I fail to adhere to the above treatment agreement and recommendations and I have an open DCP&P case, DCP&P will be notified of all positive UDS and poor attendance issues. If I do not have an open DCP&P case, a DCP&P investigation may take place to prevent harm and /or neglect to my children (if applicable).

Client agrees to and acknowledges receipt of this agreement:
Client Name _____
Date:_____
CC Signature:_____
CC Name:_____

Copy given to client ☐

WFNJ SAI/BHI

Refusal Of Treatment Recommendation

If a client refuses to attend treatment, the Care Coordinator must explain to the client the requirements of Work First New Jersey and that treatment participation in a substance use or mental health program counts towards those activities. The client must learn that failure to participate in a WFNJ work activity, which could include treatment, may result in sanctioning or loss of their benefits. If a client is exempt or deferred from a work activity and they fail to engage in treatment would not be eligible to receive housing or other ancillary services.

WFNJ SAI/BHI

Refusal Of Treatment Recommendation

I, _____, have been assessed by the
WFNJ SAI/BHI Care Coordinator, who has recommended that I participate in the following:
(Describe the recommended level of care and service provider below.)

_____

_____

I hereby acknowledge that I do not wish to accept a referral for these services at this time. I understand that the Care Coordinator will inform my welfare caseworker and DCP&P worker, if appropriate, that he/she has recommended these services and that I have declined to participate at this time.

I also understand that refusal to accept and follow through with WFNJ SAI/BHI treatment recommendations may be cause for a welfare sanction, possible loss of my welfare benefits, and further action by DCP&P (if applicable).

_____ _____
Client Date

_____ _____
Care Coordinator Date

Guidelines For The Assessment, Placement And Management Of WFNJ SAI/BHI Clients In Opioid Treatment Services (OTS)

Clients referred to the WFNJ SAI/BHI may request to be placed, or be maintained, on a treatment service plan that includes Medication Assisted Treatment (MAT). Clients may be referred who are already placed in MAT with any prescribed opioid agonist, partial agonist, or antagonist prescription, but the SAI/BHI can only authorize payment reimbursement for methadone maintenance and withdrawal management, indicated as Opioid Maintenance Treatment, "OMT" in Atlantis. All other opioid treatment prescriptions must be authorized through Medicaid. The SAI/BHI may authorize the corresponding treatment services for those non-OMT MAT clients, such as IOP or co-occurring disorder (COD) services.

During the initial assessment, consider the following ASAM dimensional criteria for OMT before making the decision to place/maintain clients on OMT.

Previous episodes of care with the WFNJ SAI/BHI must be reviewed to determine if OMT is a viable treatment option.

Clinical ASAM Assessment

Dimension 1: Withdrawal Potential: It is determined that the client meets the DSM-5 criteria for Opioid Use Disorder for at least one year and the physical dependency is confirmed by physical signs (these restriction may be waived for pregnancy or release from jail/incarceration within 6 months of release); if the program physician certifies that a female client is pregnant and finds OMT medically justified; and for previously treated clients up to two years after discharge.

Dimension 2: Biomedical Conditions and Complications: The client meets the biomedical criteria for opioid use disorder, and requires outpatient medical monitoring and skilled care; or, the client has a concurrent biomedical illness or pregnancy, which can be treated on an outpatient basis with minimal daily medical monitoring.

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications: The client's emotional, behavioral, or cognitive problems, if present, are manageable in an outpatient structured environment; or, the client has a diagnosed and stable emotional, behavioral, or cognitive problem or thought disorder that requires monitoring, management, or medication because of the risk that the problem(s) will distract the client from his or her focus on treatment; or, the client poses a mild risk of harm to self or others, with or without a history of severe depression, suicidal or homicidal behavior, but can be managed safely in a structured outpatient environment; or, the client demonstrates emotional and behavioral stability but requires continued pharmacotherapy to prevent relapse to opioid use.

Dimension 4: Readiness to Change: The client requires structured therapy and pharmacotherapy, to promote treatment progress and recovery; or, the client attributes his or her problems to persons or external events rather than to the substance-related disorder. He or she is unable to make behavioral changes in the absence of clinically directed and repeated structured motivational interventions. However, the client's low interest in recovery does not render treatment ineffective.

Dimension 5: Relapse, Continued Use, or Continued Problem Potential: The client requires structured therapy and pharmacotherapy to promote treatment progress because he or she attributes continued relapse to physiologic craving or the need for opioid; or, despite active participation in other treatment interventions without provision for OMT, the client is experiencing an intensification of addiction symptoms, and his or her level of functioning is deteriorating, despite revisions of the treatment plan; or, the client is at high risk of relapse to opioid use without opioid pharmacotherapy, close outpatient monitoring, and structured support (as indicated by his or her lack of awareness of relapse triggers, difficulty in postponing immediate gratification or ambivalence toward or low interest in treatment); or, the client is pregnant and requires continued opioid pharmacotherapy.

Dimension 6: Recovery Environment: The client has a supportive psychosocial environment to render OMT feasible. Significant others are supportive of recovery efforts, the client's workplace is supportive, the client is subject to legal coercion, the client has adequate transportation to the program, etc.; or, the client's family members or significant others are supportive, but require professional intervention to improve the client's likelihood of treatment success; or, the client does not have a positive social support system to assist with immediate recovery efforts, but he or she has demonstrated motivation to obtain such a support system or to pursue (with

assistance) an appropriate alternative living environment; or, the client has experienced traumatic events in his or her recovery environment (such as physical, emotional, sexual, or domestic abuse) or has manifested the effects of emotional, behavioral, or cognitive problems in the environment (such as criminal activity), but these are manageable on an outpatient basis.

OMT Placement and Management

All SAI-referred clients and DCP&P-involved clients who are not in treatment must be sent for an assessment UDS within 24 hours of assessment, when possible. Consider all treatment options if the UDS is positive for benzodiazepines and/or any other non-prescribed substance. If the client is already placed on OMT, or other SUD treatment program, the CC must obtain the last four UDS from the provider, described below.

The WFNJ SAI/BHI permits a three-month stabilization period to achieve a blocking dose of methadone. This stabilization period is in recognition that many clients continue to use and/or abuse opioids, and/or alcohol or other substances until a blocking dose of methadone is achieved.

If the client has been diagnosed with a mental health or medical disorder that requires prescribed medication by a physician, such as a benzodiazepine or other 'DEA scheduled' medication, a copy of this prescription must be presented to the CC before the client is placed or maintained on OMT. If the client has a prescription for a mental health disorder that was prescribed by a physician or APN without a psychiatric specialty (e.g., a benzodiazepine prescription written by a primary care physician), the client will need to complete a psychiatric evaluation within the three-month stabilization period to ensure accurate diagnosing with appropriate corresponding medication(s). Prescriptions for benzodiazepines, or other psychoactive/psychopharmaceutic mental health medications, are only accepted when they are written and monitored by a psychiatrist or psychiatric APN. The client must be willing to sign a release for the WFNJ SAI/BHI to communicate with the psychiatrist or medical practitioner. Many co-occurring disorder clients (SA2 or BH4) will likely be referred to concurrent co-occurring treatment to complement the OMT services they are receiving.

If the client requesting initial OMT treatment has been unsuccessful at previous non-medication assisted treatment attempts, and meets the criteria listed above, he/she may be placed on OMT; however, if the client's recent or current unsuccessful OMT treatment experience included more intensive levels of service, and continued use puts the client at risk, OMT treatment may be denied.

After referring the client to OMT, monitor the client's attendance and UDSs; and conduct regular ASAM-based Clinical Service Reviews (CSR) with the client's methadone program counselor.

If the client has poor attendance and/or tests positive for any non-prescribed substances, the CSR should include an expectation that the methadone counselor use motivational enhancement strategies regarding attendance and/or other drug use. Methadone dosage adjustment may be appropriate even before the end of the three-month stabilization period. If the client is still testing positive for opiates after three months on OMT, refer the client to the methadone clinic's physician for a possible dosage adjustment.

Upon three months of continued use, inclusive of the three-month stabilization period, proceed with a face-to-face follow-up session with the client. Offer a more intensive level of care to the client explaining that continued use of alcohol or other drugs places them at high risk for a possible overdose and reduces their likelihood of becoming work ready. Discuss the additional, necessary treatment options with the client and answer all questions the client may have.

If the client accepts the additional treatment recommendations to complement OMT, proceed with the following steps:

- Discuss the treatment recommendations with the provider (s) and enlist their cooperation.
- Conduct regular CSRs with the OMT provider and other treatment services providers, if applicable, utilizing the ASAM criteria in making clinical decisions about the client.
- If after three additional months of receiving OMT and attending a more intensive level of care, the client is stable on OMT with negative UDSs, determine if continued care or step down to OMT-only again is appropriate at this time.
- If the client continues to be symptomatic of continued opioid use, ask that the methadone clinic physician review the client's methadone dose for adjustment; and/or if the client continues to be symptomatic of continued other drug/alcohol use, schedule a follow-up appointment with the client to discuss client safety and assess the need for office-based or residential withdrawal management.
- If the client refuses withdrawal management and/or a residential placement**:**
  - Flag the client in Atlantis as being a "high-risk methadone client"
  - Inform the client that their WFNJ SAI/BHI case will close at the end of the administrative withdrawal management period
  - Inform the client that if welfare refers them back to the WFNJ SAI/BHI, they will not be placed on methadone.
  - Inform the client that they may remain on methadone as a self-pay or through their NJ FamilyCare, but that their WFNJ SAI/BHI case will close, which could have a negative impact on their benefits.
  - Contact the methadone provider to begin administrative withdrawal management according to the provider's methadone withdrawal management protocol.
- When the client does not respond or show up for two follow-up appointments scheduled for the purpose of reviewing and reassessing whether the client should continue in OMT, or to be referred to a more intense level of care, the CC should contact the treatment provider to arrange for an administrative withdrawal management and to inform the client.

Clients Already Placed on OMT

If a client is already placed in OMT at the time of assessment and is requesting WFNJ SAI/BHI funding to be maintained on OMT, the client will sign a release so that the WFNJ SAI/BHI can contact the provider to obtain the last four urine drug screen (UDS) results and a treatment progress report. If the client has had positive UDS results and/or a negative progress report,

he/she will be expected to attend additional substance use disorder (SUD) treatment services as stated above. If the client refuses additional SUD services, the WFNJ SAI/BHI cannot accept the client because his/her refusal is prohibiting the goal of work readiness.

OMT Policy Quick Reference Guide

Client assessed not currently on OMT

You may place a client on OMT when the client has met all of the following:

1. Met *The ASAM Criteria* for OMT
2. Failed previous treatment attempts with non-medication assisted treatment. (If the client has never been placed in any treatment before, they cannot be placed in OMT, they must try another LOC first.)
3. Successfully completed the OEE, collateral information obtained and previous EOCs have been reviewed.
4. If the client tests positive for non-opioid substances who meets *The ASAM Criteria* for OMT and an additional level of care is needed, such as IOP or PC, the CC must make the referral.
5. No positive UDS for other substances that may cause harmful drug interaction and/or require the need for withdrawal management services, such as benzodiazepines, alcohol, or methamphetamines.
6. If the client states he/she has a prescription for the benzodiazepines the client must provide a valid prescription from a psychiatrist, not a primary care physician. (Release signed and prescribing psychiatrist is aware client is on OMT.)
7. Agreed to and signed the "Client Responsibility and Treatment Agreement" for OMT and any other levels of care or recommendations

Client assessed currently on OMT

You may begin authorizing payment when the client has met all of the following:

1. Met *The ASAM Criteria* for OMT
2. Client has successfully completed the OEE (Collateral information obtained and previous EOCs have been reviewed)
3. If the client states he/she has a prescription for the benzodiazepines he/she must provide a valid prescription from a psychiatrist, not a primary care physician. (Release signed and prescribing psychiatrist is aware client is on OMT.)
4. Client has agreed to and signed the "Client Responsibility and Treatment Agreement" for OMT and any other level of care or recommendations

All new OMT clients are given up to three months to stabilize and build up to a blocking methadone dose, cease substance use, and engage in all treatment or other recommendations.

All clients assessed already on methadone maintenance, in need of an additional level care, are given three months to engage in treatment and adhere to any other recommendations.

If sufficient progress has not been made within three months at the initial level of care and the client is in violation of their agreement due to positive UDS or not adhering to recommendations:

1. The client is brought in for a follow-up meeting
2. An ASAM evaluation is conducted to determine current level of care and service needs
3. The client agrees to the new recommendations and signs the "OMT At-Risk Client Agreement"
4. If the client refuses the new recommendations, inform the client that they have 30 calendar days to change their mind to accept the new plan and that you will no longer be permitted to pay for their methadone
5. Inform the provider that you will authorize OMT for the next 30 calendar days or until the completion of an OMT detox (if the provider agrees to the detox)

Care Coordination of NN and MH SAI/BHI Clients

All efforts should be made to place clients in network substance use or co-occurring treatment providers at all times; however, as it occurs, many clients are referred to the SAI/BHI who are already placed in non-network (NN) substance use or mental health (MH) providers and they do not want to change programs.

The following guidelines were developed to define improved Care Coordination practices for clients who will be placed, or are already attending, non-network and mental health providers. **Beginning immediately, clients who consistently attend a NN or MH provider who are in good standing with his or her GA or TANF benefits should not be closed prior to 6 months of monitoring** (there will be one exception described later in this document).

All clients who placed in NN or MH treatment providers must have at least one monthly contact; this can be conducted by a face-to-face follow-up or engagement phone call to the client. These monthly contacts are particularly important for clients who are attending NN or MH treatment providers who are notoriously non-adherent to our reporting requirements. The clients should be asked to obtain the missing information (i.e., attendance, UDS, CSR) to avoid sanctions to his or her benefits.

By implementing monthly client contacts for clients enrolled in NN and MH treatment providers, and by engaging the clients with assisting the CCs with obtaining missing attendance, UDS, and CSRs, we should eliminate the need to close cases for "Lack of Provider Reporting" with non-reporting providers.

These new monthly client contacts for clients placed in NN or MH providers are the responsibility of the Care Coordinators; however, the Care Coordinator is permitted to delegate this task to their Care Coordinator Support Specialist (CCSS) if the CC's caseload is very high and time does not permit additional monthly follow-ups. The CCs must always inform all of their clients that they have a Care Coordination partner and tell the client their name; the CC will give all clients their business card and the CCSS's business card. The statewide CCSS county distribution list is below, all CCs will be given their corresponding CCSS's business cards to give to the clients:

Ebony Martin– Burlington, Monmouth, Ocean
Sheama Walker – Camden
Sally Lopez – Atlantic, Cape May, Cumberland, Gloucester, Salem
Ryane Gouveia – Mercer, Middlesex
Leonely Maarouf – Union
Vickie Winberg – Hudson, Hunterdon, Sussex, Warren
Eulisa Lucero – Bergen, Morris, Passaic, Somerset
Kiana David- Essex

Topics for monthly client contacts:

- Check-in to see how things are going.
- Are there any barriers to treatment?
- Have any new problems arisen that you can help with?
- Did the client attend all scheduled appointments (e.g., doctor, dentist, psychiatric evaluation)?
- If attendance, UDS, or CSR has not been received, the client must be instructed to assist you with obtaining. (This is how we can reduce the number of case closures for "Lack of Provider Reporting.")

Clients referred and already placed in NN or MH treatment:

Several counties refer clients to the SAI/BHI who are already placed in non-network or mental health OMT, OP, IOP, or PC. Within 24 hours of completing the assessment, the CC must contact the current treatment provider to obtain the client's participation and attendance, and to ensure all client needs are addressed in that level of care. The CC may need to be persistent as some providers are not responsive to our outreach attempts and the clients may need to get involved to assist the CC with this endeavor.

If the client is placed in a MH provider and denies a history of substance use, and there is collateral information by the CWA or DCP&P in agreement with the clients denial of a substance use disorder (SUD), and there are no previous EOCs for SUD or co-occurring treatment, the client may remain in the current MH program with no additional treatment referrals following the guidelines below.

- **The one exception to the 6-month monitoring rule:** If the client has a medical deferral and is deemed "unemployable" and has already been in NN or MH treatment for at least 6 months with verification, and the client's needs are appropriately addressed (housing, transportation, medical, LSNJ, etc.), then the case can be closed in 30 days from the date of assessment as "Successful Discharge."
- Prior to closing this type of case at 30 days, there must be clear documentation in the service log that the client's attendance, participation, needs, and psychiatric stability for the last 6 months do not warrant additional services.
- There must be a service log entry that contact with the client has occurred at approximately 30 days from the date of assessment to discuss ongoing care and to inform the client that his or her BHI case will be closing.
    - If the client does not have a medical deferral, is deemed "employable", and has been in MH treatment for at least 6 months with verification, this case must be monitored

for participation for a minimum of 6 additional months, while in good standing with benefits, to ensure employment-directed movement.

- If any client has not been in MH treatment for at least 6 months, or has outstanding needs, the CC must continue to coordinate care until such time it is deemed clinically appropriate to close the case, but no less than 6 months from the date of assessment.
- As always, all clients with chronic medical and/or psychiatric disorders in need of assistance with their SSI/SSD application must be referred to LSNJ. The only exception applies to an individual who can provide current evidence that they are working with a community law project or private attorney for Social Security benefits.

Clients who are referred as a BHI client but denies MH symptoms:

- If the client denies a history or current psychiatric symptoms, an inquiry must commence to determine the purpose of the referral. The CC will contact the referring agent to obtain their rationale for the referral.
- If it is determined that collateral information differs from the client's self-report, and the referring agent indicates the need for treatment, the client should be referred for appropriate treatment.
- If a BHI-referred client denies a history of mental health symptoms and/or substance use and there are no previous EOCs for substance use or co-occurring treatment, and the referring agent does not supply adequate information to support the need for MH or SUD treatment, the case may be closed immediately as "Treatment Not Indicated." **As always, the CC must seek senior management approval before closing these cases and all information and verification must be thoroughly documented in the service log.**
- If the client does have a history of substance use and does not meet the criteria for full remission, he/she is not a BH3 client and should be referred for co-occurring treatment in a network treatment program.

Case Worker Referral Response Form

The Case Worker Referral Response Form (CWRRF) provides the County or Municipal Welfare Caseworker with notification of a client's level of participation in work or work readiness activities, as well as the need for arranging childcare, housing, and transportation supports for the client. This is a critical piece of documentation that must be transmitted from the SAI/BHI staff to the Welfare Caseworker regularly.

A new CWRRF is completed and forwarded to the Caseworker for any of these reasons:

- If a client does not show for assessment
- If the SAI/BHI case is closed
- If the client is assessed and treatment is not indicated
- If a client shows for assessment and patient placement is arranged

- If a client is referred to a new level of care and/or Treatment Provider (and availability for work activities has changed)
- If a client does not enter treatment as scheduled
- If a client is assessed but refuses treatment
- If a client drops out of or is administratively discharged from treatment
- If a client is successfully discharged from treatment
- If any update is made in the case of which the Caseworker needs to be aware
- Every month for clients who have an open SAI/BHI case, even if there has been no level of care change
- Any point in time when sanction may be required, e.g., failure to attend the assessment, failure to adhere to treatment recommendations, failure to attend treatment, etc.

The CWRFF forms will continue to be sent to your designated contact person/workers at a County or Municipal Welfare Agency at any point of client contact that requires communication (e.g., no-show for assessment, assessment completion, refused treatment, left treatment, discharged from treatment, etc.). If there has been no change to a client's status, a CWRRF is sent monthly to provide information on SAI/BHI treatment placement and participation. This monthly report must document in the comment box the number of days that the client was scheduled for treatment in the last 30 days and the number of days they actually attended during that time; the CC must also include the number of episodes of care the client has had with SAI/BHI.

If you identify a client who is stable, regardless of Med-1 status, and could likely participate in a work activity or other employment-directed activities (i.e., job skills training, educational programs, etc.) in addition to the information above, you must begin to use this phrase: ***Client is stable, please evaluate client to engage in other/additional activities. Please call for additional information, if necessary.***

If a worker asks you what it means for them to "evaluate" the client, tell them that you are giving your recommendation of stability for other activities, but the worker needs to see if there are other factors, such as a Med-1 or other deferral/waiver, that would suggest they may not be recommended for a work activity.

If a SAI/BHI client is deemed unstable and participating in treatment, and cannot engage in other activities, the CC must provide a narrative as to why the client remains unstable, below are examples, you may use one or more, or use your own similar words. Please note, if you have a SAI/BHI client in level 1 treatment, there must be a very good reason why that client is not deemed stable to engage in other/additional activities; meaning, a work activity or a higher level of care:

Client is not stable to engage in other/additional activities because

- ***Client has a severe and persistent mental health disorder.***
- ***Client is making progress at this level of care, but continues to need support and structure at this level of service.***
- ***Mental health symptoms are interfering with daily living functioning.***

- ***Client is utilizing therapy to address mental health symptoms but continued care is required.***
- ***Client is not appropriate for a higher level of care due to mental health symptoms that would prohibit participation in a group setting.***
- ***Additional level of care is not available because of a language barrier.***
- ***Client reported he/she is pursuing social security benefits.***

Then, ***Please call for additional information, if necessary.***

DFD is asking the counties and us to increase the communication between us, hence the request for the workers to call the CCs asking for additional information, if necessary. Please ensure that your phone number is correct on the bottom of the CWRRF; if it is not, please send the Director your correct phone number and she will change it. When you do speak with the workers, please remember that you are not permitted to disclose clinical information, including diagnoses and UDS results, but you can emphasize a client's stability, or lack thereof, for employment-directed activities.

WFNJ SAI/BHI Case Closure Choices:

ADMINISTRATIVE DISCHARGE –This case closure should **only** be used when the CC has determined that further services are not likely to result in additional treatment progress and the client has been discharged from all levels of care. Typically, these clients are "red-flagged" in Atlantis due to hostile, defiant, or threatening behaviors. This differs from "Client Non-Compliant" in that the client has been discharged from treatment due to ongoing behavioral issues. Reminder: You must look into the client record; if the client completed one level of care, stepped down to a lower level of care, or is employed/or in a full-time work activity at the time of completing treatment, you will not use this choice (see below for definitions).

EMPLOYED/FULL TIME WORK ACTIVITY- A client stops attending treatment due to employment or participation in a full-time work activity. The client may not have completed all treatment goals and may continue to have positive UDS; however, he/she is sustaining employment or participation in a work activity.

LACK OF PROVIDER REPORTING - If the MH treatment provider has failed to provide the required weekly attendance, UDS results, or to engage in a Continuing Service Review and outreach attempts to the client have failed. This Case Closure Choice is used for mental health providers only, it would rarely be used for network or non-network providers.

NOT SAI/BHI/MEDICAID ELIGIBLE – The client is ineligible at the time of referral and does not become Medicaid eligible within 30-60 days; or, if the client becomes ineligible after the assessment has taken place at some point in the future. Reminder: You must look into the client record; if the client completed one level of care or stepped down to a lower level of care for "Successful Discharge," or is employed/or in a full-time work activity, you will not use this choice.
This choice would be used if a client begins to collect SSI/SSD or moves out of state, hence, closing their GA/TANF case and making them ineligible, and they did not meet one of the criteria for Successful Discharge.

REFUSED TREATMENT – If the client refuses the treatment recommendation at the time of the assessment or fails to show for the INITIAL scheduled treatment referrals. This choice is not used if a client fails to show for subsequent treatment referrals, only the first treatment referral for that episode of care.

SUCCESSFUL DISCHARGE – Client has met one of the following criteria:

1. Client entered any level of care and completed treatment goals for that level of care (except for clients entering level 3.7WM OR level 4 only). It may be clinically indicated that the client continue at next lower level of care, but does not start, this is still considered a successful discharge.
2. Client entered any level of care and subsequently entered a less intensive level of care.
3. Client enters any level of care and is known to be employable (but not employed or in a work activity) at the time that their SAI/BHI case is closed.
4. A DCP&P client entered Level 1for an extended evaluation on request from DCP&P (meaning a PPL was created for Level 1 services) and completed all treatment goals. (This case closure is not used for UDS only Extended Evaluation clients.)

CLIENT NON-COMPLIANT- If the client enters treatment and stops attending treatment. (It is not considered "Refused Treatment" if the client fails to enter the next recommended level of care.) This closure code is also used if a client consistently fails to meet service plan goals and attendance is consistently less than 75% and/or continues to have positive UDSs. Reminder: You must look into the client record; if the client completed one level of care, stepped down to a lower level of care, or is employed/or in a full-time work activity at the time of completing treatment, you will not use this choice.

FAILED TO COMPLETE ASSESSMENT – Client actually started the assessment but did not stay to complete the assessment and did not return within 30 days to complete the assessment; or, a SAI or DCP&P client completed the ASI but did not show for the UDS portion of the intake assessment within 30 days. This choice is also selected when a DCP&P client fails to complete a UDS ONLY Extended Evaluation.

REFUSED ASSESSMENT – Client is never assessed (either no show or cancelled the appointment by the client, caseworker, or other entity). If they do not show for the assessment within 30 days, it is considered a refusal.

TREATMENT IS NOT INDICATED – If the client is determined not to need treatment after the assessment/intake UDS has taken place for SAI clients; or, if the client successfully completes a UDS ONLY Extended Evaluation for DCP&P clients. (If successful completion of a Level I Extended Evaluation, it is considered Successful Discharge.)

DECEASED- Case closed due to death. If client met one of the four criteria for successful discharge or was working or in a full-time work activity at the time of death, you must indicate that information in the case closure summary.

INCARCERATED- Case closed due to incarceration and did not meet one of the four criteria listed above for Successful Discharge or Employed/Full Time Work Activity. It is expected that the client will be incarcerated for 30 days beyond SAI/BHI case closure date.

MEDICAL CONDITION OR HOSPITALIZED- Case closed due to medical condition that prevents client from participating in a WFNJ SAI/BHI or other work activity; or case closed due to medical or psychiatric hospitalization. In either case, client did not meet one of the four criteria listed above for Successful Discharge or Employed/Full Time Work Activity. It is expected that the client will be ill or hospitalized for longer than 30 days beyond SAI/BHI case closure date.

DRUG COURT- It is determined at the time of assessment that the client is not eligible for the SAI/BHI due to participation in a residential State of New Jersey Drug Court Program.

Extended Evaluation Case Closures (Extended Evaluations for DCP&P clients):

- If a DCP&P client successfully completes a Level I Extended Evaluation, the case should be closed as "**Successful Discharge**."
- If the DCP&P client successfully completes a UDS ONLY Extended Evaluation, the case should be closed as "**Treatment Not Indicated.**"
- All **Level I Extended Evaluation** DCP&P clients who fail to attend their scheduled groups or individual sessions or fail to go for their weekly UDS should be closed as "**Non-Compliant.**"
- All DCP&P **UDS ONLY Extended Evaluation** who fail to attend their weekly UDSs only should be closed as "**Failed to Complete Assessment.**"

Client Emergency Transportation Fund
Guidelines & Procedures

The SAI/BHI program maintains funds to provide client support, which includes emergency transportation to clients as needed. The fund is intended to facilitate client travel when no other option is available under the following circumstances:

- Transportation to and from an assessment (on rare occasions)
- Transportation to and from residential treatment (admission and/or discharge)
- Transportation to and from a halfway house interview, only if a phone screening is not possible
- Transportation to and from IOP, PC, or OP treatment until medical transportation/bus pass becomes available or if there is no other form of transportation available.

Medical transportation can usually be arranged through the current Medicaid transportation provider for one time travel, with 24-hour notice, or for standing orders, including bus passes, in urban areas.

Care Coordinators are to use other transportation options if they are available within a reasonable amount of time. These options may include county welfare agencies, treatment providers, and client resources. If emergency transportation is required on an ongoing basis, efforts must be made to utilize the Medicaid transportation company (LogistiCare).

In addition to this general policy, Care Coordinators must adhere to the following guidelines and procedures:

- Other transportation options must be explored and ruled out before Client Emergency Transportation Funds are used.
- The Lead Care Coordinator must be contacted to obtain approval for use of funds. Regional Manager approval is necessary in the absence of the LCC. The Director must approve any single expense in excess of $300.00.
- Emergency transportation funds may be used to purchase bus or train tickets; bus or train passes; or cab services.
- In order to maximize the availability of these resources, public transportation should be used wherever possible, particularly for clients attending outpatient services. However, client safety should not be compromised and taxi services should be used where clinically appropriate.
- If using bus/train tickets or bus passes, the LCC will contact the NCADD-NJ Accounting Office (lvidetti@ncaddnj.org, abeene@ncaddnj.org) to make payment arrangements.
- If using a taxi service, staff must use one of the NCADD-NJ approved vendors listed on the Taxi Cab Company chart and use the taxi company closest to the client pick-up location.
- After approval to use a taxi service is obtained, the CC may contact the cab company directly to set up the transportation service for the client and to determine what the charges will be.
- The CC should identify themselves as being a CC from NCADD-NJ and reference the agreement we have for them to bill NCADD-NJ.
- If the cab company requires additional agency verification or requires an American Express card number, the CC should contact the RM to have him/her complete the arrangements.
- The CC should complete the "WFNJ SA/IBHI Emergency Transportation Request Form" and forward it to the LCC for ALL TRANSPORTATION REQUESTS.
- In the event that the cab company does not provide the requested and approved transportation, the CC will complete the bottom of the "WFNJ SAI/BHI Emergency Transportation Request Form" and fax it to the LCC and the NCADD-NJ Accountant so that the cab company is not reimbursed.

Emergency Transportation Request Form

Client's WFNJ #: _____ Client's County of Residence: _____
Reason Emergency Transportation Needed:
_____
_____

This request is for: (check one) _____ a single trip_____ ongoing transportation/commuting to outpatient services (may be approved for up to one month)

Method of transportation: (check one) _____ cab _____ bus _____ train _____ other

Estimated Cost of single trip/ monthly commuting expense: _____

Departure Address:

_____

Arrival Address:

_____

Cab Company Name: _____Cab Phone #: _____
Trip Date:_____ Cab Company Contact: _____

Care Coordinator: _____ Date Requested:_____

ALL REQUESTS MUST BE FORWARDED TO THE LCC FOR APPROVAL!
LCC Signature: _____ Date Approved: _____

SINGLE EXPENSES OVER $300 REQUIRES DIRECTOR APPROVAL
Director Signature: _____ Date Approved: _____

* IN THE EVENT THE CAB COMPANY DID NOT PROVIDE THE TRANSPORTATION REQUESTED, PLEASE FILL IN THE INFORMATION BELOW AND FORWARD TO LAURA VIDETTI, NCADD ACCOUNTANT, AND LCC.

Reason Transportation not Provided:_____
Cab Company Contact: _____
Date:_____ Time:_____

Section Three- DCP&P Procedures and Forms

Managing DCP&P Clients in a SAI/BHI Caseload

- At the time of assessment, all TANF and GA clients are asked if they have current or past involvement with DCP&P.
- If the client has an open DCP&P case, the CC obtains a signed multi-agency release to contact the DCP&P worker, which should include permission to disclose information between DCP&P and the treatment provider so that the CC can report

attendance and UDS results as needed. If the client refuses to sign the release, the case is referred back to the CC's immediate supervisor to follow up with and outreach the DCP&P worker in that County.

- The ASI assessment is completed with client and the service plan is reviewed with the client.
- When an assessment is completed with a client that has an open DCP&P case, the CC initiates contact with the identified DCP&P worker by phone or via email regarding WFNJSAI/BHI involvement in the case. Standard DCP&P email address is: firstname.lastname@dhs.state.nj.us. If necessary CC can contact DCP&P CW during the assessment or immediately after to discuss treatment recommendations and to obtain any updated client history.
- CC will fax release form to designated UDS location.
- Client will then go to the designated UDS location.
- **CC completes the ASAM Assessment Summary Service Note and faxes it to the referring DCP&P caseworker.**
- CC completes CWRRF and DCP&P RRL and faxes to appropriate caseworkers.
- CC will make the treatment referral per policy requirements.
- Providers should be notified that client has an open DCP&P case.
- Once UDS results are received, the CC will then input data into the database, and create the PA.
- All communication to DCP&P should be noted in the Service Log.
- CCs are to fax a DCP&P Monthly Update to the DCP&P worker every month unless they need to report one or more of the following negative events:
    - Treatment attendance drops below 75%
    - Client has a positive UDS result(s)
    - Client presents with indicators of child abuse and or substance abuse
- CCs must contact their supervisors prior to closing any TANF or GA case with DCP&P involvement.
- If a CC has an open DCP&P case in a County where there is a designated DCP&P CC then the case should be transferred to that CC in the event the case needs to be presented at a consortium.

The DCP&P Referral Response Letter (RRL)

The Referral Response Letter (RRL) provides the DCP&P Caseworker with the information necessary for child safety and collaboration of client care at the time of the assessment. This is a critical piece of documentation that must be transmitted from the SAI/BHI staff to the DCP&P Caseworker at the time of assessment and for any of the following reasons:

- If a client does not show for assessment and outreach will be conducted to reschedule the appointment
- If the SAI/BHI case is closed
- If the client was assessed and did not self-report a substance abuse problem (they are sent for an extended evaluation)

- If a client shows for assessment and patient placement is arranged
- If a client is referred to a new level of care and/or Treatment Provider (and availability for work activities has changed)
- If a client does not enter treatment as scheduled
- If a client is assessed but refuses treatment
- If a client drops out of or is administratively discharged from treatment
- If a client is successfully discharged from treatment
- If any update is made in the case of which the Caseworker needs to be made aware
- **Every month for clients who have an open SAI/BHI case, even if there has been no change in client status.**

The DCP&P Update

The DCP&P Update is to be completed and faxed monthly, or any time there is a change to a client's status, to the DCP&P worker. It provides the DCP&P worker with information about the client's participation in the SAI/BHI. All relevant information must be communicated to DCP&P on a regular basis, including attendance and participation in treatment, employment-directed activities, client or child needs, and UDS results.

This form is to be completed by opening up the "Treatment" tab, the "DCP&P Update" menu option and then selecting "New Update." You will then select the appropriate information in the drop-down fields and check boxes on the entire form. In order for you to select a treatment provider, you must have created a PPL in order for it to show up in the dropdown selection. If the client will be attending treatment at two different treatment providers then there must be two PPLs created. Once you select "Save and Print," the data will be saved and the form will automatically fill in the client's identifying information to send to the DCP&P worker. Select the "Created" box to print previously created forms.

Guidelines for Completing the Child Welfare Reform Plan (CWRP) DCP&P Substance Abuse Consortium Case Conference Form and Case Conference Follow-Up Form

Choosing the case for presentation

- Begin to think about what case(s) you would like to present at least one month prior to the scheduled case conference. It is best to choose a difficult case that you really need help with and a case that clearly demonstrates potential for interagency cooperation.
- Ask yourself, "What is it that I would like to get by presenting this case?" That is, what is your goal for presenting this client's case at the Consortium? This stated goal would be the introduction to your case presentation on the day of the Consortium. The stated goal will give the presentation direction and promote increased interagency participation.
- Review your chosen cases with your direct supervisor during individual supervision and discuss and clarify your case presentation goals. If it is agreed that the cases are not appropriate at this time for presentation, choose alternative cases and identify goals with your supervisor.

Preparing for the case presentation

- Go into the database and closely read ASI, the ASAM Assessment Summary, and all subsequent ASAM Notes for each episode of care. You will also want to review all other data in the current EOC in the electronic record (including attendance and UDS results) to become thoroughly acquainted with the case. Become the clinical "expert" on the case by understanding the client's treatment experience and history of involvement in the WFNJ SAI/BHI (including previous episodes of care). What worked and what did not work?
- Do some detective work to determine if there are gaps or inconsistencies in the client's record. For example, why was the client initially referred to DCP&P? Is the client a good historian in giving you important information regarding the whereabouts of the children/significant others**? You must verify your information with DCP&P, Welfare, and/or the treatment provider before presenting it at the consortium.** At the very least, attempt to contact DCP&P through an email and telephone call and document your attempts in the "Service Log."
- The best defense is a good offense, therefore, predict what questions the members of the consortium may ask and answer the questions in your report before they ask them. This allows for more time to develop a team plan and eliminates unnecessary discussion about conflicting client information.
- Invite the client in for a follow-up appointment, or call the client, before the case conference so that you have the most up-to-date, accurate information.
- It might be helpful to do a paper ASI to update client information.
- Before you go to the case conference, print out the complete, most recent "Service Log" to bring with you. This serves as a back-up and/or guide to verify the work that you have done with the client and participatory agencies.

Completing the top section or client demographic sections of the Case Conference Form

- Start with a blank form and begin to fill out the Form at least two weeks prior to the presentation date.
- Be sure to fill in all of the requested information on the Form. Don't forget to select the correct county in the drop-down. **Do not leave any space blank. If it's not applicable to the client, write N/A.**
- Client information includes the top section listing the referral, assessment and admission dates. As with all of the information, insure that the dates are correct and make sense.
- Complete the client's *Housing Arrangements*, *Client information*, *Income Information* and *Legal Issues/History***. Note that the WFNJ # under the *Income Information* refers to the client's welfare number not the SAI/BHI WFNJ #. The DCP&P ID# is the same as the NJ Spirit#.**
- Complete the client's *Living Arrangement/Members of Household* information as per the key at the bottom of the Section. If you do not have the information or are not sure about the accuracy of the information, call DCP&P, welfare, or the client to verify. Include the child's name, DOB and age.

Completing the Clinical Section of the Case Conference Form

- *Dimension information* should include the *Previous Placement Dimension* rating and the *Current Placement Dimension Rating*. If this is a new case and you only have the

Admission ASAM Dimensional Rating, only include the Admission Rating or *Current Placement Dimensional Rating.* Each Dimension should have a problem statement or "NCI" if applicable, followed by a level of care.

- Picture the client in the "Here and Now," emphasizing the present and minimizing the history as you prepare the clinical piece.
- Under *Drug of Choice*, include a brief client description to include the 3 H's (History, Here and Now and How worried are you about this dimension?) on each of the 6 Dimensions. Go into the *Drug of Choice* story in Dimension 1 and/or 5. This client description will be a good way to introduce the client following your stated goal when you present the case.
- Although the *Recent Treatment Placement* includes a description of the client's most recent treatment placement, it is a good idea to briefly describe the client's past treatment experiences with the SAI (what worked and what did not work?). What was the client's response to treatment in prior episodes of care? What is the client a customer for? What leverage do we need to use?
- Complete the *Urine /Drug Screen Results* Section. If there are few or no UDS results on file, document your attempts to get these from the treatment provider.
- *Barriers in Treatment/Work Activity and Plan Suggestion* is the heart of the case presentation. In a nutshell, what are you most concerned about with this client and what is your plan of action? Consider the parties that attend the consortium meeting and clearly identify the individuals and/or agencies that you need assistance from in order to achieve your goal.

Completed After Case Presentation by CC

- The rest of the Case Conference Form is completed by the CC after the case conference.
- Directly following the case presentation, write in the information regarding the *DCP&P Case Status/Date of most recent home visit* and *Welfare Case Status/Number of years on Welfare.* You may need to ask these systems for this information if it is not provided at the case conference.
- Write in the *Team Plan of Action* for all participants and sign your name in the designated "Case Manager" area on the bottom of the last page. Complete the *Case Closure Planning* section, if applicable. Place the completed Form in the hard copy of the client's chart.
- Act on the SAI/BHI section of the *Team Plan,* assess client progress and begin to document the results for Follow-Up.

Completing the top section or client demographic sections of the Case Conference Follow-Up Form

- Start with a blank form and begin to fill out the Form at least two weeks prior to the presentation date.
- Be sure to fill in all of the requested information on the Form. Don't forget to select the correct county in the drop-down. **Do not leave any space blank. If it's not applicable to the client, write N/A. Most of this information will be the same as on the initial case conference form; however, make sure to provide the most up-to-date information you have.**

- Client information includes the top section listing the referral, assessment and admission dates. As with all of the information, insure that the dates are correct and make sense.
- Complete the client's *Housing Arrangements*, *Client information*, *Income Information* and *Legal Issues/History*. **Note that the WFNJ # under the *Income Information* refers to the client's welfare number not the SAI/BHI WFNJ #. The DCP&P ID# is the same as the NJ Spirit#.**
- Complete the client's *Living Arrangement/Members of Household* information as per the key at the bottom of the Section. If you do not have the information or are not sure about the accuracy of the information, call DCP&P, welfare, or the client to verify. Include the child's name, DOB and age.

Completing the Clinical Section of the Case Conference Follow-Up Form

- *Current Status of Client with the SAI/BHI* should include the client's current level of care and adherence or non-adherence to the recommended treatment plan. Include a brief description of the outcome of any interventions that were planned at the initial case conference. The current status will be a good way to introduce the client following your stated goal when you present the follow-up.
- Complete the *Urine /Drug Screen Results* Section. If there are few or no UDS results on file, document your attempts to get these from the treatment provider.
- *Barriers in Treatment/Work Activity and Plan Suggestion* is the heart of the case presentation follow-up. In a nutshell, what are you most concerned about with this client and what is your plan of action? Consider the identified roles and/or actions of the parties that attended the initial case conference and their follow-through (or lack thereof) on the team plan. Report the facts and do not offer opinions about the execution of the team plan. Clearly identify the individuals and/or agencies that you need assistance from in order to achieve your goals if they have not yet been met.

Checklist for Completing the DCP&P Case Consortium Form

Identify the client background data
__Age
__Ethnicity and gender
__Marital Status
__Employment Status
__Referral Source
Give a brief explanation for each ASAM Dimension rating
Dimension 1:
__History of use (number of years and substance only; no quantity
__Current use: amount and frequency
__Need for withdrawal management
Dimension 2:
__Current medical problems
__Currently under a physician's care
__Compliance with medical medications
Dimension 3:

__Current mental health problems
__Currently engaged in mental health services
__Compliant with mental health services, and medications
__Suicidal/homicidal risk
__History of childhood abuse
__Current domestic violence
Dimension 4:
__ Stated or identified motivation for treatment
__Interest in changing
Dimension 5:
__Length of abstinence
__Recent UDS results
__Continued use risk or relapse risk
Dimension 6:
__Reason for DCP&P involvement
__Housing arrangement: Substance abuse in the household?
__Work readiness
Treatment History/Summary of Treatment
__Number of episodes of care with the SAI/BHI with case closure reasons
__Current treatment placement with start date and provider
__Attendance rate
__Degree of engagement in the treatment process
__Plan for course of treatment
Barriers in Treatment/Work Activity and Plan Suggestions
__Identified Problem
__Identified Plan

__Diagnostic impression and ASAM LOC is clearly defined and congruent within the narrative

Checklist for Completing the DCP&P Case Conference Follow-Up Form

Current Status of Client with SAI/BHI
__Identified SAI/BHI tasks from previous case consortium with follow through and client update
__Identified new problems since the previous case consortium
__Change in welfare status (sanction, case closure, etc.)
__Diagnosis and ASAM LOC is clearly defined and congruent within the narrative

WFNJ SAI/BHI Statewide DCP&P Protocol – Reporting Abuse and Neglect

Any person having reasonable cause to believe that a child has been abused or neglected has a legal responsibility to report it to the Division of Child Protection and Permanency (DCP&P). At the time of initial assessment, all Care Coordinators (CC) are expected to inform all WFNJ SAI/BHI TANF or GA-DCP&P clients of our affiliation with DCP&P and to ask clients to sign a release of information permitting communication with DCP&P. Clients who have custody of

their children are informed that failure to participate in substance abuse treatment, combined with ongoing substance use, could result in a referral to DCP&P. Clients who are known to have an open DCP&P case are informed that their treatment participation and progress, as well as UDS results, will be shared with DCP&P.

Communication with DCP&P for Open Cases:

- CCs are required to report routinely to DCP&P, monthly updates are sent with the current status of each client.
- When a negative event occurs, the CC and supervisor discuss the issues involved with the case and develop a plan of action. A phone call must be made to the assigned worker summarizing the negative event.
- The CC will also call the State Central Registry (SCR) to make the referral (**1-877-NJ ABUSE/ 877-652-2873**) and provide all relevant information concerning the child safety issues for all negative events. The CC will state they are calling with "reported information" and that you are not calling for a "new investigation" to be conducted. You must be prepared to answer **all** of the following questions on the SRC questionnaire, see following document.
- A negative event is defined as one or more of the following:
  - Direct observation or reasonable suspicion of child abuse or neglect
  - One or more positive urine drug tests
  - Treatment Attendance below 75% or no attendance for two weeks or more

How to Make a Referral to DCP&P for Non-Open Cases:

If a client does not have an open DCP&P case, a referral to DCP&P may be indicated if and when a negative event(s) occurs with a client.

- The CC alerts their immediate supervisor about the negative event(s).
- The CC and supervisor discuss the issues involved with the case and develop a plan of action. The CC calls the State Central Registry to make the referral (**1-877-NJ ABUSE/ 877-652-2873**) and provides all relevant information concerning the child safety issues. If the client has an open DCP&P case, request the NJ Spirit # and DCP&P worker's name and phone number. The CC enters that information in the database referral screen if it is not already there.
- The CC should include the client in the DCP&P intervention if the client is present.
- If the client is in treatment, the CC notifies the treatment provider that a referral has been made to DCP&P.
- The CC documents all actions and communications in the Service Log:
  - Document the call to DCP&P hotline and the contents of the conversation
  - Document the communication with the treatment provider

What to Do if a Client Refuses to Sign a Release for DCP&P:

- The CC should acknowledge that the client has the right of refusal to sign a release; however, they should use motivational interviewing to encourage the client to sign the release as the SAI/BHI can be strong advocates on their behalf.

- If the client is adamant about refusing to sign the CC should inform the client that they can breach confidentiality if they fear that a child is in imminent danger of abuse and neglect.
- The CC should inform their immediate supervisor that the client has refused to sign the release and document the information in the database.
- The CC should inform DCP&P that the client has refused to sign a release and that they will not be able to provide further information.

As mandated reporters, we must express our concern regarding positive UDSs or other negative events (failure to go to treatment, failure to engage in treatment, poor treatment participation over time, dropping out of treatment, etc.), which place child safety at risk.
The SAI/BHI Care Coordinators call Centralized Screening (DCP&P hotline1-877-NJ ABUSE/ 877-652-2873) on all active and non-active DCP&P cases whenever there is a negative event that affects child safety/risk. The DCP&P caseworker and supervisor are also notified.
The research on caretaker/parental substance abuse and child endangerment is overwhelming. Given the fact that approximately 30% of our cases are already active with DCP&P, the SAI/BHI's policy of mandatory reporting ensures DCP&P is made aware of our genuine concerns regarding child endangerment. How our calls to the hotline are handled once they are made is a matter of DCP&P policy.
These are high-risk, complex, and difficult cases. The SAI/BHI's mandatory reporting of negative events shows our commitment to child safety and prevention of further abuse/neglect.

Calls Regarding Positive Urine Drug Screen and Non-Compliance with Treatment Plans: SCR's Frequently Asked Questions

When calling SCR about a client who has tested positive on a urine drug screen or is non-compliant with his/her treatment plan, please be prepared to answer the following questions appropriate to the situation:
When was the last positive urine screening and the date the screening was administered?

- How often are they tested?
- How long has the parent been in treatment?
- How many previous positive drug screens have been provided since the beginning of treatment?
- Is there a pattern of current drug use or is this an isolated incident?
- Are the levels decreasing or increasing from the last drug screen (if applicable)?

What is the parent's preferred illicit substance (i.e., drug of choice)

- Have they had positive screenings for other substances?

- Is the parent the primary caretaker of their children?
- Is the provider aware of any instances where the parent was caring for their children (or other children) while under the influence?
- Does the parent abuse drugs in the presence of their children
- Where is the parent using (i.e., at home, outside on the porch/backyard, socially, etc.)?

- Do the parents have any supports (i.e., another non-abusing adult that resides in the home and is supportive of their sobriety)?
- Is the provider aware of any other adults abusing drugs in the home and/or associated with anyone who is abusing drugs?
- If the parent is not the custodial parent, then who has custody and what are the living arrangements?
    - If not, is the provider aware of contact or visitation of the children and are they supervised or unsupervised

Up until the reported concern, was the parent compliant with treatment?

- What is the parent's treatment history (i.e., has he/she been in treatment in the past?
    - If so, did they successfully complete treatment & is the current program providing similar services to what the client underwent in the past or is it different?
- Did the parent express/indicate any stressors or hardships that resulted in the relapse or non-compliance?
- What steps is your agency taking to address this issue?
- Will the parent's treatment level/plan be changed?
- Will there be any repercussions or violation from SAI/BHI due to the positive drug screen (i.e., terminating services due to non-compliance or welfare sanctions)?
- What are your recommendations for the parent moving forward?

Was the on-going case worker and/or supervisor notified of the positive urine analysis

- Was the client informed of the results? If so, what was the client's response?
- Has the provider observed the parent impaired, or in a condition that reflects intoxication?
- Can the provider explain how does this affect or impact the children involved?

Section Four – Pre-Authorization and Utilization Review

Developing Pre-authorizations

The Service Pre-authorization and Payment Authorization Process is the method by which treatment providers are paid for services rendered.

Before a treatment provider can be paid, the Care Coordinator (CC) must first develop a "**Pre-authorization.**" The pre-authorization created by the CC authorizes the treatment provider to provide specific treatment services for an individual client over a specified period of time. At the time of the assessment and during all future Continuing Service Reviews, the CC is responsible for determining the appropriate level of care and for deciding upon a treatment provider that will best meet the needs of the client.

All ASAM Notes (ASAM Assessment Summary, Re-assessment, and the ASAM Continued Service Review) summarize the clinical information that indicates the need for the level of care required. The pre-authorized service period and service units are included in the bottom sections of these documents.

An ASAM Pre-authorization Service Note is sent to the provider following the assessment and immediately after completing a continuing service review. The *ASAM Pre-authorization Service Note* is reviewed by the treatment provider so that the treatment providers are aware of the clinical rationale for the pre-authorized service period and units of service.

It is essential that the CC makes sure that the pre-authorizations are accurate and that there are no gaps in between pre-authorizations. If there is a gap due to treatment provider noncompliance with SAI/BHI reporting procedures, this information should be documented in the Service Log.

Accurate, timely, and seamless pre-authorizations are essential in order for the PA Unit to provide the treatment providers with accurate Payment Authorizations (PAs) so that the provider can be paid for the services that they provided to the client. Accuracy of pre-authorizations and data entry facilitates cohesion among the different units of the SAI/BHI, which are all involved in this very important process. It also promotes good client care and positive relationships with treatment providers.

All services must be pre-authorized. If a treatment provide would like to provide additional services, such as a psychiatric evaluation, or co-occurring therapy, they must be pre-authorized by the CC first. No retroactive payments will be provided, in other words, all treatment services must be pre-authorized BEFORE the services are provided.

CSR and Pre-Authorization Guidelines

1. All network and Non-Network (NN) treatment providers are required to call the CCs to conduct continued service reviews (CSR) for all levels of care. The Care Coordinator must not initiate a call to a SAI/BHI network treatment provider to conduct a CSR. There is one exception to this rule, for DCP&P clients in level 4, 3.7WM, or 3.7 nearing discharge, if the CC has not heard from the provider and the 2-day grace period has passed, the CC may call the provider to facilitate discharge to a lower level of care. This is the one and only exception.

2. Non-Network providers are required to call the CC to conduct a CSR. Once completed, the same guidelines apply for Non-Network providers as they do for network providers. The CC must generate an ASAM CSR Note with pre-authorizations for the Non-Network providers. Although we do not authorize payment for the non-network providers, we must enter the pre-authorizations. If the Non-Network provider fails to conduct a CSR or to send attendance/urine drug screens, the Intent to Close process will begin.

3. CCs are permitted to call Mental Health–only treatment providers and verbal attendance may be obtained. The PA Unit may be collecting attendance on some of these providers, too. No pre-authorizations should be entered for clients attending “MH-only” providers.

4. There is a 5-day (5 business days) grace period for providers to call the CCs to conduct CSRs for clients attending OP, IOP, PC, TC, and HH and a 2-day (2 business days) grace period for detox and SR. If a provider calls the CC after the 5-day or 2-day grace period has elapsed, the pre-authorizations must begin on the date that they called, they must not be backdated. The provider will not be paid for the missing days between the due date and the actual date they called.

5. If the provider does not call to conduct the CSR beyond the grace period, the Intent to Close process will begin. This means, that for any case that has a CSR overdue 7 or more calendar days, the client and provider will be sent an Intent to Close letter. These letters are sent every 3 weeks.

6. The client and the provider will receive the letter indicating our intent to close the case if the CSR is not conducted immediately; if not conducted by the date on the letter the PPL should be discharged by the LACC or CC. If the CC has not heard from a provider and the CSR is long overdue, and the CC is concerned about the client, the CC should reach out to the client to ensure their safety and that they are engaged in treatment, the CC should not call the provider

7. The CCs must enter the date that they actually conducted the CSR with the provider. The CSR may have been due on 3/2/15 but phone tagging took place and the call was not actually conducted until 3/5/15. The CC will enter 3/5/15 as the "Date of Review" on the ASAM Note.

8. Although there is a 2-day and 5–day grace period for the provider to call to conduct a CSR and not have a gap in pre-authorizations, the database has a 14-day (calendar days) CSR entry window from the due date of the CSR. For example, if a CSR was due on 3/2/15, and the provider called on 3/6/15 the CC has the ability to enter the CSR. If phone-tagging took longer than 14 days, and the CSR was conducted on 3/17/14, the CC will not be permitted to enter the CSR and an administrative override will be needed to enter the CSR and pre-authorizations.

9. If the CC is not available to conduct a CSR when the provider calls, the CC must make every attempt to call the provider back to conduct a CSR as soon as possible. Phone-tagging should never go beyond 7-10 calendar days. In the event that a CC is on vacation, medical leave, or will be out of the office for an extended period of time, the LCC is responsible to return all calls to the provider to conduct the CSRs.

10. Once the CSR has been conducted, the CC will have two business days to enter it into the database with the corresponding pre-authorizations. All attempts should be made to enter the CSR in real-time while on the phone with the provider. In the event that a CSR is conducted and the CC is not near a computer to enter the CSR, it must be entered within 2 business days or they will be locked out and prevented from entering the CSR. Weekends and holidays are excluded but not CC scheduled days off (SDO) for each CC; the CC will have two business days to enter the CSR and pre-authorizations. If phone tagging occurred and the CSR was conducted on the 14th day from the due date of the CSR, the CC will still have two business days to enter the CSR.

Important reminder! The "Date of Review" must be the actual date that the CSR was conducted, which is why the CC will have only two business days to enter it once they have spoken with the provider. The CC must never enter a false date for the "Date of Review" in order to stay within the 14-day entry window; the date must be the actual date that the CSR was conducted with the provider. The senior staff on good faith trust that CCs will be honest with their reporting requirements in order for us to maintain the integrity of the data we are collecting to track provider compliance and to report our findings to DFD.

The CC must speak with their supervisor if they are having a problem with entering the CSR within 2 business days of when it was conducted.

Length of Stay Pre-authorization Guidelines

The following desk guide lists the SAI/BHI Length of Stay Pre-authorization Guidelines and service unit rates. Typically, the CC may pre-authorize no less than and up to double the length of stay indicated on these guidelines before requiring a Continuing Service Review (CSR).

Doubling of the length of stay is **NOT** allowed for level 3.7WM or level 4 services, where a CSR must be completed **a minimum** of every 5 days.

It is important to remember that it CSRs are often indicated at more frequent intervals than double the length of stay indicated on the desk guide. There are also instances where the pre-authorization can be extended beyond double the length of stay guidelines. CCs should review these cases in supervision to determine the most appropriate pre-authorized length of stay for each individual client.

Dimensional Considerations for Continuing Service Reviews

The Continuing Service Review will result in one of the following outcomes:
 Client is making progress toward but has not yet met all treatment goals as indicated in the most recent ASAM review; treatment continues at this level of care.
 Client has met all treatment goals as indicated in the most recent ASAM review; however, new problems have emerged in the treatment process that indicate continuing treatment at this level of care.
 Client has met all treatment goals as indicated by the most recent ASAM review; however, ASAM indicates the need for continuing treatment at a less intense level of care.
 The ASAM review indicates the need for a more intense level of care. The client has not met all treatment goals; however, further services are not likely to result in additional treatment progress.
 The ASAM review indicates that the client has completed all treatment goals and the case will successfully close.

Dimension 1: Acute Intoxication and/or Withdrawal Potential

- Client's last use of drugs/alcohol.
- Quantity of most recent use.
- Frequency of recent use.
- Possible potentiating (addictive effects) combinations.
- Level of current intoxication (Physical and Mental symptoms.)
- Level of withdrawal (Physical and Mental symptoms.)
- History of withdrawal problems, including seizures.
- Does the client require detox at this time?
- Does the client think that he/she needs detox at this time?

Dimension 1: Review for clients who had been placed in services for withdrawal management:

- Is the detox complete?
- Was the detox free of complications (e.g., seizures; medical)?
- Meds administered?
- What is the discharge from detox plan/date?

Dimension 1 Problem: _____

Dimension 1 Plan: _____

Dimension 2: Biomedical Conditions and Complications

- Does the client have a medical diagnosis?
- Is the medical condition mild, acute, chronic?
- Is the client pregnant? If so, how many months pregnant is she and does she have prenatal care?
- If the client recently had a baby, has the client gone to her postnatal check-up?
- Does the client have a prescription for meds?
- Does the client adhere to medical requirements?
- Does the client require medical management/stabilization?
- When was the last time the client had a thorough physical exam?
- When was the last time that the client went to the dentist?
- When was the last time the client had an OB/GYN exam? Mammogram?
- If the client has a chronic illness, what is the status of the illness?
- Is the client in the process of applying for SSI/medical deferment?
- Is the client physically able to work?

Dimension 2 Problem: _____

Dimension 2 Plan: _____

Dimension 3: Emotional/Behavioral/Cognitive Conditions and Complications

- Does the client have a psychiatric diagnosis?
- Prescription medications for psychiatric diagnosis?

- Is the client adherent to medication requirements?
- Do you observe feelings of anger, guilt, shame, and/or anxiety connected to his/her addiction?
- Does the client report a history of physical, sexual or emotional abuse?
- Does the client present with visual/auditory hallucinations or paranoid ideation?
- What is the client's violence potential? Describe.
- Is the client a danger to himself/herself or others? Does the client have a serious desire/intent to harm himself/herself or others?
- Describe the client's cognitive/intellectual functioning. (Slight deficit or severe?)
- Describe the client's ability to focus on treatment.
- Describe the client's social functioning (e.g., ability to relate to others).
- Describe the client's ability to care for himself/herself.
- Describe the client's ability to care for his/her children.
- Is the client work deferred or presently in the process of applying for SSI?
- Is the client able to work?

Dimension 3 Problem: _____

Dimension 3 Plan: _____

Dimension 4: Readiness to Change

- Attends treatment sessions at least 75% of the time? Attendance report for WFNJ Work Requirement. This required to be discussed weekly with all SAI/BHI clients.
- Does this attendance report reflect an improvement in attendance?
- Would you say that the client has actively engaged in treatment? Describe the level of participation.
- Has the client been court/DCP&P mandated to treatment since our last review?
- Voices awareness of drug/alcohol/mental health problems.
- Describe client's acceptance of responsibility for behavior; does client accept responsibility or blame others for his/her problems?
- Does the client have an interest in changing?
- Does he/she have confidence in the ability to change?
- Is the client willing to ask for help for change?
- Describe the client's personal treatment goals.
- Does the client follow-through with plans for change?
- What would it take to move the client into the action stage of change?

Dimension 4 Problem: _____

Dimension 4 Plan: _____

Dimension 5: Relapse/Continued Use/Continued Problem Potential

- What are the client's most recent UDS results? This is a mandatory response.
- Does the UDS report reflect an improvement in UDS results?

- What would it take for the client to be successful in getting negative UDS results?
- Is the client experiencing any cravings? If yes, how frequently?
- Describe the client's ability to resist cravings and impulses to use.
- Describe the client's coping skills to manage emotions and cravings.
- Describe the client's knowledge/use of refusal skills.
- Does the client display relapse behavior? Describe.
- Is the client a high risk for relapse? If so, is the high risk connected to a mental health problem?
- Does the client have a relapse prevention plan in place?
- What action is the client taking to prevent relapse?
- Relate the client's description of his/her relapse triggers.

Dimension 5 Problem: _____

Dimension 5 Plan: _____

Dimension 6: Recovery Environment

- How would you describe the client's social skills? Does the client make friends easily or re his/her social skills limited?
- Does the client engage in isolative behaviors?
- On a scale of 0-4 with 0 being very supportive and 4 being "no support," how would you rate the client's network of recovery support from family and friends?
- Does the client have any family/friends that don't use drugs and/or alcohol?
- In what ways does the family's use of alcohol/drugs impact the client's recovery efforts?
- Describe the client's living situation/neighborhood/work environment with regards to recovery support.
- Describe the client's ability to deal with his/her environment.
- Does the client report having any sober leisure or recreational activities?
- Does the client attend 12 Step meetings? Does the client report gaining relief from 12 Step meeting attendance? Does the client have a sponsor?
- Describe how the client utilizes his/her sponsor as a means of support.
- If the client does not attend a Twelve Step group, does the client have an alternative support (e.g., church) to 12 Step Meetings? Describe.
- Does the client's environment/social contacts put the client at risk for emotional, physical or sexual abuse?
- Does the client have unresolved legal problems?
- Describe the client's ability to get a job and keep it.
- Is there a spiritual dimension to the client's life? Describe.
- Is the client presently involved with DCP&P? History of DCP&P involvement?
- Is the client experiencing any stress related to child custody/visitation problems?
- Is there a reunification plan for this DCP&P-involved client?
- Do you get the sense that the client's children are in a safe environment?
- Do you get the sense that the client is in a safe living environment? Is there a restraining order in effect?
- If the client recently had a baby, is the client complying with well-baby checkups?

- Does the client have a work activity?
- Is the client presently working?
- Are there any vocational plans in order for this client?

Dimension 6 Problem: _____

Dimension 6 Plan: _____

Psychiatric Evaluation and Medication Monitoring Policy

Psychiatric Evaluation is provided by: MD or DO Certified in Addiction Psychiatry, Board Certified Psychiatrist who is a member of ASAM or experienced with addiction, Board Eligible and ASAM/ABAM Certified Psychiatrist, MD or DO Board Eligible for Psychiatry with 5 years of addiction experience and ASAM membership, ASAM/ABAM Certified MD or DO with 5 years of co-occurring mental health disorders experience, Certified Nurse Practitioner-Psychiatric and Mental Health (CNP-PMH), Advanced Practical Nurse-Psychiatric and Mental Health (APN-PMH), and Physician's Assistant (PA) w/Psychiatric and Mental Health certification.

A psychiatric evaluation can be provided as clinically warranted at any time throughout the course of a client's treatment. This service must be pre-authorized by the SAI/BHI CC (CC) for a total of ten (10) units of "psych testing" (Z3356) per psychiatric evaluation. A follow-up consultation with the psychiatrist may only be pre-authorized if the Treatment Provider forwards to the CC a copy of the results of the psychiatric evaluation. For example, the CC may prior authorize a psychiatric evaluation without any documentation from the provider but cannot authorize a subsequent follow-up visit unless they have received documentation of the initial evaluation.

CCs may pre-approve three (3) units of psych testing (Z3356) for subsequent medication-monitoring visits with a psychiatrist or Advanced Psychiatric Nurse Practitioner for an additional 5 months, totaling 6 months of medication monitoring. Medication monitoring units may not be pre-authorized in the same month as the original psychiatric evaluation. Subsequent medication monitoring cannot be pre-authorized unless the CC has received documentation of the initial psychiatric evaluation and summaries of each subsequent medication-monitoring visit. Follow-up documentation should be in the form of a progress or service note as would appear in the client's chart.

CCs may not approve medication-monitoring sessions (3 units Z3356) beyond 5 months at the same level of care. If it is determined that a client will need medication-monitoring beyond the initial 6 month period, at the same level of care, the CC may present the case to the WFNJ SAI/BHI Clinical Director for approval of additional sessions. If the Clinical Director agrees that the client will need continuing medication monitoring the CC may pre-approve one (1) unit of psych testing (Z3356) for up to an additional 6 months, as clinically warranted. The medication-monitoring visits cannot be pre-authorized unless the CC has received documentation

of all previous medication-monitoring visits and documentation will be required for all subsequent medication-monitoring sessions.

In the event a client requires an emergency psychiatric evaluation during non-business hours and the provider is not able to contact the CC for pre-authorization, the CCs may retroactively pre-authorize these services only if the treatment provider contacts the CC or supervisor within 24 hours of service provision and if all other requirements as described above are met.
Please also note that providers who bill Medicaid for the above-named services based on a WFNJ SAI/BHI Payment Authorization (PA), may not also bill regular Medicaid for the same services.

One (1) complete psychiatric evaluation may be pre-authorized for more profound co-occurring clients admitted to short-term residential treatment in the event that the severity of their psychiatric condition will prevent or inhibit their ability to participate in treatment. Not all co-occurring clients should be pre-authorized for a psychiatric evaluation while in short-term residential treatment; this service is reserved strictly to assist those individuals whose mental health symptoms will impede treatment participation only.
The SAI/BHI may authorize three (3) psych testing units (Z3356) for medication monitoring to clients who are currently in short-term residential treatment and have already had one full psychiatric evaluation while in treatment at that level of care. The CC must have received a copy of the psychiatric evaluation and the medication monitoring units must be pre-authorized by the CC in order to ensure payment. This service is reserved for those clients transferring to another residential treatment program in need of a 30-day supply of medication only. The purpose of this "medication bridge" is to assist clients facing lengthy waiting lists to see psychiatrists in most programs.

WFNJ SAI/BHI Co-Occurring Disorder (COD) Pre-Authorization Process For IOP, PC, HH and TC

The SAI/BHI may preauthorize one (1) full individual counseling session (OP-FUL, Z3354) and/or one (1) COD group therapy per week for SAI/BHI clients who have been diagnosed with a mental health disorder and a co-occurring substance use disorder. This service unit may be preauthorized when there is clear clinical justification for the need of individual therapy for a client with significant psychiatric impairment in daily functioning. For example, co-occurring symptoms requiring specialized therapeutic interventions may have resulted from childhood or adult trauma, military service members returned from combat, domestic violence, active DCP&P involvement, or community reintegration from the legal system.
One full session COD individual therapy unit may be preauthorized only at DMHAS licensed IOP, PC, HH, and TC COD providers. Additional COD groups may be preauthorized at HH and TC residential treatment providers. Please note, not all co-occurring WFNJ SAI/BHI clients will require this additional service, and it should be reserved for those individuals with the more profound COD disorders and greatest need.

Licensed clinicians (i.e., LCSW,LPC) or associate clinical interns (i.e., LSW, LAC) under the weekly supervision of an approved licensed supervisor, employed by DMHAS COD providers,

must conduct all preauthorized COD counseling or group sessions. There will be some clients who will not require weekly sessions and may meet with the COD therapist with less frequency. The number of weekly sessions will be determined collaboratively with the primary counselor, the COD therapist, and the SAI/BHI CC (CC).

The treatment provider must forward a legible copy of each client's psychiatric evaluation, listing all diagnoses and prescribed medications, if applicable. The psychiatric evaluation summary must substantiate the need for COD counseling service.

Not all SAI/BHI clients will need a psychiatric evaluation and not all SAI/BHI clients will require COD counseling if they had a psychiatric evaluation. In the event that a psychiatric evaluation was not conducted, documented clinical justification must be given to the CC in order to establish the need for additional COD counseling services.

If a client is preauthorized to receive COD counseling, the following must occur:
(1) The SAI/BHI must receive a copy of the Fee for Service Letter of Approval for Enhancement Services or COD license issued by DMHAS; fax or scan/email to Tracy Kale, network coordinator, at 609-689-0595 or tkale@ncaddnj.org.
(2) The LPC, LCSW, LMFT, other licensed practitioner, or LAC or LSW who will be providing individual or group therapy must provide a copy of their license; fax or scan/email to Tracy Kale 609-689-0595, tkale@ncaddnj.org.
(3) The approved licensed supervisor providing supervision to LACs or LSWs must provide a copy of their license; fax or scan/email to Tracy Kale 609-689-0595, tkale@ncaddnj.org.
(4) The sessions must not take place during the hours that the client is scheduled to attend groups for their IOP or PC program.
(5) The treatment provider must forward at the end of each COD individual or group session one progress note from the COD therapist documenting the client's progress, or lack thereof, towards their treatment goals. This note must include targeted evidence-based interventions used in each session and clearly illustrate the client's progress to date, functional status, presenting symptoms, and prognosis. If the progress notes are insufficient, or not received, the provider risks non-payment for current or future services. If therapy is conducted by an LAC or LSW, their supervisor must sign the note.
(6) This session is conducted in addition to the weekly individual counseling with the CADC/LCADC sessions that all IOP, PC, and TC clients must have with their primary substance abuse counselor, as required for the "bundled" services for all SAI/BHI clients in these levels of care. The therapy sessions with the COD therapist are not a substitute for the weekly sessions with the primary counselor. In order to ensure that all SAI/BHI clients are also meeting with their primary counselor weekly, the primary counselor must now also send one weekly progress note indicating the client's progress towards their substance abuse treatment goals.

The SAI/BHI CC will continue to conduct scheduled CSRs with the client's primary counselor. It is expected that the counselor will report progress on the client's COD symptoms from the COD therapist to determine the need for continued COD services. In the event the primary counselor has his or her LPC or LCSW, the COD sessions should be conducted within the "bundled" services for the IOP, PC, HH, or TC levels of care and additional individual sessions will not be authorized. In these instances, the sessions may be conducted during the normal IOP,

PC, HH, or TC hours and no weekly progress notes should be sent to the CC. Clinical reviews will be conducted at each CSR to discuss the need for ongoing treatment at the current level of care.

Co-Occurring Disorder (COD) Pre-Authorization Process Quick Reference Guide for Clinical Counseling Sessions (OP-FUL, Z3354)

- All COD services must be pre-approved by the SAI/BHI Care Coordinator in advance of the service.
- The treatment provider must provide clear clinical justification for this service, including recent psychiatric evaluation (if provided), diagnoses, medication, etc.
- A licensed clinician, e.g., LPC, LCSW, LMFT, must conduct all COD services etc.
- The WFNJ SAI/BHI must receive a copy of the Fee for Service Letter of Approval for Enhancement Services, which includes COD services; issued by DMHAS. (Fax to Tracy Kale 609-689-0595).
- The SAI/BHI must receive a copy of the clinician's individual license, LPC, LCSW, etc. (Fax to Tracy Kale 609-689-0595.)
- The sessions must not take place during the hours that the client is scheduled to attend groups for their IOP or PC program.
- The treatment provider must forward at the end of each session one progress note from the clinician (LPC, LCSW, etc.) indicating progress, interventions used, functional status, presenting symptoms, etc.
- This session is conducted in addition to the weekly individual counseling with the CADC/LCADC sessions that all IOP, PC, HH, and TC clients must have with their primary substance abuse counselor as required for the "bundled" services for all SAI/BHI clients in these levels of care. The therapy sessions with the LCSW/LPC are not a substitute for the weekly sessions with the primary counselor; the primary counselor must now also send one weekly progress note indicating the client's progress towards their substance abuse treatment goals.
- Not all SAI/BHI COD clients will require this service; reserved for those with most profound clinical need.

Payment Authorization Treatment Provider Desk Guide

All network treatment providers are given this document to ensure timely reporting of SAI/BHI requirements:

- Providers are expected to comply with the following key reporting requirements:
- Contact the Care Coordinator when client is admitted to treatment
- Fax or email weekly attendance reports to the SAI/BHI PA Unit at (609) 259-1458 or paunit@ncaddnj.org
- Mail, fed ex, or email weekly UDS results to the SAI/BHI PA Unit at (609) 259-1458 or paunit@ncaddnj.org
- Submit attendance and UDS results within 3 days of the end of each week for which information is being reported

- Contact the Care Coordinator to conduct continuing service reviews as indicated by the "next review" dates on the Pre-authorization Service Notes
- Contact the Care Coordinator when there is a concern about client treatment participation/progress/ appropriateness of level of care
- Contact the Care Coordinator to request pre-authorization for additional or other services when clinically indicated
- Contact the Care Coordinator if the client drops out of treatment
- All providers must address work readiness in all case notes and in all counseling sessions
- Network Providers are able to submit claims as soon as they receive PAs.
- Providers should forward attendance to the SAI/BHI PA Unit by noon on Wednesday the week after the service is provided to the client.
- Providers should forward UDS results to the SAI/BHI PA Unit and not to the individual Care Coordinators.
- Payment authorizations are issued by calendar month to network Providers; attendance and UDS results are reported weekly.
- Payment authorization for attendance and UDS reporting will be included in the PA for the month in which the week ends for all network providers. The week begins on Monday and ends on Sunday.
- Non-network and mental health providers will bill other funding sources (DCP&P, Medicaid, etc.)

Intent to Close (ITC) Report Process

Every 2 weeks, the Payment Authorization (PA) Unit develops two ITC Reports, the ITC Non-Attendance Report and the ITC CSR (Clinical Service Review) Report, and forwards the reports to the Division Director, the Regional Managers, the LCCs and the LACCs.

ITC Non-Attendance Report

The PA Unit develops an ITC Non-Attendance Report listing those clients in treatment whose attendance for the previous 2-3 weeks has not been received. The ITC Non-Attendance Report also lists the dates the report covers, and includes the client name, the WFNJ #, the treatment provider, level of care (LOC) and the client's admission date. In addition, the PA Unit sends an "Intent to Close" letter to the treatment provider warning the provider that the missing attendance for the period indicated must be received within 10 days and that if it is not received either the client will be transferred to another program or the case will be closed with the SAI/BHI.

Upon receiving the ITC Non-Attendance Report, the LCCs review each client's electronic file to determine if the client should actually be listed as in treatment with the provider indicated on the report. The LCC follows up with the CC regarding these clients and the need to conduct follow-ups and/or to refer the client to another provider. The LCC indicates on the report that these clients do not need to receive an "Intent to Close" letter and gives a copy of the report to the LACC. Upon receiving the report from the LCC, the LACC or the designated ACC should do as follows:

- Review the client's attendance in the database again in the event the attendance was received after the report was developed.
- If the attendance was received, or if the LCC indicated the client should not receive an ITC letter, do not develop an ITC letter to be sent to the client.
- If the attendance was not received, or if the LCC indicates the client should be sent an ITC letter, develop an ITC letter to be sent to the client.
- Before sending the ITC Letter to the client, also check the ITC CSR Report to determine if the client also has a past due CSR as these clients will be sent an "Intent to Close" letter for both attendance and an overdue CSR.

ITC CSR Report

The PA Unit develops an ITC-CSR Report listing those clients in treatment whose CSRs are more than two weeks overdue. The ITC-CSR Report includes the client name, the WFNJ #, the treatment provider, level of care (LOC) and the date the CSR was due. The PA Unit does not send a letter to the treatment provider for past due CSRs, but sends the ITC CSR Report to the Division Director, the Regional Manager, the LCCs and the LACC instead. Upon receiving the ITC CSR Report, the LCCs review each client's electronic file and speaks to the CC to determine if the treatment provider had attempted to contact the CC to conduct a CSR. The LCC indicates on the report which clients should not receive an ITC-CSR letter and gives a copy of the report to the LACC. Upon receiving the report from the LCC, the LACC, or the designated ACC, is responsible for the following:

- If the LCC indicated the client should not receive an ITC letter, the ACC will not develop an ITC letter to be sent to the client.
- If the LCC indicated the client should receive an ITC letter, the ACC will develop an ITC letter to be sent to the client and an ITC letter to be sent to the provider.
- Before sending the ITC Letter to the client, the ACC will check the ITC Non-Attendance Report to determine if the client's attendance is past due.

Section Five – Mental Health Resources

Psychiatric Glossary of Terms

Abstract Thinking: The ability to understand concepts.

Affect: A pattern of observable behaviors that is the expression of a subjectively experienced feeling state (emotion).

Appearance: Description of the physical size, manner of dress, hygiene, posture and any obvious handicaps.

Auditory hallucinations: A hallucination of sound, most commonly voices, but sometimes of clicks, rushing noises, music, etc. The CC should explore if the auditory hallucinations are voices commanding the client to do things. Certain types of auditory hallucinations could be experienced as two or more voices conversing with one another or voices maintaining a running commentary on the person's thoughts or behavior. They may be religious in nature and the CC must explore if they are a normal part of the client's religious experience within their cultural context

Blunted Affect: Severe reduction in the intensity of affective expression

Circumstantiality: In conversation, the use of excessive and irrelevant detail in describing simple events, the speaker eventually reaching his goal only after many digressions (e.g., the client is asked, "Who brought you to the hospital?" She replies, "Well, I wanted my husband to drive me but the car, we have a '73 Chevy and you know how our cars are, wouldn't start. So I called my sister, Sarah. It's her birthday today. She took the number five limited bus here with me.").

Concrete Thought: Literal interpretation of the environment based on what one perceives through the senses; inability to abstract (e.g., when asked "How did you come to the hospital." The person may say "in a car").

Delusion: Delusions are false or erroneous beliefs that usually involve a misinterpretation of perceptions or experiences. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, or grandiose). **Persecutory delusions** are most common; the person believes he or she is being tormented, followed, tricked, spied on, or ridiculed. **Referential delusions** are also common; the person believes that certain gestures, comments, passages from books, newspapers, song lyrics, or other environmental cues are specifically directed at him or her.

Disorientation: Confusion about the date or time of day, where one is (place), or who one is (identity). Disorientation is characteristic of some Organic Mental Disorders, such as Delirium and Dementia.

Echolalia: Repetition (echoing) of the words or phrases of others. Typical echolalia tends to be repetitive and persistent. The echo is often uttered with a mocking, mumbling or staccato intonation.

Euphoria: An abnormal and exaggerated feeling of well-being

Flat Affect: A significant lack of emotional responsiveness; virtually no affective expression (e.g., discussing events in his life that range from a death to a wedding to abandonment by a lover, the patient's expression never varies).

Flight of Ideas: Rapid verbal skipping from one idea to the next (e.g., "They always beat the drums when Dr. Lewis comes around. [Drums on table] Give you 50 to 1, the Yankees win tonight. No takers? I'll get takers. One's born every minute, Think I'll get a pass today?"

Gustatory hallucinations: A hallucination of taste, unpleasant tastes being the most common.

Hallucinations: A sensory impression in the absence of any external stimuli can arise in respect to any sensory modality – visual, auditory, olfactory, tactile, or gustatory (e.g., the patient hears the voices of several people who are not there. They are making insulting remarks about his appearance and intelligence).

Hyper vigilant: Excessively alert, as if in danger.

Impulsive: Acting in response to an external or internal stimulus without thinking through the consequences of the act.

Inappropriate Affect: The failure of feelings expressed nonverbally to match thoughts expressed verbally (e.g., Phyllis Maguire expresses glee nonverbally while verbally expressing anger about the ingratitude of her friends).

Intellectualization: A mechanism in which the person engages in excessive abstract thinking to avoid experiencing disturbing feelings.

Impoverished Thought: Few verbal communication or ones that convey little information because of vagueness, empty repetitions or stereotyped or obscure phrases (e.g., the client

replies to all questions with only one or two words, even though elaboration is invited and encouraged).

Intrusive: Lacking awareness of others' personal space and appropriate boundaries (e.g., client touching others without permission, client going into another's room without permission, interrupting conversations, asking inappropriately personal questions).

Labile Affect: Unsteady feelings that shift rapidly (e.g., Phyllis Maguire expresses feelings that change rapidly from euphoria to anger to tearfulness to elation and back).

Loose Associations: Thinking that is over generalized, diffuse and vague, with only a tenuous connection between one thought and the next (e.g., "Love is all. Energizing, generally speaking, that is. You don't carry me because I'm a composition of honesty and science, in the visible spectrum").

Mood: Subjective experience of emotion – how a person states he feels.

Nightmares: Frightening dreams accompanied by sense of uneasiness.

Night Terrors: Client wakes up in terror – screaming, crying, inconsolable (usually in first part of night before midnight) - Client has no remembrance of it in a.m. – not result of bad dream – children usually grow out of it by puberty.

Olfactory hallucinations: A hallucination involving smell (e.g., a woman complained of a persistent smell of dead bodies. Some people are convinced they have a body odor they themselves cannot smell; this symptom is a delusion not an olfactory hallucination).

Orientation: Description of the client's concept of time and ability to perceive who and where he is.

Paranoid ideation: Suspiciousness or the belief that one is being harassed, persecuted or unfairly treated (e.g., the client believes that some other clients on his block want to hurt him).

Pressure of Speech: Speech that is increased in amount, accelerated, and difficult or impossible to interrupt. Usually it is also loud and emphatic. Frequently the person talks without any social stimulation and may continue to talk even though no one is listening.

Provocative: Behavior that excites others to anger, exasperation irritation.

Psychomotor Agitation: Excessive motor activity associated with a feeling of inner tensions; the activity is usually nonproductive and repetitious. When the agitation is severe, it may be accompanied by shouting or loud complaining. The term should be used in a technical sense to refer only to states of tension or restlessness that are accompanied by observable excessive motor activity (e.g., inability to sit still, pacing, wringing of hands, pulling at clothes).

Seductive: Behaving and/or dressing in a manner to sexually arouse another.

Somnambulism: Sleepwalking.

Stereotypy: Persistent mechanical repetition of speech or motor activity (e.g., Ralph Huston repeatedly rubs his nose, smells his fingers and casts a sidelong glance.)

Tactile Hallucinations: A hallucination involving the sense of touch, often of something on or under the skin. Almost invariably the symptom I s associated with a delusion.

Tangentiality: In conversation, digressions that divert the speaker from his/her goal, which he/she never reaches; to be distinguished from circumstantialities in which the goal is eventually reached (e.g., the client begins talking about how it feels to be diabetic. Discussing her visits to the clinic, she is reminded of a nurse whose hairstyle she admires. After describing the hairstyle, it occurs to her that the nurse resembles her sister, who

recently had another baby. For several minutes, the client discussed her new niece. Meanwhile, she has said almost nothing about her feelings as a diabetic person).

Thought Process: Description of the client's thoughts (verbalized). Are they logical, cohesive, and secondary process or are flight of ideas, loose associations, and primary process thoughts present? Is the client preoccupied or having hallucinations or delusions?

Tic: A twitching of the muscles, especially of the face.

Visual hallucinations: A hallucination involving sight, which may consist of formed images, such as of people or of unformed images such as flashes of light.

Descriptive Terms

Words that describe Mood

Depressed
Euthymic
Irritable
Dysphoric
Labile
Apprehensive
Agitated
Anxious
Frightened
Angry
Sad
Worried

Words that Describe Affect

Inappropriate
Restricted
Flat
Rigid
Blunted
Dull
Non-responsive
Superficial
Overly Animated
Sad
Angry
Bright
Constricted
Apathetic/ indifferent
Full-range
Tearful

Words That Describe Speech, Thought and Perception

Word Salad Incoherent
Disjointed
Circumstantial
Organized
Articulate
Paucity of speech
Tangential
Loose Associations
Ideas of Reference
Flight of Ideas
Logical
Paranoid Thinking
Delusional
Rambling
Mute
Unrealistic
Distorted
Incoherent
Flashbacks
Illusions
Hallucinations

Words That Describe Behavior

Uncooperative
Hyperactive
Anxious
Bizarre
Explosive
Passive
Hesitant
Evidencing poor frustration tolerance
Belligerent
Restless
Withdrawn
Explosive
Disorganized
Monopolizing
Attempting to control interaction
Aggressive
Anxious to please
Evidencing poor eye contact
Attention seeking
Overwhelmed
Demanding

Crisis Building
Preoccupied
Somatic Negative Shameful
Distant
Manipulative
Intellectualizing
Needing
Blaming
Defensive
Resistant
Secretive
Suspicious
Guarded
Grandiose
Provocative

WFNJ SAI/BHI - Legal Services of New Jersey (LSNJ) – Referral Procedures

The Care Coordinator (CC) will identify all clients in their caseload who have been medically deferred for one year or longer, or who have a chronic and persistent medical or psychiatric condition that has and will continue to prohibit the client from participating in employment-directed activities and gainful employment. The CC will meet with the client to explain Social Security Income (SSI) and the application process, and give the client the brochure, to determine if the client is interested. During that meeting, the CC will ask the client to sign the Generic Release Form for LSNJ allowing two-way communication between our agencies and will give the client the LSNJ brochure. The CC will also complete the LSNJ Questionnaire for Referral below (please make sure all questions are answered and leave no blanks). The CC will fax the release form, the Questionnaire, and the ASAM Assessment Summary to LSNJ, at 732-248-5008 or 732-572-0066.

The CC will send a Case Worker Referral Response Form (CWRRF) to the client's welfare caseworker. In the comment section of the CWRRF the CC will inform the welfare caseworker that they have referred the client to LSNJ and ask for them to assist the client with the appropriate SSI application, as needed.
The CC will document the above in the Service Log of the client's database file and maintain a copy of the fax cover sheet and client release form in the client's paper file.
Complete the questionnaire below

LSNJ SSI Project Referral Questionnaire (must be filled in completely)

1. What is your current address and phone number?_____

_____

2. Who are your alternate contacts? Please give us their name with telephone number and address of any person who we can contact if we cannot reach you:

_____

_____

3. What is your Medicaid #: _____ GA TANF

4. What is your Social Security #_____

5. Do you have a pending SSI claim yes no

6. Do you know when you filed your claim? Approximate date: _____

7. Are you a U.S. citizen? yes no

8. If not, what is your immigration status? _____

9. Do you have a pending Worker's Comp. or Personal Injury claim?
yes no

10. Can you read or write more than your name? yes no
11. What is your main health problem? _____
12. Is a doctor treating you for your condition? yes no

13. If so, do you know the doctor's name, address and phone number?_____

_____

14. When did you start treatment with this doctor? _____

15. Do you see a psychiatrist or psychologist? yes no

16. When did you start treatment with this psychiatrist or psychologist?

_____

17. If so, do you know the psychiatrist's name, address and phone number?_____

_____

18. Do you need transportation for doctor appointments? yes no

Early Intervention Support Services (Crisis Intervention Services)

Early Intervention Support Services is an outpatient mental health program for adults who are experiencing significant emotional or psychiatric distress and are in need of immediate intervention. Early Intervention Support Services offers crisis intervention and crisis stabilization services in a setting that is an alternative to hospital based emergency room treatment. Consumers may attend daily up to 30 days. Similar to the WFNJ SAI/BHI, consumers may have additional "EOCs," as necessary, throughout the year without limitations. Outreach (non-office based) services are available. This service is only available in 11 counties but the hope is that it will be expanded into the 10 remaining counties in the future. Here is the current list:

Atlanticare Behavioral Healthcare
Adult Intervention Services
1601 Atlantic Avenue
Atlantic City, NJ 08401
(866) 750-6612

Catholic Charities
Diocese of Trenton
833 Cass Street
Trenton, NJ 08611
(609) 256-4200

Monmouth Medical Center
West Side Plaza
3301 Highway 66
Building B, Suite 201
Neptune, New Jersey 07753
(732) 922-1042

Twin Oaks Inc.
Early Intervention Support Service
105 Manheim Avenue,
Suite 10 & 12
Bridgeton, NJ 08302
(856) 537-2310

University Behavioral Healthcare
183 South Orange Avenue
Newark, NJ 07103
(973) 972-6100

University Behavioral Healthcare North
667 Hoes Lane West
Piscataway, NJ 08855
(732) 235-4422

Bridgeway, Inc.
152 Central Avenue
Jersey City, NJ 07306
(201) 885-2539

Comprehensive Behavioral Health Services
Wellness and Support Center
569 Broadway
Westwood, NJ 07675
(201) 957-1800

Ocean Mental Health Services
Community Resource for Emergency Support and Treatment
1376 Route 9
Toms River, NJ 08753
(732) 2400-3760

St. Clare's Hospital Behavioral Health Services
Wellness and Recovery Center
4 Pocono Road
Denville, NJ 07834
(973) 625-0096
Toll Free: (888) 476-2660

Twin Oaks, Inc.
Early Intervention Support Service
57 Haddonfield Road, Suite 125
Cherry Hill, NJ 08002
(856) 254-3800

Section Six – Other Policies and Procedures

WFNJ SAI/BHI Regional Office Functions

The WFNJ SAI/BHI has four regional offices throughout the State that provide administrative support to the SAI/BHI staff located in the various counties.

The Northern regional office is located in Clifton, NJ in Passaic County and covers Bergen, Hudson, Passaic, Morris, Sussex, Warren, Somerset and Hunterdon counties.

The Essex-Union Region is located in Newark at the Essex County Board of Social Services complete with clinical and administrative staff on site.

The Southern regional office is located in Robbinsville and includes Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Middlesex, Monmouth, Ocean, and Salem counties.

In Camden, there is also a self-contained SAI/BHI Unit, like Essex, consisting of clinical and administrative staff providing support for that unit but it falls within the Southern Region.

The function of the regional office or unit is to provide support for the staff assigned to the region or county. It also serves as the original point of contact for the welfare offices in the region for client referrals and assessment appointments. Regional office staff act as a conduit for coordination and communication with welfare and other social services agencies. They are responsible for setting and maintaining Care Coordinator schedules, for entering client referrals into the database, checking client eligibility, rescheduling client appointments and follow-ups, sending letters to clients, developing and disseminating reports, ordering supplies for staff, and performing other administrative functions that support client care, SAI/BHI Care Coordinators, and the SAI/BHI operation as a whole. Regional office staff also maintain close contact with the SAI/BHI Administrative office in Robbinsville with regard to policy and procedure. The regional offices also serve as the home base for the managerial /supervisory staff and the Lead Assistant and Assistant Care Coordinator staff of the region or unit.

CCs may contact ACC staff in the regional office to assist them with the following:

- To check assessment and follow-up appointments schedules
- To order supplies
- To call treatment providers to check on bed eligibility
- To arrange client transportation
- To send CWRRFs to welfare
- To request letter to clients
- To request help with filing
- To request assistance with other administrative tasks

WFNJ SAI/BHI Staff Conflict Resolution Policy and Procedure

Policy Rationale:

The Care Coordination Services (CCS) Division of NCADD-NJ is committed to sustaining a positive work environment in which employees work constructively together. The conflict resolution policy and procedure has been established as a foundation for ensuring that the work environment remains positive and, as a result, our clients receive higher-quality care.

It is recognized that conflict is not a problem; it is normal in any team. Disagreements, differences of opinion, varying clinical perspectives on assessment and treatment, and interpersonal conflicts are inevitable among interdisciplinary team members. Because of different life experiences, training, theoretical orientations and familiarity with recovery, personnel can be expected to encounter clinical, administrative and team-functioning conflicts.

Team members have the right and responsibility to resolve conflicts as soon as possible. Resolving conflicts helps staff stay centered and improves and/or maintains healthy team

functioning. If conflicts are not evident from time to time, it is likely that one or more members of the team are not speaking up assertively for what they believe in. They may not be advocating for their perspective, to the possible detriment of the clients served and also the health of the team.

The conflict resolution policy is intended to:

- Provide the opportunity to resolve a conflict or complaint quickly, fairly and without reprisal
- Improve communication between employees; and between employees and their supervisor
- Ensure confidence in management decisions by providing a mechanism whereby management decisions can be objectively reviewed
- Support a positive work environment in which disagreements and conflict are considered normal and in which each employee has the right and obligation to resolve disagreements and work related conflict.

Procedure: ***Informal conflict resolution and complaint process***

1. Each team member has the right and obligation to ask for clarification and discussion about any behavior, decision or treatment intervention that could compromise high quality care.
2. If the question arises because of an individual team member's behavior, decision, or treatment intervention, then the discussion should occur at the lowest level possible, face-to-face.
3. If the team member is not able to approach the individual face-to-face, he or she may request supervisory coaching in order to do so.
4. If resolution is not achieved, each person has the right and obligation to seek consultation from a team member who is next higher in the organizational structure. However, this is openly suggested and discussed together before calling in such a person. Sometimes such discussion finally resolves the conflict; while at other times, seeking such consultation will be necessary.
5. If resolution is not achieved even with this consultation and three-way discussion, each person has the right and obligation to seek consultation from a team member who is now higher in the organizational structure. This again is openly discussed together before calling in such a person. This process of consultation moving up the organizational structure continues until the conflict is resolved, even to the point of calling in a consultant outside of the organization if necessary.
6. If there is a question or conflict about administrative, clinical, or other issues that affect the whole team or agency, then it is the person's right and obligation to bring the concern to group supervision or an equivalent team meeting.
7. If the issue is unresolved, any team member has the right and obligation to openly suggest consultation from a person who is next higher in the organizational structure. As

before, this process of consultation moving up the organizational structure continues until the conflict is resolved, even to the point of calling in a consultant outside the organization if necessary.

8. A team member may require supervision to assist in resolving conflicts at the lowest level possible. However, supervision is not a substitute for open discussion of the conflict between or among team members. Follow-through on these conflict resolution policies is a performance expectation, and will be included in areas monitored in employee evaluations.
9. If the employee is not satisfied with the informal resolution of the conflict, he or she may proceed to NCADD-NJ's Grievance procedure.

WFNJ SAI/BHI Quality Assurance Reports

The Quality Assurance Supervisor (QAS) generates and reviews multiple reports monthly and quarterly, as indicated in the list of Quality Assurance (QA) reports below. The QA reports serve multiple purposes: (1) to ensure client and child safety at all times, (2) to assist LCCs with identifying training needs for individual Care Coordinators, (3) to ensure consistent Care Coordination policy implementation and practices throughout all regions; (4) to provide continuous monitoring of the quality of Care Coordination services delivered, and (5) to ensure that information in the database is valid, allowing for accurate reporting to the DFD, upon request.

Suicide Risk Report (reviewed monthly) – This report ensures that the CC recorded clear and concise comments about clients' past or current suicidal thoughts, attempts, or other self-injurious behaviors. If there were positive responses to a history of suicidal thoughts, plans, or intent, the CC would be required to document comments pertaining to these episodes. If the client reported ideation or attempts within the last 30 days, the CC is required to connect the client to services promptly.

DCP&P Hotline/High Risk Report (reviewed monthly) – Clients with custody of minors who experience a negative event (failure to participate in treatment, positive UDS, hostile behavior, etc.) must be reported to the DCP&P hotline, per program policy. The call must be made promptly after receiving and **confirming** the information. This report will indicate if a CC failed to contact DCP&P.

45-day Report (reviewed monthly) – This report shows all cases that have had no activity for 45 days or longer. Chart activity such as CSRs, CWRRFs, etc., will prevent clients from showing on this report.

Ineligible Report (reviewed monthly) - All CCs must assist clients with GA, TANF, and NJ FamilyCare (Medicaid) eligibility problems. The CCs have access to run this report from Atlantis at any time. The PA unit supervisor sends notification to the LACCs, SCs, and RMs, at the beginning of each month to inform them that the eligibility component of Atlantis has been updated; thereby, indicating that they can now generate the updated Ineligible Reports to send to the CCs to begin to troubleshoot the problems. The QAS reviews this report to ensure action has been taken in these cases.

TANF Child and DCP&P Information Report (reviewed monthly) - Child information should be in Atlantis and DCP&P case information should be updated throughout each episode of care (open, closed, etc.). If a client loses custody of his/her child (ren) during an EOC, the client must apply for GA. This report indicates data entry errors that need immediate correction and will

show clients who must apply for GA due to loss of custody or the need for TANF due to child re-unification.

Length of Stay Report (reviewed quarterly) – This report shows clients who have been in one level of care for a sustained length of time that should be reviewed for treatment needs. By ASAM criteria, these cases would not typically be in the identified LOC for the length of time indicated on the report and should be reviewed for clinical justification or movement into a lower or higher LOC.

Diagnostic Category Report (reviewed quarterly) – This report shows a discrepancy between the DSM-5 diagnostic impression and the selected diagnostic category; these two must always be congruent. The diagnostic impression is listed in order of primary diagnosis based on the current presenting symptoms at the time of assessment or subsequent ASAM Note. The diagnostic category must reflect whether the SUD or MH disorder is primary and whether there are co-occurring disorders.

Unsigned or Missing Release Report (reviewed monthly) – Releases are generated in Atlantis, and once signed, they are faxed to the PA unit to be uploaded back into the database. This report shows all releases that have been uploaded but the CC did not indicate that the release was signed, or it was indicated in Atlantis that the release was signed but was not sent to the PA unit to be uploaded.

Expired Release Report (reviewed monthly) – Signed releases expire after two years from the date of signature; this report shows all releases that have expired in open WFNJ SAI/BHI cases. The CC must fax new releases to the client's program and ask them to sign and fax back or ask the client to come in to sign new releases.

Care Coordinator Activity Summary (CCAS) (reviewed monthly) – The WFNJ SAI/BHI requires that at least 85% of all clients must be in treatment or scheduled for treatment at all times. This report indicates the number of clients in each CC's open caseload and the number of those clients who are in treatment or scheduled for treatment; thereby, permitting the ability to obtain a percentage. The IT Coordinator sends a mid-monthly list to all supervisors with the list of CCs who do not meet the 85% expectation.

Pre-authorization Error Report (reviewed monthly) – This report shows the discrepancies between the date ranges that pre-authorizations should be given and the actual pre-authorizations documented. When completing pre-authorizations, the date ranges and pre-authorizations must always match for new treatment referrals based on the treatment start date. For CSRs, the date ranges must always match unless the provider failed to call to conduct the CSR within the grace period; in these situations, the pre-authorizations would begin on the date that the provider called to conduct the CSR.

Case Closure Report (reviewed monthly) – This report is reviewed to ensure the accuracy of case closure choices used at the time the WFNJ SAI/BHI case is closed

NCADD-NJ WFNJ-SAI/BHI Program
Written Agreement of Supervision (N.J.A.C. 13:34C-6.3 (b))

This agreement, entered into on the_____ (date) of_____ (month), (year), by and between the NCADD-NJ WFNJ SAI/BHI Program Supervisor_____ and the NCADD-NJ Supervisee_____.

In consideration of the NCADD-NJ administrative policies, standards and practices, the parties hereto agree as follows:

Expectations of supervisory meetings
The weekly (non-credentialed interns) or bi-weekly (credentialed-interns) supervisory meetings will be conducted face-to-face or occasionally via telephone. The sessions will be conducted in a confidential environment to protect client and ____ (name of supervisee) _____ confidentiality.

Meetings will address issues specific to administrative policy adherence, clinical challenges/strengths, HIPAA compliance, clinical skill development, documentation, personal issues affecting _____ (name of supervisee) _____ability to work with clients effectively.

_____ (Name of supervisee) _____ will prepare for meetings by having case files to be discussed and an outline of issues to be discussed. I will prepare by reviewing and utilizing reports including Open Caseload, Clients in Active Treatment, Urine Drug Screen, CQI, etc. to monitor and facilitate work performance.
Supervisee expectations may be added:
_____

Expectations regarding evaluation
As a supervisor, I utilize a motivational method of supervision. When giving verbal feedback, I use a solution-based or strength-oriented approach. Evaluation is ongoing and is documented as such on the supervision note and on annual performance evaluations. Self-evaluation is encouraged.

When conducting supervisee assessment, areas covered include strengths and challenges along the 12 core functions listed in the Professional Development Plan (PDP), such as utilization of case management, client assessment, relationship building, service planning, crisis intervention, and report and record keeping skills. The supervisee's ability to conduct initial orientation and assessment, ASAM Continued Service Reviews (CSR), and client follow-ups will also be evaluated.
Supervisee may add expectations here:
_____

Expectations of the supervisory relationship
I expect a professional and respectful relationship based in honesty. I make myself available, even when sessions are not scheduled, when issues arise that need to be discussed immediately. I believe that I should treat others as I want to be treated. I will tell you if I have any concerns and I expect the same from you. If it is not convenient for me to talk with you at a specific time, I will tell you when I will be available to give you my undivided attention.

I deal with conflict in a direct manner. I resolve issues as soon as they arise to avoid resentments and misunderstandings. I would like the same in return. The supervisory experience increases your awareness of feelings, thoughts, behavior and aspects of self that are stimulated by the client. It is important that you discuss this in supervision to help resolve issues and to work

through the process. When and if I feel it is necessary, I will encourage you to seek out services from the NCADD-NJ Employee Assistance Program (EAP), as I cannot be your therapist and supervisor.

Because of our human nature, we cannot help but be affected by the influence of race, ethnicity, gender, sexual orientation, religion, socioeconomic status and other factors that are brought into the counseling experience. As part of the supervision process, learning to be culturally competent is stressed and I am prepared to help in any way I can to assist you in becoming culturally aware. I may find it necessary to suggest you attend a workshop or seminar to enhance your learning.

When I am unavailable to conduct supervision or you find you have a crisis situation, call your Regional Manager, the Clinical Director, the Deputy Director, or the Director of Care Coordination services.

Grievances will be settled through the NCADD-NJ SAI/BHI Conflict Resolution Policy or through the NCADD-NJ Grievance Procedure as needed.

Dual relationships
The supervisory relationship is viewed as a professional relationship and is not a friendship. As a supervisee progresses through the stages of development, this relationship changes in scope, as the supervisor and supervisee become colleagues. In the late stage of supervisee development, the relationship becomes more of a consultant type relationship. Unlike dual relationship issues with clients, dual relationships in supervision are unavoidable. Therefore, they need to be managed in a professional manner so that the supervisee will not be exploited. As supervisor, it is my responsibility to make sure that any dual relationship issues are addressed immediately.

Discontinuation of Supervision
This contract may be ended under the following circumstances, including but not limited to: If employment with NCADD-NJ is terminated, if you are re-assigned to a new supervisor, or if you are promoted to a supervisory position.

Purpose
The purpose of this form is to provide you with essential information about supervision and give structure to your experience in order to ensure a common understanding about the supervision process. During our discussion about these guidelines, I welcome your comments and suggestions.

Professional Disclosure
[Add supervisor's education, experience in working with the population for which supervision is being provided, and what qualifies you to supervise. Supervisor's updated resume to be given to the supervisee.]

Practical Issues
As agreed upon, we will meet face-to-face weekly and (non-credentialed interns) or bi-weekly (credentialed-intern). Occasionally, we will conduct supervision on the telephone. If a circumstance arises that makes it impossible for you to attend a scheduled session, please contact

me as soon as you know that you will miss the session in order to reschedule. If you need to speak to me between sessions, please call [number]. If for any reason a supervision session is cancelled, a new date/time will be chosen at the time of cancellation or as soon as possible. All cancellations will be documented on a supervision note stating the reasons for cancellation and signed by both parties at the next supervision session.

Supervision Process
My primary role is to help you master the skills necessary to become an independent, ethical practitioner and obtain the highest level of competence possible. At the same time, I have the ethical and legal responsibility for all your actions with the SAI/BHI clients while you are in supervision with me. Therefore, the success of supervision will depend on the development of a trusting, working relationship between us. The goals and purpose of supervision will include a willingness on your part to be open to review your work with clients, and hear corrective feedback from me about that work in order to learn and improve. On my part, I will take responsibility to create a supportive environment, give timely and helpful feedback, and be available as needed. As a supervisee, you will be expected to be an active participant in the supervision process, be open to feedback, be truthful and share mistakes, take responsibility for correcting any actions that could harm clients, be prepared and on time for each session, and keep proper client documentation.

As supervision continues, there may be times of tension in our supervisory relationship, particularly discomfort generated by feedback or disagreement over suggested strategies and interventions. I hope that any relationship problems can be solved in a professional manner through open discussion. If not, we must adhere to the guidelines set forth in the Conflict Resolution Policy.

Administrative tasks and evaluation
As your supervisor, I will be providing you with both formal and informal evaluative feedback throughout supervision. At the same time, I also will be seeking your evaluative feedback about supervision and ideas for improvement. A formal evaluation will be conducted annually. Your annual evaluation will be based upon your daily performance of your job responsibilities. Evaluations are not confidential; the supervisors, the Director of Care Coordination Services and the Human Resources Manager review all evaluations.

Legal or ethical issues
It is important that you agree to act in an ethical manner as outlined by the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), not engage in harmful dual relationships with clients, follow laws of confidentiality, and, at all costs, avoid acting in any way injurious to clients. It is understood that as your supervisor, I agree to follow the ethical codes and standards for my profession and treat you with dignity and respect.

The content of our supervisory sessions and evaluations will be confidential, except for the following: (1) the NCADD-NJ supervisory staff, (2) the Clinical Director must review and sign all Supervision Progress Notes, (3) any instance where treatment of a client violated the legal or ethical standards set forth by professional associations and government agencies, and (4) situations where disciplinary actions or termination of employment is being considered.

Statement of agreement
I have read and understand the information contained in this document and agree to participate in supervision according to these guidelines. I understand this agreement of supervision will be reviewed and renewed annually.

_____ _____
Supervisee Signature Date Supervisor Signature Date

SUPERVISION PROGRESS NOTE

NAME: DATE: START TIME:

END TIME:

SUPERVISOR:

1. Administrative/Clinical Challenges and Strengths
2. Considerations: HIPAA Compliance, clinical skill development, documentation, policy adherence
3. Case Review: Reports attached (Open Caseload, Clients in Active Treatment, UDS, CQI, etc.)

Areas of concern: ____SI/HI Duty to Warn_____Breach of Confidentiality___Child Safety/Hotline Call

Client Incident Report

Every time the police or other emergency personnel are called to the Care Coordinator's office, the Care Coordinator must complete the "Client Incident Report" with the Clinical Director or the Director of Care Coordination:

Client Incident Report

Report Filed by:_____
Position:_____

Reported To:_____

Client Name:_____ WFNJ #:_____

Where Incident Occurred: _____

Incident Date:_____ Incident Time:_____

Describe situation or incident as specifically as possible:
(Include names of individuals and/or agencies involved.):

Action/Resolution taken by NCADD-NJ employees:

This form is to be completed whenever a major incident occurs that impedes the care coordination process; for example, police or security are involved in the incident, an ambulance is called to the site, physical altercations between two parties, etc.

The Clinical Director must be notified by phone when a major incident occurs. If the Clinical Director is not available, the Director of Care Coordination Services must be notified.

Critical Incident Report (Due to client death)

Every time a Care Coordinator learns of a client's death, the CC must review the case with the Clinical Director or the Director of Care Coordination who will complete a Critical Incident Report.

WFNJ-SAI/BHI

Critical Incident Report

Reviewer Name:	Reviewer Title:
Date of Review:	

Client Information:

Client Name:		**Client WFNJ #:**	
DOB:	**Gender: Male**	**Race:**	
County:		**Marital Status:**	
Care Coordinator:		**Date Assessed:**	**EOC:**

Critical Incident:

Type of Incident: Client death	**Date of Incident:**
Reported Cause of death:	
Reported Medical Concerns:	
DSM/ICD Diagnosis: By self-report,	

Treatment Information

Treatment Provider: People helping People	**Level of Care:**
Adherence to Treatment Recommendations: ☐ **Very Good** ☐ **Good** ☐ **Poor** ☐ **Very Poor**	**Comments:**

Cross-System Coordination

System's Response:		
Welfare :	Poor Fair Good	Comments:
DCP&P:	Poor Fair Good	Comments:
Medical Provider:	Poor Fair Good	Comments:
Treatment Provider:	Poor Fair Good	Comments:
SAI/BHI:	Poor Fair Good	Comments: