

Provider Press

September 2015

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Program Highlight:

Recovery Oriented Systems of Care Growing in Kansas

By Les Sperling, LAC and Harold Casey, LAC

Two organizations in Kansas are using a commitment to Recovery Oriented Systems of Care (ROSC) to expand immediate access to recovery support services for individuals, families, and community members in Kansas. **The Pathfinder Recovery Center**, in Salina, and the **Crossover Recovery Center** located in Wichita; both operate a drop in center where access to recovery supports is available without an appointment and free of charge. Connecting recovering individuals to community resources and providing them opportunities to re-connect with the community at-large are vital to sustaining quality, long-term recovery.

The principles of the ROSC model include the following:

1. There are many pathways to recovery and there is no wrong door for entering recovery.
2. Recovering persons have the authority over their own recovery through choice
3. Recovery is holistic and is influenced by the mind, body, and spirit, affecting the individual, family and community.
4. Recovery is unique to each person and is impacted by cultural beliefs and traditions.
5. Persons often gain the hope of recovery from others who share similar experiences.
6. Recovery involves building or rebuilding a life within the community which may include education, work, family, church, housing, etc.
7. Recovery must be supported across the lifespan.

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Recovery Centers offer a safe, confidential place to begin early recovery, meet others who share common barriers and solutions, and a place to find peer support. Both Recovery Centers are staffed with Kansas Certified Peer Mentors. Peer Mentors, also called Recovery Coaches, have experienced recovery first hand and serve as a point of initial contact for persons seeking recovery assistance. Licensed Addiction Counselors are also available to provide assistance as needed.

Recovery Coaches, in coordination with treatment providers and other community support services, work with each individual to engage them in services and to develop their own unique, individualized and self-directed plan for recovery. Participants are supported by a variety of both formal and informal activities including services that focus on Wellness, Recreation, Employment/Education, Family/Life Skills, and Mental Health/Substance Use. The individual recovery plan may or may not include formal treatment services.

For more information about ROSC or Recovery Centers contact: Charles Bartlett Project Coordinator, KDADS Charles.Bartlett@kdads.ks.gov

Crossover Recovery Center is operated by the Substance Abuse Center of Kansas and is located at 730 N. Waco in Wichita. Crossover can be reached by calling 316-267-3825, <http://saack.org>, Facebook: Crossover Recovery Center. Contact them for an initial assessment.

Pathfinder Recovery Center is operated by the Central Kansas Foundation and is located at 1809 S. Ohio in Salina and can be reached by calling 785-825-6224,

www.c-k-f.org, ckf@c-k-f.org, Facebook: Pathfinder Recovery Center and Twitter: @CKFSalina or any community member is welcome to walk-in.



Minors and Confidentiality



In Kansas a minor, age 14 and older, may admit themselves to SUD treatment without the consent of their parent (including guardian or other person legally responsible for the minor). Once admitted, the program must promptly contact the parent and notify them that the child has been admitted. Without a release from the child, no other information can be released.

Children, regardless of their age, should sign all releases. For children younger than 14, the parents must also sign. Releases should always be very specific and limited to only the information that is absolutely necessary.

When a release for payment purposes is needed, each child should be reassured that releases for insurance companies and billing purposes will be used solely for that purpose. If the minor refuses to sign a release which would allow payment for their treatment, the program may refer the minor elsewhere. In other words, if the minor's refusal to release information impedes the program's ability to have the services reimbursed, the program can refer the child to another program.

It's possible that a minor, 14 and older, may enter a program and, while still in treatment, revoke releases. This includes the ability of juvenile offenders to revoke their consent to communication with the judge or those involved with monitoring progress. A statement of revocation needs to be included in these releases with a dated signature from the child.

Other things to consider when working with Minors:

- A **guardian ad litem** may request information about a minor. Typically, a guardian ad litem is appointed by a court in child custody and child abuse and neglect cases to ensure the best interests of the minor are represented. Programs may not disclose any information about the minor or give access to records to a guardian ad litem unless the correct written consent has been given or a court order has been issued which follows 42CFR Part 2 requirements.
- **Reporting suspected child abuse and neglect** to DCF is permitted. Substance abuse by itself is not a condition that must be reported as child abuse or neglect—there must be some reason to suspect actual or imminent danger of harm to the child. This reporting exception applies only to the initial reporting and to a written confirmation of that initial report. This means that the exception does not apply to requests or subpoenas for additional information—even if the requests are for investigation, proceedings or court ordered treatment resulting from the initial report. Any further information must be withheld unless there is written consent, a court order for the records or, in some cases, a QSO-BA. To report suspected child abuse in Kansas call: Kansas Protection Report Center (KPRC) at 1-800-922-5330.

Concern arises with minors who have relapsed or who are engaging in risky behavior like driving while impaired. The fact that, once in treatment, programs cannot communicate information about minors to their parents without consent does not mean there are no means to deal with situations in which minors are headed for serious trouble. Here are some options:

- **Option 1: Plan ahead—get consent—look for other choices:** At your first appointment with a minor-- request consent. When entering treatment, many do not think they will have a relapse and therefore feel a consent form won't be needed or used. Minors who refuse to consent with their parent may be open to communication with

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someone else they trust or like—especially if they are given the choice of naming that person. This also gives the minor a greater sense of security, knowing you will not inform their parents without their permission while having a back-up available if the need arises. Remember, any disclosure must include a “prohibition on redisclosure” notice and thus, this third party should not tell the minor’s parents without consent.

- **Option 2:** 42 C.F.R. 2.14 (d) Exception: if: (1) the minor has only applied for services and (2) refuses to consent to parental notification and (3) the program director believes the minor, due to extreme youth or medical condition does not have the capacity to decide rationally whether to consent to parental notification; and (4) the disclosure is necessary to cope with a substantial threat to the life or well-being of the minor or someone else.
- **Option 3:** Medical Emergency Exception: If/ when a minor’s relapse poses an immediate threat to their health and requires immediate medical intervention a disclosure could be made to medical personnel who can treat the emergency condition. Medical personnel may not be prohibited themselves from contacting parents/others.
- **Option 4:** Court Order: A court can find that there is “good cause” for disclosure. The public interest and the need for disclosure must outweigh any adverse effect that the disclosure will have on the patient, patient-doctor relationship and the effectiveness of the program’s services. There are several procedures the court must follow before issuing an order, so this option won’t be much help if you’re in a hurry.

References: Legal Action Center. Confidentiality and Communication. New York: LAC, 2006 & 2012.

<http://www.dcf.ks.gov/services/PPS/Pages/ReportChildAbuseandNeglect.aspx> “A Guide to Reporting Child Abuse and Neglect in Kansas” Revised Dec 2013.

42 CFR Part 2 Sub Part B: General Provisions 2.14 Minor Patients and Kansas State Statute 59 Article 29b49 A-B.

Who Am I?

Hi, I am ????

Those of you who know me will quickly figure out who I am. My siblings and I grew up being Navy brats. I’m very proud of my father who served this country for 20 years. In support and honor all Veterans I am a member of the American Legion Riders. I enjoy riding our Harley across the country with the music cranked up and the wind blowing in my face, but more recently I have been enjoying sitting in the hot tub watching our fish swimming around the koi pond.

Do you already know who I am?

I have worked for the state for 17 years. Through my work I enjoy making a difference in people’s lives. Sometimes we get so caught up in the day to day demands of our jobs that we forget the amazing opportunities we have to make a difference each day by simply acknowledging someone with a smile and “hello” as you walk by.

Surely by now you know my name...

I was asked for a favorite quote. One of mine is: “If it doesn’t make sense, it’s not true.” To me it means, “trust your instincts.”

I am....answer found on page 8.



Compliance Corner

This is the second installment of Compliance Corner. Each issue of Provider Press will focus on a particular area related to KDADS standards and is meant to help providers maintain compliance with licensing standards and adapt to changes within our field. Our topic in this issue is **Discharge Documentation**.

Discharge Documentation: Standards 603 B 18, 604 A 4, 608 A, & 608 B 1-4.

Discharge Documentation includes not only discharge summaries and discharge plans, but also documentation of discharge planning starting upon admission and during the course of treatment. See the table below for a description of the relevant KDADS standard and ways providers can meet each standard.

First some definitions

Discharge planning: The process of identifying, documenting, and coordinating services and resources needed to support the client's recovery upon completion of treatment services.

These are just a few examples of areas that might be addressed as part of discharge planning: housing, employment assistance, medical evaluation/treatment, psychological evaluation/treatment, financial counseling/assistance, building a support network, etc.

Discharge Plan: This is a document that outlines a client's plan for maintaining sobriety and addressing other needs upon discharge from treatment. It may contain items such as a plan to avoid and manage triggers, a list of supportive people to contact, a schedule of support meetings to attend, referrals to other professionals such as mental health or medical providers, etc.

Discharge Summary: The documentation and clinical analysis of the client's progress in treatment including progress with identified treatment goals.

Standard #	Description	Suggestions for Implementation
603 B 18	The date of discharge and presence of a discharge summary in the client file.	This standard means the discharge date and summary must be kept in each client's file.
604 A 4	When discharge planning occurs, it shall be documented in progress notes.	If discharge planning is discussed in group or individual counseling, make sure to document it in your progress notes.

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608 A	Document that the discharge plan is photo copied and provided to the client upon discharge, if possible.	<p>One way to document that a client received a copy of their discharge plan is to add a client's signature line on the discharge plan and a statement that acknowledges they received a copy.</p> <p>If a client leaves treatment unexpectedly and a discharge plan cannot be completed, document that fact in the client file.</p>
608 B1	Information necessary to complete the discharge summary begins at admission.	There are many ways to document discharge planning upon admission: in progress notes, assessment summaries, treatment plans, discharge planning forms, discharge criteria, etc.
608 B2	Recommendations/ referrals are developed with the participation of the client	Collaborate with your client to address their current and post-treatment needs and supports. List both recommendations & referrals which occurred during the course of treatment and should be completed post treatment in the discharge summary. These should be individualized based on the client's particular needs.
608 B3	Evaluation of the client's progress on treatment plan goals.	Clearly state what progress or lack of progress the client made on their short term goals during treatment.
608 B 4	Discharge summary is entered into the client record within 30 days of completion of treatment.	State the date of discharge on the discharge summary. In addition, the counselor will need to sign and date his/her signature. During a site review, your Program Consultant will look for the discharge date and then see if the counselor's dated signature falls within 30 days of the client's completion of treatment.

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Tips for Writing a Discharge Summary

- Consider the audience when writing the summary. Summaries are written for future clinicians. If you were a counselor receiving this person as a client, what would you need/want to know?
 - a. So that your client can progress from where they left off.
 - b. To see what worked/didn't work for this client.
 - c. To not spend time repeating what has already been completed.
 - d. To show you respect the work the client has already completed.
- The more specific, measurable and individualized the short term goals on your treatment plans and updates are, the better your discharge summaries will be. See the article on Treatment Planning in the March 2015 issue of the Provider Press.
- Before writing a discharge summary, review the client's treatment plans and progress notes assessing the progress or lack of progress on treatment plan goals.
- Write a brief description of the progress or lack of progress made on each of the short term goals from the treatment plans.

Poor Example of evaluation of progress on treatment plans goals:

- "Client completed all treatment plan goals."
 - a. What's wrong with this example? It does not tell us what the goals were and gives no detail about progress.

Good Example of evaluation of progress on treatment plans goals:

The client's goals while in treatment were: 1) Remain sober; 2) Complete a relapse prevention plan; 3) Meet legal obligations; 4) Find a job.

The clinical interventions that proved most helpful were exploring the client's reasons both using and maintaining sobriety. Once his awareness of the severity of his use became clearer to him, we were able to move into looking at ways to maintain sobriety through skill training.

The client reported that he had remained sober throughout his time in treatment. He was given 3 urine drug screens and all were negative. The client completed a relapse prevention plan and was able to identify the triggers that typically lead to: relapses managing emotions and associating with friends who use. He developed coping strategies to deal with emotions. Client made payments required by court and made all probation meetings. The client applied for several jobs, but at the time of discharge he was still unemployed.

- List the recommendations you and the client have collaborated on during the course of their treatment. If the client stops attending or does not complete treatment for some reason, make recommendations based on your professional opinion as to what would benefit the client, even if that is just to return to treatment or complete a new evaluation.

Poor Examples of recommendations/referrals:

- Stay sober, avoid friends, complete probation, and find a job.
- Stay sober, attend 12 step meetings, and return to treatment if needed.
 - a. What's wrong with these examples? Although they are focused on recovery and the client's goals, they are generic and do not address all the client's needs.

Good Example of recommendations/referrals:

- Continue meeting court and probation obligations.
- Continue utilizing new coping skills and relapse prevention plan to avoid relapse
- Client has been referred to the job training center for help with employment and he has an appointment on 10/1/15.
- Client has also been referred to the Consumer Credit Counseling office for help with his financial issues. He has not set an appointment yet.
- The client has found Celebrate Recovery meetings helpful, and he has been encouraged to continue these meetings.

Treatment & Technology



By Kim Brown LAC, MPA

A-CHES (Addiction-Comprehensive Health Enhancement Support System) is a recovery smart phone application that is compatible with android and apple devices. Mirror Integrated Health has been using the A-CHES system of care for our clients in the Kansas City metro area since February of 2015. The reports from clients and staff alike are that they love it! In recent analysis of our satisfaction surveys we saw specific comments about how helpful A-CHES is to our clients' recovery. Currently we are grateful to receive funds for these services through dollars from the Unified Government in Kansas City.

Rooted in self-determination theory, A-CHES offers patients the opportunity to become self-determining and to access a range of supports at digital speed. A-CHES allows patients to use a convenient, always available support system to build coping skills, autonomy, and social connectedness.

The system's capacity to offer and analyze predictive analytics affords both patient and provider the capacity to see that risk of relapse is rising and to intervene prior to the adverse event occurring. Extending care outside of the treatment setting: traditionally, patients leaving treatment for alcohol

and drug use disorders receive insufficient aftercare and monitoring, despite the recognition of alcohol and drug dependence as chronic disorders.

Aftercare obstacles can include: relapse prevention information may be provided, but with limited face to face treatment interactions or only after relapse has occurred; follow-up sessions with counselors are limited in duration and frequency; peer supports and recovery coaching is encouraged but may be difficult to access on-demand due to limitations of time, place and transportation.

A-CHES reduces or removes these barriers, providing constant access to a constellation of supports, such as family, friends, and caregivers; information on relapse prevention and coping strategies; interactive tools to elicit clients' perspective and provide tailored responses; and GPS monitoring with notifications and auto-generated supports for users entering high-risk locations. Users will also have at their fingertips access to a library of information about addiction and relapse prevention.

A-CHES has a strong evidence base from the NIAAA-funded randomized control trial, indicating that A-CHES users experienced fewer heavy drinking days and more days abstinent, compared to the control group receiving treatment as usual.

If you are interested in investigating A-CHES for your clients (you'd be surprised at how affordable it is!) more information can be found at:

<http://www.chesmobilehealth.com/aches.html>

Answer to Who Am I?

Rhonda Gabel

Interpretation/Guideline R03-607A3 Drug Screens



The intent of this Standard R03-607A3 is to protect the client from incurring any negative consequences from a Drug Screen until the results have been confirmed by GCMS or similar lab test. The points below should help to provide further clarification:

- If the client admits to use prior, during or after the initial Drug Screen the program is not required to confirm with a lab test. The client must sign and date a document attesting they acknowledge drug use.
- After a positive Drug Screen, if the client requests confirmation or denies usage: the test must be confirmed.
- If your program does not release results of Drug Screens to any outside entity or person and strictly uses the results within the program therapeutically – you may request a waiver for this Standard (607A3) and therefore would not be required to have the results confirmed by a lab test. Procedure for therapeutically responding to Drug Screen results must be stated in program policy.
 - o Examples of therapeutic use of Drug Screen results:
 - Results of test trigger change in frequency and/or type of treatment services required. Treatment plan is adjusted accordingly. Confirmation is not required.

- Result of test extends time in treatment required. Treatment plan is adjusted accordingly. Confirmation is not required.
- Program refers client to another treatment provider (i.e.: physician, mental health center, therapist who specializes in problem gambling) to seek additional support. Confirmation is not required.
- If results of the Drug Screen conducted by the program are shared with any outside entity or person the client **must** sign a release specifically allowing the program to disclose those results.
 - o Examples of negative consequences that require confirmation:
 - Results of test, when sent to DCF, may result in parental rights being severed, loss of custody, reduction/loss of visitation, etc. If client requests confirmation or denies usage: test must be confirmed.
 - Program policy requires unsuccessful discharge from treatment following a positive screen. If client requests confirmation or denies usage: test must be confirmed.
 - Results of test, when released to a court, may result in probation revocation and/or incarceration. If client requests confirmation or denies usage: test must be confirmed.

Q: My Client's UDS is positive, I've documented they admit to using, with a written release, these results are sent to the Client's Probation Officer and I believe the Client's probation will be revoked: do I need to confirm the UDS?

A: Not if your client has signed acknowledgement of use and a valid release is being used to share the information with the Probation Officer

Program Self-Evaluation Check-Up

Program Self-Evaluation allows you to do your own preventative exam and check to see how your program is doing in regard to a particular standard. Read the question and answer below and see if your program is meeting the standard!

Standard	Description	Question	Answer
R03 602 C 2	A licensee shall ensure that written permission for release of a client record or information, is obtained according to the following: 2. Is obtained in a language understood by the individual signing the written permission	If a counselor speaks another language (ex: Spanish) and can translate the release, consent and intake forms to a client, do the forms still have to be written in the language a client understands?	YES. Releases, consents and all documents required by 601C1a-d must be written in a language that the client clearly understands, even if someone is available to translate for the client.
		If the written forms are not in the client's language, is it ok to have an interpreter read them the forms?	NO. Forms must be written in a language the client understands.

Jewish Vocational Services provides interpreting:
<http://www.jvskc.org/language-and-cultural-services/>

Release for ER contact

Best Practice: Ask each client to sign a release for their emergency contact at your first appointment



More on Irrevocable releases

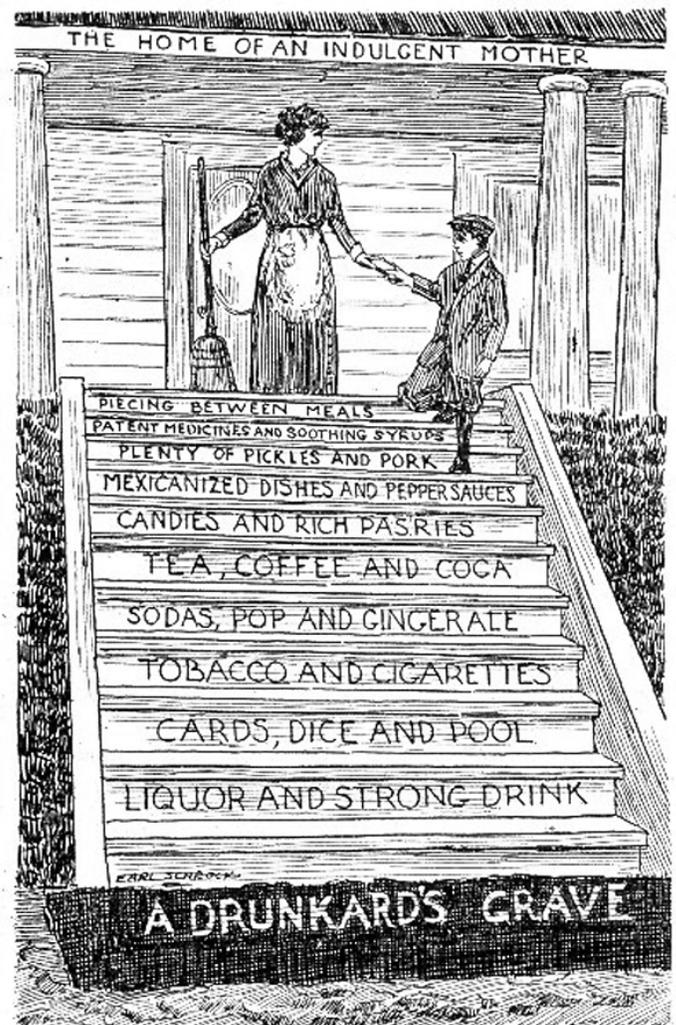
By Stacy Chamberlain, LAC

Some of the changes we discussed in the September of 2014 issue came about with the implementation of the 1996 HIPAA rules. Since these rules are more stringent when it comes to revocable releases we must abide by the HIPAA rules. These rules state we must allow the client to freely revoke a release. BHS staff researched a little more and found a sample release and a sample court order that can be used in these cases. You can find them at www.lac.org. Since beginning the discussion of this topic, a couple of issues my staff and I have identified when conducting site visits are below:

- Writing a clear purpose: Simply writing “the purpose of the disclosure is to inform the person(s) listed above of my attendance and progress in treatment” meets the regulation.
- The revocation statement: The language below is copied directly from the release provided by the Legal Action Center:
 - ◇ I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability Act of 1996 (HIPAA), 45 C.F.R. Pts. 160 and 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:
 - ◇ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or
 - ◇ Specify other time when consent can be revoked and/or expires.

I think all of this language is clear and indicates that even a criminal justice client may revoke a consent. The Legal Action Center book is clear on their interpretation of the rules. The language above does look the same to most of us except for the part about revocation. It is in your best interest to explain to each of your clients the rationale for having them sign consent forms and to assure them they are not only to protect them but allow you to share progress and completion with treatment.

Headlines from the Past



“Courtesy Illinois Addiction Studies Archives”

New SUD Programs Licensed Since January 1, 2015

Effective Date of License	Program Name	Program Director	Contact Information	Modalities
12/22/15	Thomas County Alcohol & Drug Abuse Council	Wendy Wacker	109 W. 11th St. Goodland, KS 67735 785 462-6111	OP, Assessment & Referral
1/21/15	Heart of Kansas Family Health Care	Carie Brown	1905 19th St. Great Bend, KS 67530 Phone 620 792-5700	Early Intervention, IOP, OP, Assessment & Referral
3/9/15	City on a Hill-Liberal	Christopher Lund	529 N. New York St. Liberal, KS 67901 620 276-0840	OP, Assessment & Referral. *Reintegration added 5/11/15.
3/10/15	RC Counseling	Raymond Colligan	105 S. Norton Ave Norton, KS 67654 785 202-0684	OP, Assessment & Referral
3/23/15	Project Dream	Sheryl Butler	129 W. 8th Russell, KS 67665 785 483-6468	OP, Assessment & Referral
3/23/15	Project Dream	Sheryl Butler	2006 Washington Great Bend, KS 67601 785 483-6468	OP, Assessment & Referral
4/1/15	Sunflower Wellness Retreat	Joseph Hammer	29875 W. 339th St. Osawatomie, KS 66064 913 755-4357	Intermediate, IOP, Assessment & Referral
4/1/15	Lakeside Academy	Walter Thiessen	244401 W. 39th St. South Goddard, KS 67052 316 794-2760	IOP, OP, Assessment & Referral
4/1/15	Riverside Academy	Walter Thiessen	2050 W. 11th St. Wichita, KS 67203 316 267-5710	IOP, OP, Assessment & Referral
4/3/15	SACK Residential	Brian Jarman	1720 E. Morris # 107 Wichita, KS 67211 316 633-4705	Social Detox, Assessment & Referral
4/8/15	Solid Ground	Kim Bowers	110 N. 3rd St. Burlington, KS 66839 620 364-1415	Early Intervention, IOP, OP, Assessment & Referral

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Effective Date of License	Program Name	Program Director	Contact Information	Modalities
6/26/15	Counseling Center at MHA	Shawna Allen	555 N. Woodlawn #130 Wichita, KS 67208 316 652-2590	IOP, OP, Assessment & Referral
7/17/15	Agape BHH Addiction Treatment Center	Rosemary Njoroge	928 S. Broadway # M-9 Wichita, KS 67203 316 390-0840	Early Intervention, IOP, OP, Assessment & Referral
8/1/15	Alpha Recovery Services	Richard Ostrander	4105 W. 6th St. # B-4 Lawrence, KS 66049 785 218-3229	OP, Assessment & Referral

October 2015 Provider Meetings

Please plan to attend one of the following meetings in October:

Date	Time	Place
Tuesday October 20th	9 a.m. -12 p.m.	Preferred Family Healthcare 830 S. Hillside Wichita, KS 67211
Thursday October 22nd	9 a.m. -12 p.m.	Valeo Recovery Center 330 SW Oakley Topeka Lower Level Conference Center
Friday October 23rd	9 a.m. -12 p.m.	Dept. of Transportation 1811 Frontier Rd, Hays, KS 67601

Kicked out of Citrix?

You must log into Citrix at least once a month to keep your KCPC access from being deleted!

In order to restore your access to the KCPC, you have to send in new forms for security.
Send forms 2-5 to Billie Fuller no matter what the forms say!

To find the forms please go to this link: www.kdads.ks.gov and follow this path:

*Providers Home

*Click on the KDADS Web Application Access Security Agreement yellow box

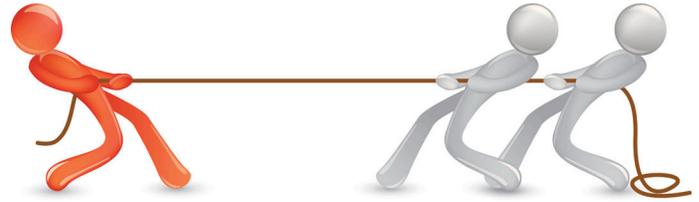
- 1) The KDADS security agreement is the embedded on-line submission form on this page
- 2) The EAS application for Citrix security form
- 3) The DCF security form
- 4) Complete the awareness training & submit a copy of the completion certificate to Billie Fuller

This training must be renewed annually!! Put it on your calendar

- 5) If your computer doesn't already have the KCPC, then you will also need to complete the computer questionnaire



Evaluations



Evaluations are the property of the person being evaluated. The person being evaluated chooses to whom their evaluation is and is not released...not the treatment program that completed the evaluation.



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