Withdrawal Management Standards

Topic	Timelines/Forms	Process
Admit/Assessment – First Face to Face contact with the client. This starts the timeline requirements.	Completed with SUD Counselor and/or LPHA within **24 Hours** of admission: • **Initial LOC Assessment** • **Risk Assessment** • **Health Questionnaire** • **TB Screening Form**	• Review all acknowledgements, financial info, releases and consents. • Complete Initial LOC Assessment with Risk Assessment, Health Questionnaire, and TB Screening to determine level of care (LOC). • Face to Face interaction between SUD Counselor and LPHA.
Other WM Admission Procedures	At Admission must provide withdrawal management interventions and complete for initial 24 hours: **WM Observation Log** (**Observation -** The process of monitoring the client's course of withdrawal. It is to be conducted as frequently as deemed appropriate for the client, and at least every 30 minutes for the first 24 hours. This may include but is not limited to observation of the client's health status.) • Observation can be done up to 72 hours or longer according to the client's needs and current withdrawal symptoms. • At 24 hours, trained staff assess client symptoms and determine whether the frequency of the observations will be continued, reduced, or discontinued.	• Complete substance(s) specific withdrawal management scoring tool at admit and as required thereafter. (Program decides appropriate tools to use depending on substance used) • Closely observe client for withdrawal symptoms as clinically appropriate 24-72 hours from admission. • Complete Withdrawal Management Observation Log for at least the initial 24 hours. • At 24 hours from admission and at least every 24 hours until the determination is made to discontinue observations, staff select an Observation Status that specifies whether observations will be continued, decreased, or discontinued and document the reason for the selected Observation Status based on symptomatology and protocols approved by the Medical Director.

Withdrawal Management Standards

Withdrawal Management (WM) Treatment Plan, Diagnosis and Medical Necessity (use of ASAM LOC, DSM 5 Dx)	These 2 forms are be completed within 72 hours of admission: • **DDN** • **WM Treatment plan** --- This form is completed prior to a planned discharge and/or at maximum of 7 days from admission to withdrawal management: • **Level of Care Recommendation**	• LPHA establishes medical necessity criteria via DSM 5 and ASAM LOC. • LPHA must document the criteria met specific to the substance use disorder diagnosis. • Complete individualized WM Treatment Plan by SUD Counselor and/ or LPHA • Tx Plan signed by client as soon as clinically appropriate (or document why client did not sign) • Client offered MAT services whenever appropriate. • LOC Recommendation is used to assist the client with transition to the appropriate next level of care.
Withdrawal Management (WM) Programs: Physical Examination Requirements	WM programs must follow these physical examination requirements within the timeline of 72 hours from admission to program: • Program MD review of results of a physical examination conducted within the past 12 months; or provide a physical examination of the client (if the program is IMS certified). • If the physical examination results are not reviewed within 72 hours or the client has not had a physical examination within the past 12 months or within 72 hours from admission, the treatment plan must include a goal for the client to obtain a physical examination. This is required even if the program is unable to assist in completing the goal during the	The Physical Exam requirements can be satisfied in these 3 ways: • Documentation of physical exam results within the last 12 months, and results are reviewed by the MD within 72 hours of admission. • Goal to obtain a physical exam on the Treatment Plan (MD can perform the exam at the program. Residential must have IMS certification for this option) • Physical exam completed while at program, and MD reviews and signs/dates the physical exam. (Printed name/signature and date need to be adjacent and done within 72 hours of admission. A stamped signature is not acceptable.)

	client's treatment episode. • Disallowances related to this issue for chart reviews will be for new clients and new treatment plans as of November 1st, 2019 at WM programs. (As found in the Oct 2019 Up to the Minute)	
Incidental Medical Services (IMS) (Recommended but not required)	Complete within 72 hours from admission: • **DHCS 4026 Form (IMS Certification)** (See DHCS Info Notice 18-031 for IMS guidelines)	• Face to Face assessment by Medical Doctor or Healthcare Practitioner (must be within scope of practice)
Drug Toxicology Testing and Screening	Upon admission and per program policies complete: • **Drug Test and Results Log**	• Breathalyzer • Urine Screening • Blood Testing • Document results and reporting • Documents and documentation of results must be filed in client chart.
Centrally Stored Medications	Throughout the client's stay, complete: • **Centrally Stored Medication and Destruction Record**	• Medication storage requirements within Federal, State and local regulations. • Proper storage and handling of Schedule II-IV Medications • Diversion Control Policy and staff
Disposal of Client Medications	Within 30 Days of discharge	• Disposal of unclaimed medications • Policy and Procedure in place for a disposal plan that follows Federal, State and local regulations.
Medication Self-Administration	Admission throughout client stay	• Inventory of prescribed and over the counter medication with required information upon admission. • Medication times logged/monitored

Withdrawal Management Standards

Naloxone	Permitted at all residential and AOD treatment programs	• Recorded, stored and destroyed in same manner as Rx medications. • Administering staff competency per AOD standards. • Stocking doses • Policies, procedures and protocols.
Summary of Clinical Services	Daily documentation and evidence of clinical services (e.g., Groups have sign-in sheets): • **WM Daily Progress Note, or** • **SUD Treatment Progress Note**	• Clinical services to be documented using observation logs, WM Daily PN or SUD Treatment PN and group sign- • in sheets. There must be a note present for each day of service. • In WM, the expectation is monitoring the client for safety during the withdrawal process. Once observation can be discontinued, the client can participate in the milieu. The standard is that a daily progress note document what is happening with the client, and what service the program provided to assist the client on that day (not a minimum number of contact hours). • Programs are encouraged to consult with the MD for continuing of observation when the client reports continued symptoms. This should be documented in the progress notes. • The narrative section of the WM Daily Progress note is intended to summarize the day. Providers should not itemize each service in this section. Respond to each prompt so as to meet the minimum standard requirements.

Group Sign in Sheet	• Use the group sign in sheet form to document attendance at each group session (See SUDPOH Appendix D.4). • The group sign in sheet must be completed and signed the same day the group was provided.	• The topic and start/end time must be documented on this sheet and must match the topic and start/end time documented on the service record portion of the progress note (don't forget to add AM/PM). • Client's full (first and last) printed names must be adjacent to their signature. The SUD or LPHA printed name must be adjacent to their signature and date signed.
Discharge Plan	Completed prior to a planned discharge.	• Assist client in preparing for relapse triggers and how to avoid them, along with support plan that includes referrals for ongoing care and resources. • Must be signed and dated by counselor and client with a copy offered to the client and original placed in the client record. • Reminder, ASAM LOC Recommendation form is completed prior to a planned discharge.
Discharge Summary	Completed within 72 hours from the last face-to-face or telephone contact with client.	• Written summary of the treatment episode including duration of treatment, reason for discharge, whether voluntary or involuntary, discharge prognosis and disposition. • Complete CalOMS Discharge in SanWITS. • Use CalOMS Administrative Discharge, if client has left treatment and cannot be interviewed.

Staffing plan that includes Nursing (Recommended but not required)	Admission throughout client stay	• When 24/7 nursing staff is not used/available, providers are expected to implement policies and procedures that have been developed with the Medical Director that includes, at a minimum, working collaboratively with emergency departments and primary care physicians to ensure that the client is safe to receive treatment at the WM program.