Kolpia Counseling Services
Service Delivery Policies

Index

1. Fee Agreements: For specific fee schedule see "Fee Schedule." All fees will be available for patients and practitioners to see. The fees will change appropriately with increases in expenditures and to reflect market inflation. When it is available we will provide a dedicated agency representative to explain fees, payment schedules and insurance reimbursement. Otherwise it is the role of the office manager and / or billing service, Excel Medical Billing, to explain the fees and fee structure.

a. Cancellations and failure to show: Cancellations require a 24-hour prior notification during the week and 72 hours during the weekend otherwise the client is responsible for a $35 cancellation fee which they must pay before making a following appointment. The fee may be waived by the management for extenuating circumstances, emergencies and with the advocacy of their provider at Kolpia. OHP / Medicaid clients are exempt from this fee.

b. Outstanding Balances: Our first priority is to provide quality service to clients and to ensure accessibility to our services. As such we practice an understanding and compassionate attitude toward the life and financial circumstances that makes payment for services difficult. In order to maintain continuity of care we will not prematurely end services due to financial difficulty. If a client or financially responsible party is unable to pay for services and has an outstanding balance, a finance counselor or representative of the billing service will contact them to arrange payment. At that time the finance representative will discuss with the financially responsible party:

i. An adjustment in overall balance.
ii. A payment plan (non-interest accruing).
iii. The various forms of financial assistance available to them through federal, state, community or private sources.
iv. Formal collections and credit-reporting process if necessary.

If a client or the financially responsible party is unwilling to work with the finance representative to reach an agreed upon payment / repayment plan, Kolpia reserves the right to deny services and pursue financial collections of fees due Kolpia for services rendered.

c. Certificates of completion and ongoing care: If a client completes a program (DUII) requiring certification and they have an unpaid balance, we have the option to complete a client as unsuccessful until the balance is paid. We are not to extend treatment services as a means to wait and collect payment. In the case that a client has completed a program with an unpaid balance the finance representative will work with the financially responsible party using the criteria outlined in (1.b.) above. If a client stops treatment and has an unpaid balance, they are able to resume treatment at any time without full payment of balance once payment arrangements have been made. A finance representative will discuss the various payment options available to them. If a client or the financially responsible party is unwilling to work with the finance representative to reach an agreed upon payment / repayment plan, Kolpia reserves the right to report the client treatment as incomplete, refer the client to other agencies, and pursue formal collections of fees due Kolpia for services rendered.

d. Provisions for Medicaid and Medicare Billing: Kolpia provides treatment for patients currently enrolled in Medicaid and/or Medicare. Medicaid and Medicare patients will not be charged the overage or difference between our fees outlined in the fee schedule (*see fee schedule*) and what Medicaid or Medicare pay. Medicaid and Medicare patients are responsible for whatever copays or coinsurance is mandated by their managed care plan. If there is financial hardship and the patient is unable to pay their bill, provisions allow for repayment options outlined in *Outstanding Balances (see 1.a.)*.

e. Sliding Fee Scale:

The agency will extend discounted services for those clients that do not qualify for Medicare and Medicaid but do qualify for local food stamps through the Oregon SNAP services. The client must present documentation that they are currently qualified for SNAP services. This documentation must identify the person by name and they must present proof of identification by photo ID. See Sliding Scale Fee Schedule for specific information about fees.

2. Confidentiality: In accordance with HIPAA, 42 CFR part 2, and ORS 179.505 and 192.518 and 192.530, all patient information is to be protected. This includes:

- **a.** Obtaining informed consent to procure verbal or written medical history and provide treatment.
- **b.** Obtaining written consent in the form of a release of information (ROI) to share information with another medical provider, agency or family member. The ROI must:
  - i. identify each agency or individual we wish to share the information with, or who wishes to share information with us.
  - ii. identify the specific information that is to be shared
  - iii. designate a specific period of time for the sharing of information.
  - iv. be corrected in the case of errors by placing one line through the error and initialing the correction.
- **c.** A release of information (ROI) form is necessary when reporting any information to referants including presence in treatment. Clients have the legal right to engage in or continue in services without an ROI for their referent. When a referent is paying for the treatment, the client may be required by that contract to either keep the ROI in place or pay for any services when an ROI is not valid.
- **d.** Revocation of ROI. It is the client's right to revoke an ROI or refuse to renew one that is about to expire. If a client wishes to revoke an ROI the steps outlined below should be followed.
  - i. The client must submit in writing their desire to revoke the ROI. The written request must include the date of the request as well as the specific name, agency or program that the ROI is for.
  - ii. The counselor is to update the client's ROI log with the word "revoked" next to the ROI entry.
  - iii. The written request is to be scanned into the client's chart and named "ROI-revocation-*name of entity*".
- **e.** In the case of an emergency or urgent care the practitioner is able to share PHI with medical providers in accordance with 42 CFR part II. This needs to be documented on the incident report which is scanned into their chart and named "Incident-report-*date*"
- **f.** In the case of collaborative care with another practitioner, provider or prescriber PHI can be shared with the client's consent and a ROI that identifies the specific collaborative care provider that information is to be shared with.
- **g.** It is important to not re-share protected PHI. For example if we receive PHI from a primary care provider, and we are referring a patient for hospitalization, we can only provide the PHI we have generated in our assessments and service delivery and cannot share the the information that was shared with us from the primary care provider.
- **h.** Written and signed consent must be granted by a parent or guardian if the client is 13 years of age or younger. It is important to check the informed consent form to ensure the document has been signed by the parent/guardian in addition to or in lieu of the child.
- **i.** No client or patient information is to be shared between providers or anyone else using unsecured email programs. Patient information should only be shared using the secured platform within the electronic medical records program provided by the agency.
- **j.** Faxing: Avoid writing any PHI in the subject line on fax cover sheets.

k. Client contact outside of the agency: To maintain the anonymity of the client as well as to discourage inappropriate relations between clients and employees of the agency it is important that our conduct with them outside of the agency is professional. Contact should be avoided when possible and intentionally limited to short and cordial interactions if it is not possible to avoid contact. All conversation regarding the agency, programs and especially any private information related to that client or any other client is strictly not allowed. If this policy is breached by an employee they will be counseled appropriately which may include immediate termination.

l. Communication with family members or interested parties: When a person calls to inquire about a client that is receiving or about to receive services at Kolpia it is important to follow these steps.

i. No client information is to be shared with any family member or interested party until their identity has been verified by visual ID.
ii. Check to see if an ROI is in place for the person requesting information and identify which information is to be disclosed as specified on the ROI.
iii. In the case that there is not an ROI in place for the interested party and/or if they are not able to verify their identity by visual photo ID then you must inform them that they cannot confirm anyone's presence or involvement at Kolpia."
iv. In the case that an ROI is in place for the interested party and their identification has be confirmed visually then you may share only the information expressly identified on the ROI form. Only clinical staff should share any information regarding client progress or the specifics of their involvement at Kolpia.

m. In accordance with 42 CFR part II there are express exceptions to the Confidentiality Agreement in the following circumstances:

i. When emergency or urgent care are necessary.
ii. When mandatory abuse reporting conditions apply (see Mandatory Abuse Reporting).
iii. When a crisis situation has occurred at the agency that includes a threat to the safety and security of the client, the employees and other persons on agency property.
iv. When a client has indicated a desire to cause harm to themselves or another person.
v. When criminal activity has occurred at the agency or witnessed by an employee of the agency.
vi. When Communicating with other agencies, organizations, providers or prescribers is necessary for collaboration and continuity of care. The client will sign an ROI indicating the parties or agencies they wish to share information with.
vii. When required by the criminal justice system to share information by a court order.

3. Americans with Disability Act (ADA title 2):

- **a.** Kolpia does not discriminate against qualified persons with disabilities regarding any programs, activities or services administered by the agency.
- **b.** If an individual needs to file an ADA complaint we will direct them to the ADA.gov webportal so they can download and file the appropriate forms.
- **c.** Building access:
    - i. Ashland Location: The 607 building has limited access for clients using wheelchairs. There is a small step a the entrance to the building and we provide assistance to persons in wheelchairs to help them with the step. The hallways are adequate for standard-sized ADA assistance devices, and bathrooms are adequate for most standard wheelchairs. Some larger wheelchairs and electric wheelchairs will require a larger bathroom in which case we will help them to access the 611 building which is less than 50 feet from the 607 building. It has a service ramp and ADA approved and retrofitted bathrooms.
    - ii. Medford Location: This facility has ADA approved building access and bathroom facilities.
- **d.** Document accessibility:
    - i. Sight or reading impaired: For those clients who are sight impaired or are unable to read, the counselor will read all the entry and assessment documentation to them. The client is encouraged to have a representative in the room with them to ensure that information is being adequately communicated and understood.
    - ii. Non-english speaking clients: See the section of this document entitled *Culturally and Linguistically Appropriate Services*.

4. Entry and Assessment:

- **a.** All policies regarding entry and assessment are written in accordance with OAR 309-019-0135
- **b.** Individuals are considered for entry without regard to race, ethnicity, gender, gender identity, gender presentation, sexual orientation, religion, creed, national origin, age, except when program eligibility is restricted to children, adults or older adults, familial status, marital status, source of income, and disability.
- **c.** Individuals are scheduled for assessment once their referral information and insurance / payment information has been verified. If an assessment and future appointments require a preauthorization from the payer they will be notified and put on the schedule once the authorization for payment has been received.
- **d.** Eligible individuals will be scheduled for the first available appointment unless there is a wait list at which time we inform them of the approximate wait time and provide them with referrals to other agencies if they do not want to be on the wait list.
- **e.** Scheduling personnel will call each person on the waitlist every friday to update them about the expected wait time and to see if they want to continue to be on the list.
- **f.** We only maintain 15 individuals on a waitlist for a specific service at any given time.
- **g.** Written informed consent for services is obtained from the individual or guardian, if applicable prior to to the start of services and is included in the new client entry paperwork. The front desk staff and the assessing counselor / provider are responsible to ensure the informed consent has been signed before any assessment or services have been rendered. If such consent is not obtained due to acute crises intervention or an emergency situation, the reason must be documented and further attempts to obtain informed consent must be made as appropriate.
- **h.** All clinical records and other documentation which supports the specific care, items, or services for which payment has been requested are maintained in the electronic health records (EHR).
- **i.** It is the responsibility of the provider and the provider's supervisor to ensure all documentation is uploaded and noted in the individual's EHR. If there are any issues with ensuring adequate and timely documentation, the clinical supervisor will be held accountable and responsible for creating a performance improvement plan for the provider they are supervising.
- **j.** Once an individual has been assessed, if OHP is paying for their care, their information is to be entered into the state monitoring system (MOTS).
- **k.** In accordance with ORS 179.505 and HIPAA, an authorization for the release of information must be obtained for any confidential information concerning the individual being considered for, or receiving services.
- **l.** <u>Orientation</u>: At the time of entry, the program must offer to the individual and guardian if applicable, written program orientation information. The written information must be in a language understood by the individual and must include:
    - i. An opportunity to complete a declaration for mental health treatment with the individual's participation and informed consent;
    - ii. A description of individual rights consistent with these rules;
    - iii. Policies concerning grievances;
    - iv. Notice of privacy practices; and
    - v. An opportunity to register to vote.

m. Assessment (*See Appendix A for and example*):

- **i.** A complete assessment includes: (1) demographic and payment information, (2) completed orientation checklist, (3) signed informed consent (4) signed fee schedule, (5) medical history, (6) clinical assessment and diagnosis.
- ii. The assessment must be completed by qualified program staff as follows:
    1. A QMHP in mental health programs. A QMHA may assist in the gathering and compiling of information to be included in the assessment.
    2. Supervisory or treatment staff in substance use disorders treatment programs, and
- iii. Each assessment must include sufficient information and documentation to justify the presence of a diagnosis that is the medically appropriate reason for services.
- iv. For Substance Use Disorders services, each assessment must be consistent with the dimensions described in the ASAM PPC, and must document a diagnosis and level of care determination consistent with the DSM and ASAM PPC.
- v. When the assessment process determines the presence of co-occurring substance use and mental health disorders, or any significant risk to health and safety, all providers must document referral for further assessment, planning and intervention from an appropriate professional, either with the same provider or with a collaborative community provider.
- vi. Providers must update assessments as applicable when there are changes in an individual's clinical circumstances that necessitate a change to their diagnosis. For example if an individual who is receiving mental health services reports having a problem with drugs or alcohol, an addendum can be added to the initial assessment that includes this information. if the individual wants treatment for a SUD an ASAM multidimensional assessment can be obtained and added to their EHR.
- vii. All Assessments must be signed within 10 days of the initial assessment appointment.
- viii. For all Assessments that are not completed, a reason for non-completion as well as a note indicating the individual has been contacted to complete the Assessment must be added as an addendum to the Assessment Note in the EHR.
- ix. Provider Qualifications:
    1. For A&D services the Assessment must be completed by a CADC I-III, or an Allied Health Provider that has been credentialed to provide treatment for SUD (see Personnel Policies: *Personnel Qualifications and Credentialing*).
        a. A counselor in training (CIT) may complete the Assessment as long as it is reviewed and duly signed by the clinical supervisor.
    2. For MH services the Assessment must be completed by a licensed QMHP.
        a. A MH intern or QMHA can assist in completing the Assessment by interviewing the client and gathering data. The diagnosis must be made by the supervising QMHP and the Assessment must be signed by them within 10 days of the Assessment.
        b. Any individual continuing to receive mental health services for one or more continuous years, must receive an annual assessment by a QMHP.
- x. Documentation Method:
    1. A specific note (A&D Assessment, MH Assessment) must be created in the EHR for each Assessment.
    2. Providers may complete the Assessment using the Assessment Templates available on the EHR, or complete the Assessment using Microsoft Word and copy/paste the completed Assessment into the EHR note. ****If completing the assessment in MS Word, the file must be stored in an encrypted / password protected*

file on the provider's computer. Assessments are not to be completed using MS Word on a personal computer.

5. Patient Orientation:

a. It is the responsibility of the provider who is conducting the initial assessment for treatment to review all the orientation paperwork with the patient and to ensure the paper work is complete and accurate, including signatures and initials.

b. The patient must initial each of the orientation items on the orientation checklist in the presence of the provider conducting the assessment.

c. The provider will ensure the patient has received the complete Individual Rights, Privacy Policy and Grievances and Appeals policies at the time of assessment. For all medicaid clients the provider must ask the client if they wish to vote and provide them with a voter registration card if they want one.

d. The provider must ask the client if they have any questions about anything in the orientation packet prior to the start of the assessment.

6. Individual Service Plans:

a. The Individual Service Plan (ISP) is the main operating document for establishing the care of the individual and includes (1) the projected time in treatment, (2) the specific services the individual will participate in, (3) referrals within and without the agency, (4) the timing and duration of the services, (5) who will be performing the services including their credentials (6) expected goals and outcomes for a specific period of time, and (7) re-assessment date. (*See Appendix B for an example).*

b. The point of the (ISP) is to establish care, communicate expectations, coordinate services with the rest of the treatment team and to establish benchmarks that will determine progress in treatment from which the provider will determine when to end, continue or transfer service to another agency or provider.

c. The ISP must be completed prior to the start of services. It is idea that the service plan be completed on the same date of the assessment but if that is not possible due to the length of the assessment, the provider is given one more visit to finalize the initial ISP.

d. The ISP must reflect the assessment, diagnosis and the level of care to be provided.

e. The ISP can Include the participation of the family members as well.

f. All referrals to a specific service within or outside the agency must be documented in the Service Plan and must include (1) the specific service, (2) reason for referral, (3) timing, (4) who will be performing the service, including their credentials.

g. Provider Qualifications:

i. For A&D services the ISP must be completed by a CADC I-III, or an Allied Health Provider that has been credentialed to provide treatment for SUD (see Personnel Policies: *Personnel Qualifications and Credentialing*).

1. A counselor in training (CIT) may complete the ISP as long as it is reviewed and duly signed by the clinical supervisor.

ii. For MH services the ISP must be completed by a licensed QMHP.

1. A MH intern or QMHA can assist in completing the ISP which must be reviewed by the supervising QMHP.

h. The ISP must be signed within 10 business days by the rendering or supervising QMHP.

i. Documentation Method:

i. A specific note (*A&D Service Plan, MH Service Plan*) must be created in the EHR for each ISP.

ii. Providers may complete the ISP using the Service Plan templates available on the EHR, or complete the ISP using Microsoft Word and copy/paste the completed ISP into the EHR note. ****If completing the ISP in MS Word, the file must be stored in an encrypted / password protected file on the provider's computer. ISP's are not to be completed using MS Word on a personal computer.*

j. The ISP is reviewed and updated with the individual every 12 weeks if they are continuing to receive services. If they are no longer receiving services, an Exit/Transfer Summary is to be completed (see 8. *Closing Charts*). When an ISP is updated a new Service Plan note is to be created with the updated ISP information similar to the initial ISP.

k. A Licensed Mental Health Provider (LPC / LCSW) must approve the ISP at least annually for each individual continuing to receive mental health services.

7. Service Notes

a. Service Notes: (*See Appendix C for an example*)

i. Service notes are important tools to document how the individual is doing, their progress in treatment, obstacles to progress, what services are being performed and any other information related to their treatment.

ii. Service notes must include at a minimum:

1. Individual progress and factors affecting their treatment.
2. The specific services provided at the time of the appointment.
3. The date, time of service, and the actual amount of time the services were rendered.
4. Who rendered the services.
5. The setting in which the services were rendered.
6. The relationship of the services to the ISP.
7. Any incidents, grievances or reports made by the client.

b. Exit / Transfer Summary: (*See Appendix D for an example*)

i. Decisions to transfer individuals must be documented, including the date, reason for the transfer, and referrals / recommendations if any.

ii. The reasons for exiting or transferring a client are as follows:

1. Successful completion:
    a. DUII - an individual can be considered successfully completed when they have met all the service goals outline in their ISP and DUI minimum requirements (*See DUI Minimum Requirements in the Program Policies section)*
    b. IOP - an individual has successfully completed IOP when they have met all the service goals outlined in their ISP, have attended all required IOP modules and have demonstrated they are ready for lower level of care.
    c. Voluntary SUD / COD - an individual may cease treatment at any time but to be considered successfully completed they must have met the service goals outlined in their ISP and be in the maintenance stage of the Stages of Change Model.
2. Unsuccessful Completion: When an individual has prematurely ended treatment, failed to meet the service goals outlined in their ISP or the DUI minimum requirements established by their counselor, they are considered to have unsuccessfully completed treatment. At this time a referral should be made to another agency or service provider.
3. Communicating with Referents:
    a. All referents requesting a timeline or a confirmation of completion must have in place an ROI that specifies what information is to be shared with them.
    b. Timelines and completion can be communicated through telephone, fax, encrypted email and by postal delivery (*See HIPAA / HITECH)*.
    c. All communication with referents regarding completion must take place within 30 days of completion.

8. Dual Diagnosis Documentation:

- **a.** For those clients that have received a complete substance abuse ASAM assessment and are recommended for mental health services as well, a comprehensive mental health assessment is not necessary if they are continuing to receive substance abuse counseling for a substance use disorder as long as both services are taking place at Kolpia and regular continuity of care meetings occur between the substance abuse and mental health counselor.
- **b.** For those clients who have received a comprehensive mental health assessment and are being referred to substance abuse services, an ASAM assessment must be completed prior to treatment.

9. Closing Charts:

- **a.** Patient charts should be closed when:
  - i. They have not received any services for more than 6 months.
  - ii. They are enrolled in a mandatory DUI program and have been absent without approval for more that 30 days
  - iii. They have graduated from a program and do not intend on continuing services.
  - iv. Their services at Kolpia have been intentionally discontinued by the patient or staff.
- **b.** The procedure is as follows:
  - i. Chart is to be reviewed for completion.
  - ii. An exit / transfer summary is to be completed.
  - iii. An Action Plan Letter (APL) is to written:
    1. Choose the appropriate APL format and select the reason for completion. Be sure to add any comments or referrals along with your name, credentials and signature.
    2. Scan the signed document into their chart
    3. Give the APL to the designee who will then call and send the letter.
  - iv. Once the APL letter has been written and scanned into their chart, open the patient's profile in Practice Fusion and change them to "inactive" by un-checking the "active" box.
  - v. If the patient wants to keep their chart open and continue services, they must talk with the primary counselor or whoever is closing the chart, and a continuation of care appointment is to be made. They can be marked as "active" at that time.

10. Grievances and Appeals:

a. Any individual receiving services, or the parent or guardian of the individual receiving services, may file a grievance with the agency, the individual's managed care plan or the Division.

b. A counselor or other agency employee will review a written copy of the agency's grievance procedures with the individual receiving services, the parent or guardian upon entry to the program.

c. A copy of the grievance and appeals procedure and form will be made available at the front desk as well as posted in a conspicuous place (the policy tree) in the common area / waiting room.

d. Grievance and Appeals Procedures. (For individuals whose services are funded by Medicaid, grievance and appeal procedures are outlined in OAR 410-141-0260 through 410-141-0266).:

i. It is our practice to attempt to resolve any dispute or grievance at the lowest level starting with the counselor, office manager, direct supervisor, clinical supervisor and director.

ii. If the individual is unable to resolve the grievance or dispute by speaking with the staff, or does not feel comfortable doing so, the may obtain a grievance form by asking the counselor directly or getting one from the front desk or from the policy tree posted in the common area.

iii. If a grievance is submitted verbally, the staff accepting the grievance will ask if the individual would be willing to fill out a grievance form or if they would like a staff member to fill one out on their behalf.

iv. Write in detail the complaint, grievance or appeal including pertinent dates and persons involved. If the individual is having difficulty in filling out the form they may receive assistance from a staff member in completing their grievance form.

v. Turn the grievance into the front desk or the counselor.

vi. Once the form has been received the agency has 30 days to complete any investigation necessary. A timeline follows:

1. The next business day: The form is to be given to the appropriate program manager depending on what program the client is enrolled in. If there is a conflict of interest the form is to be given to the clinical director or executive director.
2. The manager or director will contact the client, parent or guardian within 24hrs to confirm receipt of the form.
3. Documentation will be made in the client's chart of the receipt of the form and the initial contact by the manager or director responsible for processing the complaint. A copy of the grievance form is to be scanned into the client's EHR.
4. The manager or director will then consult with all parties involved and conduct the investigation.
5. Once the investigation has finished, the manager or director will issue a determination no later than 30 days after the beginning of the investigation.
6. The client, parent or guardian will be contacted by the next business day once the determination has been made.

7. The client, parent or guardian may appeal the determination following the same procedures if they disagree with the determination or have novel information regarding the initial complaint.

e. Expedited Grievances: In circumstances where the matter of the grievance is likely to cause harm to the individual before the grievance procedures outlined in these rules are completed, the individual, or guardian of the individual, may request an expedited review. The program administrator must review and respond in writing to the grievance within 48 hours of receipt of the grievance. The written response must include information about the appeal process.

f. Retaliation: A grievant, witness or staff member of a provider must not be subject to retaliation by a provider for making a report or being interviewed about a grievance or being a witness. Retaliation may include, but is not limited to, dismissal or harassment, reduction in services, wages or benefits, or basing service or a performance review on the action.

g. Immunity: The grievant is immune from any civil or criminal liability with respect to the making or content of a grievance made in good faith.

h. Appeals: Individuals and their legal guardians, as applicable, must have the right to appeal entry, transfer and grievance decisions as follows:

i. If the individual or guardian, if applicable, is not satisfied with the decision, the individual or guardian may file an appeal in writing within ten working days of the date of the program administrator's response to the grievance or notification of denial for services as applicable. The appeal must be submitted to the CMHP Director in the county where the provider is located or to the Division as applicable;

ii. If requested, program staff must be available to assist the individual;

iii. The CMHP Director or Division, must provide a written response within ten working days of the receipt of the appeal; and

iv. If the individual or guardian, if applicable, is not satisfied with the appeal decision, he or she may file a second appeal in writing within ten working days of the date of the written response to the Director.

i. Contacts: A person filing a grievance may contact any of the following agencies directly at any time.

i. Department of Human Services: (541) 482-2041

ii. CHMP (Jackson County Health and Human Services): (541) 774-8200

iii. Disability Rights Oregon: (503) 243-2081

iv. Jackson Care Connect: (855)-722-8208

v. AllCare: (541) 471-4106

11. Individual Rights:

In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to:

i. Choose from available services and supports, those that are consistent with the Service Plan, culturally competent, provided in the most integrated setting in the community and under conditions that are least restrictive to the individual's liberty, that are least intrusive to the individual and that provide for the greatest degree of independence;

ii. Be treated with dignity and respect;

iii. Participate in the development of a written Service Plan, receive services consistent with that plan and participate in periodic review and reassessment of service and support needs, assist in the development of the plan, and to receive a copy of the written Service Plan;

iv. Have all services explained, including expected outcomes and possible risks;

v. Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, 179.505, 179.507, 192.515, 192.507, 42 CFR Part 2 and 45 CFR Part 205.50.

vi. Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances:

1. Under age 18 and lawfully married;
2. Age 16 or older and legally emancipated by the court; or
3. Age 14 or older for outpatient services only. For purposes of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs;

vii. Inspect their Service Record in accordance with ORS 179.505;

viii. Refuse participation in experimentation;

ix. Receive medication specific to the individual's diagnosed clinical needs;

x. Receive prior notice of transfer, unless the circumstances necessitating transfer pose a threat to health and safety;

xi. Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;

xii. Have religious freedom;

xiii. Be free from seclusion and restraint;

xiv. Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule;

xv. Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented;

xvi. Have family and guardian involvement in service planning and delivery;

xvii. Make a declaration for mental health treatment, when legally an adult;

xviii. File grievances, including appealing decisions resulting from the grievance; See grievance policy and procedures.

xix. Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules;

xx. Exercise all rights set forth in ORS 426.385 if the individual is committed to the Authority; and

xxi. Exercise all rights described in this rule without any form of reprisal or punishment.

xxii. Notification of Rights: The provider must give to the individual and, if appropriate, the guardian, a document that describes the applicable individual's rights as follows:

xxiii. Information given to the individual must be in written form or, upon request, in an alternative format or language appropriate to the individual's need;

xxiv. The rights, and how to exercise them, must be explained to the individual, and if appropriate, to her or his guardian; and

xxv. Individual rights must be posted in writing in a common area.

12. Quality Assessment and Performance Improvement:

a. Quality Assurance:

i. During the course of enrollment in a Kolpia program the client will be provided an outcomes assessment survey to measure effectiveness of treatment, quality of services and professionalism of staff. An assessment will also be given at the end of the program. These assessments are anonymous.

ii. Every quarter the results will be compiled and discussed among the staff and providers. If it is determined that changes to programs and policies must take place the appropriate program manager will consult with the director, revise the item and implement it over a prescribed course of time.

iii. Each quarter all incident reports for that period will be reviewed and any pertinent situations will be discussed to determine timeliness and appropriateness of response, timeliness or follow-up and what was learned from the incident. The management will then discuss any new policies and training that need to be conducted based on the learning points from the incident report review.

b. Performance Assessment and Improvement:

i. Each counselor and clinical staff member is required to meet with their supervisor a minimum of 2 hours per month. At this time a representative sample of records from each category of service rendered by the supervisee will be reviewed for to ensure:

1. Completed assessment
2. Appropriate Individual Service Plan including measurable goals and outcomes
3. Adequate service notes
4. Appropriate services rendered
5. Continuity of service
6. Completeness of chart notes and documentation

ii. During supervision the supervisor will provide support for career and clinical development as well as counsel regarding personal and professional challenges.

iii. The agency will provide periodic education, workshops, and professional development related to:

1. Trauma Informed Care
2. Family Involved Care and Support
3. Evidence-based methods
4. Communication Skills
5. Policy updates and revisions
6. Wellness and self-care

iv. Performance Improvement Plans (PIP's): The agency uses PIP's primarily for two purposes:

1. Disciplinary Processes: When an employee is in breach of agency policies and procedures, ethical or professional standards, and best practices, and the management has determined they are eligible to continue employment, a PIP will be enacted by the employee's direct supervisor and clinical director. The PIP consist of:
    a. The issue being addressed
    b. Disciplinary actions taken
    c. Performance improvement goals
    d. Specific steps to achieve those goals
    e. Time frame, frequency and duration for the improvement activities
    f. Who will supervise the activities
2. Implementing New Programs or Processes: When a new program, process, policy or procedure is being implemented that significantly changes the operations of the agency a PIP will be use for those employee that are affected by or contributing to the change.
    a. Example: We are changing our orientation process to make sure that each individual client is familiar with the facilities, knows where the fire exits are and understands how the programs work at Kolpia including pertinent policies and procedures. The PIP for the employee will include:
        i. The overall goal
        ii. Action steps to achieve that goal
        iii. Methods to measure success
        iv. How to address difficulties in implementing this system
        v. Incentives for achieving goals

c. Reviewing Quality Assessments and Performance Improvement

i. Each quarter the director and the clinical supervisors will review the following:.
    1. Performance assessments of clinical staff
    2. Outcomes assessments for clinical programs
    3. Grievance reports
    4. Incident reports
    5. EMR reports on attendance, engagement, retention and completion.

ii. Twice annually the administration will review staff satisfaction and suggestion surveys.

13. Crisis Prevention and Response:

a. Crisis prevention includes a trauma-informed approach (see *Trauma Informed Care*) that is based on the principles of respecting individual needs, active listening, compassionate conflict resolution and the use of de-escalation techniques (see *De-Escalation* in the Employee Handbook*)*.

b. It is the responsibility of the mental health counselor and / or CADC to conduct an appropriate crisis risk assessment during the first appointment. The assessment should determine risk for:

i. Bodily Harm
ii. Suicide or self harm
iii. Homicide or harm to others

c. If it is determined that the risk of physical, mental or emotional crisis is beyond the scope of the practitioner or agency, the patient is to be referred to an appropriate agency.

d. If a person undergoing treatment at Kolpia experiences a crisis situation and the situation is safe the counselor is encouraged to attempt to resolve the crisis at the time of the situation. If the counselor is unsure, they should bring in their immediate supervisor or clinical director to help address the situation. If it is determined that the situation is unsafe or if there is no likelihood of resolving the crisis at that time, the following steps should be followed.

i. In cases of mental health crisis where there is no threat of physical harm the patient is to be referred to Jackson County Mental Health and the client's next of kin or emergency contact is to be contacted. If there is no next of kin available, local law enforcement or emergency medical services may be contacted by dialing 911. It is important to inform the dispatcher of the nature of the situation and to inform the emergency workers that the individual is experiencing a mental health crisis. Both the Ashland and Medford police departments have attested that their officers have all been trained in dealing with individuals experiencing mental health crises.
ii. In the case of physical health crisis or mental health crisis where there is the threat of abuse and potential for bodily harm or damage to the facilities, the provider or staff is to contact emergency services immediately by dialing 911 as well as notify the supervisor of the situation.

e. If a crisis occurs that necessitates emergency intervention, referral to another agency or activation of EMS an incident report is to be filed. For more information of Incident Reporting please see *Incident Reporting* below.

f. In the case that a person is acting out in a threatening manner the security and safety of staff and other clients is of the utmost importance. In all situations the most proximal staff member is to assess the situation to see if there is immediate and imminent harm.

i. If harm is imminent and immediate all persons are to calmly and methodically exit the building. Ideally a supervisor will assist the evacuation and ensure all persons are safe and accounted for.
ii. If harm is not imminent and immediate the most proximal staff member will try to de-escalate the person in crisis. Another staff member will get a supervisor if one is not in the direct area. Emergency response services will be notified and a trauma-informed officer or team will be requested. If other clients or visitors are present they are to be slowly removed from the area and taken to a safe place.
iii. It is important when attempting to de-escalate a person in crisis to be aware of surroundings. Both the staff member and the person in crisis should not feel threatened by being placed in a corner or a location with no access to an exit. It is also important to use non-threatening language or to engage in a dialogue that could escalate the situation.

g. If mental health crisis intervention is necessary during the hours that the agency is not open, or when a counselor is not available, the client will be directly referred to Jackson County Mental Health for mental health crisis services.

h. The recorded message and the answering service both refer mental health crises to Jackson County Mental Health for crisis intervention.

14. Incident Reporting:

a. In the case that there is an incident a supervisor or management should be immediately contacted. If it is an emergency the appropriate emergency service is to be contacted. An incident report will be filled out by the one making the report and submitted to the management or supervisor. A copy of the report will be retained by the reporter as well as maintained by Kolpia. It is the responsibility of the Kolpia to notify the appropriate authority or agency related to the incident.

b. Examples of situations requiring an incident report:
i. Bodily harm.
ii. Automobile accident while traveling for company business.
iii. Accidental needle stick.
iv. Physical or verbal abuse by a contractor, employee or management.
v. Physical or verbal abuse by a client or client representative.
vi. Sexual harassment by client, client representative, employee, contractor or management.
vii. Theft or damage to personal property
viii. Theft or damage to property of Kolpia
ix. Suspicious activity or suspicious persons in or near the facility
x. Suspected criminal activity by clients, employees, management or contractors of Kolpia

c. Documenting Incident Report:
i. The incident report form is available on our shared Drive as well as at the front desk.
ii. Fill the form out completely following the directions provided on the form (See Appendix E) and scan the form into the individual's EMR.
iii. Incident reports will be reviewed each quarter and the person recording on the report may be asked to participate in the review for the reports that they fill out.

15. Policy Regarding Seclusion and Restraint Practices:

a. It is the policy of Kolpia never to use seclusion or restraint with any clients at any time. If there is a crisis situation the staff should react appropriately in accordance with the policies of the agency (*see Crisis Prevention and Response).*

b. If it is found that any Kolpia staff is using or threatening the use of seclusion and/or restraint, that staff member will be immediately put on disciplinary probation and an investigation will ensue. The staff member may be subject to termination, reporting to their licensing board and applicable criminal charges.

16. Culturally and Linguistically Appropriate Services:

a. The majority of the population in Ashland and Medford are English speaking with a small minority of exclusively Spanish, Chinese, Vietnamese and other languages respectively. As such Kolpia does not have any culturally specific programs or providers.

b. When a culturally specific program or service is required it is our policy to refer the client and family to a program or agency that is appropriate for their cultural needs.

c. If one is not available we can proceed with individual sessions using a translating family member that the client trusts and chooses.

d. When the above options are not available the agency will provide interpretive services at no cost to the client or client's financially responsible party.

17. Family Involvement:

a. It is the policy of Kolpia counseling to allow the family of clients to be involved in the treatment process of the client as long as the client agrees to their involvement or if they are under the age of 14.

b. If a client is 14 years of age or older, an ROI must be signed by the client to allow Kolpia to share any personal or medical information with the parent, caregiver or guardian.

c. We provide mental health support and education for qualified family members and caregivers in need of support.

18. Trauma Informed Care (TIC):

Background: Kolpia serves a population often diagnosed with co-occurring mental health and substance use disorders (COD). It is assumed that much of this population has experienced some form of physical, sexual, verbal or psychological trauma related to their condition and the reason they are seeking services. In this way we are taking Universal Precautions related to trauma. Our Trauma Informed Care (TIC) policy reflects our approach and practices aimed at (1) reducing trauma in the workplace, (2) screening for trauma in our clientele, (3) developing and implementing trauma programs and interventions, (4) participating in community training and education, (5) coordinating with OHA, AMH and the CCO's.

Purpose: The purpose of our TIC policy is to establish consistent practices aimed at reducing the effects of trauma in our community. We accomplish this by providing an atmosphere, screening processes and interventions consistent with evidence-based, trauma informed care practices.

Components:

1. Trauma Informed Approach in the Workplace.
2. Wellness in the Workplace.
3. Assessing and Addressing Vicarious Trauma in the Workplace.
4. Universal Precautions for Trauma.
5. Trauma Screening for Clients (acute, chronic and complex trauma).
6. Trauma Intervention (acute, chronic and complex trauma).
7. Education and Training.
8. Coordination with Oregon Health Authority (OHA) and Addictions and Mental Health Division (AMH).

Implementation:

1. Trauma Informed Approach: Kolpia has adopted a trauma informed approach that was collaboratively created and implemented by the management, administrative and clinical staff. We reviewed the 10 key principles of a trauma-informed approach provided by AMH and discussed how this can inform our policies and practices. We then outlined how we can put these principles into action in order to minimize trauma in the workplace for our staff and clientele alike. The 10 principles can be found in appendix (A) at the end of this policy.

2. Wellness in the Workplace: Kolpia has created and implemented an employee wellness program aimed at improving work conditions, preventing burnout and enhancing the health and wellness of our staff. This includes a healthy weekly work schedule, paid sick time, paid vacations, a manageable caseload, enough time for lunch and breaks throughout the day, as well as education on nutrition, exercise and other wellness practices. Health and emotional resilience are both necessary to prevent vicarious trauma.
3. Assessing and Addressing Vicarious Trauma in the Workplace: The staff is being educated through trainings about signs of burnout and vicarious trauma personally and in our coworkers. Our supervision and management structure is set up in such a way that we are able to bring a situation up to supervisors, to the director or to the person we are concerned about directly. Our open door policy and weekly staff meetings provide an outlet for those who have identified burnout or vicarious trauma in themselves to voice their concern and collaboratively put together a plan to address it.
4. Universal Precautions for Trauma: By assuming that all our clients have experienced trauma in some way we are taking universal precautions. The following practices ensure our adherence to the universal precautions:
    a. The use of clear, non-threatening language and nonverbal communication.
    b. Acknowledging the client's complaint or issue regardless of the details or validity and resolving it as quickly and professionally as possible.
    c. Spending time with the client during orientation to familiarize them with the facilities and exits.
    d. Creating and maintaining a clean, comfortable and safe atmosphere.
    e. Abstaining from loud and abrupt noises in the workplace.
    f. Protecting client confidentiality.
    g. Universal respect for all differences related to race, sex, gender, culture, and sexual preference.
    h. Matching clients with an appropriate male or female provider when requested.
    i. Establishing cultural norms of mutual respect for all group therapies.
5. Trauma Screening for Clients: Our initial assessment process for both mental health and A&D services have as part of it a mandatory trauma screening. The counselors are trained to look for evidence of trauma initially and during subsequent visits and to include it in the treatment plan if appropriate.
6. Trauma Intervention: If a client has been identified as having acute, chronic or complex trauma, the counselor will use their good clinical decision making to determine when and how to address the client about the trauma. The counselor and client will collaboratively create a treatment plan and strategy to address the trauma using modalities and methods that are appropriate for the client's mental acuity, readiness and ability to engage in treatment. Supervision is available onsite as well as through off site resources, and there is a weekly integrative meeting where practitioners can seek guidance from other practitioners related to their trauma clients.
7. Education and Training: The agency will provide periodic training related to Trauma Informed Care and a Trauma Informed Approach in the workplace. The OHA, Jackson County Mental Health, and the CCO's also provide Trauma Informed Care workshops and training. We will strive to have at least one member of the management or clinical team to attend all meetings and trainings available through local resources.
8. Coordination with Oregon Health Authority (OHA) and Addictions and Mental Health Division (AMH): The agency is dedicated to coordinating and collaborating with the Authority and the Division regarding new developments in Trauma Informed Care. This includes adopting policies and practices given by those entities as well as sharing our approaches and practices we use to assess and address trauma.

19. Urine Drug Screens:

It is the policy of Kolpia Counseling Services to monitor the use of drugs and alcohol by collecting indirectly observed, and temperature-monitored urine samples at a frequency determined by the clinical staff in accordance with Federal and State regulations and best practices. The frequency of UDS administration includes mandatory, discretionary and random collections.

1. Frequency:
    a. Mandatory: All A&D / DUII clients shall receive at minimum 3 UDS while receiving counseling services at Kolpia. The first should be conducted on their first day of service to establish a baseline. They will receive at minimum one more UA in the middle of their program and one more before the end of their program.
    b. Discretionary: Any A&D counselor or A&D intern can request a UDS for any client at any time in order to support good clinical decision making.
    c. Random: In addition to the three mandatory UDS and any discretionary UDS, we will conduct weekly random UDS for all A&D clients of Kolpia.
        i. When a followup client checks in for their appointment, the front desk administrative staff will employ a numerical tool that will change each day, and will not disclose the method to the client.
        ii. If they have chosen a number indicating they are to be tested, they are to provide a urine sample before they leave that day.
        iii. If they are unable to provide a sample that day, they must come back to provide on the next business day.
        iv. No random UDS to be performed on Fridays.
2. Collection: Kolpia employs an indirectly observed / temperature-monitored UA collection procedure following these steps.
    a. The bathroom is checked to be free of potential adulterants, contaminants or any items that could alter or invalidate the UA.
    b. The client is asked to leave coat, outer garments, purse and bags outside the bathroom to prevent falsification of the sample. The are also to demonstrate they have nothing in their pockets or on their person that could adulterate or interfere with the UA.
    c. The client is asked to wash and dry their hands before and after giving samples to prevent urine contamination.

d. A collection cup is given to the client by the test administrator.
e. The patient provides a minimum of 50cc of urine.
f. The sample is checked for color, temperature (90.5-99.8F), and any contamination. The temperature is to be checked 30 seconds after the sample is provided.
g. If the counselor requires an immediate determination before sending it out, they may use a 5 panel dipstick and record the results.
h. The sample will be stored in an exclusive refrigerator designated for laboratory samples until it is picked up to be delivered to the laboratory.
i. If it is suspected a client is tampering with a UA sample or the collection process is not being followed, a counselor may conduct a direct observed draw or schedule one with the appropriate gender-specific counselor if there is not one immediately available.
j. If a patient is unable to provide a urine sample, he or she is asked to drink no more than 8 oz of water. Special considerations are given to patients with health problems that interfere with urination including renal failure, neurological disorders, anuresis, dysuresis and paruresis. Any patient who still is unable to provide a urine sample must be prepared to give the sample on the following business day.
k. If a patient refuses to provide a sample, he or she must be referred back to their Primary Counselor for a clinical review.
l. Refusal to provide a sample and positive UA results will be reported to the client's referent if an applicable ROI is in place.

3. Positive UDS and Anomalies:
    a. All positive UDS and anomalies must be addressed directly through counseling and documented in the individuals EMR (see documentation below).
    b. If a UDS is positive or anomalies and tampering are suspected, the individual must give a UDS sample the very next appointment and they will be put on an enhanced UDS schedule as determined by the counselor and the supervisor.
    c. UDS for those who are suspected of tampering with the sample must include a point of service rapid collection as well as a urine dipstick. Anomalies are to be reported to the counselor using the secure message system on the EMR.
    d. Counselor may request a re-test of the sample at the lab up to 60 days from the date of the initial report.
4. Documentation:
    a. All UDS results are recorded in the individual's EMR by scanning in the requisition form.
    b. All positive UDS, anomalies and those suspected of being tampered with must be addressed by the individual's counselor and documented in the individual's service note for that date of service. The note should contain at a minimum:
        i. The details of the positive UDS or anomaly including date and time of draw.
        ii. Details of the confirmation report from the lab.
        iii. Actions taken (ie starting the DUII program over, issuing an incomplete, use of MI to address).
        iv. Revised UDS schedule for that individual.

20. Medical Marijuana

a. OMMP card holders shall not be initially denied treatment due to the use of medical marijuana.

b. The OMMP is a recommendation from a medical doctor and not a valid prescription due to the inconsistency and variability of dosing as well as insufficient clinical evidence as to the effectiveness for medical treatment. Marijuana is considered a substance of abuse and it will be considered as such throughout the duration of treatment.

c. Clients may not use medical marijuana while participating in mandated programs such as DUII, DUI Diversion, DUI Info Only, MIP, RDL and other mandated programs and referrals.

d. Clients enrolled in a voluntary substance abuse or dependence program while using medical marijuana will have as part of their program:

i. Marijuana use and abuse education
ii. Marijuana use harm reduction
iii. Introduction and reinforcement of alternatives to marijuana
iv. Discussion about marijuana tapering.
v. Assistance with marijuana tapering.

e. Concurrent use of medical marijuana while at Kolpia (non-mandated individuals).

i. Clients will be clinically monitored to determine if they are using marijuana as suggested by their provider and not abused.
ii. Urine THC levels shall be monitored to help in this determination.
iii. If the counselor and the counselor's supervisor agree that marijuana usage is preventing progress in recovery a staff determination can be made regarding that client's continuation in a program or issuance of a certification of completion.
iv. Client must sign an ROI in order for the counselor to collaborate with the medical marijuana prescriber.

21. Emergency Evacuation Procedures:

a. The evacuation routes and fire exits are to be prominently posted throughout the facility and every employee, client and family member is to be shown where the emergency exits are during their orientation process.

b. Fire, explosion or serious damage to the building:

i. The counselor, group leader, supervisor or director will safely lead all building occupants to a safe and designated fire exit and will ensure the occupants safely exit.
ii. The supervisors and group leaders will take an accounting of all evacuees to ensure that all clients and personnel have exited safely.
iii. A designee will call 911 to report the fire and activate EMS.

c. Threatening persons:
i. See *Crisis Prevention and Response.*
ii. In the case that a client or person is acting in a threatening manner a staff member will assist all the non-involved parties in exiting the building through the nearest emergency exit. In the case of imminent and immediate danger all other emergency routes can be used including egress windows.

22. Medical Protocols:

a. All assessments must include a pertinent medical history. This is to be filled out by the patient, parent or guardian at the time of admission to the program and must be reviewed by the physician, provider or counselor.
b. All medical symptoms that require further investigation, physical examination or testing constitutes a referral to appropriate medical services. These are symptoms or diseases that if left untreated could result in loss of organic function, limb or life. This includes but is not limited to:
i. Present emergency situations: In the case of any medical emergency, 911 is to be called and the staff or provider must remain with the patient until emergency medical help has taken responsibility of the patient.
1. Severe, persistent shortness of breath
2. Choking / airway obstruction
3. Decreased levels of consciousness
4. Chest pain
5. Dizziness
6. Paralysis or convulsions
7. Severe bleeding
8. Traumatic accident at or around the facility.

ii. Ongoing situations: If the following conditions or symptoms are found during an assessment or follow-up appointment, the client is to be referred to appropriate medical care.
1. Uncontrolled cardiovascular disease including heart attacks, hypertension, angina and stroke.
2. Untreated traumatic injuries including breaks, bleeding, lacerations, severe contusions, deformity and severe pain.
3. Signs of infection from an injury or injection site for IV administered drugs.
4. Signs of physical or sexual abuse.
5. Current and unexpected withdrawals.
6. HIV and other STD's
7. Pregnancy
8. Chronic and consistent infection or illness including chronic cold or flu-like symptoms.

9. any other medical condition or sign that is concerning and if left untreated could result in loss of organic function, limb or life.

c. A client must be referred for a physical examination and appropriate lab testing within 30 days of entry to the program if they are:
   i. Currently injecting or intravenously using drugs
   ii. At risk for withdrawal
   iii. May be pregnant
   iv. This requirement may be waived by the medical director if the required services have been received within the past 90 days and documentation is provided.
d. Pregnant clients must be referred for prenatal care within 2 weeks of entry to the program. This requirement can be waived if they are currently receiving prenatal care and documentation is provided including the physician or provider's name and contact information.
e. An HIV, AIDS, Tuberculosis, STD, Hepatitis and other infectious disease risk assessment is to be completed upon admission to the program. Pertinent information will be offered to the patient and a referral for medical treatment will be made within 30 days.

23. Pharmacogenetic testing (PGT):

a. PGT is a biometric test to determine how a person will react to a given medication based on their genetic predisposition to be fast metabolizers, slow metabolizers or non-metabolizers of a given drug.
b. At Kolpia we use the PGT to help the patient understand how their body will react to drugs that are either being currently prescribed or may be prescribed by their medical provider. These tests can help patients and counselors to communicate effectively with the prescriber in order to help them determine accurate drug type and dosage for their patient, considering these results along with their own clinical decision making.
c. We will suggest these tests for the following patients:
   i. All patients undergoing pain management and using opioid medication.
   ii. All patients receiving services related to opioid addiction (abuse and dependence).
   iii. All patients who are receiving suboxone services through Kolpia.
   iv. All patients with a mental health diagnosis regardless if they are currently using or not using psychiatric medication.
d. These tests are mandatory for Suboxone patients.

Appendix A - A&D Assessment

KOLPIA COUNSELING SERVICES
SUBSTANCE ABUSE DIAGNOSTIC ASSESSMENT

Name: q1
Date of Birth: q2
Assessment date: q3
Age:
Gender:
Referred by:
Assessor, Credentials:
Service Location: 607 Siskiyou Blvd., Ashland, OR, 97520

REASON FOR ASSESSMENT (*in individual's own words*):

DIMENSION 1

INTOXICATION & WITHDRAWAL

DUII HISTORY:

GAMBLING HISTORY:
[ ] Feel the need to be secretive about gambling
[ ] Have trouble controlling gambling
[ ] Gamble when you can't afford it
[ ] Friends and/or family are worried about your gambling
[ ] Individual reports no history of problem gambling

A&D HISTORY:
[ ] Alcohol
[ ] Amphetamines
[ ] Bath Salts
[ ] Caffeine

[ ] Cannabis
[ ] Cocaine
[ ] Hallucinogens
[ ] MDMA
[ ] Opiates/Opioids
[ ] Sedative/Hypnotics
[ ] Tobacco
[ ] Other Substances Used:

PRIMARY SUBSTANCE:
Age of first use:
Period of greatest use: Frequency:
Route:
Last use:

PRIMARY SUBSTANCE DEPENDENCE CRITERIA (*must meet 3 criteria within the last 12 months*):
[ ] Tolerance: increased amounts to achieve effect and/or diminished effect with continued amount
[ ] Withdrawal (w/d): characteristic w/d symptoms and/or other substance taken to avoid w/d symptoms
[ ] Using larger amounts or for a longer period than intended
[ ] Persistent desire to use, unsuccessful efforts to cut down, and/or control substance use.
[ ] Great deal of time spent obtaining, using, and/or recovering from the substance
[ ] Reduction of social, occupational, or recreational activities due to substance use
[ ] Substance use continues despite recurrent physical or psychological problems caused by use
[ ] Individual does NOT meet at least 3 criteria for dependence

PRIMARY SUBSTANCE ABUSE CRITERIA (*must establish a pattern of behaviors meeting at least 1 criteria within a 12 month period*):
[ ] Placed self in physically hazardous situations while drinking or using
[ ] Substance related family issues
[ ] Reoccurring legal problems due to substance use
[ ] Reoccurring social or interpersonal problems (failure to fulfil major role obligations)
[ ] Individual does NOT meet criteria for abuse

PRIMARY SUBSTANCE REMISSION CRITERIA SPECIFIERS:
[ ] Early Full Remission
[ ] Early Partial Remission
[ ] Sustained Full Remission
[ ] Sustained Partial Remission
[ ] On Agonist Therapy
[ ] In a Controlled Environment
[ ] Individual does NOT meet remission criteria

SECONDARY SUBSTANCE:
Age of first use:
Period of greatest use: Frequency:
Route:
Last use:

SECONDARY SUBSTANCE DEPENDENCE CRITERIA (*must meet 3 criteria within the last 12 months*):
[ ] Tolerance: increased amounts to achieve effect and/or diminished effect with continued amount
[ ] Withdrawal (w/d): characteristic w/d symptoms and/or other substance taken to avoid w/d symptoms
[ ] Using larger amounts or for a longer period than intended
[ ] Persistent desire to use, unsuccessful efforts to cut down, and/or control substance use
[ ] Great deal of time spent obtaining, using, and/or recovering from the substance
[ ] Reduction of social, occupational, or recreational activities due to substance use
[ ] Substance use continues despite recurrent physical or psychological problems caused by use
[ ] Individual does NOT meet at least 3 criteria for dependence

SECONDARY SUBSTANCE ABUSE CRITERIA (*must establish a pattern of behaviors meeting at least 1 criteria within a 12 month period*):
[ ] Placed self in physically hazardous situations while drinking or using
[ ] Substance related family issues
[ ] Reoccurring legal problems due to substance use
[ ] Reoccurring social or interpersonal problems (failure to fulfil major role obligations)
[ ] Individual does NOT meet criteria for abuse

SECONDARY SUBSTANCE REMISSION CRITERIA SPECIFIERS:
[ ] Early Full Remission
[ ] Early Partial Remission
[ ] Sustained Full Remission
[ ] Sustained Partial Remission
[ ] On Agonist Therapy
[ ] In a Controlled Environment
[ ] Individual does NOT meet remission criteria

TERTIARY SUBSTANCE:
Age of first use:
Period of greatest use: Frequency:
Route:
Last use:

TERTIARY SUBSTANCE DEPENDENCE CRITERIA (*must meet 3 criteria within the last 12 months*):
[ ] Tolerance: increased amounts to achieve effect and/or diminished effect with continued amount
[ ] Withdrawal (w/d): characteristic w/d symptoms and/or other substance taken to avoid w/d symptoms
[ ] Using larger amounts or for a longer period than intended
[ ] Persistent desire to use, unsuccessful efforts to cut down, and/or control substance use
[ ] Great deal of time spent obtaining, using, and/or recovering from the substance
[ ] Reduction of social, occupational, or recreational activities due to substance use
[ ] Substance use continues despite recurrent physical or psychological problems caused by use
[ ] Individual does NOT meet at least 3 criteria for dependence

TERTIARY SUBSTANCE ABUSE CRITERIA (*must establish a pattern of behaviors meeting at least 1 criteria within a 12 month period*):
[ ] Placed self in physically hazardous situations while drinking or using
[ ] Substance related family issues
[ ] Reoccurring legal problems due to substance use
[ ] Reoccurring social or interpersonal problems (failure to fulfil major role obligations)

[ ] Individual does NOT meet criteria for abuse

TERTIARY SUBSTANCE REMISSION CRITERIA SPECIFIERS:
[ ] Early Full Remission
[ ] Early Partial Remission
[ ] Sustained Full Remission
[ ] Sustained Partial Remission
[ ] On Agonist Therapy
[ ] In a Controlled Environment
[ ] Individual does NOT meet remission criteria

OTHER SUBSTANCES USED:

DIAGNOSIS: Individual meets criteria for diagnostic impression:
Primary: d1
Secondary: d2
Tertiary: d3

DIMENSION 1 COUNSELOR COMMENTS (*include justification for each criteria indicated, detoxification history, withdrawal potential, prior treatment and/or abstinence history*):

DIMENSION 1 RECOMMENDED TREATMENT: LEVEL

DIMENSION 2

BIOMEDICAL CONDITIONS

CURRENT MEDICAL CONDITIONS:

Is individual pregnant?
[ ] Yes
[ ] No

PAST MEDICAL HISTORY:

CURRENT PCP:

CURRENT MEDICATIONS:

STATEMENT OF CURRENT PHYSICAL HEALTH (*in individual's own words*):

DIMENSION 2 COUNSELOR COMMENTS:

DIMENSION 2 RECOMMENDED TREATMENT: LEVEL

DIMENSION 3 EMOTIONAL, BEHAVIORAL, COGNITIVE CONDITIONS

HISTORY OF MENTAL HEALTH SERVICES:

MENTAL HEALTH SYMPTOMS AND/OR COGNITIVE LIMITATIONS:
No observed cognitive dysfunction.

CURRENT COUNSELOR AND/OR SUPPORT SERVICES:

TRAUMA HISTORY (*if present discuss in counselor comments*):
[ ] Individual reports history of traumatic experiences.
[ ] Emotional abuse
[ ] Physical abuse
[ ] Sexual abuse
[ ] None, Individual reports NO traumatic experiences
[ ] Exposure to domestic violence:
    [ ] Towards you
    [ ] Towards other
    [ ] Witnessed
    [ ] None
[ ] Suicidal thoughts or attempts:
    [ ] Past
    [ ] Currently, explain response and referral:
    [ ] None
[ ] Homicidal thoughts or attempts:
    [ ] Past
    [ ] Currently, explain response and referral:
    [ ] None
[ ] Self-harm behaviors:
    [ ] Past
    [ ] Currently, explain response and referral:
    [ ] None
[ ] Any history of eating disorders (*restricting, binging, and/or purging*):
    [ ] Past
    [ ] Currently, explain response and referral:
    [ ] None

PTSD SYMPTOMS:
[ ] Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
[ ] Feeling very upset when something reminded you of a stressful experience from the past?
[ ] Avoided activities or situations because they reminded you of a stressful experience from the past?
[ ] Feeling distant or cut off from other people?
[ ] Feeling irritable or having angry out bursts?
[ ] REFERRALS MADE:
[ ] Individual reports NO PTSD symptoms

BRIEF CHILDHOOD SUMMARY (*including exposure to A&D abuse, family members with mental health issues, and/or family members who have attempted or completed suicide*):

BRIEF RELATIONHIP HISTORY:

INDIVIDUAL'S OPINION ON THEIR CURRENT SITUATION AND FUNCTIONING (*in own words*)**:**

PERSONAL STRENGTHS (*in individual's own words*)**: s1**

DIMENSION 3 COUNSELOR COMMENTS:

DIMENSION 3 RECOMMENDED TREATMENT: LEVEL 1

DIMENSION 4

READINESS TO CHANGE

ACCEPTANCE OF TREATMENT (*in individual's own words*)**:**

INDIVIDUAL'S GOALS FOR TREATMENT: g1, g2

DIMENSION 4 COUNSELOR COMMENTS: Individual is in the Stage of Change as evidenced by:

DIMENSION FOUR RECOMMENDED TREATMENT: LEVEL

DIMENSION 5

RELAPSE POTENTIAL

STATEMENT OF CURRENT STRESSORS:

STATEMENT OF CURRENT COPING:

RECOVERY POTENTIAL:
[ ] Individual reports an awareness of healthy alternatives to A/D use, such as:
[ ] Individual reports NO awareness of healthy alternatives to A/D use.

[ ] Individual reports an awareness of potential triggers, **such as**:
[ ] Individual reports NO awareness of potential triggers.

[ ] Individual reports having an ability to resist environmental pressures to use.
[ ] Individual reports NO ability to resist environmental pressures to use.

DIMENSION 5 COUNSELOR COMMENTS: Individual presents as having a risk of relapse **as evidenced by:**

DIMENSION 5 RECOMMENDED TREATMENT: LEVEL

DIMENSION 6 RECOVERY ENVIRONMENT

CURRENT LIVING AND FINANCIAL SITUATION:

LEGAL HISTORY:

HIGHEST GRADE COMPLETED:

MILITARY:
[ ] No
[ ] Yes, explain:

NATIONALITY/CULTURE AND RELIGIOUS/SPIRITUAL HISTORY:

HEALTHY SUPPORT SYSTEM (*include participation in groups or social activities*):

BARRIERS TO RECOVERY (*explain*):

[%] of individual's associates who drink and/or use on a regular basis.

Likelihood that A/D will be present in individual's environment during treatment:
[ ] Not Likely
[ ] Somewhat likely
[ ] Very likely

Is individual in danger in their current environment?
[ ] No
[ ] Yes, explain situation and referrals made:

DIMENSION 6 COUNSELOR COMMENTS:

DIMENSION 6 RECOMMENDED TREATMENT: LEVEL

CLINICAL SUMMARY, RECOMMENDATIONS, AND REFERRALS

COUNSELOR SUMMARY: Individual meets criteria for diagnostic impression: d1, d2, d3

RECOMMENDED LEVEL OF TREATMENT:

CURRENT LEVEL OF TREATMENT PLACEMENT (*include justification*): p1

COUNSELOR'S SERVICE AND SUPPORT RECOMMENDATIONS (*check all that apply*):

[ ] Education only DUII
[ ] Level 1 DUII
[ ] Level 1 Outpatient Services
[ ] Intensive Outpatient Services
[ ] Integrative Recovery Therapy Services:
    [ ] Integrative Medical Assessment
    [ ] Meditation Group
    [ ] Gentle Yoga and Relaxation Group
    [ ] Indigenous Perspectives to Balance
    [ ] Peer Support Group
[ ] Inpatient Treatment Services
[ ] Pain Management Services
[ ] Mental Health Counseling
[ ] Case Management Services
[ ] Submit random drug and alcohol urinalysis upon request

REFERRALS MADE:

ROIs SIGNED:

Assessor, Credentials: Date: q3

KOLPIA COUNSELING SERVICES
ASSESSMENT ADDENDUM

NAME: q1 DOB: q2 REFERRED BY:
DIAGNOSIS AT ASSESSMENT: d1, d2, d3
LEVEL OF CARE PLACEMENT AT ASSESSMENT:
ASSESSOR:

IDENTIFYING INFORMATION & PRESENTING PROBLEM: Individual is a

PRESENTING PROBLEM: “

DIM 1 CHANGES SINCE ASSESSMENT: Individual reports

DIM 2 CHANGES SINCE ASSESSMENT: Individual reports

DIM 3 CHANGES IN DIM 3 SINCE ASSESSMENT: Individual reports

DIM 4 CHANGES IN DIM 4 SINCE ASSESSMENT: Individual is in Stage of Change, as evidenced by:

DIM 5 CHANGES SINCE ASSESSMENT: Individual is at risk for relapse, as evidenced by:

DIM 6 CHANGES IN DIM 6 SINCE ASSESSMENT: Individual reports

INDIVIDUAL’S GOALS FOR TX: “

INDIVIDUAL’S STRENGTHS: “

DIAGNOSIS AT ADDENDUM:

LEVEL OF CARE PLACEMENT AT ADDENDUM (*include justification*): Level

ASSESSOR: DATE:

Service Provided at Kolpia Counseling Services: 607 Siskiyou Blvd, Ashland, OR 97520

Appendix B - Service Plan

KOLPIA COUNSELING SERVICES
DRUG AND ALCOHOL INDIVIDUAL SERVICE & SUPPORT PLAN

Name: q1 DOB: q2 Date of Plan: q3
Diagnosis: d1, d2, d3
Level of Care: LEVEL 1
Primary counselor providing this service:
Service Location: 607 Siskiyou Blvd., Ashland, OR, 97520

GOAL 1

INDIVIDUAL'S GOAL STATEMENT (*what client wants to see happen in treatment, in own words*): g1

TREATMENT OBJECTIVES TO MEET INDIVIDUAL'S GOALS (*must be specific, measurable, and time limited to be completed by projected timeline*): j1

1) SERVICE & SUPPORTS (*type of service*): Random urinalysis drug screenings

PROJECTED SCHEDULE OF SERVICES & SUPPORTS (*ex. 90 days*): 90 days

FREQUENCY (*ex. 1x weekly*): Random throughout treatments

DURATION (*ex. 45 mins*): 15 mins

CREDENTIALS NEEDED TO PROVIDE SERVICES (*ex. CADCI*): CADCI

2) SERVICE & SUPPORTS (*type of service*): Individual counseling sessions

PROJECTED SCHEDULE OF SERVICES & SUPPORTS (*ex. 90 days*): 90 days

FREQUENCY (*ex. 1x weekly*): 1x monthly

DURATION (*ex. 45 mins*): two 30 minute appointments and one 1 hour appointment at exit

CREDENTIALS NEEDED TO PROVIDE SERVICES (*ex. CADCI*): CADCI

3) SERVICE & SUPPORTS (*type of service*): Education groups

PROJECTED SCHEDULE OF SERVICES & SUPPORTS (*ex. 90 days*): 90 days

FREQUENCY (*ex. 1x weekly*): 1x weekly

DURATION (*ex. 45 mins*): 90 mins per week

CREDENTIALS NEEDED TO PROVIDE SERVICES (*ex. CADCI*): CADCI

GOAL 2

INDIVIDUAL'S GOAL STATEMENT (*what client wants to see happen in treatment, in own words*): g2

TREATMENT OBJECTIVES TO MEET INDIVIDUAL'S GOALS (*must be specific, measurable, and time limited to be completed by projected timeline*): j2

1) SERVICE & SUPPORTS (*type of service*):

PROJECTED SCHEDULE OF SERVICES & SUPPORTS (*ex. 90 days*):

FREQUENCY (*ex. 1x weekly*):

DURATION (*ex. 45 mins*):

CREDENTIALS NEEDED TO PROVIDE SERVICES (*ex. CADCI*): CADCI

2) SERVICE & SUPPORTS (*type of service*):

PROJECTED SCHEDULE OF SERVICES & SUPPORTS (*ex. 90 days*): 90 days

FREQUENCY (*ex. 1x weekly*):

DURATION (*ex. 45 mins*):

CREDENTIALS NEEDED TO PROVIDE SERVICES (*ex. CADCI*): CADCI

3) SERVICE & SUPPORTS (*type of service*):

PROJECTED SCHEDULE OF SERVICES & SUPPORTS (*ex. 90 days*): 90 days

FREQUENCY (*ex. 1x weekly*):

DURATION (*ex. 45 mins*):

CREDENTIALS NEEDED TO PROVIDE SERVICES (*ex. CADCI*): CADCI

GOAL 3

INDIVIDUAL'S GOAL STATEMENT (*what client wants to see happen in treatment, in own words*): g3

TREATMENT OBJECTIVES TO MEET INDIVIDUAL'S GOALS (*must be specific, measurable, and time limited to be completed by projected timeline*): j3

1) SERVICE & SUPPORTS (*type of service*):

PROJECTED SCHEDULE OF SERVICES & SUPPORTS (*ex. 90 days*):

FREQUENCY (*ex. 1x weekly*):

DURATION (*ex. 45 mins*):

CREDENTIALS NEEDED TO PROVIDE SERVICES (*ex. CADCI*): CADCI

2) SERVICE & SUPPORTS (*type of service*):

PROJECTED SCHEDULE OF SERVICES & SUPPORTS (*ex. 90 days*): 90 days

FREQUENCY (*ex. 1x weekly*):

DURATION (*ex. 45 mins*):

CREDENTIALS NEEDED TO PROVIDE SERVICES (*ex. CADCI*): CADCI

3) SERVICE & SUPPORTS (*type of service*):

PROJECTED SCHEDULE OF SERVICES & SUPPORTS (*ex. 90 days*): 90 days

FREQUENCY (*ex. 1x weekly*):

DURATION (*ex. 45 mins*):

CREDENTIALS NEEDED TO PROVIDE SERVICES (*ex. CADCI*): CADCI

Projected schedule for re-evaluation of Service and Support Plan (specific *date*):

This Service and Support Plan was created by individual client and their primary counselor in this individual counseling session. Electronic signature constitutes agreement with these goals and objectives by this client.

Relapse Prevention Plan

Name: q1 DOB: q2 Date of Plan: q3
Primary Counselor:
Location of Service: 607 Siskiyou Blvd., Ashland, OR 97520

Plan 1

My most significant relapse warning sign is:

What does it look like/feel like when I experience this relapse sign?

Internal cues:

External cues:

What healthy actions will I take when I or someone else notices these signs in me?

Immediate strategies:

Preventative strategies:

Plan 2

Another relapse warning sign for me is:

What does it look like/feel like when I experience this relapse sign?

Internal signs:

External signs:

What healthy actions will I take when I or someone else notices these signs in me?

Immediate strategies:

Preventative strategies:

Healthy activities I can do to take care of myself when I am feeling squirrely?

Healthy people I can reach out to when I am feeling at risk?

Projected schedule for re-evaluation of this Relapse Prevention Plan (specific *date*):

This Relapse Prevention Plan was created by individual client and their primary counselor in this individual counseling session. Electronic signature constitutes client agreement with these plans.

Appendix C - Service Note

A&D SERVICE NOTE TEMPLATE

Client Name: q1

****This part is just FYI, to help us follow the golden thread:**
SERVICE AND SUPPORT PLAN GOALS: g1, g2, g3
OBJECTIVES: j1, j2, j3

****Note should look like the following:**

A&D Individual session, time-time, total time in minutes

SITUATION:

INTERVENTIONS USED THIS SESSION:

PROGRESS TOWARDS GOALS:

PLAN:

Appendix D - Exit / Transfer Summary

TRANSFER SUMMARY

Name: q1 Date of Birth: q2 Enrollment Date: q3
Primary Counselor:
Level of Care: p1
Discharge date:

TYPE OF DISCHARGE:
[ ] Successful Completion
[ ] Against Staff Advice, explain:
[ ] At Staff Request, explain:

DIAGNOSTIC IMPRESSION AT ADMISSION: d1, d2, d3

PARTICIPATION AND PROGRESS IN TREATMENT

ATTENDANCE & PARTICIPATION:

INDIVIDUAL'S PROGRESS ON TREATMENT GOALS:
Goals at Intake: g1, g2, g3

INDIVIDUAL'S CURRENT STAGE OF CHANGE:
Individual is in the Stage of Change, as evidenced by:

INDIVIDUAL'S CURRENT RISK FOR RELAPSE:
Individual is at Risk of relapse, as evidenced by:

CONTINUING CARE RECOMMENDATIONS

PROGNOSIS:

RECOMMENDATIONS:

REFERRALS:

Primary Counselor, Credentials _____ Date _____

Clinical Supervisor, Credentials_____ Date _____

Appendix E - Incident Report

Scan: Incident-report-date

Kolpia Counseling Services
Incident Report

Date of Report: _____. Date of Incident:_____.

Name of person making the report_____.

Please write below the nature and details of the incident including the (1) full names and identities of those involved, (2) the time(s) of the incident, (3) dates related to the incident if different from above, (4) the details of the incident.

Please continue on the following page if you need more room.

Signature of person making the report:_____. Date:_____.

Please write any follow-up details related to the incident report: **Date:**_____.