COUNTY OF LOS ANGELES
Public Health

# Specialty Substance Use Disorder (SUD) System Documentation Examples

1. Service Request Form
2. Progress Notes
3. Treatment Plan
4. Discharge / Transfer Form
5. Miscellaneous Note Options

# Service Request Form

# SERVICE REQUEST FORM

All services delivered in managed care environments require a determination of eligibility for services, and certain services require preauthorization or authorization by the managed care entity, in this case SAPC. This process of reviewing services is known as utilization management. Utilization management ensures that delivered services are medically necessary and appropriate.

The Service Request Form is an essential part of utilization management and is the provider's opportunity to demonstrate a patient is eligible for services (Part A of the Service Request Form) and request preauthorization or authorization for a certain service (Part B of the Service Request Form).

Although the Service Request Form can sometimes be viewed as purely an administrative requirement, it also represents an opportunity for providers to reflect on why they are recommending certain services for their patients to ensure that they are necessary and appropriate.

**A strong justification for services tells a brief story of why certain services are needed, and includes the following elements:**

- **What** – What service is being requested?
- **Why** – Why is this service necessary and appropriate?
    - Summary of the case, including brief history of past and current substance use, for example:
        - ASAM Dimension 1
            - Substance (e.g., heroin, meth, etc)
            - Route of administration (e.g., IV, snorting, smoking, etc)
            - Duration (e.g., used substance for the last 10 years, etc)
            - Frequency (e.g., uses substance 2-3 times per week)
            - Consequences of use (e.g., impact on family, job, life responsibilities, finances, etc)
            - History of treatment (e.g., 2 prior residential admissions with sobriety for 1 year each, followed by relapse)
        - Consideration of other ASAM dimensions to guide clinical rationale and level of care decisions (e.g., living situation, readiness to change, co-occurring mental health conditions, etc)

Importantly, although this may appear to be a lot of information, this information can be captured in just several sentences.

A well-written Service Request Form will maximize the likelihood of timely service authorization approvals to facilitate the delivery of effective and appropriate substance use disorder (SUD) services. The easier it is for SAPC staff to understand the justification for the service(s) being requested, the more likely the service(s) being requested will be authorized and done so in a timely manner.

Periodic internal reviews of Service Request Form submissions by clinical supervisors and treatment staff is encouraged and will ensure consistent quality of this documentation.

Below are examples of several justifications of Service Request Forms for fictional cases. For the purposes of these samples, the focus is on the Medical Necessity and Level of Care section of the Service Request Form (fields #22-24) given that other information contained within the Service Request Form is either demographic or straightforward to answer. Examples are provided for outpatient, residential, inpatient, and Opioid Treatment Program (OTP) levels of care. Importantly, these are only examples and there are various acceptable ways to provide good documentation to justify medical necessity for care, but the important thing is to include relevant clinical information and rationale for providing that level of care in submitted Service Request Forms.

**SUBSTANCE ABUSE PREVENTION AND CONTROL**
**Service Request Form**

| | | | |
|---|---|---|---|
| 1.Today's Date: | | 2. Treatment Start Date: | |
| **Part A** | **PART A – MUST BE COMPLETED FOR ALL LEVELS OF CARE** | | |
| **PATIENT INFORMATION** | | | |
| 3. Name: (Last, First, Middle) | | 4. Date of Birth: (MM/DD/YY) | 5. Medi-Cal or MHLA Number: |
| 6. Address: | | | |
| 7. Phone Number: | Okay to Leave a Message? ☐ Yes ☐ No | | 8. Gender: |
| 9. Perinatal Patient: ☐ Yes ☐ No<br>If yes, provide verification | 10. Criminal Justice Involved Patient: ☐ Yes ☐ No<br>If yes, provide Criminal Justice Identification Number: _____ | | 11. Race/Ethnicity (Optional): |
| **PROVIDER INFORMATION** | | | |
| 12. Provider Agency Name: | | | |
| 13. Address: | | | |
| 14. Name of Contact Person: | | 15. Email Address of Contact Person: | |
| 16. Phone Number of Contact Person: | | 17. Fax Number: | |
| **ELIGIBILITY REQUIREMENTS FOR SPECIALTY SUBSTANCE USE DISORDER SERVICES IN LOS ANGELES COUNTY** | | | |
| 18. Is the patient a resident of Los Angeles County? ☐ Yes ☐ No<br><br>19. Is the patient Medi-Cal Eligible? ☐ Yes ☐ No. If yes, please go to question 20. If no, please go to question 21.<br><br>20 Are the beneficiary's Medi-Cal benefits assigned to Los Angeles County? ☐ Yes ☐ No.<br><br>21. Is the patient a participant in the My Health LA (MHLA) program or other qualified county funded benefits? (e.g. AB 109)<br>☐ Yes ☐ No | | | |
| **MEDICAL NECESSITY FOR ALL LEVELS OF CARE** | | | |
| 22. DSM-5 Diagnosis for Substance Use Disorder or Substance Use Diagnosis At Risk For: | | | |
| 23. Level of Care Determination: | | | |
| 24. Explanation of Need for Ongoing Services and Justification for Level of Care, as applicable: | | | |
| 25. Printed Name of Licensed LPHA from the ASAM Assessment Form: | | | |

| 26. Discipline: | 27. Licensed LPHA License Number: |
|---|---|

| **Part B** | **PREAUTHORIZATION / AUTHORIZATION SERVICE REQUEST**<br>COMPLETE THIS SECTION **ONLY** IF REQUESTING ONE OF THE SERVICES LISTED BELOW |
|---|---|

28. Check One: ☐Preauthorization ☐Authorization ☐*Expedited Authorization ☐Reauthorization (Current Authorization #: _____)

29. Check if the patient is: ☐Youth (under age 18) ☐Young Adult (age 18-20) ☐Adult (age 21 and over)

**Preauthorized Services**

Residential Services

☐ ASAM level 3.1 Clinically Managed Low-Intensity

☐ ASAM level 3.3 Clinically Managed High Intensity (Population Specific)

☐ ASAM level 3.5 Clinically Managed High-Intensity (Non-Population Specific)

☐ ASAM level 3.7 Medically Monitored Intensive Inpatient Treatment Services

☐ ASAM 4.0 Medically Managed Intensive Inpatient Treatment Services

**Authorized Services**

Withdrawal Management (WM) for Youth Under Age 18

☐ ASAM level 1-WM (outpatient/ambulatory)

☐ ASAM level 3.2-WM (residential)

☐ ASAM level 3.7-WM (inpatient)

☐ ASAM level 4-WM (inpatient)

Medication-Assisted Treatment for Youth Under Age 18

☐ Medication-Assisted Treatment for Youth Under Age 18

☐ Recovery Bridge Housing - *must submit authorization request via RBH Authorization Request Form*)

| 30. Name of Provider submitting request: | 31. Provider Signature: | 32. Date: |
|---|---|---|

**EXTERNAL SAPC REVIEW** *This section will include communication between SAPC and the agency/provider.*

☐ Approved ☐ Denied ☐ Further review required

Comments:

Reviewed by: Supervisor Reviewer Date:

**INTERNAL SAPC USE ONLY** This section is reserved for internal SAPC use only.

☐ Approved ☐ Denied ☐ Further review required

Comments:

Reviewed by: Supervisor Reviewer Date:

**Service Request Form**

**Medical Necessity and Level of Care Section (fields #23 – 25)**

**Outpatient Example**

**Field #23: DSM-5 Diagnosis of Substance Use Disorder or At-Risk Diagnosis**

- Opioid Use Disorder – MILD

**Field #24: Level of Care Determination**

- Outpatient ASAM 1.0

**Field #25: Explanation of Need for Ongoing Services and Justification for Level of Care, as applicable**

- ASAM considerations:
    - Dimension 1: Mr. Doe is a 27 y/o man with a 1-year history of abusing opioid medications he obtained from friends about once every 2 weeks. He denies any IV heroin or other drug use, and has never been in SUD treatment before, but is interested in treatment now because his family found out about his use and is concerned. He has also noticed that his work performance in construction has been negatively impacted, so is concerned about eventually losing his job and is interested in outpatient treatment so it doesn't disrupt his work
    - Dimension 2: High cholesterol, managed by primary care provider (PCP)
    - Dimension 3: Mild anxiety, not receiving treatment
    - Dimension 4: Ready for and interested in outpatient treatment
    - Dimension 5: Has not used any drugs in the last 2 weeks. Moderate-high relapse potential
    - Dimension 6: Lives with his family, who is supportive of his recovery
- In summary, this is a 27 y/o man with mild opioid use disorder who has misused prescription opioids about twice per month for the past year, and who is interested in outpatient treatment. He is working and lives with his family, who are supportive. Given concerns about worsened use and increasing negative consequences of use, the ASAM assessment determined that he met the criteria for outpatient SUD treatment. Assessor believes this is appropriate for now considering the severity level of his substance use, as patient has a stable living situation and does not appear to require or want treatment in a higher level of care at this time.

**Residential Example – INITIAL PREAUTHORIZATION**

**Field #23: DSM-5 Diagnosis of Substance Use Disorder or At-Risk Diagnosis**

- Opioid Use Disorder – SEVERE
- Methamphetamine Use Disorder – MODERATE

**Field #24: Level of Care Determination**

- Residential ASAM 3.5

**Field #25: Explanation of Need for Ongoing Services and Justification for Level of Care, as applicable**

- ASAM considerations:
    - Dimension 1: Mr. Doe is a 27 y/o man with a 10-year history of abusing IV heroin about 3x per week, and meth about once a month. He denies any other drug use, and has received SUD treatment numerous times in the past, both in residential and outpatient settings, with longest period of sobriety being 6 months. He is interested in treatment now because he states he is "sick and tired of using." He reports withdrawal symptoms when he stops using, but is not presenting with any withdrawal symptoms currently and despite encouragement to consider it, states that he is not interested in medications to support withdrawal management at this time
    - Dimension 2: High blood pressure, managed by primary care provider (PCP)
    - Dimension 3: Mild depression and anxiety, not receiving treatment
    - Dimension 4: Ready for and interested in treatment
    - Dimension 5: Last heroin use 3 days ago, meth use about 1 month ago. High relapse potential
    - Dimension 6: Lives with his family, but family are "fed up" and not supportive of patient returning

home at this time

- In summary, this is a 27 y/o man with severe opioid use disorder who has a 10-year history of IV heroin use 3x per week and meth use once a month, who meets criteria for residential treatment given the duration, frequency, and intensity of his drug use. Although he is appropriate for withdrawal management, he is not interested, despite use of motivational interviewing techniques to get him to consider this. He is also appropriate for residential 3.3 given his co-occurring depression and anxiety, but patient prefers to be treated at current site, where 3.3 is not available, and his depression and anxiety are currently stable and anticipated to increase with sobriety. Although he lives with his family, patient has burned bridges with his family and they are not supportive of patient returning home at this time. As a result, the most appropriate ASAM level of care currently is residential 3.5, which is consistent with the ASAM assessment recommendation.

**Residential Example – REAUTHORIZATION**

**Field #23: DSM-5 Diagnosis of Substance Use Disorder or At-Risk Diagnosis**

- Opioid Use Disorder – SEVERE
- Methamphetamine Use Disorder – MODERATE

**Field #24: Level of Care Determination**

- Residential ASAM 3.5 (reauthorization)

**Field #25: Explanation of Need for Ongoing Services and Justification for Level of Care, as applicable**

- ASAM considerations:
    - Dimension 1: Mr. Doe is a 27 y/o man with a 10-year history of abusing IV heroin about 3x per week, and meth about once a month. He has been in residential 3.5 treatment for approximately 50 days, and has been engaged and made progress in terms of becoming more comfortable sharing in individual and group sessions, better able to utilize his coping skills, and reporting reduced but ongoing cravings, and continues to be only contemplative and minimally confident in his ability to maintain his recovery. He is now open to consideration MAT for his long history of heroin use and is in the process of being referred for MAT evaluation by our Medical Director.
    - Dimension 2: High blood pressure, managed by primary care provider (PCP)
    - Dimension 3: Mild depression and anxiety, stable
    - Dimension 4: Interested in continuing treatment, but still contemplative about his ongoing recovery
    - Dimension 5: Last heroin use 53 days ago and meth use 1 month ago. Moderate-high relapse risk
    - Dimension 6: Currently in residential treatment. Able to return home with family once stabilized
- In summary, this is a 27 y/o man with severe opioid use disorder who has a 10-year history of IV heroin use 3x per week and meth use once a month, who has been in residential 3.5 treatment for about 50 days. Engaged and making progress, but ongoing cravings and only contemplative stage of change regarding ability to maintain recovery is concerning. Patient would benefit from ongoing residential 3.5 treatment, and patient does not appear ready for step down to Intensive Outpatient Treatment. Would like to request additional 30 days in residential 3.5 setting to continue treatment and prepare for step-down to lower level of care later.

**Inpatient Example**

**Field #23: DSM-5 Diagnosis of Substance Use Disorder or At-Risk Diagnosis**

- Opioid Use Disorder – SEVERE
- Alcohol Use Disorder – SEVERE

**Field #24: Level of Care Determination**

- Inpatient ASAM 3.7

**Field #25: Explanation of Need for Ongoing Services and Justification for Level of Care, as applicable**

- ASAM considerations:
    - Dimension 1: Mr. Doe is a 27 y/o man with a 10-year history of abusing IV heroin and alcohol on a daily basis. Typically drinks about 8 drinks per day of vodka. Last heroin use was yesterday, and last drink was 4 hours ago. Patient presents with visible withdrawal symptoms of sweating and mild tremors. He has received SUD treatment numerous times in the past, both in residential and outpatient settings, with longest period of sobriety being 3 months. He is interested in treatment now because he states he is "sick and tired of using." He reports severe withdrawal symptoms when he stops using and is interested in detox to assist with his treatment. He reports a history of delirium tremens (DTs) and one prior alcohol-related withdrawal seizure in the past.
    - Dimension 2: High blood pressure, managed by primary care provider (PCP). History of alcohol-related withdrawal seizure about 6 months ago
    - Dimension 3: Mild depression and anxiety, not receiving treatment
    - Dimension 4: Ready for and interested in treatment
    - Dimension 5: Last heroin use yesterday and last drink about 4 hours ago. Very high relapse and withdrawal potential
    - Dimension 6: Homeless, no supportive family
- In summary, this is a 27 y/o man with severe opioid and alcohol use disorders who has a 10-year history of daily IV heroin use and daily alcohol use of about 8 drinks per day of vodka. History of severe withdrawal from both opioids and alcohol, including one prior alcohol-related withdrawal seizure about 6 months ago. Given long duration and high frequency/intensity of use, and prior history of withdrawal, patient is at high risk for both relapse and withdrawal. As a result, he meets criteria for stabilization in inpatient treatment in ASAM 3.7 currently, with MAT for withdrawal management support, which patient is interested in.

## Opioid Treatment Program (OTP) Example – REAUTHORIZATION

**Field #23: DSM-5 Diagnosis of Substance Use Disorder or At-Risk Diagnosis**

- Opioid Use Disorder – SEVERE

**Field #24: Level of Care Determination**

- Opioid Treatment Program

**Field #25: Explanation of Need for Ongoing Services and Justification for Level of Care, as applicable**

- ASAM considerations:
    - Dimension 1: Mr. Doe is a 27 y/o man with a 10-year history of daily IV heroin use. He has been stable on methadone maintenance at 120 mg daily for 4 years, and has maintained his recovery during this period. Engaged with OTP on a regular basis, participating in counseling sessions.
    - Dimension 2: No major health issues, managed by primary care provider (PCP)
    - Dimension 3: Followed by outpatient psychiatrist for mild and stable depression
    - Dimension 4: Maintenance stage of change, interested in continuing with treatment in OTP setting
    - Dimension 5: Has not used any heroin or drugs in 4 years since starting methadone maintenance. Relapse potential is low assuming ongoing treatment
    - Dimension 6: Lives with his family, who is supportive of his recovery
- In summary, this is a 27 y/o man with severe 10-year history of opioid use disorder using IV heroin for the past 10 years on a daily basis, who has been stable on methadone maintenance on 120 mg daily for the past 4 years. He has had no relapses during this time and is interested in continuing with OTP treatment. He is appropriately engaged with the OTP and would benefit from ongoing OTP services to maintain his recovery.

# Progress Notes

# PROGRESS NOTES

Progress notes can sometimes be viewed as busy work, not central to the client's progress, or only necessary to fulfill administrative requirements. This can be an issue when caseloads are demanding and face-to-face contact seems more important and/or satisfying. However, progress notes are important to chart a client's recovery journey and progress through the various levels of care of their treatment.

Note writing is an opportunity to reflect on the session, your role and work with the client, and the client's progress or barriers to progress. Without this opportunity for reflection, counselors and clinicians may get stuck in a cycle of reactivity, responding to the latest crisis without the foundation setting that may prevent future crises, and repeating past mistakes or doing what has always been done without reflecting on their practice.

**In addition, progress notes are critical in order to provide a summary of the unique treatment goals, barriers, progress, and needs of a particular case, and communicate the need for recommended services.** Provider agencies are encouraged to ensure that their counselors and clinicians document accordingly and that clinical documentation is thorough, purposeful, and conveys the important details of why services are being provided and how the client is responding to their care.

**Elements of purposeful and thorough progress notes include:**

1. Client's past history and current presentation
2. Client's overall treatment objectives and goals
3. Current issues, barriers to progress, experiences, and/or reactions to care provided
4. The counselor/clinician's assessment of the client's overall situation and how best to address the client's unique needs
5. What interventions the counselor/clinician is employing to address the assessed problems and achieve treatment goals
6. Summary of progress in recovery, such as skills learned or goals achieved
7. The plan in terms of next steps, both for the client and counselor/clinician, in order to achieve the individualized treatment goals of the client

There are many formats for writing progress notes (e.g., SOAP, SIRP, GIRP, BIRP), as described in the Provider Manual. All are similar and each has useful elements that are relevant for the practice of counselors and clinicians in delivering high quality SUD services. However, **some common themes of all good progress notes are that they contain the following characteristics:**

- Provide a clear summary of the clinical picture to someone unfamiliar with the case.
- Tell a story that makes sense and flows so that it is organized in a manner that the reader can follow and understand the client's progress and the treatment provider's rationale for treatment.

Periodic internal reviews of progress notes by clinical supervisors and treatment staff is encouraged and will ensure consistent quality of this documentation.

Below is a fictional example of a progress note in the SOAP (Subjective, Objective, Assessment, Plan) format for both an individual session, as well as a group session. For the purposes of this sample progress note, the focus is on the content of the progress note, rather than the format. This sample offers examples of why certain details that strengthen the documentation are included. Additionally, counselors and clinicians should consider using relevant American Society of Addiction Medicine (ASAM) dimensions to guide their clinical rationale and approach toward SUD care, as demonstrated below.

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| Progress Note Sample – SOAP (Subjective, Objective, Assessment, Plan) Format |
|---|
| **INDIVIDUAL SESSION** |
| **S (Subjective)** – *Counselor/clinician records what the client says* |
| SUD Goal – *In client's words:* "I want to stop using so I can get my job and life back."<br><br>Mr. Doe states that his cravings for heroin are still strong, and "about 6 times a day" he still thinks about leaving residential SUD treatment and going to his old neighborhood to score drugs **(Dimension 5 – relapse risk information, objective measure for monitoring progress)**. However, after 5 weeks, Mr. Doe states that he's finally "comfortable "speaking in group and believes that treatment is helping **(Dimension 4 & 5 – client progress)**. He wants to stay clean from heroin, and believes he's "better," but still says, "I'm not strong enough; I still can't stop thinking about the feeling of using and still have trouble getting it out of my head" **(Dimension 4 & 5 – statement that speaks to justification for continued LOC)**. But overall, he states that he's "getting better" because during the last visit with his family, he said that for the first time he apologized for "giving them grief" and they had a good visit **(Addresses Dimension 4 & 6 – behavior changes].** |
| **O (Objective)** – *Counselor/clinician records observations about session and client's progress* |
| Mr. Doe appears calm and engaged in session **(Immediate presentation)**. There are no visible signs of withdrawal, sweating, tremors, or agitation, and client's drug tests during residential SUD treatment have all been negative **(Dimension 1)**. He is still easily distracted and reports occasional anxiety, but his attention and concentration is improved, as evidenced by talking for five minutes about the visit from his family and being able to reflect on this without issue **(Dimension 3 – monitoring of attention, concentration, anxiety)**. His mood remains mostly flat, but he laughed when talking about a humorous incident during a group counseling session **(Dimension 3 – monitoring of mood)**. |
| **A (Assessment)** – *Counselor/clinician consolidates information into an overall assessment of the client's overall situation and how best to address the client's unique needs* |
| Overall, Mr. Doe is slowly improving. His cravings have reduced from "all the time" to about 6x a day. He is more engaged in treatment during both individual and group sessions, and has identified high-risk triggers for use (anger, fights with his family and boss, and being around old neighborhood). He is learning to use his coping skills (visualization, relaxation, practicing delay and examining the evidence when he's angry) and reports he now likes going to men's NA meetings because he feels like the men "get me" **(Dimension 4 & 5 – description of specific measurable progress)**. However, given his 30-year history of heroin use and continued strong cravings, he needs more time solidifying the use of his coping skills, along with learning new skills to manage cravings and his intense emotions which have previously been triggers to use. (**Justification for ongoing treatment at his current LOC**). Given his ongoing challenges and the historical severity/frequency/duration of his heroin use, he may be an appropriate candidate for medication-assisted treatment (MAT). Although he initially said that he wasn't interested in considering the use of medications to help with his treatment, he now says he's like to know more after the counselor used motivational interviewing techniques to engage the client and speak with him about the pros and cons of MAT and how it may help him achieve his recovery goals **(Dimension 4 – description of how MI intervention were used to advance client through stages of change).** |
| **P (Plan)** – *Factoring in all the considerations outlined in the assessment of the case, counselor/clinician outlines the plan to achieve the client's recovery goals, both in terms of the client and the counselor/clinician* |
| - Will request additional 30-day extension of residential treatment to address ongoing cravings, and the fact that positive progress is being made with current interventions.<br>- Will continue motivational interviewing techniques to facilitate patient engagement in treatment.<br>- Will introduce CBT interventions to show the cycle of anger.<br>- Provided additional literature and information regarding MAT for discussion during next session.<br>- Plan to continue family sessions, as family seems to be a positive influence on patient's recovery |

and are strongly supportive.
- Will continue interventions outlined in Treatment Plan, and to monitor client and relapse potential closely.

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| **Progress Note Sample – SOAP (Subjective, Objective, Assessment, Plan) Format** |
|---|
| **GROUP SESSION** |
| **S (Subjective)** – *Counselor/clinician records what the client says* |
| Common themes of today's group session included one member's description of a recent family visit and how it was both stressful because it caused him to realize how much he had hurt his family, but also how encouraging it was to see how much his family loved him, giving him strength to continue with his recovery. The group also focused on how different members dealt with their cravings in productive ways, strategies to avoid going back to "old ways," and discussions about what goals members of the group have for themselves. **(General description of the group which can be used to describe and summarize the key points of the group for all group participants, followed by more individualized documentation below of the group for Mr. Doe specifically)**<br><br>Mr. Doe stated that he related to the story of the family visit his peer mentioned, recounting with the group his own recent family visit and how hopeful he felt about his recovery after the visit. He received encouragement from the group. He described how he uses visualization of his goals to help him deal with cravings and avoid slipping back into his "old ways." |
| **O (Objective)** – *Counselor/clinician records observations about session and client's progress* |
| Mr. Doe was engaged throughout the group session and appeared hopeful after listening to his peer talk about his family visit and after describing his own recent visit from his family. He shared with peers appropriately and also encouraged a peer when the group lead commented that it appeared he had been sleeping during the session. |
| **A (Assessment)** – *Counselor/clinician consolidates information into an overall assessment of the client's overall situation and how best to address the client's unique needs* |
| Compared to prior groups at the start of his treatment, it is clear that Mr. Doe is more comfortable sharing in the group setting and is progressing with his recovery. He is better able to share his personal feelings related to his substance use, and in his comments demonstrates an understanding of how to use his coping skills to help deal with cravings. |
| **P (Plan)** – *Factoring in all the considerations outlined in the assessment of the case, counselor/clinician outlines the plan to achieve the client's recovery goals, both in terms of the client and the counselor/clinician* |
| - Continue to encourage participation on group sessions, as patient appears to be benefiting from this intervention.<br>- Discuss progress made with family, and encourage continued family visits, given the positive impact on the patient, as described above.<br>- Will continue interventions outlined in Treatment Plan, and to monitor client and relapse potential closely. |

# Treatment Plan

# TREATMENT PLAN

Before a treatment plan can be developed, counselors and clinicians should develop a case formulation. A **case formulation** is a comprehensive conceptualization of a patient that is obtained from interactions and assessments with the patient. Case formulations are used to provide a framework for developing the most suitable treatment approach, and inform what should be included in a treatment plan.

Treatment plans are critical to ensure providers are thinking through all the important aspects necessary for a patient's recovery and mapping out the course of treatment, both within a given level of care and in collaboration with external health and social service partners (e.g., housing partners, mental health providers, etc). Without the consolidation of information in a well-developed treatment plan that contains short- and long-term treatment goals, and a plan for how those goals will be achieved, counselors and clinicians may overlook important elements of treatment that are either important to the patient and/or recovery.

**Importantly, treatment plans should be individualized, meaning that treatment plans should tailored to the patient, and contain different goals and action steps for each patient. Individualized care assumes that different patients require different services and treatment approaches in order to meet their specific needs.**

**There are many ways to write effective treatment plans, but some common themes of all good treatment plans are that they contain the following characteristics:**

- Clearly states the problems that the patient and provider are trying to address.
- Contain goals and corresponding action steps that are SMART (Specific, Measurable, Attainable, Relevant, and Time-Bound).

Periodic internal reviews of treatment plans by clinical supervisors and treatment staff is encouraged and will ensure consistent quality of this documentation.

Below is a fictional example of a treatment plan. For the purposes of this sample treatment plan, the focus is on the Problem sections of the treatment plan, given that other information contained within the treatment plan template is either demographic or straightforward to answer. For this example, there are more than 3 problems, so the Treatment Plan Addendum template is used to document additional problems.

COUNTY OF LOS ANGELES
Public Health

# SUBSTANCE ABUSE PREVENTION AND CONTROL TREATMENT PLAN

Substance Abuse Prevention and Control
1000 S. Fremont Ave, Bldg. A9 East, 3rd Floor, Alhambra, CA 91803
To check submission status call: (800) 832-6334
Fax: (626) 299-4390
Website: http://publichealth.lacounty.gov/sapc/

| PATIENT INFORMATION | | | |
|---|---|---|---|
| 1. Name (Last, First, and Middle: *Doe, John* | 2. Date of Birth (MM/DD/YY): *XX/XX/XX* | 3. Medi-Cal or MHLA Number: *XXXXXXXXX* | |
| 4. Address: *123 Home Address Drive; Los Angeles CA 99999* | | | |
| 5. Gender: *M* | 6. Preferred Language: *English* | 7. Race/Ethnicity: *Caucasian* | 8. Phone Number: *XXX-XXX-XXXX*<br>Okay to Leave a Message?<br>☒ Yes ☐ No |
| 9. DSM-5 Diagnosis(es): *Opioid Use Disorder - SEVERE* | | | |
| 10. Was a Physical Exam Completed?<br>☒ If yes, provide the date the physical exam was completed: *XX/XX/XX*<br>☐ If no, provide the date of scheduled physical exam appointment: | | | |
| 11. Initial treatment Plan Date: *XX/XX/XX* | 12. Updated Treatment Plan Date: *XX/XX/XX* | | |

| PROVIDER AGENCY | | |
|---|---|---|
| 13. Name: *ABC Healing Provider Agency* | 14. Address: *123 Provider Agency Drive; Los Angeles CA 99999* | 15. Email: *SSmith@Provider.com* |
| 16. Contact Person: *Sam Smith* | 17. Phone Number: *XXX-XXX-XXXX* | 18. Fax Number: *XXX-XXX-XXXX* |

**ASAM Dimensions:** 1. Acute intoxication and/or Withdrawal Potential; 2.Biomedical Conditions and Complications; 3.Emotional, Behavioral or Cognitive Conditions/Complications; 4. Readiness to change; 5. Relapse Continued Use, or Continued Problem Potential; 6. Recovery Environment

| PROBLEM # 1 | |
|---|---|
| 19. Problem Statement: *Continued opioid use despite negative consequences on home, work, and health* | |
| 20. Long-Term Goal: *"I want to stop using drugs"* | |
| 21. Treatment Start Date: *1/21/2016* | 22. Dimension(s): *5* |

| 23. Short-Term Goal(s): | 24. Action Steps: | 25. Target Date: | 26.Completion Date: |
|---|---|---|---|
| 1. *Reduce cravings by at least 50% (5 out of a 10 point scale) within 1 month* | *1A. Learn at least 3 new coping skills within the next month.*<br>*1B. Continue to use motivational interviewing to explore the option of MAT with patient as a means to reduce cravings* | *2/21/16*<br>*3/21/16* | |
| 2. *Learn to recognize at least 3 triggers to reduce the chance of relapse within 1 month.* | *2A. Participate in relapse prevention group sessions 3 times a week.* | | |
| 3. *Increase control over cravings by learning to use coping skills from 0 per week to 3 per week to prevent relapse.* | *3A. Individual counseling sessions at least 3 times per week will be the forum to learn these additional coping skills* | | |

**PROBLEM # 2**

19. Problem Statement: *Living situation – most recently, patient has been living on friends' couches.*

20. Long-Term Goal: *"To have my own place to live"*

| 21. Treatment Start Date: *1/21/2016* | 22. Dimension(s): *6* |
|---|---|

| 23. Short-Term Goal(s): | 24. Action Steps: | 25. Target Date: | 26. Completion Date: |
|---|---|---|---|
| 1. *Explore housing options available via the Coordinated Entry System (CES)* | *1A. In the next 2 weeks, perform VI-SPDAT housing assessment to determine what housing options are appropriate within the Coordinated Entry System (CES)* | *2/4/16*<br>*3/12/16* | |
| 2. *Recovery Bridge Housing (RBH) after this residential treatment stay to wait for housing options within CES to become available* | *2A. Prepare RBH service authorization request 2 weeks prior to anticipated discharge from residential treatment* | | |

**PROBLEM # 3**

19. Problem Statement: *Lack of social support*

20. Long-Term Goal: *"To have supportive people surrounding me"*

| 21. Treatment Start Date: *1/21/2016* | 22. Dimension(s): *5 & 6* |
|---|---|

| 23. Short-Term Goal(s): | 24. Action Steps: | 25. Target Date: | 26. Completion Date: |
|---|---|---|---|
| 1. *Will engage in social activities with family and friends at least once a week for the next month.*<br>2. *Will identify a sponsor within the next 2 weeks.* | 1A. *Attend social activities or have a phone conversation with family or friends at least once a week for the next month.*<br>2A. *Will provide patient with the resource list for local self-help groups.*<br>2B. *Patient will call at least 3 support groups to explore the possibility of connecting with a sponsor within next week*<br>2C. *Will follow up on patient's progress in acquiring a sponsor in the next 2 weeks.* | *2/21/2016*<br>*2/04/2016* | |

**TYPE OF SERVICES PROVIDED**

27. ☒ Individual Counseling as needed *3* x week ☒ Group Counseling *5* x week
☐ Community Support Group _____ x week ☒ UA/Breathalyzer *1* x week ☒ Case Management *1* x week
☐ Recovery Support Services ☐ Crisis Intervention ☐ Other: _____

28. Was MAT offered: a) Yes b) No. Please specify: *No, because patient initially expressed reluctance to consider MAT. However, will continue to engage patient and utilize motivational interviewing techniques, as this case was discussed with Medical Director, who recommended MAT given patient's history and the severity of his use history.*

| 29. Patient Signature: John Doe | 30. Date: *1/21/2016* |
|---|---|

31. If the patient refuses or is unavailable to sign the treatment plan, please explain:
*N/A*

32. If the patient's preferred language is not English, were linguistically appropriate services provided?
Yes No. If no, please explain: *Answer is Yes*

| 33. Counselor Name (if applicable): *Mary Sunshine* | 34. Counselor Signature (if applicable): Mary Sunshine | 35. Date: *1/21/2016* |
|---|---|---|

| 36. License eligible LPHA Name (if applicable): | 37. License eligible LPHA Signature (if applicable):_____ | 38. License eligible LPHA license Number: | 39. Date: |
|---|---|---|---|
| 40. Licensed LPHA Name: *Sam Smith* | 41. Licensed LPHA Signature Sam Smith | 42. Licensed LPHA License Number: *XXXXXX* | 43. Date: *1/21/2016* |

**TREATMENT PLAN REVIEW**

| 44. Treatment Plan Review Date: *N/A* | 45. Date of Progress Note Documenting Treatment Plan Review: *N/A* |
|---|---|

46. Explanation of Need for Ongoing Services and Justification of Level of Care, as applicable: *N/A*

| 47. Counselor Name (if applicable): | 48. Counselor Signature (if applicable): | 49. Date: |
|---|---|---|

| | | | |
|---|---|---|---|
| 50. License Eligible LPHA Name (if applicable): | 51. License Eligible LPHA Signature (if applicable):_____ | 52. License Eligible LPHA License Number: | 53. Date: |
| 54. Licensed LPHA Name: *N/A* | 55. Licensed LPHA Signature *N/A* | 56. Licensed LPHA License Number: *N/A* | 57. Date: *N/A* |

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**EXTERNAL SAPC REVIEW** *This section will include communication between SAPC and the agency/provider*

Comments:

Assigned Staff:_____ Reviewed by: _____ Signature: _____ Date: _____

**INTERNAL SAPC USE ONLY** *This section is reserved for internal*

Comments:

Assigned Staff:_____ Reviewed by: _____ Signature: _____ Date: _____

COUNTY OF LOS ANGELES
Public Health

**SUBSTANCE ABUSE PREVENTION AND CONTROL**
**TREATMENT PLAN ADDENDUM**

| **PATIENT INFORMATION** | | |
|---|---|---|
| 1. Name (Last, First, and Middle: *Doe, John* | 2. Date of Birth (MM/DD/YY): XX/XX/XX | 3. Medi-Cal or MHLA Number: *XXXXXXXXX* |
| **PROVIDER AGENCY** | | |
| 4. Name: *ABC Healing Provider Agency* | 5. Address: *123 Provider Agency Drive; Los Angeles CA 99999* | 6. Phone Number: *XXX-XXX-XXXX* |

**ASAM Dimensions:** 1. Acute intoxication and/or Withdrawal Potential; 2.Biomedical Conditions and Complications; 3.Emotional, Behavioral or Cognitive Conditions/Complications; 4. Readiness to change; 5. Relapse Continued Use, or Continued Problem Potential; 6. Recovery Environment

**PROBLEM # 4** *(enter Problem #)*

7. Problem Statement: *Patient reports symptoms of depression*

8. Long-Term Goal: *"I have been finding myself feeling more and more down the past 2 years and think I need help"*

| 9. Treatment Start Date: *1/21/2016* | 10. Dimension(s): *3* | | |
|---|---|---|---|
| 11. Short-Term Goal(s): | 12. Action Steps: | 13. Target Date: | 14.Completion Date: |
| 1. *Obtain mental heath assessment within the next month to determine if patient meets criteria for depression and requires mental health treatment* | *1A. Will refer patient to DMH to obtain a mental heath assessment and determine most appropriate next steps* | *2/21/16* | |

**PROBLEM # 5** *(enter Problem #)*

7. Problem Statement: *Chronic back pain related to the bike accident 3 years ago*

8. Long-Term Goal: *"I want to go back to work eventually, but this back pain is killing me".*

| 9. Treatment Start Date: *1/21/16* | 10. Dimension(s): *2* |
|---|---|

| 11. Short-Term Goal(s): | 12. Action Steps: | 13. Target Date: | 14.Completion Date: |
|---|---|---|---|
| *1. Ensure the client have an appointment to see his primary care provider (PCP) for pain management within next week.* | *1A. Patient will call his PCP to make an appointment by next week.*<br><br>*1B. Case manager will follow up to ensure the patient has made an appointment with PCP by next week.* | *1/28/16* | |

| **PROBLEM # _____** *(enter Problem #)* | | | |
|---|---|---|---|
| 7. Problem Statement: | | | |
| 8. Long-Term Goal: | | | |
| 9. Treatment Start Date: | 10. Dimension(s): | | |
| 11. Short-Term Goal(s): | 12. Action Steps: | 13. Target Date: | 14. Completion Date: |

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# Discharge / Transfer Form

# DISCHARGE / TRANSFER FORM

Best practice for the treatment of SUDs requires that we treat it as a chronic condition by leveraging the full continuum of care available (e.g., withdrawal management levels of care, outpatient, intensive outpatient, residential, inpatient, Opioid Treatment Program). By treating patients throughout these various levels of care, the SUD treatment system is able to provide services that best align with patient needs.

When patients with SUDs first enter treatment, they typically require the highest levels of care, such as withdrawal management, inpatient, or residential treatment given the acuity of their condition. However, once they stabilize, they can be safely transitioned to lower levels of care, such as intensive outpatient and outpatient treatment.

**The Discharge/Transfer Form facilitates the use of the full SUD continuum of care by providing counselors and clinicians an opportunity to reflect on why a patient is being discharged and if they are best served at another level of care.**

**Well-written Discharge/Transfer Forms provide a summary of the patient's episode of care and the rationale for the transition in care, whether it is a discharge or transfer in care.**

While completing the Discharge/Transfer Form, providers are encouraged to think of their treatment agency as *one* of the levels of care a patient enters as they progress in their recovery, as opposed to *the only* level of care, as is traditionally the case in SUD treatment systems. Ultimately, the Discharge/Transfer Form facilitates the transformation from a system comprised of various treatment agency silos to an interconnected network of care.

Periodic internal reviews of Discharge/Transfer Form submissions by clinical supervisors and treatment staff is encouraged and will ensure consistent quality of this documentation.

Below is a fictional example of a Discharge/Transfer Form.

COUNTY OF LOS ANGELES
Public Health

**SUBSTANCE ABUSE PREVENTION AND CONTROL**
**DISCHARGE AND TRANSFER FORM-ALL LEVELS OF CARE EXCEPT RBH**

| | | |
|---|---|---|
| 1.Today's Date: *1/21/16* | 2. ☐ Grace Period: Length of Stay ≤ 7 days? Specify number of days: _____ | |
| **PATIENT INFORMATION** | | |
| 3. Name (Last, First, Middle): *Doe, John* | 4. Date of Birth: (MM/DD/YY): *XX/XX/XX* | 5. Medi-Cal or MHLA Number: *XXXXXXXXX* |
| 6. Address: *123 Home Address Drive; Los Angeles CA 99999* | | |
| 7. Phone Number: *XXX-XXX-XXXX* Okay to Leave a Message? ☒ Yes ☐ No | | 8. Gender: *M* |
| 9. Admission Date: *1/21/16* | 10. Discharge or Transfer Date: *3/14/16* | 11. Discharge or Transfer Diagnosis: *Opioid Use Disorder - SEVERE* |

| **DISCHARGING PROVIDER** | **ACCEPTING PROVIDER (IF TRANSFERRED)** |
|---|---|
| 12. Provider Agency Name: *ABC Residential Provider* | 16. Provider Agency Name: *ABC Intensive Outpatient Provider* |
| 13. Address: *123 Residential Drive; Los Angeles CA 99999* | 17. Address: *123 Intensive Outpatient Drive; Los Angeles CA 99999* |
| 14. Contact Person: *Mary Sunshine* | 18. Contact Person: *Walt Disney* |
| 15. Contact Person Phone Number: *XXX-XXX-XXXX* | 19. Contact Person Phone Number: *XXX-XXX-XXXX* |

**REASON FOR DISCHARGE OR TRANSFER**

20.

☐ Completed treatment goals/plan at this level of care
☒ Completed treatment goals/plan at this level of care and transferred
☐ Left before completing treatment goals/ plan
☐ Left before completing treatment goals/plan and transferred
☐ Voluntary (Specify):
☐ Administrative discharge (Specify):
☐ Discharged into other, more appropriate system of care (e.g., mental health, acute care hospital) Specify:
☐ Incarceration
☐ Death
☐ Other (Specify):

21. If transferred to another level of SUD care, please check if:

☐ Transferred to a **higher** level of SUD care ☒ Transferred to a **lower** level of SUD care

22. A description of each trigger for relapse, and a relapse prevention plan for each trigger (please use additional sheets if necessary):

*Patient reported triggers being:*

- *Cravings: Mr. Doe agreed to use coping strategies of deep breathing, positive visualization, and distraction. He also agreed to continue with buprenorphine as prescribed, which has greatly helped with his cravings. He also agreed to continue to attend and actively participate in NA meetings.*
- *Associating with old friends and neighborhoods: Mr. Doe agreed to avoid old friends/neighborhoods and to check in with his sponsor and recovery network at least 3x per week, and as needed. He also agreed to use coping strategies (see above).*
- *Stress from being unemployed: Mr. Doe agreed to continue working with his case worker to explore vocational training opportunities and to apply for jobs.*
- *Not having stable housing: Mr. Doe is currently on the waitlist for permanent supportive housing within the Coordinated Entry System (CES). In the meanwhile, he is being transferred to Intensive Outpatient Treatment connected with Recovery Bridge Housing (RBH) to ensure he continues to have a stable living situation as he waits for placement within CES. Will coordinate housing with new case manger.*

23. Justification for Transfer or Discharge:

*Mr. Doe has completed 55 days of residential 3.5 treatment and done well. He is ready to transition to a lower level of care and after discussion with the patient, his case manager, and the counselors that have treated Mr. Doe, the determination was made that transitioning to Intensive Outpatient Treatment connected with Recovery Bridge Housing (RBH) would be the most appropriate next step in his treatment to allow him to continue with his treatment and recovery, while also ensuring he has a living situation supportive of his recovery, since he is currently still homeless as he awaits placement in permanent supportive housing in the Coordinated Entry System (CES).*

24. A narrative summary of the treatment episode including prognosis:

*Prognosis: Good*

*Dimension 1: Patient has not used opioids since entering residential treatment and continues to use buprenorphine, as prescribed. He has been fully engaged in treatment, has grown much more comfortable participating in group sessions, is able to more freely talk about the feelings which have contributed to his drug use over the years, and is following up with his buprenorphine prescriber and using this medication appropriately. He is highly motivated to maintain his recovery and after about 55 days in residential treatment, the decision was made to transition Mr. Doe to a lower level of care - Intensive Outpatient Treatment connected with Recovery Bridge Housing (RBH).*

*Dimension 2: Patient has been referred to his primary care provider for pain management for his low back pain from his bike accident from 3 years ago. He is following up approximately every 2 months.*

*Dimension 3: Patient is following up with a DMH therapist and psychiatrist for his mild depression after he was referred during his residential SUD treatment.*

*Dimension 4: Patient remains engaged and motivated to maintain his sobriety and recovery, and is highly motivated to continue with Intensive Outpatient Treatment.*

*Dimension 5: Patient continues to experience occasional cravings, but they are significantly reduced from previously. He is able to identify triggers to his SUD use and use various coping strategies (described above) and buprenorphine to help reduce his risk of relapse.*

*Dimension 6: Patient is being placed in RBH and will need continued support as he awaits placement in permanent supportive housing in the Coordinated Entry System (CES). He is working with his case manager to pursue vocational training and actively looking for employment. His relationships with his family have also improved; they are supportive of his recovery and see each other approximately twice a month.*

25. Prescriber Name and Medications (Including dosage): *Dr. Seuss is the prescriber of Mr. Doe's Suboxone (buprenorphine and naloxone), 16mg/4 mg once a day (this is the current maintenance dose). He reports better control over cravings while taking this medication.*

26. Has the Patient Been Screened for Whole Person Care (WPC)? ☒ Yes ☐ No. If no, is the Patient Interested?

*Patient was screened for WPC, but was not interested at this time.*

27. Has a copy of the Discharge and Transfer Form been given to the patient or guardian? ☒ Yes ☐ No. If no, please explain:

| 28. Counselor Printed Name (if applicable): *Mary Sunshine* | 29. Counselor Signature (if applicable): Mary Sunshine | 30. Date: *3/14/16* | |
|---|---|---|---|
| 31. LPHA Printed Name (if applicable): | 32. LPHA Signature (if applicable): | 33. LPHA License Number: | 34. Date: |

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**EXTERNAL SAPC REVIEW** *This section will include communication between SAPC and the agency/provider*

Comments:

Assigned Staff: _____ Reviewed by: _____ Signature: _____ Date: _____

**INTERNAL SAPC USE ONLY** *This section is reserved for internal SAPC use only.*

Comments:

Assigned Staff: _____ Reviewed by: _____ Signature: _____ Date:

# Miscellaneous Note Options

# MISCELLANEOUS NOTE OPTIONS

Documentation is necessary to demonstrate that services were provided, and to provide evidence to support billing for those services.

Miscellaneous Notes are available to document instances when services rendered do not require a progress note or treatment plan. Miscellaneous Notes offer counselors and clinicians flexibility in what they would like to document.

**Examples of when Miscellaneous Notes should be used are:**

- **Case Management** (e.g,. documentation of time spent assisting patients enroll in Medi-Cal, phone calls with community resource partners, time spent performing the VI-SPDAT housing assessment to facilitate entry into the Coordinated Entry System, etc).
- **Documentation of miscellaneous notes** (e.g., phone calls with collateral/family, other patient-related encounters that providers want to demonstrate have been performed – such as case conferences).

**A good rule of thumb to follow is that from an auditing perspective, if services were not documented, they cannot be verified as having been performed. As a result, providers are encouraged to document all services they deliver that they think is relevant for both patient care and billing.**

**Well-written Miscellaneous Notes are brief, but describe in detail the activity or encounter, as well as relevant outcomes, next steps, and services provided. Miscellaneous Notes should also be well organized.** Given that Miscellaneous Notes can be used for a variety of purposes, it is recommended that counselors and clinicians label the note in the free-text box with what the purpose of the note is for. For example, if the Miscellaneous Note is being used to document case management that was provided, users may write “Case Management Note” at the beginning of the free-text box to quickly and easily indicate to future reviewers what the purpose of the note is.

Below is a fictional example of documentation for two Miscellaneous Note options for case management and documentation of a call with collateral/family. For the purposes of these Miscellaneous Notes, the focus is on the free-text box for notes in field #18 that states, “Please document the activity or encounter,” as opposed to other information contained within the Miscellaneous Note that is either demographic or straightforward to answer.

**SUBSTANCE ABUSE PREVENTION AND CONTROL**
**Miscellaneous Note Option**

| **NOTE TYPE** | | | |
|---|---|---|---|
| 1. Select note type: a) Case Review b) Case Management c) Miscellaneous Note 2. Start time: ___ End time: ___<br>3. Date: | | | |
| **PATIENT INFORMATION** | | | |
| 4. Name (Last, First, and Middle): | 5. Date of Birth (MM/DD/YY): | 6. Medi-Cal or MHLA Number: | |
| 7. Address: | | | |
| 8. Gender: | 9. Preferred Language: | 10. Race/Ethnicity: | 11. Phone Number:<br>Okay to Leave a Message?<br>☐ Yes ☐ No |
| **PROVIDER AGENCY** | | | |
| 12. Name: | 13. Contact Person: | 14. Phone Number: | |
| 15. Address: | 16. Fax: | 17. Email: | |
| **NOTE** | | | |
| 18. Please document the activity or encounter: | | | |
| 19. If the patient preferred language is not English, were linguistically appropriate services provided?<br>Yes No. If no, please explain: | | | |
| 20. Provider Name: | 21. Signature: _____ | 22. Date: | |
| 23. Additional Provider Name if applicable: | 24. Signature: _____ | 25. Date: | |
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| **EXTERNAL SAPC REVIEW** *This section will include communication between SAPC and the agency/provider*. | | | |

Comments:

Assigned Staff: _____ Reviewed by: _____ Signature: _____ Date: _____

**INTERNAL SAPC USE ONLY** *This section is reserved for internal SAPC use only.*

Comments:

Assigned Staff: _____ Reviewed by: _____ Signature: _____ Date: _____

**MISCELLANEOUS NOTE OPTION**

**CASE MANAGEMENT**

**Field #18: Please document the activity or encounter**

**Case Management Note**

- Medi-Cal Enrollment:
  - *Worked with Mr. Doe to fill out the YourBenefitNow application to enroll in Medi-Cal. Called DPSS to address questions regarding patient's county of residence status given that patient was previously enrolled with San Bernardino County Medi-Cal, but DPSS confirmed that patient's benefit will be moved to Los Angeles County now that he has moved to LA. DPSS stated that patient should have his Medi-Cal benefits transferred to Los Angeles County within 45 days. Spent a total of 30 min working with the patient and coordinating with DPSS.*
- Housing Assessment and Referral
  - *Performed the VI-SPDAT on Mr. Doe to determine what housing options are appropriate to meet his needs within the Coordinated Entry System (CES), which demonstrated that he would be most appropriate for permanent supportive housing. Spent 30 min completing the VI-SPDAT. Will schedule time tomorrow to input data into the HMIS to report this info to CES and ensure patient is on the waitlist for permanent supportive housing.*

**MISCELLANEOUS NOTE**

**Field #18: Please document the activity or encounter**

**Phone Call with Family**

- *Mr. Doe's family called and provided information that they had a family visit today and that the patient seemed to be doing well. Family was pleased and stated they would try to visit the patient at least twice per week. I conveyed this to the patient to provide positive reinforcement with regard to his recovery progress, and encouraged continued family engagement and visits. Patient seemed happy to hear about this. Spent 5 min speaking with family and 10 min speaking with patient.*