Monterey County Behavioral Health Quality Improvement

Re:	Assessment of Tobacco Use Disorder in Substance Use Disorder (SUD) Recovery or Treatment Facilities: Passage of Assembly Bill (AB) 541
Form Reference	Behavioral Health Information Notice No: 22-024 DHCS 5103 (Revised 04/2022)
Effective	November 14th, 2022

Topic

According to the Centers for Disease Control and Prevention (CDC), a person with a mental health issue, substance use disorder, or both are more than twice as likely to smoke cigarettes as a person without these behavioral health conditions and are more likely to die from a smoking-related illness than from their behavioral health condition (Citation: BHIN 22-024). As a result, AB 541 was passed, which outlines licensed and/or certified SUD recovery or treatment facility to complete the following:

1. Conduct an assessment of tobacco use during the initial intake.
2. Utilize the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for determining a tobacco use disorder diagnosis.
3. Provide information to the person in care on how continued use of tobacco products could affect their long-term success in recovery.
4. Recommend treatment for tobacco use disorder in the treatment plan.
5. Offer either treatment, subject to the limitation of the license or certification issued by the department, or a referral for treatment for tobacco use disorder.

As a result, Monterey County Behavioral Health and substance use disorder (SUD) contracted providers will make ongoing efforts at reducing barriers to tobacco use disorder treatment in order to eliminate disparities among persons with substance use disorders. **In order to comply with AB 541, the updated Client Health Questionnaire and Initial Screening Questions (DHCS 5103 Revised 04/2022) shall be used by all SUD providers for every person that enters care** (enclosed).

Procedure

Previous requirements:

1. DMC-ODS providers used the DHCS 5103 (06/16) Health Questionnaire and Initial Screening Form.

Requirements as of November 14th, 2022

1. All DMC-ODS providers shall use the updated Client Health Questionnaire and Initial Screening Questions (DHCS 5103 Revised 04/2022) form.
2. LPHA's will use the most recent version of the DSM criteria to assess and ensure the identified tobacco use disorder diagnosis is reflected in the person in care's chart.

State of California — Health and Human Services Agency
Department of Health Care Services
Licensing and Certification Division
Substance Use Disorder Licensing and Certification Section
PO Box 997413, MS 2600
Sacramento, CA 95899-7413
LCDQuestions@dhcs.ca.gov

CLIENT HEALTH QUESTIONNAIRE AND INITIAL SCREENING QUESTIONS

HEALTH QUESTIONNAIRE INSTRUCTIONS

If Incidental Medical Services (IMS) are to be provided, the Incidental Medical Services Certification Form (DHCS 4026), and the Health Care Practitioner Incidental Medical Services Acknowledgement Form (DHCS 5256), must be completed, reviewed and signed by a Health Care Practitioner.

CLIENT HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____

Date: _____

Physical

	Yes	No	
1.	☐	☐	Have you ever had a heart attack or any problem associated with the heart? If ***yes***, please list when, what was the diagnosis and if you are currently taking medication:
2.	☐	☐	Are you currently experiencing chest pain(s)? If ***yes***, please give details:
3.	☐	☐	Do you have any serious health problems or illnesses (such as tuberculosis or active pneumonia) that may be contagious to others around you? If ***yes***, please give details:

	Yes	No	
4.	☐	☐	Have you ever tested positive for tuberculosis? If ***yes***, when? Please give details:
5.	☐	☐	Have you ever been treated for HIV or AIDS? If ***yes***, when? Please give details:
6.	☐	☐	Have you ever been tested for sexually transmitted diseases? If ***yes***, please give details and list any medications you are taking:
7.	☐	☐	Have you had a head injury in the last six (6) months? Have you ever had a head injury that resulted in a period of loss of consciousness? If ***yes***, please give details:
8.	☐	☐	Have you ever been diagnosed with diabetes? If ***yes***, please give details, including insulin, oral medications, or special diet:
9.	☐	☐	Do you have any open lesions/wounds? If ***yes***, please explain and list any medications you are taking:

	Yes	No	
10.	☐	☐	Have you ever had any form of seizures, delirium tremens or convulsions? If ***yes***, date of last seizure episode(s) and list any medications you are taking:
11.	☐	☐	Do you use a C-PAP machine or dependent upon oxygen? If ***yes***, please explain:
12.	☐	☐	Have you ever had a stroke? If ***yes***, please give details:
13.	☐	☐	Are you pregnant?
14.	☐	☐	Do you have a history of any other illness that may require frequent medical attention? If ***yes***, please give details and list any medications you are taking:

13. a. If ***yes***, Which Trimester: ☐ 1st ☐ 2nd ☐ 3rd
Are you receiving pre-natal care? ☐ Yes ☐ No
Any complications? ☐ Yes ☐ No If **yes**, please explain:

Department of Health Care Services
Licensing and Certification Division
Substance Use Disorder Licensing and Certification Section
PO Box 997413, MS 2600
Sacramento, CA 95899-7413
LCDQuestions@dhcs.ca.gov

	Yes	No	
15.	☒	☐	Have you ever had blood clots in the legs or elsewhere that required medical attention? If ***yes***, please give details:
16.	☐	☒	Have you ever had high-blood pressure or hypertension? If ***yes***, please give details:
17.	☐	☒	Do you have a history of cancer? If ***yes***, please give details and list any medications you are taking:
18.	☐	☒	Do you have any allergies to medications, foods, animals, chemicals, or any other substance? If ***yes***, please give details and list any medications you are taking:
19.	☒	☐	Have you ever had an ulcer, gallstones, internal bleeding, or any type of bowel or colon inflammation? If ***yes***, please give details:
20.	☐	☐	Have you ever been diagnosed with any type of hepatitis or other liver illness? If ***yes***, please give details and list any medications you are taking:

	Yes	No	
21.	☐	☐	Have you ever been told you had problems with your thyroid gland, been treated for, or told you need to be treated for, any other type of glandular disease? If ***yes***, please give details:
22.	☐	☐	Do you currently have any lung diseases such as asthma, emphysema, or chronic bronchitis? If ***yes***, please give details:
23.	☐	☐	Have you ever had kidney stones or kidney infections, or had problems, or been told you have problems with your kidneys or bladder? If ***yes***, please give details:
24.	☐	☐	Do you have any of the following: arthritis, back problems, bone injuries, muscle injuries, or joint injuries? If ***yes***, please give details, including any ongoing pain or disabilities:
25.	☐	☐	Do you take over the counter pain medications such as aspirin, Tylenol, or Ibuprofen? If ***yes***, list the medication(s) and how often you take it:
26.	☐	☐	Do you take over the counter digestive medications such as Tums or Maalox? If ***yes***, list the medication(s) and how often you take it:

	Yes	No	
27.	☐	☐	Do you wear or need to wear glasses, contact lenses, or hearing aids? If ***yes***, please give details:
28.	☐	☐	When was your last dental exam? Date:
29.	☐	☐	Are you in need of dental care? If ***yes***, please give details:
30.	☐	☐	Do you wear or need to wear dentures or other dental appliances that may require dental care? If ***yes***, please give details:

31. Please describe any surgeries or hospitalizations due to illness or injury that you have had in the past.

32. When was the last time you saw a physician and/or psychiatrist? What was the purpose of the visit? Please give details:

Department of Health Care Services
Licensing and Certification Division
Substance Use Disorder Licensing and Certification Section
PO Box 997413, MS 2600
Sacramento, CA 95899-7413
LCDQuestions@dhcs.ca.gov

33. In the past seven days what types of drugs, including alcohol, have you used?

Type of Drug	Route of Administration

34. In the past year what types of drugs, including alcohol, have you used?

Type of Drug	Route of Administration

35. Do you take any prescription medications including psychiatric medications?

Type of Drug	Route of Administration

Mental/Emotional

	Yes	No	
36.	☐	☐	Are you currently feeling down, depressed, anxious or hopeless? If ***yes***, describe:
37.	☐	☐	Are you currently receiving treatment services for an emotional/psychiatric diagnosis? If ***yes***, for what are you being treated?
38.	☐	☐	Over the last 2 weeks, have you felt nervous, anxious, or on edge? Did you feel like you were unable to stop or control your worrying? If ***yes***, describe:
39.	☐	☐	Over the last 2 weeks, have you had thoughts of suicide or thought that you would be better off dead? If ***yes***, describe:
40.	☐	☐	Have you attempted suicide in the past two (2) years? If ***yes***, give dates:
41.	☐	☐	Have you ever harmed yourself/others or thought about harming yourself/others? If ***yes***, describe:

	Yes	No	
42.	☐	☐	Are you currently feeling that you're hearing voices or seeing things? If ***yes***, describe:

43. ☐ ☐ Have you ever been in a relationship where your partner has pushed or slapped you? If ***yes***, describe:

Previous Drug and/or Alcohol Treatment Services

44. Have you received alcoholism or drug abuse recovery treatment services in the past? If ***yes***, please give details:

Type of Previous Recovery Treatment (Outpatient, Residential, Detoxification)	Name of Previous Treatment Facility	Dates of Previous Treatment	Treatment Completed (Yes or No)

45. Have you ever been treated for withdrawal symptoms? If so, please state the dates you were treated and list any medications that were prescribed:

46. The client has been informed of the risks and benefits of Medications for Addiction Treatment (MAT) also known as Medication Assisted Treatment. Additionally, the provider described the availability of MAT at the program, if applicable, or the referral process for MAT.

_____ _____
(Client Initial) (Staff Initial)

47. The client has been screened for use of all tobacco products utilizing questions recommended in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders under tobacco use disorder, or similar evidence-based guidance, for determining that an individual has a tobacco use disorder.

_____ _____
(Client Initial) (Staff Initial)

I declare that the above information is true and correct to the best of my knowledge:

Client Name (printed) _____

Client Signature: _____ Date: _____

Program Staff Name (printed) _____

Program Staff Signature: _____ Date: _____

Facility Name: _____

Additional Comments: