LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
SERVICE AREA 2 QUALITY IMPROVEMENT COUNCIL (QIC) MEETING

May 19, 2022
10 am

Type of meeting:	Virtual Microsoft TEAMs
Meeting Link:	https://teams.microsoft.com/l/meetup-join/19%3ameeting_MDM0Y2M5NzUtNmU2Yy00M2RlLTk3Y2ItNmQwODEzNDllNzhi%40thread.v2/0?context=%7b%22Tid%22%3a%2207597248-ea38-451b-8abe-a638eddbac81%22%2c%22Oid%22%3a%22d58ce716-744e-43bb-bc24-43fa428e2ab1%22%7d
Members Present:	See table below

Aubrey Ferman RSA
Cheryl Driscoll Hillview
Connie Kessinger DMH Home
Dave Mendez RSA
Heylee Barriola Didi Hirsch
Iliana Martinez ECDA
Jeanine Caro-Delvaille C & F Ctr
Jennifer Regan DMH QI
Jesus Romero, Jr. DMH SA 2 DC
Julie Jones Hillview
Katy Ihrig DMH SCVMHC
Kristen Fraley TTC

Leslie A. DiMascio
SFVCMHC, INC

Marina Martin DMH
SFMHC

Megan McDonald TWGH

Michelle Rittel DMH SA 2

Sherry Winston TTC

Tiger Doan APCTC

AGENDA ITEMS	DISCUSSIONS/RECOMMENDATIONS/ACTIONS OR SCHEDULED TASKS	RESPONSIBLE UNIT/STAFF

Welcome- Introductions & Agency Updates – Review of Agenda	Quality Improvement
	• Knowledge Assessments
	• ASL Clinical Appts
	• Access to Care
	Quality Assurance
	• QA on the Air
	• CalAIM
	  • New Criteria to Access SMHS
	  • Diagnosis Codes
	  • No Wrong Door
	  • Documentation Redesign
	  • Screening/Transition Tools
	  • Payment Reform
	  • Peer Support Services
	• Training & Operations:
	  • LE Chart Reviews
	  • QA Knowledge Assessment
	  • Collaborative Documentation
	  • LE Workgroup on Documentation Redesign
	• Policy & Technical Development:
	  • FINAL QA Bulletin Continuity of Care
		ALL

	• Concurrent Review Update • Procedure Codes • Access to Care • Upcoming webinars	
SERVICE AREA EMAILS SENT	• TUESDAY MAY 10 • UPDATED: Medi-Cal Certification Checklist and Medi-Cal Certification Documents Submission Guideline for DO and LE Providers (4-26-2022) • DRAFT OF MARCH 2022 SA 2 ADULT QIC MTG MIN	Kimber/All
QA Knowledge Assessments	Dr. Borkheim presented on QA Knowledge Assessments: highlight the utility and purpose of the knowledge assessments. clarify misunderstandings	Marc Borkheim, Ph.D.
QI UPDATES	**QI UPDATES**	**QI UPDATES** Provided by QI Staff (Provided by Kalene Gilbert, LyNetta Shonibare, Jen Regan, Daiya Cunnane) – reported by Kimber
CCU ASSISTING WITH ASL CLINICAL APPTS	▶ The cultural competency unit now has the responsibility of scheduling ASL clinical appointments for business hours and that covers the hours between 8:00 AM and 5:00 PM. And we have developed a particular mailbox for all the clinics to submit requests ▶ For the purpose of scheduling ASL services during business hours, please utilize our mailbox: **ARDIaccessibility@dmh.lacounty.gov** ▶ Anti-Racism, Diversity & Inclusion (ARDI) Division	Provided by by Sandra Chang – reported by Kimber
ACCESS TO CARE DATA REVIEW from the Countywide QI Council Meeting May 16, 2022	Discussion of the system wide summary: • Q1 2022 • 2021 Q3 vs Q4 vs 2022 Q1 • Number of referrals by Service Area Q1 2022 • Percentage of timely appts by Service Area Q1 2022	Provided by David Crane – reported by Kimber

QA UPDATES	QA UPDATES	QA UPDATES Provided by QA Staff (Provided by Brad Bryant, Jen Hallman, Nikki Collier) – reported by Kimber
QA on the Air	**May 25th from 9:00-10:00** The topic will be "**Documentation Requirements**"	
CalAIM	**Effective January 1, 2022 New Criteria to Access SMHS & Medical Necessity** **Criteria to access SMHS and Medical Necessity are now separate** ○ **Criteria to Access SMHS:** Applies to a person (is this person eligible to receive SMHS?) ○ A mental health diagnosis is no longer a prerequisite for receiving SMHS ○ No more "Included" Diagnosis List – can be a mental health disorder or suspected mental health disorder not yet diagnosed per DSM and ICD ○ Those w/ a condition placing them at high risk due to trauma are able to access SMHS ○ **Medical Necessity:** Applies to services (is the service provided clinically appropriate?) Reminder -- Frequently Asked Questions posted at: http://file.lacounty.gov/SDSInter/dmh/1119877_QABulletin21-08FAQs.pdf **Only update is to NOABD status** **Beneficiary Handbook** ○ Waiting for DHCS to provide us with the template **NOABD –Service Delivery form** ○ Finalized and will release shortly; will also update form in IBHIS (for DO) and the NOABD application (for LE) **Existing Training Videos on the QA website** ○ Reimbursement and Claiming Module has been updated to reflect the new criteria and medical necessity language	Provided by QA Staff (Provided by Brad Bryant, Jen Hallman, Nikki Collier) – reported by Kimber Provided by Brad Bryant- reported by Kimber

	○ Evaluating when/how to modify other modules given known changes coming to documentation requirements in July **Chart Review Tools** ○ The Legal Entity Chart Review Tool has been updated for the Chart Reviews by the Training & Operations Team ○ In the process of reviewing the Directly Operated Chart Review Tool **Policy Updates** ○ In the process of reviewing and updating with the new criteria and requirements; Policy 302.14, Policy 401.02, Policy 312.02 **<u>Diagnosis Codes Information Notice</u>** The following options during the assessment phase may be used when a diagnosis has yet to be established: ○ Non-Diagnosing Staff may use Z55-Z65 ○ Diagnosing Practitioners may use any appropriate, valid ICD code including Z codes QA has developed a draft proposal that takes into account concerns with ensuring clients' needs are best met while also monitoring to ensure non-diagnosing practitioners can't accidently use diagnosis codes other than the identified Z codes **<u>QA Proposal</u>** First contact with the client may be with whomever can best meet the needs of **what the client is requesting/needing** (e.g., may be with a case manager). ○ Goal is to prevent clients having to be seen for assessment even though their immediate need is for Crisis Intervention, TCM and/or MSS ○ Will stop the access to care "clock" even if not for a formal Assessment	

	○ Should be actively working to get in for assessment while doing these services ○ Prevent having to claim non billable or COS for these activities ○ May <u>not</u> do just because an assessment cannot be provided timely • Still need Consent for Services (unless crisis intervention) and other intake processes prior to this contact • If first contact is with a non-diagnosing staff: ○ An Assessment form should not be completed at this time ✓ Minimally need to complete State standardized screener to determine SMHS eligibility and progress note should explain need for services ✓ Best practice is to do Assessment (with someone who can diagnose) as soon as possible and in accord with clinically accepted practice or, if first contact is Crisis Intervention, to refer client to Assessment, as applicable - Need guardrails around when an Assessment should be completed (e.g., within 30 days) or documentation of attempts to engage for assessment ○ Non diagnosing practitioners can use Z55-Z65 ICD codes ○ For DO: Create ability to limit codes in the Diagnosis form to Z codes or have clinical supervisor enter the diagnosis (Z55-Z65) in the Diagnosis Form on behalf of non- diagnosing practitioner **<u>No Wrong Door- Coming July 1, 2022</u>** Clinically appropriate and covered SMHS are covered and reimbursable Medi-Cal services even when: ○ Services are provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met:	

	○ The beneficiary has a co-occurring mental health condition and substance use disorder (SUD); or ○ NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated. **Status/Update:** ○ Will be developing a QA Bulletin regarding No Wrong Door ○ Based on our initial reading, ○ For #1, implemented with the New Criteria Jan 1, 2022 ○ For #2, continue with practice that treating diagnosis should be the primary (i.e., the mental health diagnosis) however there will be no disallowances if the substance use is the prim ○ #3 is more of a change for the MCPs that have been reluctant to continue with treatment when referring to the MHP. **<u>Documentation Redesign - Coming July 1, 2022</u>** **Assessments** ○ Greater integration of the CANS ○ Requirements will focus on "domains" that are required and not specific data elements ○ No frequency requirements – update as clinically needed **Treatment Plans** ○ Only required for TCM, ICC, and Peer Support Services ○ No specific data element requirements ○ Medication Consent is still required **Problem List** ○ Should be updated regularly/ongoing basis **Progress Notes** ○ Should support the service provided ○ Include narrative describing the service, including how it addressed the identified need ○ Include next steps (planned action steps, updates to the problem list) **Status/Update:** ○ Finale DHCS Information Notice released	

	○ Drafting QA Bulletin and brief training video, updating Organizational Providers Manual ○ All requirements for LE providers will be in the Organizational Providers Manual – up to LEs how they implement in their EHRS 2. For DO providers, we are conducting "QA Roadshows" to get feedback on proposed form changes and working to finalize forms **Assessment** ○ **DMH Proposed Policy Changes**: ○ Removal of triannual and addendum Assessment form requirements ○ Clinical discretion for re-assessments (i.e., when client comes back into treatment) instead of always required, will have factors that would suggest need for re-assessment ○ Initial Medication Evaluation (IME) may serve as the assessment if the MD is the most appropriate first contact for the client (i.e., a clinician would not need to come in and do another assessment after) ○ Will look at how to make viewing the IME easier for staff to view in IBHIS ○ **DMH Proposed IBHIS Form Changes:** ○ Current assessment forms meet requirements of these domains so no immediate form changes on July 1 ○ Want to modify the form in IBHIS to make more user friendly and streamlined based on user-feedback – ETA is **October 1st** ○ We have heard from users that the assessment forms are repetitive, take too long, and cause delays in client's getting to treatment ○ We have also heard from users that they want to integrate more information from elsewhere in IBHIS into the Assessment forms	

	- Plan will be to discontinue the use of all current Assessment forms and create new form(s) - There will be no Assessment Addendum form **One assessment form for all client age groups**, with questions populating based on the selected age **Incorporating the CANS or NET questions** into each of the respective domains **Only Seven (7) Free Text fields:** one for each required domain **Incorporating the 17 PCL questions** to the Trauma section for adult assessments **Functionality to bring in / auto-populate information** already entered in IBHIS (e.g., Client Contacts, Demographics, IBHIS history, DCFS contact name/number) **Incorporating the GAD-7, PHQ-9, PHQ-A, PSC-35 and PCL-5 score -** keep the ability to launch the form to complete, then have the score and interpretation of the score pulled into the assessment **For Medical History Section, populate fields if medical concerns identified** - starting with “Are there any medical concerns,” and if “yes” is selected, will have the ability to multi- select from different medical issues 8. For Developmental Milestones – populate fields if delays/issues identified 9. Template for clinical formulation **Problem List** **Medi-Cal Policy:** - A problem identified during a service encounter may be addressed by the service provider (within their scope of practice) during that encounter and subsequently added to the Problem List - Anyone on the treatment team can add problems to the Problem List, not just diagnosing practitioners **DMH Proposed Policy Changes:**	

	○ Problem list will be used to reflect a client's current presentation instead of adding new information on an assmt or CTP ○ **DMH Proposed IBHIS Form Changes:** ○ Form already in IBHIS but will incorporate/focus on more ○ Will account for Problem List in the Progress Notes *(refer to Progress Note changes)* **Treatment Plan** ○ **Medi-Cal Policy:** ○ Formal Client Treatment Plan requirements will no longer be required ○ Care Plans will only be required for Targeted Case Management, Intensive Care Coordination, Peer Support Services, STRTP services and shall be documented in the Progress Note ○ Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the beneficiary ○ Includes activities such as ensuring the active participation of the client and working with the client to develop those goals ○ Identifies a course of action to respond to the assessed needs of the beneficiary ○ Includes development of a transition plan when a beneficiary has achieved the goals of the care plan ○ **DMH Proposed Policy Change:** ○ No longer require progress notes to be associated with an objective/intervention on the Client Treatment Plan ○ No more formal annual and update Client Treatment Plans for MHS and MSS	

	○ No longer need to obtain client signatures, write measurable and specific goals and objectives and document duration/frequency of interventions ○ Care plan for TCM and ICC can be documented within the note ◦ **DMH Proposed IBHIS Form Changes:** ○ Will remove the following: ○ Client Treatment Plan form ○ Treatment plan elements in the Medication Consent/MSS Treatment Plan form (will only be a Med Consent) ○ Treatment plan field in the Progress Note that pulls from the Client Treatment Plan ○ Will add a new Care Plan field in Progress Note *(refer to progress note changes)* **Progress Note** ✓ **Medi-Cal Policy:** ▪ Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description ○ Narrative describing the service, including how the service addressed the beneficiary's need ○ Next steps including, but not limited to, planned action steps by provider or by the beneficiary, collaboration w/ beneficiary & other provider(s), and any update to the problem list as appropriate ▪ Need to submit/finalize progress notes within 3 days of providing the service; exception is for crisis intervention which shall be completed within 24 hours ✓ **DMH Proposed Policy Change:** ▪ Need to document Care Plan if TCM or ICC is provided	

	▪ Focus in note should be about providing a medically necessary Specialty Mental Health Service instead of focusing on linking back to the Assessment and Client Treatment Plan ▪ Notes need to be written within 3 business days except for crisis intervention **<u>Overall Proposed Progress Note Changes</u>** ✓ **DMH Proposed IBHIS Form Changes:** ▪ Phase 1 (July 1): o Will remove the following fields: ▪ "Do any special circumstances apply" ▪ Treatment plan section ▪ "Was this service provided in a language other than English" – will default in language to English o Add a field to view the active Problems, with a button to Launch the Problem List form o Add a free text field for Care Plan ▪ Phase 2 (TBD): o Restructure form: Move progress note text field higher, Move service duration fields, procedure code field, location of service to the end of form o Add drop downs fields or checkboxes to help auto-populate the correct procedure code and modifier o Add "new service" option so notes can be written outside of the Scheduling Calendar **<u>Screening and Transition Tools - Coming January 1, 2023</u>** DHCS will be requiring the use of standardized screening and transition tools across the State Goals of the tools: **Screening tool:** to facilitate accurate determinations of when care would be better delivered in the MCP or MHP service system.	

	Can refer over PRIOR to conducting an assessment (currently requires an assessment before referring) **Transition of care tool:** to support a beneficiary's transition to the other delivery system when their condition changes. **Status/Update:** ✓ LACDMH will be piloting the child tools with several Managed Care Plans – pilot will be from June 20 to Sept 16 ✓ Looking for child providers to participate in the pilot ✓ Contact Cesar Franco (cefranco@dmh.lacounty.gov) if interested **Payment Reform / CPT Codes - Coming July 1, 2023** ▪ No longer bill by the minute: some codes will be in 15 min increments ▪ Pre-Licensure practitioners must have their licensed supervisor's NPI on claims ▪ Will utilize "add-on" procedure codes ▪ Only bill for "direct patient care", documentation/travel time/review of records/etc. will be considered "admin" ▪ Increased use of modifiers ▪ Complex rules around which codes can be billed on the same day **Status/Update:** ▪ DHCS released the Final Billing Manual ▪ DMH has an internal workgroup that is reviewing the Manual to provide greater information to providers – looking to conduct a webinar in July **Peer Support Services** **Effective Date of July 1, 2022 Peer Support Services are a new covered SMHS benefit (LACDMH will be opting in for July 1st)** Peer Support Services: Individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to	

	prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. ◦ Educational Skills Building Groups (H0025) ◦ Engagement (H0038) ◦ Therapeutic Activity (H0038) Peer Support Services are available to parents/legal guardians of beneficiaries 17 years of age and younger when the service is directed exclusively toward the benefit of the beneficiary. Peer Support Specialists providing services to the parents/legal guardians of a beneficiary 17 years of age and younger must have a “Parent, Caregiver, and Family Member” Peer Support Specialist Certification specialization Peer Support Services are provided by Peer Support Specialists. ○ A Peer Support Specialist is an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and who meets all other applicable California state requirements, including ongoing education requirements. ○ Peer Support Specialists provide services under the direction of a Behavioral Health Professional. A Behavioral Health Professional must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider. ○ Peer Support Specialists may be supervised by a Peer Support Specialist Supervisor who must meet applicable California state requirements 1. How does Peer Support Services effect current Peer Advocates and ability to provide services? **It should not restrict what they can do in any way.** 2. Will Peer Support Services require current parent partners or peer staff to be certified?	

TRAINING & OPERATIONS	**If you wish to claim as Peer Support Services, yes, it will require certification**. 3. Would Peer Support Services be for all programs including Wraparound? **It will be for any program that has Medi-Cal funding and the service it's with the program.** **Legal Entity Chart Reviews** • Wrapping up the following current reviews • In the process of coordinating additional reviews for June and July **QA Knowledge Assessment Survey** Survey #5 is now closed • Answer rationales and results will go out soon • Will discuss and get feedback from providers during May service area QICs Previous Surveys available on QA Webpage • https://dmh.lacounty.gov/qa/knowledge-assessment-surveys/ **Collaborative Documentation** Anticipating schedule for next set of General CD Trainings will be available before next Central QA/QI Meeting • Providers will be notified via the subscriber email for this meeting once details confirmed • Direct questions to Wanta Yu at wyu@dmh.lacounty.gov Collaborative Documentation Webpage • https://dmh.lacounty.gov/qa/collaborative-documentation/ **Legal Entity Workgroup on Documentation Redesign** Began last month Allows Contract Providers an opportunity to provide feedback & pose questions regarding Documentation Redesign 2 upcoming (and final) sessions this month • This Thursday, May 12th from 9 – 10 • Thursday, May 26th from 9 -10	

Policy & Technical Development	Contract providers interested in participating • Contact Nikki Collier, NCollier@dmh.lacounty.gov • Welcome to bring their EHR vendors **QA Bulletin 22-03 – Continuity of Care** • Finalized and released QA Bulletin 22-03 regarding Continuity of Care requirements • If an LA County Medi-Cal beneficiary who qualifies for SMHS is seeing a provider that is not a directly operated or contracted provider of LAC-DMH and would like to request continuity of care, a formal request for Continuity of Care shall be made to the QA Unit (email NetworkAdequacy@dmh.lacounty.gov) or call 213-943-8268 • If a Medi-Cal beneficiary is seeing a provider that is a directly operated or contracted provider of LAC-DMH and either transfers their Medi-Cal to another county of jurisdiction or no longer qualifies for SMHS, the beneficiary may request continuity of care to their new network of care. **Concurrent Review Requirements** • DMH is planning to implement Concurrent Review requirements for Psychiatric Health Facilities (PHF), Crisis Residential Services and Adult Residential Services beginning in July • We will have a meeting of PHF, CRTP and the one ARF providers to review the concurrent authorization protocol during the week of May 16 **Procedure Codes** Summary of upcoming changes: • POS 10 – Telehealth when the client is located at their home • FFPSA codes (QI Assessment and STRTP Aftercare) • H2010 Group codes (Phone & Telehealth) • ECM & Community Support codes (Directly Operated Only) • Neurofeedback codes – still in discussion around adding **Access to Care: NAPPA - Provider Directory – SRTS** • Network Adequacy is a key factor in Access to Care	

	• If we do not have enough providers accepting new clients, then timely access will suffer • NAPPA, the Provider Directory, and the SRL/SRTS are core to Network Adequacy and Access to Care **NAPPA** Providers enter pertinent information about their sites and capacity in NAPPA: • Accepting/Not Accepting New Clients • Programs available • What age groups they serve • Accessibility **Info helps us know if our network is adequate** **Provider Directory** Consumers and providers (including ACCESS agents, SFC, navigators, etc.) use the directory to find provider sites who can see new clients. **SRTS / SRL** • Referrals that need to be transferred to another provider are sent to providers via SRTS – ensures referrals are followed-up • Programs log requests that do not need to be transferred to another provider using the SRL • Both SRL and SRTS help track A2C in our system. **Info helps us know if we can provide timely access to care** **NAPPA:** Please ensure information is accurate and kept up-to-date! **Provider Directory:** Please take a short survey regarding the Provider Directory - continuing to look at improving the usability and reliability of the Provider Directory as it will be core to Access to Care within the DMH System of Care **SRL/SRTS:** Please ensure all requests for care are logged in the SRL/SRTS. All providers with General Outpatient or PEI should be registered in the SRTS. (still working through completing all LE requests for access to SRTS 2.0 which went LIVE on May 2nd.)	

Electronically Signed & Respectfully Submitted by:
Kimber Salvaggio

SA 2 Adult QIC Chair
NEXT MEETING:
July 21, 2022 10 am
Via TEAMs