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 18, 2023
10 am-11:30 am

Type of Mtg:	Virtual Microsoft TEAMs
Meeting Link:	https://teams.microsoft.com/l/meetup-join/19:meeting_MDM0Y2M5NzUtNmU2Yy00M2RlLTk3Y2ItNmQwODEzNDllNzhi@thread.v2/0?context=%7B%22Tid%22:%2207597248-ea38-451b-8abe-a638eddbac81%22,%22Oid%22:%22d58ce716-744e-43bb-bc24-43fa428e2ab1%22%7D

Members Present:	
Arlin Adwani	Tarzana Treatment Centers
Armen Yekyazarian	LACDMH QA
Cheryl Driscoll	Hillview MHC, Inc.
Claudia Morales	Pacific Asian Counseling
Dave Mendez	Rancho San Antonio
Dora Escalante	Jewish Family Service
Elidia Olmos	Santa Clarita Valley MHC
Evelyn Ramos	The Help Group Child and Family Center
Grace Florentin	Pacifica Hospital of the Valley Behavioral Health Urgent Care Ctr
Gwendolyn Thomas	Rancho San Antonio
Heather Bowen	The Help Group
Iliana Martinez	El Centro de Amistad
James e. Walters	west valley mental health
Jeanine Caro-Delvaille	Child & Family Center
Karely Gutierrez	The Village Family Services

Katy Ihrig	SCVMHC
Kaylee Devine	Tobinworld
Kevin Crandall	Pacifica Hospital of the Valley
Leslie A DiMascio	SFCMHC, Inc
Lezly Zavala	Children's Bureau
LyNetta Shonibare	Olive View MHC
Megan McDonald	TWGH/ACT Health and Wellness
Michele Burton	The Help Group
Michelle Rittel	DMH SA2 Administration
Myan Le	LACDMH Quality Improvement
Priscilla Peraza	Penny Lane centers
Sherry Winston, LMFT	Tarzana Treatment Center
Stephanie Ochoa	Star View
Tiffany Rabbani	Tarzana Treatment Centers
Tyler London	Penny Lane Centers

AGENDA ITEMS	DISCUSSIONS/RECOMMENDATIONS/ACTIONS OR SCHEDULED TASKS	RESPONSIBLE UNIT/STAFF
Welcome-Introductions & Agency Updates – Review of Agenda	**Welcome – Introductions - Announcements** **Quality Improvement** • CPS 2023 Updates — Myan Le • CANS/PSC Tips — Jeanine Caro-Delvaille **Quality Assurance** ➢ QA Website Highlights and FYIs — Armen Yekyazarian, QA ➢ QA on the Air ➢ **CalAIM** ➢ *Survey Findings from last month* ➢ *New Criteria to Access SMHS* ➢ *No Wrong Door* ➢ *Diagnosis Codes*	All

	➢ *Documentation Redesign* ➢ *Peer Support Services* ➢ *Screening/Transition Tools* ➢ *Chart Review and Training* ➢ Payment Reform • **Training & Operations:** ➢ LE Chart Reviews ➢ QA Website Updates ➢ Trainings in Development • **Policy & Technical Development:** ➢ Changes to IHBS Pre-Authorization ➢ Directly Operated QA Process/Chart Reviews ➢ Access to Care ➢ Network Adequacy: NAPPA • **Upcoming webinars**	
Quality Improvement	**Quality Improvement**	**Quality Improvement**
UPDATES	CPS Updates	Daiya Cunnane, QI unit Provided by QI Staff (Provided by Kara Taguchi, Daiya Cunnane) – reported by Kimber
Quality Assurance	**Quality Assurance**	**Quality Assurance**
UPDATES	Certifications – nothing currently QA Website Highlights and FYIs Discussion led by Dr. Armen	Provided by QA Staff (Provided by Brad Bryant, Jen Hallman, Nikki Collier) – reported by Kimber
QA ON AIR	The next QA on the Air will be held on **Wed., May 24th from 9:00-10:00**	
CalAIM	What have providers done to communicate changes/change the culture? • Trainings, viewing as a team • Meetings – clinical, all staff, supervision, change management, case conferences	

	• Constant reminders and communication • Real time feedback as progress notes are submitted • Trickle down starting with Leadership What additional support is needed to realize the benefits of CalAIM? • Sample notes, assessments • Examples of expected durations for services • Live & recorded trainings from DMH • Collaborative documentation trainings • Reduce caseloads (too many clients/staff are still overwhelmed) • Specific documentation training for community workers, peers • Concise list of changes • Educating clients/community on Specialty Mental Health Services • Guidance on writing a good progress note • Infographics/graphics to help simplify the changes • Examples of care plans – specifics on requirements for the care plan • Time CalAIM Quiz • Addresses basic understanding of key CalAIM initiatives • https://forms.office.com/g/v5Ke2thegE • Please encourage staff to complete the quiz!! Reviewed previously released CalAim info: • New Criteria to Access SMHS & Medical Necessity • No Wrong Door • Diagnosis Codes Information Notice • Documentation Redesign • Peer Support Services • Screening and Transition Tools ➢ **Manage Care Plan (MCP) Contact List updated 4-5-23 – to create as a Clinical Form** ➢ **(DO) Service Request Log in IBHIS updated 3-10-23** ➢ Screeners embedded ➢ Updated dispositions (e.g., Appointment given, Screened & referred to MCP) ➢ **Service Request Tracking System (SRTS): updates to be LIVE 4-17-23** ➢ Screeners embedded / Updated & New dispositions	

	➢ ACCESS agents – trained on the SRTS/Screeners this week ➢ **Coordination of Care between MCPs & LACDMH** • Updates in SRTS – ETA 4-17-23 DISPOSITIONS	
Legal Entity Chart Reviews	**Chart Review and Training** To achieve the improved access to care and streamlined administrative requirements goal of CalAIM, it is crucial that LACDMH and its network of providers fully embrace the new requirements under CalAIM. To achieve this, the following documents have been updated: • Chart Review Tool, • QA Requirements for Directly-Operated and LE's • QA/QI Report for Legal Entities to account for the new requirements. **Non-compliance with documentation requirements will not have accompanying recoupment** • **Shifted reasons for monetary disallowances to instances of fraud, waste and abuse as identified in the DHCS Medi-Cal Specialty Mental Health Services Reasons for Recoupment Fiscal Year 2022-2023** All new and existing providers and practitioners are strongly encouraged to view the videos prior to service delivery. • Standardized Screening Process • Access to Care Timeframe Reminders • Criteria to Access SMHS and Medical Necessity • Documentation Requirements • Reimbursement & Claiming • Standardized Transition Process **QA Bulletin:** https://file.lacounty.gov/SDSInter/dmh/1137613_QABulletin23-02ChartReview_TrainingUnderCalAIM.pdf **Chart Review Tool:** https://file.lacounty.gov/SDSInter/dmh/1137357_LACoMHP_ChartReviewTool.pdf **Reasons for Recoupment:** https://www.dhcs.ca.gov/Documents/BHIN-22-063-Enclosure-3-SMHS-Reasons-for- Recoupment-FY-22-23.pdf **Training:** https://dmh.lacounty.gov/qa/qa-training/ **Upcoming Reviews** • Working on summary reports and coordination of related meetings for recent reviews • In the process of coordinating additional reviews	

Payment Reform / CPT Codes	**Payment Reform / CPT Codes** ▪ No longer bill by the minute: some codes will be in 15 min increments ▪ 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 **Key Concepts Under Payment Reform** 1. **The most specific code to describe the service should be used whenever possible** • CPT codes (codes beginning with a number) describe specific services and should be used whenever possible • Majority of CPT codes already in use by LACDMH but some will need to be modified in use to align with Federal definitions • Add-On codes will be utilized to further describe the service (e.g., additional time and/or complexity) • HCPCS codes (codes beginning with a letter) are more generic and may be used when a CPT code is not available • Some HCPCS already in use or will be replaced with new ones (e.g., H2017 instead of H2015) • Students of clinical disciplines (e.g., social workers) will only be allowed to use HCPCS • Modifiers (two characters added to a procedure code) will be used to further defined a CPT or HCPCS code 2. **Claims shall be by Units of Service instead of by the exact minutes** • Some CPT codes are determined by the minute range and the Unit will always be one (1) • Some codes (mostly HCPCS) are claimed based on 15-minute increments 3. **Focus should be on direct patient care: only Direct Client Care is billable** • For the client care codes (e.g., therapy or evaluation and management), direct client care means time spent with the client for the purpose of providing healthcare. Note: AMA allows code selection to include time with parent/caregiver. Will confirm with DHCS.	

- For a consultation code, direct client care means time spent with the consultant/members of the client's care team. Note: For a TCM code, the activity requires completing forms. Will confirm with DHCS.
- Direct patient care does not include travel time, administrative activities, chart review, documentation, utilization review and quality assurance activities or other activities a practitioner engages in either before or after a client visit. Should acknowledge that no longer have to pay attention to the exact minutes

4. **Reimbursement will be by Provider Type (Discipline) at a Fixed Rate, no matter the service provided**
    - The set rate included documentation and travel time
    - Was set by DHCS for Directly Operated; DMH set for Legal Entities

Payment Reform: Status Update

- Working on a draft version of the Guide to Procedure Codes that will be released in the next two weeks
- There are several outstanding issues we are still awaiting a response from DHCS:
    - Students
    - Collateral
- For Directly Operated, we will be utilizing this as an opportunity to simplify progress note documentation while also deriving the procedure code for the practitioner

Direct Care

For Directly-Operated, QA is working with management to identify changes in what is billable will have on productivity expectations

- Will be focused on how staff are spending their time and ensuring staff can focus on being with clients
- Working to design progress notes in the EHRS so staff do not need to know what is billable and what is not – goal to have drop down lists to derive the procedure code

Collateral

- The recently approved State Plan Amendment (SPA) removed "Collateral" as a Service Component
- Instead it is listed as a method of service contact
- Under Payment Reform, there will no longer be a specific code for "Collateral"
- Instead codes (services) will be identified in which the method of service contact may be a significant support person – e.g. H2017 T1017

	• The Organizational Providers Manual will be updated to account for this and other changes under Payment Reform	
TRAINING & OPERATIONS	**LE Contract Provider Chart Reviews** Recent Reviews: ➢ Optimist Youth Homes ➢ Tobinworld ➢ Los Angeles LGBT Center **TRAININGS IN DEVELOPMENT** ➢ Collaborative Documentation Training-QA Unit will be developing video training for Collaborative Documentation instead of resuming live webinar trainings ➢ QA Knowledge Assessment Survey #6 ➢ Consent in a Mental Health Setting Training Video Collaborative Documentation Training Video Interactive Progress Note Training Module	

POLICY & TECH DEVELOPMENT	QA Bulletin 23-03 Updated Medi- Cal Beneficiary Handbook & Notification to Beneficiaries discussed
	
	Changes to IHBS Pre-Authorization - Effective 7/1/23 with Payment Reform
	• **Pre-authorization will be for one year**
	  • No longer 6 months/9,999 minutes
	• **Must utilize the general P-Authorization on claims**
	  • No longer utilize a specific M-Authorization
	• **Valid for any funding sources within a Legal Entity**
	  • No longer require a new pre-authorization when funding source changes
	• **Initial pre-authorizations**
	  • **Automatically filed when authorized for FSP, IFCCS or Wraparound**
	  • May also request via Provider Connect
	• Subsequent pre-authorizations
	  • Must be requested via Provider Connect
	Directly Operated QA Process
	• We have resumed our QA Process/Chart Reviews for Directly Operated
	  • Edelman Adult will be reviewed in May
	• With CalAIM implementation still the priority, only one provider will be reviewed every 2 months
	• Reviews will utilize the updated Chart Review Tool	

	• Review will focus on clinical services in relation to administration requirements, including efficient utilization of services and timely access to care.
	• The goal of the review is to support the Department's mission to provide high quality Medi-Cal Specialty Mental Health Services (SMHS) to the residents of the County.
	ACCESS TO CARE MEMO
	• CMMD will now confirm Access to Care data with QA prior to approving closure
	• Based on review of current sites not accepting (General Outpatient Care Services & PEI), many do not meet the criteria identified in Policy 302.14
	• Plans of correction will be required
	• If a provider turns away a client due to capacity (i.e., indicates "at capacity" within SRTS and closes the referral or transfers to another provider) and has not been approved by CMMD, must serve the client and submit a POC
	Network Adequacy: Program Selection in NAPPA
	• **QA is reviewing the set-up of providers within NAPPA**
	  • If you have a school-based services, you should select school-based in NAPPA. You do not need to also select PEI (referral only).
	  • Other should be selected very rarely. QA is looking at all "other" selections and will be contacting providers. Prior to selecting "other", send an email to NetworkAdequacy@dmh.lacounty.gov
	  • If you have General Outpatient Care Services (i.e. OCS) or PEI, the expectation is that you will accept any referral from the general public. The accessible by should be phone/walk-in or phone only. Prior to selection any other option, send an email to NetworkAdequacy@dmh.lacounty.gov
	  • QA is developing a "cheat sheet" on program selection to assist in identifying the correct programs.
	Access to Care
	• Have reached over 80% timely access to care with latest data
	• Need to continue to improve Access to Care
	• All providers not currently accepting new clients are strongly encouraged to review workflow and see if they can begin accepting
	  • Some sites have not been accepting for over a year!
	• Will be looking at Urgent appointment timeliness as well as issuing NOABDs for untimely appointments	

	• Network Adequacy/Access to Care webinar on 4/3/23 focused on ways clinics have improved capacity and access to care • https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10578 • All providers are expected to assist in improving access to care • Please join our next webinar to continue the discussion **Network Adequacy: NAPPA** • Providers must continue to ensure NAPPA is updated on a regular basis and all practitioner's information is kept up to date • DMH is currently working to submit NAPPA data to the State on a monthly basis **Access to Care – Big Picture Interventions** • Leverage the flexibility & efficiency that CalAIM provides ➢ Doc Redesign ➢ First Point of Contact • Screening & Transition Tools ▫ Youth & Adult Screening Training: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10551 ▫ Transition of Care Training: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10617 • Monitor & Tracking ▫ Scheduling Calendars / Monitoring Reports • Workflows ▫ If client no shows, then what? **Access to Care – Recommended** • Create standardized intake slots • Have supervisors' complete assessments in order to create more intake slots • Double book appointments due to No Shows (create Stand-By lists, wait 15 min then assign different intake or walk-in) • Create Assessment-only team • Case management/rehab/ or nursing evaluation first when medically necessary • Reduce intake slot duration to increase slots (implement Immediate/Same Day Assessment) • Have clinicians take on additional assessments (increase # of intakes clinical staff are completing per week) • Implement screening and transition tools • Closely monitor intake slots: add slots when appointments going beyond 8 or 9 days out, supplement with supervisor intake slots	

ACCESS TO CARE BEST PRACTICES SHARING

- Shared & discussed Antelope Valley Mental Health Center & Antelope Valley Wellness & Enrichment Center's CAL AIM- ACCESS TO CARE CLINIC REDESIGN
- Shared & discussed Augustus F Hawkins FMHC
- Shared & discussed Long Beach Child and Adolescent Program – Effective Strategies for Improving Access to Care

Policy: 302.01 First Service Contact

- Published on March 6, 2023
- Replaced the Opening Episodes policy (312.02)
- Provides policy and procedures related to first service contacts (including Consent) and timely opening of service episodes
- https://secure2.compliancebridge.com/la cdmh/public/index.php?fuseaction=print.preview&docID=4004

Prior to delivering Specialty Mental Health Services (SMHS) to a client, staff shall:

1. Log the request for services in accordance with DMH Policy 302.14 Responding to Initial Requests for Service
2. Provide the client with the Notice of Privacy Practices in accordance with DMH Policy 502.01 Notice of Privacy Practices
3. Obtain Consent for Services and, if applicable, consent for telehealth and/or telephone services in accord with the procedures section of this Policy
    1. Consent for Services shall be obtained prior to opening an Episode.
    2. Notify the client they may request the DMH Provider Directory at any time;
    3. Offer the client a copy of the Mental Health Plan Beneficiary Handbook and notify it is available upon request in accord with DMH Policy 201.01 Beneficiary Rights & Responsibilities;
    4. For adults, provide information on Advanced Health Care Directives in accordance with DMH Policy 200.01;
    5. Conduct Financial Screening and inform the client of the results in accord with the procedures section of this policy; and,
    6. Open an Episode in the DMH electronic health record (EHR) in accordance with the procedures section of this policy.

The first SMHS provided may be any appropriate service that best meets the needs of the client.

1. Best practice is for the first service to be in-person or via telehealth in accordance with DMH Policy 308.01 Telehealth & Telephone Services, with the exception of record review.

2. The first service may be via telephone in accordance with DMH Policy 308.01 if clinically appropriate and best meets the needs of the client.
3. The first service contact shall include informing the client of the assessment and service process.

302.01: Obtaining Consent for Outpatient Mental Health Services

1. The Consent for Services form shall be used to obtain informed consent for outpatient mental health services.
    1. Verbal consent or electronic signature may be obtained and documented on the Consent for Services form. In the case of verbal consent or electronic signature, information on the Consent for Services form must be made available (e.g., the blank form provided) to the client so the client is aware of what they are consenting to.
2. In most cases, the following individuals can consent for outpatient mental health services:
    1. Adult Clients, 18 years of age and older
    2. Parents/Legal Guardians of clients who are minors
    3. Conservators of clients as designated by the court
    4. Minor Clients, 12 through 17 years of age, who meet State legal criteria as applicable (e.g., Family Code 6924, Health & Safety Code 124260, Family Code 7002, Family Code 7120)
        i. The legal criteria for minor consent are identified in the Consent for Services form, and staff must attest to the criteria being met
        ii. If the minor qualifies under both Family Code 6924 and Health & Safety Code 124260, consent should be obtained under the Family Code.
3. "Qualified Relatives" of the minor using the Caregiver Authorization Affidavit when appropriate (i.e., spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great," or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.)
4. In most cases, the following individuals cannot consent for outpatient mental health services:
    1. Foster Parents
    2. Attorneys
    3. Caregivers not meeting criteria in #2
    4. Social Workers

	5. A Court Order, Minute Order, or DCFS 179MH may be obtained in lieu of the Consent for Services form. The information within the Consent for Services form and the Frequently Asked Questions shall be provided to the client. 6. For emergency psychiatric conditions, completing the Consent for Services form is not required. Consent for Services shall be obtained at the next contact that occurs when the emergency condition has been resolved. 1. In situations where the client appears to be unable to provide written or verbal consent in the standard manner, client engagement in the assessment process may be considered implicit consent. It shall be documented that the potential client was informed that the client's information will be entered into the DMH electronic health information system. 1. The Consent for Services form covers all directly operated providers from which the client receives services. When the client leaves treatment and returns, a new Consent for Services form is required to be signed. 2. If the individual who is eligible to consent for services changes (e.g., legal guardianship changes), a new Consent for Services form shall be obtained. **3.** If, at any point, the client/legal representative wishes to revoke consent for any item on the Consent for Services form, a new form shall be completed. **302.01: Financial Screening & Opening Episodes** Financial Screening 1. Providers must complete financial screening in order to provide the client with a preliminary assessment of whether there will be a fee related to the services in accordance with DMH Policy 807.01. 2. For emergency psychiatric conditions, financial screening is not required prior to services. Upon resolution of the emergency psychiatric condition, the financial screening shall be completed if the client is to continue with services. Opening Episodes 1. For episodes created by DMH and Legal Entity providers, the episode shall be opened at the legal entity level. If an outpatient episode is already open at the legal entity level, another episode is not required to be opened when the client returns for treatment. The episode shall remain open until the death of the client unless otherwise directed by the QA Unit. 2. In most cases, the episode admission date should be the date Consent for Services is obtained. In all cases, the episode admission date shall be no later than the date of the first claimed service.	

	302.01: Service Contacts 1. If the first contact is with a practitioner for whom diagnosing is not within the scope of practice, the following apply: 1. In order to submit claims, a Z55-Z65 Social Determinants of Health ICD code shall be utilized based upon the initial observations of the non-diagnosing practitioner until a diagnosing practitioner can determine the presence/absence of an additional ICD 10 code(s). 2. Non-diagnosing practitioners shall minimally document in the progress note information that supports that the service provided was medically necessary. 2. An assessment shall be done with a practitioner who can diagnose as soon as possible and in accordance with clinically accepted practice. 1. As a best practice, an assessment by a diagnosing practitioner should be started within five (5) service contacts and/or thirty (30) days of treatment unless there is a clear clinical rationale as to why this did not occur. **2.** Once the assessment is completed, the diagnosis shall be updated with the most appropriate diagnosis by the assessing/diagnosing practitioner.	

Electronically Signed & Respectfully Submitted by:
Kimber Salvaggio
SA 2 Adult QIC Chair
NEXT MEETING: JULY 20, 2023, 10 am