COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

Edition 2011-01

Program Support Bureau
550 S. Vermont, 5h Floor
Los Angeles, CA 90020

March 30, 2011

Clinical Records Staff: Rose Esquibel, Director — Phone: (213) 739-6335 — Fax: (213) 739-6298
Jen Eberle — Phone: (213) 738-3770 — Fax: (213) 381-8386
Yvonne Mijares — Phone: (213) 738-2157 — Fax: (213) 381-8386

CLINICAL RECORDS BULLETIN

Important Reminder

Authorized Mental Health Disciplines (AMHD) includes the following disciplines:

- Licensed MD/DO,
- Certified NP, Registered CNS, Registered Nurse (RN),
- Licensed or Registered and Waivered PhD/PsyD,
- LCSW or Registered MSW (Associate Clinical Social Worker - ASW) or Out-of-State Licensed-Ready Waivered MSW, and
- Licensed MFT or Registered MFT (MFT Intern) or Out-of-State Licensed-Ready Waivered MFT
- Students of these disciplines with co-signature

MENTAL HEALTH TRIAGE FORMS

NEW FORMS AVAILABLE ON INTERNET

(http://dmh.lacounty.gov/ToolsForClinicians/clinical_forms.html - Triage)

DMH Official Form Usage

Directly Operated Clinics: *must* use this form, when applicable, in its original format.

Contractors: DMH Optional Clinical Record Forms meaning the forms may be used in its original format when applicable or Contractors may create a triage form of their own in accord with DMH Policy 202.40. ***Please note this Bulletin only discusses the use of the DMH forms and NOT the required Triage Process.***

The Office of the Medical Director, the Clinical Risk Manager, program representatives, and Quality Assurance collaborated in developing new triage forms:

- MH 679-Adult Mental Health Triage
- MH 680-Child Mental Health Triage
- MH 681-SFC Co-Located Mental Health Triage

These forms are for use by Programs who are unable to complete an Assessment on the same day an individual calls, presents or is referred for mental health services and simply giving an appointment time for an assessment is not clinically appropriate or agreed to by the individual. The majority of the content of the Mental Health Triage forms is not new. The forms are a combination of data elements currently on the MH 542-Disposition Screening and elements of a short/brief

PURPOSE OF THE MENTAL HEALTH TRIAGE FORM

The purpose of the Mental Health Triage form is to be able to quickly "triage" individuals in situations in which a detailed Assessment cannot be completed on the same day in order to determine if the individual is in need of immediate services or how quickly the individual needs to be seen. The information gathered during triage is different from that gathered during an assessment in that staff are only getting enough information to make a decision regarding priority of need for mental health services. Triage does NOT determine diagnosis or Medical Necessity. While assessments can take anywhere between an hour and several hours, triage should only take, as an estimate, 20-30 minutes.

assessments. The new Mental Health Triage form clearly identifies areas of safety or risk concerns, as well as, gives a place to clearly document all information that leads to the disposition of service needs and scheduling of priority for individuals seeking services.

While this form assists staff in making a disposition regarding an individual's priority of need for mental health services, staff must continue to use their *clinical judgment* in making decisions. All decisions made regarding disposition should be supported by the documentation on the Triage form. It is important to note on the form where information is coming from (i.e. individual's report, collateral's report, IS Screen Print, telephone call to hospital).

If prior to starting the triage form it is apparent that the individual is in need of an Assessment during the same contact, Triage does NOT need to be done and the usual intake/assessment procedure can occur. If, while completing a triage, it becomes apparent that the individual is in need of an immediate assessment, then staff completing the triage form may go directly to the appropriate "Disposition/Recommendations/Plans" section of the triage form, move to completing an Assessment form, and attach the triage form to be referenced as information is gathered during the assessment.

The Summary/Disposition section MUST be completed on every Mental Health Triage form and clearly state the rational/justification, in the "Summary/Clinical Summary" section, for the disposition marked under "Disposition/Recommendations/Plan" section. The "Disposition/Recommendations/Plan" section must be completed in its entirety.

Other Revised/Obsolete Forms:

- MH 224A-Client Face Sheet has been revised to assist in the triage process. Highlighted sections of the form should be completed during the triage process. For episodes that are opened, the form must be completed in its entirety
- MH 542-Disposition Screening is now OBSOLETE and should no longer be used.
- MH 513-Initial Contact is now OBSOLETE and should no longer be used.

Key Points to Remember:

- The triage forms may be initiated by any appropriately assigned staff but must be completed by an AMHD whenever significant risk/safety concerns are identified.
- Section IV is completed only when the form is completed by a Non-AMHD or for telephone contacts
- MH 224A-Client Face Sheet and IS Screen Prints (if applicable) MUST be attached to the form
- The Mental Status section should not be completed if the contact is by telephone
- All forms MUST be filed and retained in accordance with filing/retention instructions
- Unless an Assessment is completed and documented on the SAME DAY, the form MUST be completed in its entirety
- All relevant information obtained from the individual MUST be documented
- If additional room is needed, an Assessment Addendum form may be used
- Completing the Mental Health Triage form is NOT the same as completing an Assessment

DO YOU KNOW THE ANSWERS TO THESE QUESTIONS? (FOR DIRECTLY-OPERATED PROGRAMS)

1. Does HIV and Aids information go in the Clinical Record?
2. How long must we retain information held in a non-open case file?

Answers on the next page

Retention and Filing of the Mental Health Triage form (For Directly-Operated Programs):
If an episode is NOT opened on the individual on the same day as the triage contact, the form should be filed in a manila folder in a secure, locked cabinet where the files are accessible only to designated staff in accord with DMH Policy 202.38-Non Open PHI File. When a COS or MAA form or any other documentation is completed along with the Mental Health Triage form, a copy of the COS or MAA form should be filed along with the Mental Health Triage form.

If an episode is opened on the individual on the same day as the triage contact, the form should be filed in the Clinical Record sequentially by date (most recent on top) in the Assessment/Plan section.

Implementing the Mental Health Triage forms-Directly Operated Programs:
Effective as of the date of this Clinical Records Bulletin, the new Mental Health Triage forms should be used when appropriate.

Implementing the Mental Health Triage forms-Contract Programs:
Contract providers are not required to use the Mental Health Triage forms so there is no required implementation date of the Triage forms. These forms are optional forms which may be used if a program chooses. Please see the below references for additional information regarding Triage for Contractors.

References:
For additional information regarding Triage and Non-Open PHI Files please see the following New DMH Policies and Procedures located on-line:

- 202.38 Non-Open Protected Health Information (PHI) File
- 202.40 Triage

For additional information regarding claiming for Triage please see the following QA Bulletins:
- QA Bulletin No. 09-07 Opening Date for Episodes
- QA Bulletin No. 09-10 Revised Procedure Code Changes

If you have questions regarding the information in this Clinical Records Bulletin, please contact your Service Area QA Liaison.

c: Executive Leadership Team
District Chiefs
Department QA Staff
Program Heads
Provider Record Keepers
QA Service Area Liaisons
TJ Hill - ACHSA
Nancy Butram - RMD

I KNOW THE ANSWERS TO THOSE QUESTIONS! (FOR DIRECTLY-OPERATED PROGRAMS)

1. The client's HIV/AIDS status is part of a comprehensive Assessment and should be documented in the Clinical Record. However, when releasing this information, DMH staff should be aware that this information should ONLY be disclosed if the client specifically asks DMH to disclose their HIV/AIDS status. It is necessary to ask the client if they would like their HIV/AIDS information disclosed. If they do not, they should specifically state this on the Authorization to Disclose PHI form.
2. All information in a Non-Open PHI File should be maintained for the same retention period as a Clinical Record. Please refer to DMH Policy 202.38 Non-Open PHI File for more information.