Quality Assurance Bulletin
Quality Assurance Unit
County of Los Angeles – Department of Mental Health
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LEVEL OF CARE TOOLS

This Bulletin provides information related to the use of level of care tools for the Los Angeles County Department of Mental Health (DMH) Intensive Outpatient, Outpatient, and Early Intervention continuums of care. A standardized level of care tool allows the system to calibrate service availability to service needs which assists in providing timely access to care, manageable and equitable workloads, and quality care. It also establishes consistent language regarding the needs of clients, service expectations, and approaches to transitioning care across the various levels of care within the DMH continuum of care.

Within the DMH Intensive Outpatient, Outpatient, and Early Intervention continuums of care, DMH selected and implemented the Level of Care Utilization Scale (LOCUS) as the level of care tool for adults 21 and over to improve flow between the levels of outpatient care in 2024. DMH has selected the Child and Adolescent Needs and Strengths (CANS) as the level of care tool for children ages six through twenty (6-20) because it is already a required functional assessment tool for all children receiving Early Periodic Screening, Diagnostic, and Treatment (EPSDT) and Specialty Mental Health Services (SMHS) as initially announced in QA Bulletin 19-02. By selecting the CANS as the level of care tool for children, it reduces the need for an additional required form.

While a level of care tool provides recommendations for level of care, it is not meant to replace the determination of medically necessary services by the treating provider, clinical judgment of the treatment team, or the wishes or preferences of the client. The administration of the tool provides an opportunity to discuss the results with clients in relation to clinical progress the client has made and can empower clients to meaningfully participate in decisions around transitioning to higher or lower levels of care. The tool promotes the concept that clients can and do recover and that there is a beginning, middle, and end to public mental health treatment.

Effective July 1, 2026, DMH implemented new Program Service Exhibits/Expectations (PSE), the primary foundational document that establishes the specific requirements, standardized expectations, and allowable services for a given program, and Specialty Service Exhibits/Expectations (SSE), an addendum attached to a primary PSE, that further defines and tailors the program for a specific subcategory. Each PSE and SSE identifies the anticipated level of care for clients served under the PSE/SSE. The anticipated level of care is intended to be one factor available in determining which model of care (i.e., program) is most appropriate for a client but it is not meant to serve as the determining factor. Many PSE/SSE serve the same level of care, thus, other client factors must also be taken into consideration. In addition, some clients may meet criteria for a PSE/SSE but their level of care score does not fall into the anticipated level. As mentioned above, the use of the level of care tool and score does not replace clinical judgment or determination of medically necessary services. When the client's level of care falls outside of the typical level for the PSE/SSE in which the client is being served, it should prompt a clinical discussion amongst the treatment team and/or the client around the appropriateness of the program. As always, clinical decisions made around the client's treatment should be well documented within the clinical record.

REQUIREMENTS

The LOCUS and CANS are to be used by both directly-operated (DO) and Legal Entity (LE) providers that deliver PSE/SSEs related to the Intensive Outpatient, Outpatient, and Early Intervention continuums of care. The initial level of care tool should be completed along with the initial assessment or immediately following the completion of the assessment and then administered at regular six-month intervals, minimally. If there are significant changes for the client, such as the need for urgent/crisis services, providers should consider if a new level of care tool should be completed. Please note, these are not new requirements and there are no changes to the existing requirements related to completion of the CANS or LOCUS.

Note: If a client only receives crisis intervention or limited assessment services (i.e., does not receive on-going clinical care), the provider is not required to administer a level of care tool. Linkage only teams may, but are not

required to, utilize the LOCUS/CANS to assist in determining the appropriate level of care/treatment program if they have sufficient knowledge of the client to complete the tool. In addition, CalWORKs providers are not required to use the LOCUS.

For information related to training and certification, please refer to QA Bulletin 19-02 for the CANS and QA Bulletin 24-09R for the LOCUS.

FORMS & SUBMITTING DATA

Directly Operated providers:

- LOCUS → Entered directly into Integrated Behavioral Health Information System (IBHIS) and a recommended level of care is generated.
- CANS → Entered directly into IBHIS and, effective July 2, 2026, a recommended level of care is generated.

Contracted providers:

- LOCUS → Available through a LOCUS Application Programming Interface (API) which submits and retrieves LOCUS scores from their own electronic health record (EHR). Must be submitted to DMH within 30 calendar days of completion. A recommended level of care is generated through the API.
- CANS → Available through:
    - a CANS API which submits and retrieves CANS ratings from their own EHR and, once configured in accordance with technical specifications available July 1, 2026, a recommended level of care will be retrievable OR
    - the CANS EPSDT OMA Application which allows providers to submit CANS and, effective June 22, 2026, will generate a CANS level of care.

CLAIMING

If the LOCUS/CANS is administered as part of a claimable service (e.g., assessment, treatment planning, therapy), the time spent administering the LOCUS/CANS with the client may be included in direct care. The LOCUS/CANS is not claimable as a stand-alone activity in the absence of a client interaction.

BEST PRACTICES

1. While any practitioner who has sufficient knowledge of the client and has completed LOCUS training/is certified in the CANS can complete the CANS/LOCUS, it is up to the Program Manager to determine which disciplines are best suited for completing.
    a. “Sufficient knowledge” is defined as knowledge of the client’s level of risk for engaging in harmful behaviors, their current functional status, presence and severity of co-morbidities impacting their social and emotional functioning, the level of social support and stress in the client’s daily life, the client’s treatment and recovery history (including history of relapses and trauma) and engagement and recovery status.
    b. Typically, practitioners completing the CANS/LOCUS should minimally have provided a service to the client within the last month and should have reviewed the clinical record, including progress notes from other treatment team members.
    c. In circumstances where a client is only receiving limited on-going services and may only see a psychiatrist regularly, a Registered Nurse may administer the CANS/LOCUS with the client while evaluating the client, taking vitals and/or providing medication education prior to meeting with the psychiatrist.

2. It is best practice for the CANS/LOCUS to be completed with the client/collateral during a previously scheduled/planned service contact (i.e., assessment, rehabilitation, treatment planning).

a. For the initial administration of the CANS/LOCUS, it is best to complete it as part of the initial assessment or initial treatment planning session. As practitioners become more proficient at administering the tools, it will be easier to incorporate the dimensions of the CANS/LOCUS into components of the initial assessment.
b. Subsequent CANS/LOCUS administrations should be completed as part of a clinical service (e.g., "Today, we are discussing your treatment needs") and not as an administrative exercise (e.g., "I am calling to complete your CANS/LOCUS because it is overdue").

3. The CANS/LOCUS should be used as a way to ensure all members of the treatment team, the client and any significant supports are all on the same page regarding the client's needs in treatment and level of care.
    a. Practitioners who complete a CANS/LOCUS should strive for shared agreement by those who are involved in the client's care on the ratings/scores, the overall assessment of the client and the accompanying treatment plan.
    b. Practitioners completing the CANS/LOCUS should talk with the client about what the CANS/LOCUS ratings/scores are, what it means, and how it matches with how the client/significant supports feels about their treatment needs and progress.
    c. Within treatment teams, space should be created for case consultations through routine weekly team consultations or joint sessions with the client/family in order to discuss level of care ratings/scores and any differences in views.

4. Administration of the CANS/LOCUS should include recovery messaging and focus on how the results of the administration impact the treatment needs of the client.
    a. The CANS/LOCUS identified level of care should be used as a way to identify treatment progress, make treatment adjustments, including referrals to other services or programs, and to validate the continued need for SMHS. Engaging in the conversation around level of care is a great opportunity to discuss treatment goals and additional service/program needs.
    b. While administering the CANS/LOCUS, practitioners should reinforce that treatment in SMHS should focus on defined treatment targets and client goals with the goal to transition to Non Specialty Mental Health Services through the Managed Care Plans (MCP), Fee-For-Service Medi-Cal providers or other community supports once goals are achieved and the client no longer meets criteria for SMHS.
    c. Treatment teams and clients should utilize motivational interviewing to engage clients in readiness for change and discuss any concerns that the client will "relapse" if they leave DMH services and talk through ways to mitigate these concerns such as the use of certified peer support specialists, natural supports or WRAP plans.

5. When clinical judgment and the CANS/LOCUS assigned level of care indicate the client is ready to transition to a lower (or higher) level of care, referrals to other appropriate PSE/SSE should be made.
    a. While a change in CANS/LOCUS score should prompt discussions around transition to a lower/higher level of care, if it is determined a transition is appropriate, transitions and referrals should be done in a clinically indicated way. For example, if the client now scores a level 4 and it is determined Day Treatment Intensive would be appropriate, a referral may be made immediately after discussion with the client. If the client now scores a level 1 and it is determined the client is ready for Non SMHS through their MCP, a certified peer specialist or certified community health worker may be assigned to the client to discuss the transition and prepare the client. As soon as the client/treatment team are ready for the transition, a transition of care tool shall be submitted to the MCP.
    b. When transitioning to another PSE/SSE, the most recent completed CANS/LOCUS should be sent along with the referral and the receiving provider should review along with any other clinical documentation.

c. The receiving provider should accept the most recent CANS/LOCUS identified level of care and should not complete a new one for another six months (from the last completion date) unless clinically indicated (such as in the case of crisis services or significant change for the client).
d. If transitioning to an MCP, follow the guidelines outlined in the DHCS Transition of Care (TOC) training video: https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10617. Before transitioning (referring) a client to an MCP, staff must verify the client's current financial eligibility/benefit coverage and confirm the correct plan assignment. This is important to ensure the TOC is sent to the appropriate payer/plan, since some clients may no longer have active Medi-Cal MCP coverage or may have other primary coverage requiring a different referral pathway. Please note: DMH will be updating the training video with more detailed information on verifying financial eligibility in the coming months.

Managers and supervisors should monitor differences between actual and recommended levels of care, especially differences of more than one level, to ensure agreement amongst treatment team on assigned levels of care and consistent rating/scoring practices. Managers and supervisors should also monitor that clients are receiving services congruent with the actual assigned level of care.

The attachment on Levels of Care includes the level of care score and associated continuum of care, program(s) and service frequency to assist practitioners when treatment planning with clients as of July 1, 2026.

If DMH directly-operated or contracted providers have questions related to this Bulletin, please contact the QA Policy & Technical Development team at QAPolicy@dmh.lacounty.gov. For technical assistance on the CANS/LOCUS tools, please contact the Outcomes team at levelofcare@dmh.lacounty.gov.

cc: DMH Executive Management
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Levels of Care

Programs and frequency of service contact listed below are the "typical" or suggested and provide some guidance to practitioners to lead discussions around treatment planning. The Level of Care listed below corresponds with the actual level of care assigned via either the LOCUS or CANS.
Note: Specialty Service Exhibits/Expectations (SSE) are only listed if the typical level of care for the SSE falls outside of the typical level of care for the PSE.*

Level 6 (not applicable for the CANS)	Continuum of Care	Hospital & Acute Care Services Subacute & Long Term Care Services
	Program(s)	✓ Psychiatric Inpatient Hospital ✓ Psychiatric Health Facility ✓ Skilled Nursing Facility
	Service Contact Frequency	24-hour treatment programs
Level 5	Continuum of Care	Residential Treatment Services
	Program(s)	✓ Crisis Residential Treatment Program (CRTP) ✓ Enriched Residential Services (ERS) ✓ Residential for Eating Disorders ✓ Short-Term Residential Therapeutic Program (STRTP)
	Service Contact Frequency	24-hour treatment programs
Level 4	Continuum of Care	Intensive Outpatient
	Program	✓ Day Treatment Intensive (DTI) ✓ Day Rehabilitation (DR) ✓ Assertive Community Treatment (ACT) ✓ Homeless Outreach & Mobile Engagement (HOME) ✓ Child & Youth Full Service Partnership (Child & Youth FSP)
	Service Contact Frequency	Multiple contacts per week
Level 3	Continuum of Care	Intensive Outpatient Outpatient Services Early Intervention
	Program	✓ Full Service Partnership – Intensive Case Management (FSP-ICM) ✓ Outpatient Care Services ✓ Child & Youth Wellbeing ✓ Intensive Services Foster Care (ISFC) ✓ Coordinated First Episode Specialty Care
	Service Contact Frequency	Weekly interventions, depending on the type of service. Peer services or Evidence Based Treatment may be more frequent.
Level 2	Continuum of Care	Outpatient Services Early Intervention
	Program	✓ Outpatient Care Services ✓ CalWORKs ✓ Child & Youth Wellbeing ✓ Family Preservation
	Service Contact Frequency	1-2 times/month or less, depending on type of service. Focus on groups and peer services and supports.
Level 0 & 1* (Level 0 is not applicable for the CANS)	Continuum of Care	Non Specialty Mental Health Services
	Program	✓ Managed Care Plan (MCP) ✓ Fee For Service Medi-Cal (e.g., Primary Care) ✓ Graduation from mental health services
	Service Contact Frequency	N/A

* Follow the guidelines outlined in the DHCS Transition of Care (TOC) training video. Before transitioning (referring) a client to an MCP, staff must verify the client's current financial eligibility/benefit coverage and confirm the correct plan assignment. Please refer to the Verify Eligibility Before TOC document.