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QRTips

Behavioral Health Services
Authority and Quality Improvement Services
Quality Assurance & Quality Improvement Division
AOABH / CYPBH / Managed Care / Certification and Designation Support Services Teams

CANS and PSC 35 Reminders

AQIS Data Analytics and the BHS IRIS Liaison Team are beginning to send out error corrections to programs completing CANS and PSC-35. Please be on the lookout for e-mails in the coming weeks and months.

One reminder: if you are working with a client and never have a chance to complete CANS and/or PSC-35 before the client discharges from services, do not complete a Discharge or Administrative Close CANS/PSC-35 without an Initial in the chart first. Doing so will cause an error that will need to be corrected. If you do not have a chance to complete CANS and PSC-35, simply notate this in your Discharge Summary and progress note.

For further questions please contact Andrew Parker, BHSIRISLiaisonTeam@ochca.com

Telephone Assessment Services

With many COVID-19 restrictions beginning to relax, the Department of Health Care Services (DHCS) will begin issuing updated guidance on flexibilities granted during the pandemic. One of the updates coming sooner rather than later will be regarding telephone assessment services. More specifically, telephone assessment services will no longer be permitted at some point in the near future. AQIS will provide an update on the exact date DHCS plans to disallow telephone assessment services once that information is dispersed by DHCS. In the meantime, please plan future intake appointments accordingly as they relate to telephone services. Please note that telehealth services will continue to be allowable and should be utilized as deemed appropriate. As a reminder, telephone services involve just an audio component while telehealth services involve an audio and visual component meaning the provider has to be able to see the client/beneficiary for the service to be considered telehealth.

TRAININGS & MEETINGS

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AOABH Online Trainings

New Provider Training (Documentation & Care Plan)

2020-2021 AOABH Annual Provider Training

AOABH MHP QI Coordinators' Meeting

WebEx Mtg. 7/1/21 10:30-11:30am

CYPBH Online Trainings

2020-2021 CYPBH Integrated Annual Provider Training

CYPBH MHP QI Coordinators' Meeting

WebEx Mtg.8/5/21 1:00pm-2:30pm

**More trainings on CYPBH ST website*

HELPFUL LINKS

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AQIS AOABH Support Team

AQIS CYPBH Support Team

BHS Electronic Health Record

Medi-Cal Certification

Community Functioning Evaluation (CFE) Refresher

The Community Functioning Evaluation (CFE) is a required document that is to be completed during the initial assessment and on an annual basis along with the Psychosocial, Dx Form, and Care Plan. The CFE includes nine sections to assess for impairments related to mental illness in the client/beneficiary's life. The CFE helps to identify mental health symptoms that lead to behaviors which lead to impairments. Providers should use this "formula" as a guide when completing the CFE to make it clear how the different areas of functioning are impacted by the client/beneficiary's mental health. Recent audits indicate providers are not including behaviors or impairments in some areas of functioning identified to be impacted by the client/beneficiary's mental illness. Please review the grid below for examples on how to complete sections of the CFE.

Diagnosis			Symptoms (all identified in assessment)		
		Schizoaffective	delusions (others trying to harm clt); labile mood (irritable, depressed); poor concentration; paranoid ideation; disorganized thinking		
		Impairments in Functional Area (CFE)	**SX**	**Behavior**	**Impairment (consequence)**
CFE Area			SX OF MI (specific subset of sx)	Things client thinks or does that causes problems (action words)	Consequence of behavior resulting in problem in functional area
1		**Living Arrangements Impairment**	paranoid ideation, irritable mood, delusions	client accuses others of stealing personal items, sets traps in room to prevent others from accessing belongings things; doesn't trust others	staff and roommate have been injured by traps client sets in room; relationships with house staff and house mates are strained - resulting in client being isolated; client has 60-day eviction notice
2		**Financial Status/Money Management Impairment**	delusions; disorganized thinking;	unable to organize bills; believes others owe him and that he has paid bills a year in advance; is behind on bills; spends money on unnecessary items that client cannot use;	accounts in collection status; evicted x2; in last 8 months. client has a payee to manage day to day finances
3		**Social Relationships & Communication Impairment**	paranoid ideation, irritable mood, delusions	thinks others are talking about him/her; is easily frustrated and yells and physically threatens others accused of stealing personal items from room; client stays in room to protect belongings from alleged theft	others avoid client; social isolation; misses opportunities to socialize and participate in skill building activities

Managed Care Support Team

- GRIEVANCES & INVESTIGATIONS
- NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABDS)
- APPEAL/EXPEDITED APPEAL/STATE FAIR HEARINGS
- CLINICAL SUPERVISION
- PAVE ENROLLMENT FOR COUNTY SUD DMC-ODS CLINICS AND PROVIDERS
- CREDENTIALING
- ACCESS LOGS
- CHANGE OF PROVIDER/SECOND OPINION (MHP)
- MHP/SUD DMC-ODS PROVIDER DIRECTORIES
- PAVE ENROLLMENT FOR MHP PROVIDERS

REMINDERS

PAVE ENROLLMENT FOR MHP & SUD

- PAVE enrollment and affiliation for County SUD Staff and County Clinics has officially transferred over to MCST as of 7/1/21.
- Programs are required to have providers enrolled in PAVE before they can provide any Medi-Cal covered services.
- The providers required to enroll in PAVE are: Nurse Practitioner, LCSW, LMFT, LPCC, Psychologist, MD, DO, Physician Assistant, Pharmacist, Speech Therapist, AOD Counselors and SUD DMC-ODS County Clinics.
- MHP and County SUD Staff/Clinics may send all questions and information to process PAVE enrollment/affiliation to AQISManagedCare@ochca.com with the Subject Line: PAVE Enrollment - _____.

PERSONNEL ACTION NOTIFICATION (PAN) FORM

- A newly revised PAN form is available, and programs are now required to include MCST and e-mail it to AQISManagedCare@ochca.com.
- New providers are required to be enrolled in PAVE and/or Credentialed (if your program has completed credentialling for all their providers) **FIRST** before IRIS can allow the provider to begin billing for Medi-Cal covered services.

NOABDS

- NOABDs are required to be written in the beneficiary's primary language. When a clinic is completing an NOABD in a language other than English they may utilize the HCA Employee Directory that lists the available translators to assist with writing the NOABD in the language needed. Please contact Bijan Amirshahi, Ethnic Services Manager from the Multicultural Development Program at (714)667-5600 for further assistance.
- MCST reviews NOABDs and will provide quality comments and/or correction requests. The provider **MUST** submit the correction within 5 business days and mail the revised NOABD to the beneficiary. MCST also needs to have a copy of the program memo that informs the beneficiary about the reason for receiving a second NOABD due to corrections.

ACCESS LOGS

- Service Chiefs/Program Directors are to run and review Access Log reports **weekly** to fix errors, issue NOABDs for timely access and ensure Access Log entries are entered **daily** by the clinic staff.
- When MCST is requesting Access Log corrections the provider/supervisor needs to promptly respond within 3 business days to make the correction needed.
- Should your staff require a training regarding the Access Log requirements, please email MCST. Emails for MCST are listed at the end of this section.

CLINICAL SUPERVISION

- Recent audits conducted by AQIS Audit Teams indicate that Clinical Supervision Reporting Forms are not being updated in a timely manner when there are changes in Clinical Supervision. This includes the addition of another clinical supervisor and/or the end of clinical supervision with the current clinical supervisor. A licensed-waivered provider who is required to participate in Clinical Supervision must be receiving supervision from a qualified supervisor at the time services are rendered on a weekly basis. Please note, that any lapse in Clinical Supervision will result in services being recouped.

Managed Care Support Team Cont.

CLINICAL SUPERVISION CONT.

- A licensed mental health professional who provides supervision to an ACSW, AMFT, APCC who is pursuing licensure must meet certain qualifications to be a Clinical Supervisor (e.g. Complete a minimum of 15 hours of supervision training prior to the commencement of supervision). Refer to the BBS website to ensure you meet the required minimum qualifications to be eligible as a Clinical Supervisor.

GRIEVANCES, APPEALS, STATE FAIR HEARINGS, NOABDS, 2ND OPINION AND CHANGE OF PROVIDER
Lead(s): Esmi Carroll, LCSW Jennifer Fernandez, MSW

CREDENTIALING AND PROVIDER DIRECTORY
Lead: Elaine Estrada, LCSW

ACCESS LOGS AND CLINICAL SUPERVISION
Lead: Elizabeth Sobral, LMFT

PAVE ENROLLMENT FOR MHP & SUD
Araceli Cueva Elizabeth "Liz" Martinez Sam Fraga

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E-MAIL ADDRESSES
AQISGrievance@ochca.com (NOABDs/Grievance Only)
AQISManagedCare@ochca.com

CPS/APS Report Reminders

All BHS Staff who meet the definition of a mandated reporter are required by law to report known or suspected child abuse, elder abuse, and dependent adult abuse. BHS P&P 01.06.03 Mandated Child Abuse Reporting and P&P 01.06.02 Mandated Dependent Adult/Elder Abuse Reporting outline the policies and procedures HCA has in place for these requirements. All staff who are mandated reporters should review these P&Ps as a reminder of the procedures involved with mandating reporting. Please note that all abuse reports are **non-billable** for both verbal and written reports. For County providers, completed and signed Child Abuse Reports (CAR) shall not be filed in the client's clinical record of the EHR, but should be scanned into the appropriate folder for child abuse reports. County programs who are still using paper charts should send the completed CAR form to BHS Health Information Management by the 30th day after the completion of the CAR. Information regarding CPS/APS reporting should not be entered into the County Access Log. County contracted providers should follow their agency's policies and procedures regarding the filing of the completed CAR form. Providers should follow documentation standards outlined in the P&Ps as well as the documentation manual for completion of a progress note related to mandating reporting. Progress notes should accurately reflect the service provided and should contain the minimum amount of information necessary to adhere to the documentation standards and expectations.

If you have any questions on mandated reporting requirements or documentation, please reach out to the AQIS Support Teams inbox at AQISSupportTeams@ochca.com or the Health Information Management Team at BHSHIM@ochca.com

Purpose of Visit/Establishing Medical Necessity for Service

During recent audits AQIS CYPBH Support Team has made Quality Compliance Comments pertaining to progress notes establishing Medical Necessity for session. This is important because each progress note should be a standalone document. In other words, just by looking at the note alone, the reader/Medi-Cal should know how the client is presenting that day, what specific problem needs to be addressed today and understand why that specific service/intervention was provided. A common pattern that shows weak medical necessity is only providing a templated version of client's symptoms and behaviors. Here are some helpful tips on how to establish strong medical necessity in your progress note.

While this information was identified as a result of CYPBH audits, this information applies to all AOABH and CYPBH programs. Please feel free to reach out to your respective AQIS Support Team by sending an email to the AQISSupportTeams@ochca.com inbox with any questions and an AQIS staff will be happy to assist.

Tips:

1. Not only explain the "What" you are doing today but include the "Why" you are doing it.
    - Poor example: Purpose of meeting today is to teach client coping skills.
    - Better example: Purpose of meeting today is to teach client how to identify warning signs of anger and to help regulate his mood as he continues to have daily outbursts (cursing, throwing objects) at home.
2. Use detailed wording instead of vague wording.
    - Poor example: Client is non-compliant this week.
    - Better example: Client is not attending school and consequently falling behind on assignments. As a result, he is feeling overwhelmed and refuses to complete home chores which is causing conflicts with his mom.
3. Avoid templates
    - Templates do not let the reader/Medi-Cal know how client is currently presenting.
4. The medical necessity should be related to the client's care plan goals and/or established diagnosis, the symptoms, the behaviors or impairments. The reader or Medi-Cal should be able to connect the dots.
    - Example
        - A Care Plan goal: Client will increase ability to verbalize their needs (ex. taking space and relaxing their body when feeling upset or angry; and then using their words rather than expressing raw emotions, etc) to caretaker.
        - Medical Necessity in the progress note could read: To provide psychoeducation and process with client about feelings as they struggle with expressing their needs that results in arguing with caretaker.

ANNOUNCEMENTS

AQIS would like to congratulate Ian Kemmer, LMFT, on his promotion to AQIS Director! Ian comes to AQIS after being promoted from AOABH Division Manager. Please join us in welcoming him to the team!

REMINDERS

Service Chiefs and Supervisors:

Please remember to submit monthly program and provider updates/changes for the Provider Directory and send to: AQISManagedCare@ochca.com

Review QRTips in staff meetings and include in meeting minutes.

Thank you!

***Disclaimer**: The AQIS Quality Assurance (QA) and Quality Improvement (QI) Division develops and distributes the monthly QRTips newsletter to County and County Contracted Behavioral Health providers as a tool to assist with compliance with various QA/QI regulatory requirements. IT IS NOT an all-encompassing document. Programs and providers are responsible for ensuring their understanding and compliance with all local, state, and federal regulatory requirements.*

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