### AGENDA

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<th>Time</th>
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<tr>
<td>8:30am - 8:40am</td>
<td>Welcome and Introductions</td>
<td>Julie Agojo, Sr. MHC, RN</td>
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<td>Managed Care Division</td>
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<td>8:40am - 12:00pm</td>
<td>Basic Documentation</td>
<td>Lori Dobbs, PSYD</td>
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<td>12:00pm - 1:00pm</td>
<td>Break for Lunch</td>
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<td>1:00pm - 1:30pm</td>
<td>Child Welfare</td>
<td>David Cantu, MA, CCDC</td>
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<td>- Katie A</td>
<td>Child Welfare Division</td>
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<td>- Shared Core Practice Model</td>
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<td>- Quality Service Review</td>
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<td>1:30pm - 2:00pm</td>
<td>Outpatient Review Protocol</td>
<td>Julie Agojo, Sr. MHC, RN</td>
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<td>Lead, Compliance Unit,</td>
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<td>2:00pm - 2:30pm</td>
<td>ACA &amp; the Growth of Managed Care at Los Angeles County, DMH</td>
<td>Robert Burchuk, MD</td>
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<td>Office of the Medical Director</td>
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<td>2:30pm - 2:45pm</td>
<td>Transition to Electronic Data Interchange</td>
<td>Karen Bollow</td>
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<td>Transition Project Manager</td>
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<td>Chief Information Office Bureau</td>
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<td>2:45pm – 3:00pm</td>
<td>Wrap Up</td>
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INTRODUCTION

This DMH Clinical Record and Documentation training highlights the clinical record and documentation standards for mental health services managed by the Los Angeles County Department of Mental Health Plan (MHP)
Overview of the Clinical Record

- Clinical Records are:
  - required for all persons receiving mental health services
  - a record of mental health services
  - a legal document
    - DMH does not provide legal advice to Contractors
  - to be maintained by the Contractor
  - either a Paper Clinical Record or Electronic Medical Record (EMR)
Basic Information for the Clinical Record

- Contractors must refer to their own Counsel to interpret laws/codes and answer any questions regarding release of information.
- All information in the Clinical Record is considered confidential information:
  - Protected under Welfare & Institutions Code 5328
    - Professionals may share Protected Health Information (PHI) with other professionals providing care to a person without client authorization
      - Between DMH and its Contractors
      - Health and mental health professionals outside the LA County DMH system of care
  - Safeguarded against unauthorized access
  - Refer to HIPAA Privacy for more information
Content of the Clinical Record

- Shall include complete, accurate and current documentation of any and all information related to a client:
  - Demographics
  - History
  - Support for the diagnosis and/or condition of the client
  - Treatment provided
  - Current status/condition of the client
DMH provides Official Clinical Forms for use by Contractors

- Official forms may not be altered or changed in any way and must be used in their original format
- Official clinical forms have been designed in order to encompass required elements based on:
  - Clinical Record guidelines
  - Medicare and Medi-Cal reimbursement rules
  - HIPAA Procedure Code definitions
  - Integrated System (IS) fields
  - State Contract requirements
  - LACDMH Policy & Procedures
Approved Clinical Forms

- Official clinical forms for use by Contractors fall into four (4) categories:
  - Required
  - Required Data Elements
  - Optional
  - Ownership

DMH Policy #104.8
Approved Clinical Forms

- If you have an Electronic Medical Record (EMR), DMH does not have any set format for data collection
  - i.e. you may have any structure or use any appropriate collection tools/methods and you do not have to incorporate the DMH official forms into the EMR as is
Approved Clinical Forms

- **Required:** Forms in PDF format or hardcopy format which must be used by all Contract Providers without alteration in content, format, or structure.
  - Forms Include:
    - Payor Financial Information
  - EMR: all Data Elements on these forms must be in the EMR
    - Produce an e-report which contains all data elements and the general structure (sequence) of the DMH Required Form or
    - Produce an XML message (DMH will provide the structure of the XML)
Approved Clinical Forms

- **Required Data Elements:** Forms in PDF format or hardcopy format in which all data elements on these forms are required in the DMH valid format, i.e., the only valid date format is mm/dd/yyyy; however, the layout and presentation of the form is up to Contractors.
  - Forms include:
    - Client Face Sheet
    - Open/Close Episode
  - May choose to use the DMH form or may choose to use a form of their own creation.
    - Responsible for ensuring all data elements in the DMH valid format are on the form they create.
  - EMR: all Data Elements on these forms must be in the EMR
    - There are no e-report or XML requirements
Approved Clinical Forms

- **Optional:** Forms in PDF format or hardcopy format in which neither data elements, format, or structure of the form are required to be used by Contract Providers. Contractors must have a method of documenting the concept captured by the title of the form.
  - Forms Include:
    - Assessments *(These are required for LE Providers)*
    - Client Treatment Plans *(These are required for LE Providers)*
    - Progress Notes
  - May choose to use the DMH form or may choose to use a form of their own creation.
  - EMR: only the “concept” of these forms are required
    - There is no requirement to incorporate the exact data elements on these forms into an EMR
Approved Clinical Forms

- **Ownership:** Forms which are required by state or federal law/code or County/Department policy/procedure but because of their potential legal implications cannot be “DMH Required” forms.
  - Forms include:
    - HIPAA notices
    - Consents
    - Authorizations
  - If choose to use the DMH form, must understand they are agreeing to take on the legal responsibilities associated with the language of the form.
  - EMR: only the “concept” of these forms are required
  - Must adhere to all State and Federal laws, HIPAA laws, and LAC-DMH policy and procedures
Chart Structure

- Each Contractor must create its own chart structure
  - The chart structure is used to identify where required documents can be found
Documentation
DOCUMENTATION GENERAL GUIDELINES

- All direct services must be documented in the clinical record prior to submission of the claim.
- Assumptions cannot be made by readers about what happened, who was present, or actual time spent.
  - This information must be documented.
- Services shall be provided and documented within the staff person’s scope of practice.
Definitions

- **Medical Necessity**: Mental Health criteria consisting of a covered diagnosis, impairments and interventions, required by third party payers for reimbursement of Specialty Mental Health Services. Ensures services are justified as reasonable, necessary and/or appropriate based on clinical standards and practice.

- **Annual Cycle Month**: the month of admission to a Reporting Unit and the month by which all annual clinical paperwork must be completed for client’s receiving ongoing specialty mental health services (Future Policy Change)
Definitions

- **Clinical Loop**: The sequence of documentation established to help ensure that services fulfill the clinical needs of the client by relating back to the client’s Assessment and Treatment Plan and all payer requirements for eligibility of reimbursement are documented.

- **Medi-Cal**: California’s Medicaid program which provides needed health care services for low-income individuals and is financed equally by the State and federal government.
Definitions

- **Assessment**: Documentation of the evaluation of a client’s mental, physical, and emotional health to determine the presence of a 5 axis diagnosis.

- **Treatment Plan**: Documentation of a client’s goals and objectives for mental health treatment, interventions provided by mental health staff, and participation of the client which is used to guide client care and provide staff with sound markers of progress related to a client’s mental illness. (Future Policy Change: Coordination Plan is no longer part of the CCCP)
Definitions

- **Coordination Plan**: Document which allows those working with a client to see a comprehensive record of specialty mental health services provided to a client within the DMH System of Care *(Future Policy Change: Coordination Plan is no longer part of the CCCP)*. Network providers are not required to complete the Coordination Plan but may choose to if coordinating services with other Providers.

- **Progress Note**: Documentation of all services, regardless of reimbursement, with or about a client which includes specific interventions regarding the client.
Definitions

- **Specialty Mental Health Services**: Services provided to Medi-Cal beneficiaries who require treatment from county mental health plans.
Definitions

- **Clinical Discharge**: The closing of an episode by providing a clinical summary of treatment including the admitting diagnosis and problem area, services provided, response to services, prognosis, reason for discharge, medications, and recommendations regarding effective interventions and targets for services.

- **Administrative Discharge**: The closing of an episode due to inactivity when the primary service provider or primary contact is no longer at the program.
Medical Necessity

- An “Included” DSM Diagnosis
- Impairment as a result of the “included” DSM Diagnosis
  - A significant impairment in an important area of life functioning
  - A probability of significant deterioration in an important area of life functioning
  - A probability a person under 21 years of age will not progress developmentally as individually appropriate
- Intervention is:
  - The focus of the proposed intervention is to address the impairment
  - The proposed intervention is expected to do one of the following:
    - Significantly diminish the impairment
    - Prevent significant deterioration
    - Allow the child to progress developmentally
  - The condition would not be responsive to physical health care based treatment
Medical Necessity

- Every claimed service must meet Medical Necessity
  - i.e. Fit into the Clinical Loop
- Medical Necessity is an ongoing process
Included Diagnosis

- List of DSM diagnoses that are covered under Medi-Cal Specialty Mental Health Services
- Must be the primary diagnosis for treatment
  - Exception for initial contacts during assessment or crisis
  - May have other “excluded” diagnoses
- Examples:
  - Major Depression
  - Bipolar Disorder
  - Adjustment Disorder
  - ADHD
Impairments

- A significant impairment in an important area of life functioning **as a result of** the client’s mental health symptoms
  - Home
  - Work
  - School
  - Social
  - Family
Impairments

- How do your symptoms impact your
  - Social/family relationships?
    - Decreased contact with friends
    - Affected family relationships
  - Performance at school or work?
    - Cause avoidance of or lack of participation in certain classes/meetings
    - Being late to school/work due to depression
    - Decreased contact with classmates/coworkers
    - Failing grades/work performance due to depressive mood / poor concentration
  - Participation in hobbies, leisure activities?
    - Avoidance of certain leisure/sports/extracurricular activities
Interventions

● What is an intervention?
  – “The act of intervening, interfering or interceding with the intent of modifying the outcome. An intervention is usually undertaken to help treat a condition.” MedicineNet.com

● What must an intervention do to meet Medical Necessity?
  – Address an identified mental health impairment
  – Significantly diminish the impairment or prevent deterioration in life functioning
  – Allow the child to progress developmentally as individually appropriate
Interventions

- Interventions should focus on:
  - The **purpose** of the activity, not the activity itself
  - What **staff** did to help the client reach his/her objectives
  - Reimbursement is based on STAFF time and intervention
Clinical Loop

1. Completion of a Mental Health Assessment which documents:
   - Symptoms and Behaviors to formulate a diagnosis
   - Impairments, Needs and Strengths
2. Carry Assessment information forward into the Treatment Plan which documents:
   - Goals linked to symptoms/behaviors/impairments
   - Interventions to achieve the identified goals
3. Carry forward into the Progress Note which documents:
   - Goal-based interventions provided to the client
The Clinical Loop

- That sequence of documentation on which Medical Necessity requirements converge is:
  - The Assessment
  - The Treatment Plan
  - The Progress Note
Step 1: Mental Health Assessment

What is the purpose?

- Learn the client’s story
- Get to know who the client is
- Identify strengths, needs, barriers
- Identify interrelationships between mental illness and the whole person
- Collect foundation/baseline information for a treatment plan
Step 1: Mental Health Assessment

- **Must be completed:**
  - Within 2 months (1 month if open elsewhere) of intake

- **Recommend it is completed:**
  - On a DMH OPTIONAL Network Provider Assessment form
Step 1: Mental Health Assessment

- Must include:
  - Presenting problems (symptoms/behaviors, reason for referral)
    - Frequency, duration, severity, onset
  - Conditions affecting life functioning (impairments)
    - Functioning prior to onset (premorbid)
  - Special status situations (Language, cultural and linguistic needs)
  - Risks to client or other (DCFS involvement, domestic violence, homelessness)
  - Client strengths/protective factors (personal, familial and environmental resources that get an individual through adversity – developed to meet challenges)
  - Mental health history, previous treatment dates, providers, therapeutic interventions and responses
  - Relevant family information
Step 1: Mental Health Assessment

- Must include:
  - Physical health conditions reported by the client
  - Allergies/adverse reactions
  - Medication, dosages, dates of initial prescription/refills
  - Substance Use
  - Developmental history (for children)
  - Mental status
  - Five Axis Diagnosis
  - Impact of collaterals, living situation, substance use, etc on mental health of client
Step 1: Mental Health Assessment

- Points to Remember:
  - For any client identified to have substance use/abuse issues the link between substance use/abuse and mental health must be made
  - Ensure the diagnosis is the same in the IS and the Clinical Record
  - Anytime the diagnosis is updated, must ensure it is clearly justified in the Clinical Record
Step 1: Mental Health Assessment

• Assessment Addendum:
  - Updates assessment information throughout the course of treatment
  - Purposes:
    • Allows new assessment information to be easily found in the Clinical Record
    • Ensures treatment (interventions) continue to fit into the documented Clinical Loop
  - Due: anytime the change/additional information impacts the treatment provided
Step 2: Treatment Plan

What is the purpose?

- Identify steps needed to reach long-term goal
- Ensures client care is goal directed and purposeful
- Identifies markers of progress
- Ensures Medi-Cal requirements are met
- Addresses cultural/linguistic needs
- Supports client and family participation
Step 2: Treatment Plan

● The Treatment Plan as a Road Map
  – Creates a “road map” or “compass” for the client, family and staff that steers the course in treatment
  – A tool for the client and staff to guide services and not get “lost”
    ● Helps direct the client back to their treatment plan…don’t constantly put out fires
    ● A fixed point of reference to assist in setting and staying on the course of treatment
  – Staff assist clients in developing a road map that:
    ● Identify a long term goal
    ● Specify objectives
    ● Select services (or interventions)
    ● Becomes the focal point of each contact (if possible)
Step 2: Treatment Plan

- How to use the Treatment Plan:
  - Let the agreed upon treatment plan drive the services

- Example:
  - Client calls regarding issues with landlord
    - Anger management is on the tx plan...bring the conversation back to how the client managed his anger when dealing with the landlord
    - Nothing on tx plan relates to landlord issues...have a discussion with the client regarding how mental health symptoms/behaviors impact the landlord issues and whether a new objective on the tx plan is needed
Step 2: Treatment Plan

- May choose to:
  - Document the Treatment Plan in a Progress Note OR
  - Use the DMH Optional Client Care Coordination Plan

- Recommended to document the Treatment Plan in a Progress Note for all short-term services (i.e., consultations in the hospital or Board and Care)

- Recommended to document the Treatment Plan in the Client Care Coordination Plan (CCCP) for long-term services (i.e., outpatient psychotherapy or meds)
Step 2: Treatment Plan

- Must be completed:
  - Within 2 months (1 month if open elsewhere) of intake
    - Best Practice: prior to treatment services being provided
  - Annually prior to the cycle date
    - Annual cycle month=month of admission (Future Policy change)
    - May be additional review periods based on the type of service
  - By each program providing services
  - For all non-emergent, direct services
    - Must have an objective associated with each type of service provided
    - One time unplanned services do not need an objective
Step 2: Treatment Plan

- Network Providers must include the following elements no matter where the Treatment Plan is documented (progress note or CCCP):
  - Goals/objectives
  - Proposed duration of goals
  - Type of intervention
  - Proposed frequency of interventions
  - Client’s involvement
  - Signature of service provider
Step 2: Treatment Plan

- If completed the CCCP form, required signatures:
  - Rendering Provider
  - Client
    - Whomever consented to services
      - May need to obtain Conservator’s signature
    - Age is not a factor
      - If the client can understand what they are signing, any age can sign
    - Lack of signature – must have documentation justifying lack of signature and plan to obtain (if possible)
  - Parent, Authorized Caregiver, Guardian, Conservator or Personal Representative (if applicable)
    - If consented for services

Note: On the CCCP, the client’s signature meets the requirement of having client involvement
Step 2: Treatment Plan

● What does it mean for the client to sign?
  – By the California Code of Regulations and State Contract, the client must participate in the development of their treatment plan
  ● Signing the CCCP means the client is agreeing to the Treatment Plan and is showing that they have participated in its development
Step 2: Treatment Plan

- Long Term Goal *(not required for Network Providers)*
  - The client (or family members) hopes and dreams for their future
  - A motivating force for the client/family member
  - Exactly what the client and, for children, his/her caregiver says
  - All goals are valid (does not have to be “Mental Health” statements)

- Short term goals and objectives
  - A change that will help the child and his/her family achieve their long term goals
  - Must be linked to symptoms/behaviors/impairments from the Assessment
  - Something mental health staff can help the client achieve
  - Should match where the client is at
  - Must be SMART *(Specific, Measurable, Attainable, Realistic and Time-Bound)*
Step 2: Treatment Plan

- **Specific**: Clear and well defined
- **Measurable / Quantifiable**: Ability to measure when the objective has been achieved; how will you know if you have accomplished the objective
- **Attainable**: A realistic path to achievement
- **Realistic**: Reasonable for the client to achieve
- **Time-bound**: There is enough time to complete it within the 1 year timeframe
  - Staff may set a shorter timeframe
  - Must document timeframe if less than 1 year (especially for EBPs that have a specific timeframe)
Step 2: Treatment Plan

- **Interventions**
  - How will staff contribute to achieving the changes
  - Must identify type(s) of services (MHS, MSS, TCM, etc)
  - Must identify the specific interventions, including the modality (individual therapy, group rehab, family therapy, etc) associated with the type of service
  - Must identify proposed frequency of interventions (e.g. number of times per week)

- **Client and Family Participation** *(not required for Network Providers)*
  - How will the client and family contribute to achieving the behavioral change

- **Outcomes** *(not required for Network Providers)*
  - Outcomes when goals have been achieved or, at a minimum, every time the client plan has a scheduled review
  - Should specifically reference the objective and where the client is now (i.e. use the measurements identified in the objective)
Step 2: Treatment Plan

- Things to think about when developing Treatment Plans:
  - Do we (staff and the client) have a clear understanding of what the “problem” is?
    - Problem can be a symptoms, behavior that is causing distress or an impairment in the client’s life functioning
  - Which “problem” can mental health have the most impact on?
    - Does this “problem” make sense given what the Assessment says?
  - Can we write this “problem” in a clear and precise way so we all know if our interventions are helping?
  - Will the way of measuring make sense to the client?
    - Percentages vs # of times per day vs measurement scales
Step 2: Treatment Plan

- **Examples of ways to write Objectives:**
  - Decrease level of anxiety by making 1 calming statement to self daily instead of 0 statements
  - Participate in 2 community-based activities per month from 0 to improve socialization and decrease isolation
  - Maintain part time employment for 2 months
  - Increase social skills as evidenced by engaging in 2 conversations per week from 0 conversations per week.
  - Decrease anxiety in social situations from a level 8 anxiety to a level 4 anxiety
  - Reduce auditory hallucinations from daily to less than twice per week
  - Reduce depression to feeling depressed less than 50% of the day from 100% of the day
  - Decrease panic attacks from daily to weekly
  - Decrease PHQ 9 score from 18 to 5
Step 2: Treatment Plan

● **Examples of ways NOT to write Objectives:**
  - Provide linkage and broker to community resources as requested by client
  - Will consistently meet with psychiatrist and comply with taking medications
  - Client will maintain medication compliance
  - Client will request linkage to community services such as medical, financial, housing and treatment services as needed
  - Client will reduce symptoms
  - Client will reduce severity of symptoms
Step 2: Treatment Plan

- **Examples of ways to write Interventions:**
  - Assist client with understanding and identifying appropriate social skills
  - Identify recent maladaptive behaviors or situations in the client’s life and discuss how substance use may contribute to mental health problems
  - Identify effective communication techniques to enhance the ability to interact with others
  - Discuss techniques of self-care and self-management
  - Provide cognitive restructuring: assist with learning self-monitoring, identify negative thoughts that stimulate depression, evaluate for logical errors, generate rational alternatives
  - Assist with learning thought stopping techniques to reduce negative self-verbalization that increases depression
Step 2: Treatment Plan

- **Examples of ways NOT to write Interventions:**
  - Provide TCM as needed
  - Rx
  - Attend groups
  - Comply with meds
Step 2: Treatment Plan

- Examples of ways to write Client Participation:
  - Client will practice social / assertiveness / relaxation / problem-solving / etc. skills with therapist
  - Client will practice skills at home/school/work and report back to therapist his/her successes/difficulties and feelings about the experience
  - Client will research jobs and apply to several jobs per week
  - Client will look into different social activities he/she would be interested in
Step 3: Progress Notes

What is the purpose?

- Identifies what you and any other participating staff did (i.e. what intervention was provided)
- Provides continued care information (for the next person working with the client)
- Documents what is going on with the client
- Establishes an audit trail
- Provides basis for benefits establishment
- Identifies progress and response to treatment
Step 3: Progress Notes

- Must be completed:
  - Prior to a claim being submitted and within a “reasonable” time
    - DMH requires our staff to complete by the end of the next scheduled workday
  - On a DMH OPTIONAL Network Provider Progress Note form
  - For every service claimed
    - Frequency depends on the type of service
    - Examples:
      - Outpatient services: every contact
Step 3: Progress Notes

- Every claimed service must meet the test of medical necessity by being related to the Clinical Loop
  - Translation: Be a needed service for the client to improve/maintain symptoms, behaviors, impairments
- There must be a Progress Note for all services claimed
  - Each service related to a client must be charted, including clinical decisions and interventions made
  - For Audits, a *Progress Note* must be present in the Clinical Record for every claim made to a Payer source
Step 3: Progress Notes

- Progress Notes must contain:
  - Service date
  - Rendering Provider signature, discipline/title, license/registration/certification number (if applicable)
  - The procedure code
  - Amount of time
    - Face to face for Rendering Provider
Step 3: Progress Notes

Progress Notes must:

- Provide a description of what was attempted and/or accomplished
- Provide clinical results and responses, progress, and/or outcomes
- Specify plan for future work with the client. e.g. “Continue with assignment to identify triggers for anger.”
- Include a description of changes in medical necessity criteria, if applicable and not in an assessment addendum
- Include names of others present in the session
- The treatment plan and/or discharge summary if not recorded on a separate form
Step 3: Progress Notes

- When claiming on a Progress Note:
  - Claim only the **actual** time it took to deliver the service
    - Outpatient services are claimed by minute
    - Example: Do not always assume it takes you 15 minutes to write a progress note
  - Must ensure the note justifies the duration of the claim
Step 3: Progress Notes

- **Progress Notes should:**
  - Summarize the client’s condition
    - Using descriptive, behavioral statements or quoting client statements is a good way to illustrate his/her condition
      - e.g. pacing in room, said “I never do well on tests…”
    - Indicate the purpose of your intervention(s), e.g. “… to assess client’s cognitive functioning….,” which must relate back to goals on the treatment plan
Step 3: Progress Notes

- Documentation Hints:
  - Use active verbs to describe your actions
  - Lengthy, detailed process documentation is not required
  - Refer to other documents instead of repeating information
  - Identify progress the client has or has not made in reaching the goal
Progress Note
The base of the note may include:

- **Goal**
  - Should tie back to the goals listed on CCCP and what progress did the client make in reaching his/her goals?

- **Intervention**
  - What did you do/What service did you provide

- **Response**
  - How did the client/family respond to your (intervention)?
    - Physical and Verbal

- **Plan**
  - What steps will the client take in reaching his/her goal

**Please note, the G.I.R.P. format is not an endorsed format, but points out important elements of a note.**
Progress Notes
Things to think about when writing a note

- What is written in the note, is the ONLY information anyone reading the Note has to know what intervention you provided to the client
  - You can’t assume that a person will understand why/how taking a client surfing will benefit the client
- The intervention must connect to the client’s objective
Procedure Codes

● Important to:
  – Accurately reflect service provided for claiming by choosing the right code
    ● Prevent over or under billing
  – Correctly assign face to face time
    ● Face to Face time is time spent directing services towards the client
  – Only use procedure codes available for your discipline and your contract with DMH
Procedure Codes

● 2013 CPT Procedure Code Changes:
  – Effective January 1, 2013
  – Will have a 6 month period to implement
    ● Note: Medicare or other payers may not give this grace period
  – Some important changes:
    ● 90801 and 90802 will be inactive; replaced by 90791
    ● Psychotherapy goes will be inactive; replaced by 90832, 90834, 90837
    ● Medication code 90862 will be inactive; replaced by E&M codes
  – Watch for additional detailed information from Provider Relations Unit
Basic Documentation

● CLEAR: what occurred or what happened is obvious to the reader, the reader does not have to guess or fill in the gaps
  – Try to use facts, observations, direct client quotes and behaviors
  – Make sure to answer who, what, when, where and why
  – Try not to use words that could mean different things to different people without describing them
    ● Bizarre, Non-compliant, Mood swings, Defiant/Resistant
● CONCISE: use as few words as possible to give the necessary information
  – Be blunt, if appropriate
  – Use quotes, if needed
● COHESIVE: make sure documentation works together as a united whole within the Clinical Record
  – Does it make clinical sense given what is going on with the client?
  – Does it give a cohesive picture of what YOU did to help the client achieve his/her goals?
● READER-CENTERED: written in language anyone can understand

Always keep in mind that the Clinical Record belongs to, and is about, the client!
QUESTIONS?
Contacts/Resources

- For more information on documentation and claiming, see the Network Providers Manual:
  - Located online at: dmh.lacounty.gov
  - Under For Providers, Administrative Tools, Provider Manuals
  - [http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals](http://dmh.lacounty.gov/wps/portal/dmh/admin_tools/prov_manuals)
  - FEE For Service Provider Relations can be reached at (213) 738-3311.
Support & Services for Youth who are Dependents of the Court

Department of Mental Health
Child Welfare Division
Today’s Presentation will include information on:

- Katie A. Settlement Agreement
- Shared Core Practice Model
- Quality Service Review (QSR)
Katie A. Settlement

BACKGROUND: 2002

CLASS ACTION LAWSUIT FILED AGAINST THE STATE AND LOS ANGELES COUNTY ALLEGING:

1. Failure to assess mental health needs
2. Inadequate mental health services
3. Placement disruptions
4. Over-reliance on congregate care
5. Institutionalization—MacLaren Children’s Center
JULY 2003

• Los Angeles County entered into a Settlement Agreement resolving the County-portion of the lawsuit.

• The Settlement Agreement required the County to make systemic improvements to better serve members of the class & Federal Court appoints Katie A. Panel to monitor progress.
KATIE A. CLASS MEMBERS

1. Are in the custody of the Los Angeles County DCFS in foster care or who are at imminent risk of foster care placement by DCFS

2. Are eligible for services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program

3. Have a mental illness or condition that is documented

4. Are in need of individualized mental health services to treat or ameliorate their illness or condition.
SETTLEMENT OBJECTIVES

1. Promptly receive necessary individualized mental health services in their own home, a family setting, or the most homelike setting appropriate to their needs

2. Receive care and services needed to prevent removal from their families or dependency or when removal cannot be avoided, to facilitate reunification, and to meet their needs for safety, permanence, and stability
Katie A. Summary

- Katie A. requires fundamental systems and practice change on the part of both child welfare and mental health.
- The change must be driven by leadership committed to a shared vision and a set of principles that articulate the mission.
- Significant enhancements to current resources will be needed across a variety of organizational efforts, including program development, funding, training, coaching, and evaluation.
- Infrastructures are likely to need to be augmented to support these enhancements.
- It’s a lot of work, but it’s the right thing to do.
Shared Core Practice Model

- Review Shared Core Practice Model Values
- Strength-Based Approaches to Systems Change
- Building Relationships Across Systems
Creating a Paradigm Shift

Be the Change
You wish to See
In the World

Gandhi
Shared Core Practice
Model Values

• Child Protection & Safety: All children have the right to live in a safe environment

• Permanence - Lifelong, Loving, Families: Children are entitled to a safe, nurturing and permanent family environment

• Strengthening Child & Family well-being and self-sufficiency: Identify the strengths of children and families - Services should be trauma informed

• Child Focused Practice: Assessments that focus on the child’s individualized underlying needs and strengths – Change results from individualized client-centered service approaches
Shared Core Practice
Model Values (cont.)

• Family-Centered Practice: Respecting family’s voice and choice, using services to empower families
• Community-Based Partnerships: Harnessing the multiple community supports available to families
• Cultural Humility: Recognizing the culture, ethnic and spiritual roots of the child, youth and family
• Promising Practice and Continuous Learning: Creating an environment of continuous listening and learning
Organizing the Practice:
(Shared) **PRACTICE FRAMEWORK**

- **Engaging**
- **Teaming**
- **Track & Adapt**
- **Assessment**
- **Planning & Intervention**

**Strength Needs Practice**

**Basic knowledge, values, principles, legal mandates**
Mobilizing STRENGTHS, addressing NEEDS with these skills

- **Engaging**: Building rapport and effective relationships.
- **Teaming**: Effectively collaborating with others, coordinating and guiding teams.
- **Assessing**: Gathering important information; identifying safety and underlying needs.
- **Planning/Intervening**: Interventions utilizing client strengths and preferences.
- **Tracking**: Evaluating results and adapting results to improve practice.
Quality Services Review

- Intensive Case Review
- Aligned with Core Practice Model
- Systems Performance
- Client and Family Outcomes
STATUS INDICATORS
- Safety
- Stability Pattern
- Permanency Prospects
- Living Arrangement
- Health/Physical Well-being
- Emotional Well-being
- Learning & Development
- Family Functioning & Resourcefulness
- Caregiver Functioning
- Family Connections

PRACTICE INDICATORS
- Engagement
- Voice and Choice
- Teamwork
- Assessment & Understanding
- Long-term View
- Planning
- Supports & Services
- Intervention Adequacy
- Tracking & Adjustment
Wise and Gentle Teachers

**Debriefing**
- Providing feedback to the CSW and the SCSW to stimulate and assist practice improvement where indicated.
- Most readily accomplished when a constructive approach and helpful tone are used.
- A reviewer has the opportunity to teach and encourage frontline practitioners when providing feedback.

**Grand Rounds**
- Presenting case findings to the office management and specialized program staff to stimulate and assist practice improvement where indicated.
- Affirming good work and positive accomplishments observed in the cases as well as the key challenge points.
- Carefully thinking through immediate, relevant, doable, next-step suggestions.
Challenges

- Teaming
- Engagement
- Voice and Choice
- Need and Strengths Based Assessment/Planning
- Long Term View
- Permanency
- Child Emotional Well Being
November 14, 2011

TO: Juvenile Probation Staff  
Department of Children and Family Services Staff  
Department of Mental Health Child and TAY Staff  
Children's Mental Health Contract Agency Staff

FROM: Marvin J. Southard, D.S.W.  
Director, Department of Mental Health

Calvin C. Remington  
Acting Chief Probation Officer, Probation Department

Phillip L. Browning  
Interim Director, Department of Children and Family Services

SUBJECT: SHARED CORE PRACTICE MODEL

Our departments have committed to a shared Core Practice Model that describes our common vision, guiding principles, and practice activities for improving the lives of the children, youth, and families we serve. The attached "Foundations of Shared Practice" provides an overview of this approach. This practice model provides an overarching framework for promoting best practice standards, recognizing the need to strengthen and integrate the day-to-day work of our staff and represents nothing less than a transformation of our approach to partnering with children and families to address the needs that have brought them to our attention.

Fundamental to our shared practice model is the belief that we must work together to ensure that children and youth are safe, free from abuse, neglect, and are afforded nurturing and permanent living environments whenever possible with their families. Our work is best accomplished through strong partnerships that start with community based agencies, a sensitivity to family, cultural values, and a focus on promoting child and family well-being, and self-sufficiency.

In our work with children and families, we need to strengthen our efforts at engagement, for without the establishment of a trusting relationship with those we seek to serve, we cannot accomplish our shared objectives. Best practice calls for a team approach. Every child and youth should have a child and family team that works together to

"To Enrich Lives Through Effective And Caring Service"
identify the needs and strengths of the youth and family, and provide for the formal and informal supports and services needed to achieve identified goals. We also need to be vigilant in tracking progress and adapting our efforts as necessary to promote and sustain desired outcomes.

We have begun working together to train and coach our workforces in the application of these principles and activities in their daily work and are committed to moving forward in these efforts. We expect that these fundamental changes in practice will transform our broad service system, lead to better experiences, and outcomes for those we serve and have established mechanisms to evaluate our progress with respect to systems performance and outcomes for children and families.

We encourage all staff – Child Welfare, Mental Health, and Probation - to participate fully in the training and coaching support for the Core Practice Model.

MJS:BM:GL:ag

Attachment
Our Shared Foundations of Practice
Department of Children and Family Services, Department of Mental Health, Probation Department

Our Departments have developed a shared and evolving model of practice to better integrate services and supports for children, youth, families and communities. Our commitment and approach are cemented in the crucial elements of community partnership, teamwork, family voice and choice, cultural competence, respect, accountability, continuous quality improvement and implementation of best practice.

Key Outcomes: Safety, Permanence, Well-Being, Self Sufficiency, Organizational Excellence

Shared Values and Guiding Principles

- **Child Protection & Safety:** Children and youth have the right to live in a safe environment, free from abuse, and neglect.

- **Permanent, Lifelong, Loving, Families:** Children and youth need and are entitled to a safe, nurturing and permanent family environment ideally in their own home.

- **Strengthening Child & Family Well-Being and Self Sufficiency:** Identifying the unique strengths of children, youth and families allows services and supports to be individualized and tailored.

- **Child Focused Family Centered Practice:** Focusing on the child's individualized, underlying needs and strengths, and the strengths and capacities of families provide the best guide to effective intervention and lasting change.

- **Community-Based Partnerships:** Services and interventions for children, youth and families are delivered collaboratively by agencies, providers, community and informal and naturally occurring supports in order to meet each family's needs.

- **Cultural Competency:** We maintain an attitude of cultural humility; honoring and respecting the beliefs and values of all families and recognizing that the cultural, ethnic and spiritual roots of the child, youth and family are a valuable part of their identity.

- **Best Practice and Continuous Learning:** We commit to developing an environment of continuous listening and learning and to ensuring that policy and practice decisions are based on reliable data as well as evidence, research and feedback.

The Practice Wheel: Our Shared Core Practice Model in Action

Our values and guiding principles are applied through a set of practice activities depicted by the Practice Wheel:

- **Engaging** is the practice of creating trustful working relationships a child and their family by increasing their participation, validating their unique cultural perspective, and hearing their voice and choice.

- **Teaming** is the practice of building and strengthening the child and family's support system, whose members meet, communicate, plan together, and coordinate their efforts in a unified fashion to address critical issues/needs.

- **Assessing** is the practice of collaborating with a family's team to obtain information about the salient events impacting children and families and the underlying causes bringing about their situation.

- **Planning and Intervening** is the practice and process of tailoring and implementing plans to build on strengths and protective capacities in order to meet individual needs for each child and family.

- **Tracking, Adapting and Transitioning** is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, reworking the plan, celebrating successes, adapting to challenges and organizing after-care supports as needed for the child and family.
The Quality Service Review (QSR)
Frequently Asked Questions

WHAT IS THE QSR?

The Quality Services Review (QSR) is an action-oriented learning process that is used to improve practice and service delivery for children and families. Findings from these case reviews are used to guide our next steps for supporting practice and enhancing efforts, leading to better outcomes for the families that we serve.

WHO ARE THE QSR REVIEWERS?

QSR Reviewers currently are a combination of child welfare experts, DCFS staff and DMH staff. DCFS Reviewers include a core group from the Quality Improvement Section as well as a wide cross-section of DCFS and DMH staff.

HOW DOES QSR WORK?

The QSR process includes several focus groups representing line staff, supervisors, and managers from the office. At the case level, the process involves case file reviews, observations, and interviews with key parties to the case.

The QSR process occurs one office at a time. Cases to be reviewed are chosen through a computer-generated random selection process.

QSR uses an in-depth and practice review appraisal process. The services reviewed include not just direct DCFS services, but services provided by schools, DMH, DPSS, Probation, community providers, medical providers and any other service providers involved in the reviewed case. Specifically, the QSR looks at two major categories (see reverse for sample review questions):

1. Current Child and Family Status
2. System Practice and Performance Results

WHAT IS LEARNED THROUGH THE QSR?

Results from the QSR provide a rich array of learning opportunities for next step action and improvement. These include:

- Detailed stories of practice, results, and recurrent themes and patterns observed across reviewed cases.
- Deep understanding of factors that affect daily practice.
- Patterns of child and family status and practice performance results.
- Noteworthy accomplishments and success stories.
- Emerging problems, issues, challenges, and system barriers in current practice.
- Critical input for improving local practices, working conditions, and results.

Adapted from "Using the Quality Service Review to Learn about Frontline Practice, Services, and Results" by Human Systems & Outcomes, Inc., 2007
2/23/11 BP version 1.0
The Quality Service Review (QSR)
Frequently Asked Questions

Typical questions that are explored through the Quality Service Review (QSR) Process:

**Current Child Status:** Questions used to determine how children and families are doing right now include:

- Is the child safe from manageable risks of harm caused by others or him/herself? Is the child in a stable home?
- Are the child’s basic physical and health needs met?
- Is the child doing well in school? Making academic progress?
- Is the child doing well emotionally and behaviorally?
- Are the parents/caregivers able and willing to assist, support and supervise the child reliably on a daily basis?
- Is the child making progress in key life areas and are parents satisfied with services being received?

**System Practice and Performance Results:**
Are the actions and services provided to the child and family moving the family in the right direction? Does the system we work in provide for the right conditions to allow us to effectively help families? Questions used include:

- Do the child’s parents, clinicians, teachers and service providers share a “big picture” understanding of the child and family situation, their strengths and needs, and a Long-Term View for the family (including conditions for safe case closure) so that sensible supports and services can be planned?
- Are the child and family part of a clear and sensible service plan that organizes and integrates all supports, services and interventions?
- Are the child’s caregivers receiving the necessary training and support to parent effectively and provide a safe and stable home for the children?
- Are the supports and services provided reducing any risks and improving safety and family functioning? Is a sustainable network being built with and for the family?
- Are services and results monitored frequently and adjusted to reflect changing needs and life circumstances?

Adapted from "Using the Quality Service Review to Learn about Frontline Practice, Services, and Results" by Human Systems & Outcomes, Inc., 2007 2/23/11 BP version 1.0
FFS2 Network Providers
Transition Project Overview

Direct Data Entry (DDE) to
Electronic Data Interchange (EDI)
Presentation Outline

• Introduction
• EDI Basics
• Getting Started
• Important Dates
• Helpful Links
• Questions
Introduction

- DMH is moving to an Electronic Health Record System (EHRS) called IBHIS for directly operated facilities only.
- All network providers will be required to submit clinical, financial (claims) and administrative data electronically – they will not be able to access the new DMH IBHIS.
- Today only claims are submitted electronically and IBHIS may require modifications to the current claims data.
EDI Basics

• EDI is the sending and receiving of information between trading partners using computer technology

• Computers need to communicate but we must be sure that each computer is speaking the same language

• EDI requires formal standards to avoid misinterpreting what is being sent electronically
EDI Basics

• EDI requires each Network Provider (trading partner) or designated agent to be identified with a unique ID (Digital Certificate) to ensure security of PHI data exchanged with another payer.

• Each Network Provider and/or designated agent must complete EDI testing with DMH prior to submitting electronic transactions to the IS or the new IBHIS.
Getting Started

- Begin now to assess your EDI readiness to meet the IBHIS and IS timelines
- Evaluate your options for EDI
  - Billing Service
  - Clearinghouse
  - Vendor Software (Application Service Provider)
  - Vendor Software (Hosted or In-house)
  - Custom Software (Not Recommended)
Getting Started

• Review the list of EDI vendors currently certified to submit EDI claims transactions to DMH

• Review the Vendor/Biller Selection Criteria Checklist to assist in the selection of potential vendors or billers

• Review the Network Provider website materials on EDI Basics, EDI - Getting Started and the EDI Registration Packet
Getting Started

• For network providers that are already EDI capable, contact your billers/vendors regarding IBHIS data exchange requirements

• DMH cannot recommend any vendor or product or assist in the purchase or implementation of any EDI option

• DMH has established the Network Provider Transition project to communicate EDI requirements and keep providers informed on the IBHIS project
Important Dates

• IS Claims processing will begin to phase out by June 2014 and no new claims will be accepted.
• The Integrated System (IS) is scheduled to be shutdown by December 31, 2014.
Helpful Links

- Network Provider EDI Website:

- Vendor/Biller Selection Criteria Checklist:

- EDI Readiness Assessment:

- Provider Relations: [FFS2@dmh.lacounty.gov](mailto:FFS2@dmh.lacounty.gov)
Questions