Clinical Documentation Training:
Mental Health Medi-Cal Specialty Mental Health Services

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Outpatient Behavioral Health Services Provided by Medical Staff

October 2016

San Francisco Department of Public Health
Behavioral Health Services
Quality Management
Clinical Documentation Improvement Program

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Requirements & Resources

- **Requirements:**
  - *Mental Health Plans (MHPs) are responsible for* setting standards and implementing processes that support the understanding of and compliance with documentation standards set forth by DHCS and the MHP (p23, MHP-DHCS Boilerplate Contract)
  - *Providers/organizations are required to*: (a) maintain certification and/or licensure for services; (b) maintain client records in accordance with Federal/State/Local standards & (c) meet the MHP Quality Management Program standards (CCR Title 9, §1810.435)

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Requirements & Resources

- **BHS Resources:**
  - Clinical documentation support: BHS' QM Clinical Documentation Improvement Program
  - Regulatory compliance support: DPH's Office of Compliance and Privacy Affairs
  - Contract compliance support: DPH's Business Office of Contract Compliance

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Chapters in this Training Curricula

Chapter and Title
1. Clinical Documentation in an Electronic Health Record (Avatar Example)
2. Training Philosophy & Logic of Mental Health Medi-Cal Insurance
3. Medical Necessity for Mental Health Medi-Cal Specialty Mental Health Services (SMHS)
4. Credentialing, Qualifications and Billing Privileges
5. Assessments
6. Client Plans [aka “Treatment Plan of Care” (TPOC)]
7. Outpatient Services & Documenting Progress Notes
8. Insights from a 2015 DHCS Training

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Agenda For Today

Chapter and Title	Objective
1. Clinical Documentation in an Electronic Health Record (Avatar Example)	• Primary strategy = "read the prompts on the screen…."
2. Training Philosophy & Logic of Mental Health Medi-Cal Insurance	• "Golden Thread" = Logic of Medi-Cal + Logic of Clinical Practice
3. Medical Necessity for Mental Health Medi-Cal Specialty Mental Health Service	• 4 Required Elements and 4 Pathways
4. Credentialing, Qualifications and Billing Privileges	• Who are you in this Managed Care Organization?
5. Assessments	• What is the problem (11 elements)
6. Client Plans/Treatment Plan of Care	• Why does the problem exist (11 elements)
7. Outpatient Services & Documenting Progress Notes	• How to address the problem (11 elements)
8. Insights from a 2015 DHCS Training	• How does DHCS think?

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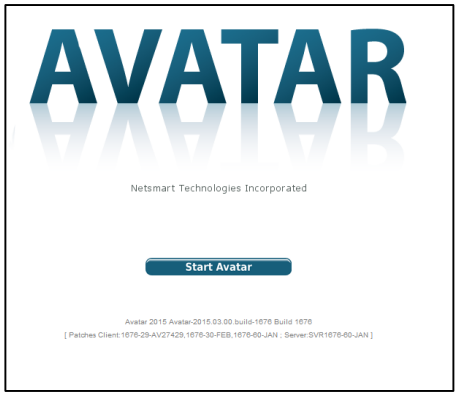
Chapter 1:

Clinical Documentation in an Electronic Health Record (Avatar Example)

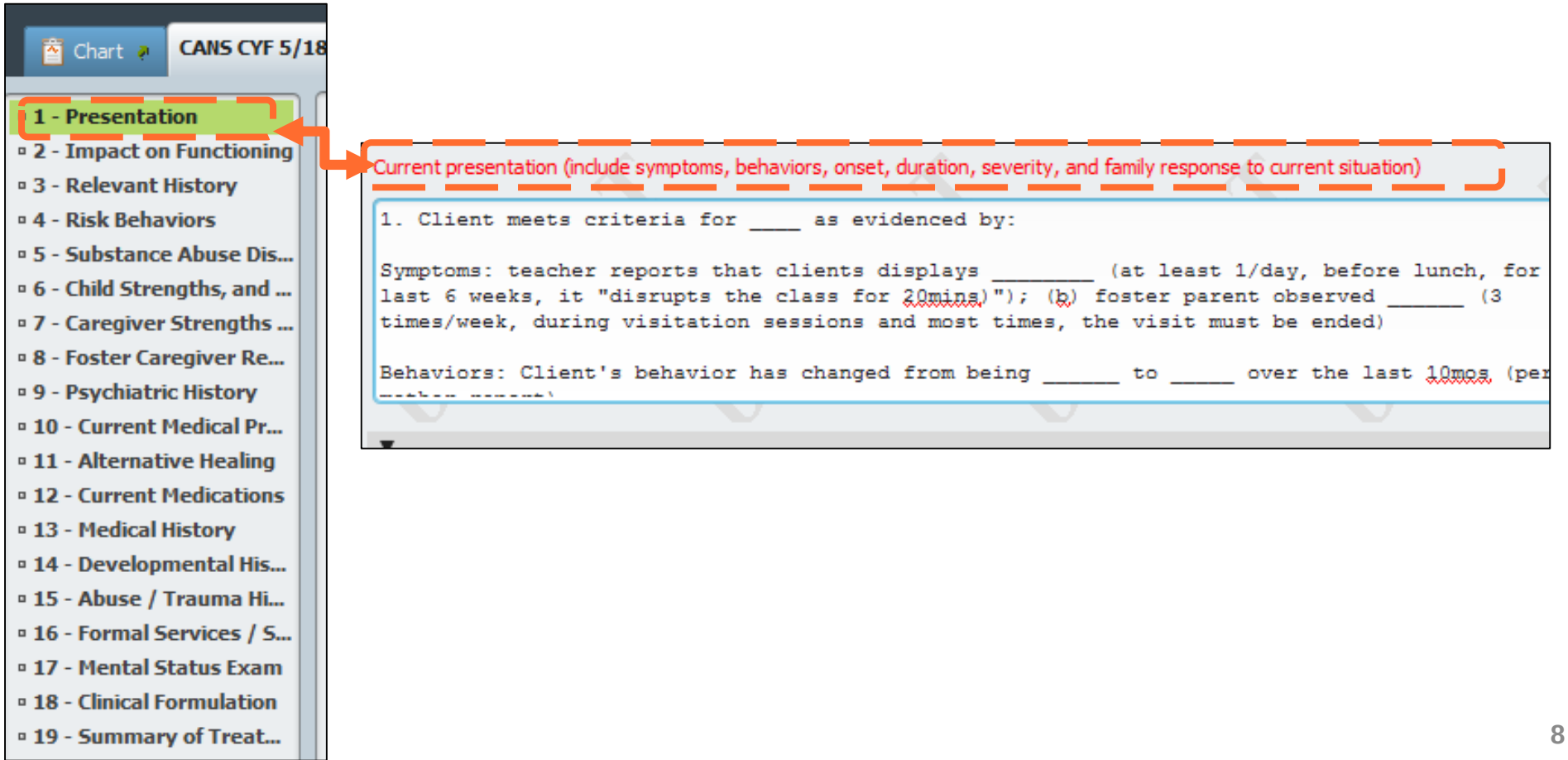
Chapter 1: Clinical Documentation in an EHR

- **It's easy to get overwhelmed and/or disoriented in a clinical documentation training!**

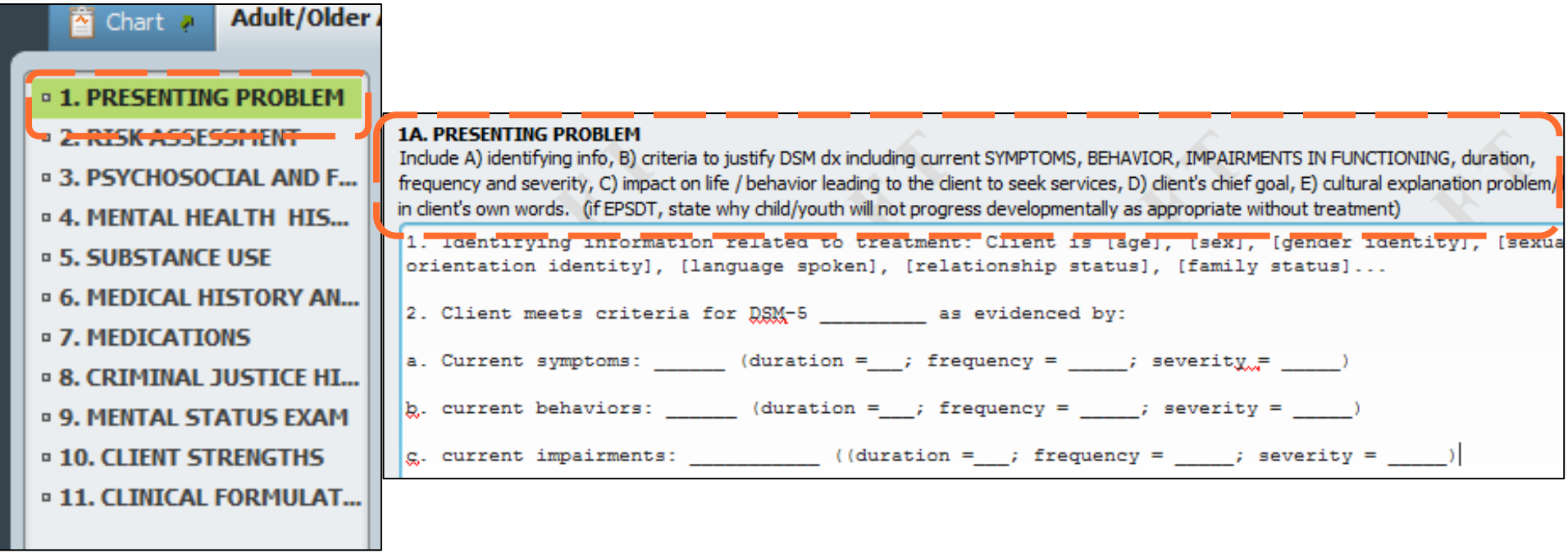
REMEMBER: if you **read** the sentence prompts that appear on the Avatar EHR screen and **answer them specifically**, then you are on the right track!



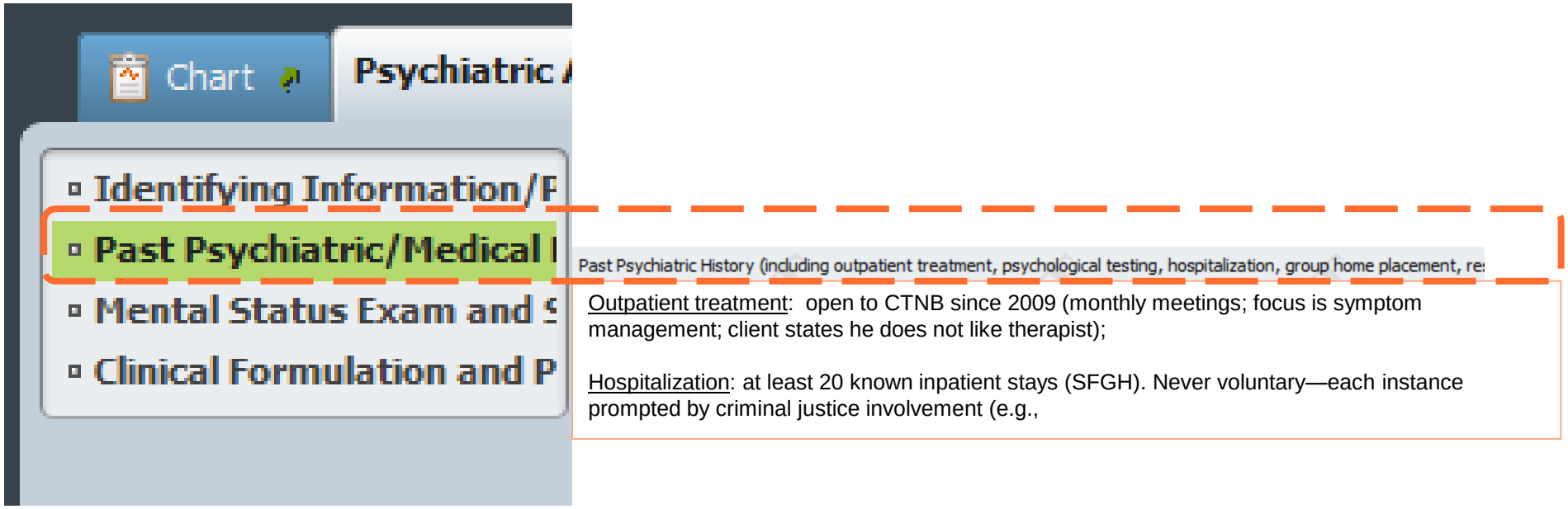
- **Children Aged 5-18 Assessment:**
  - 19 Sections—respond to the prompts on the screen



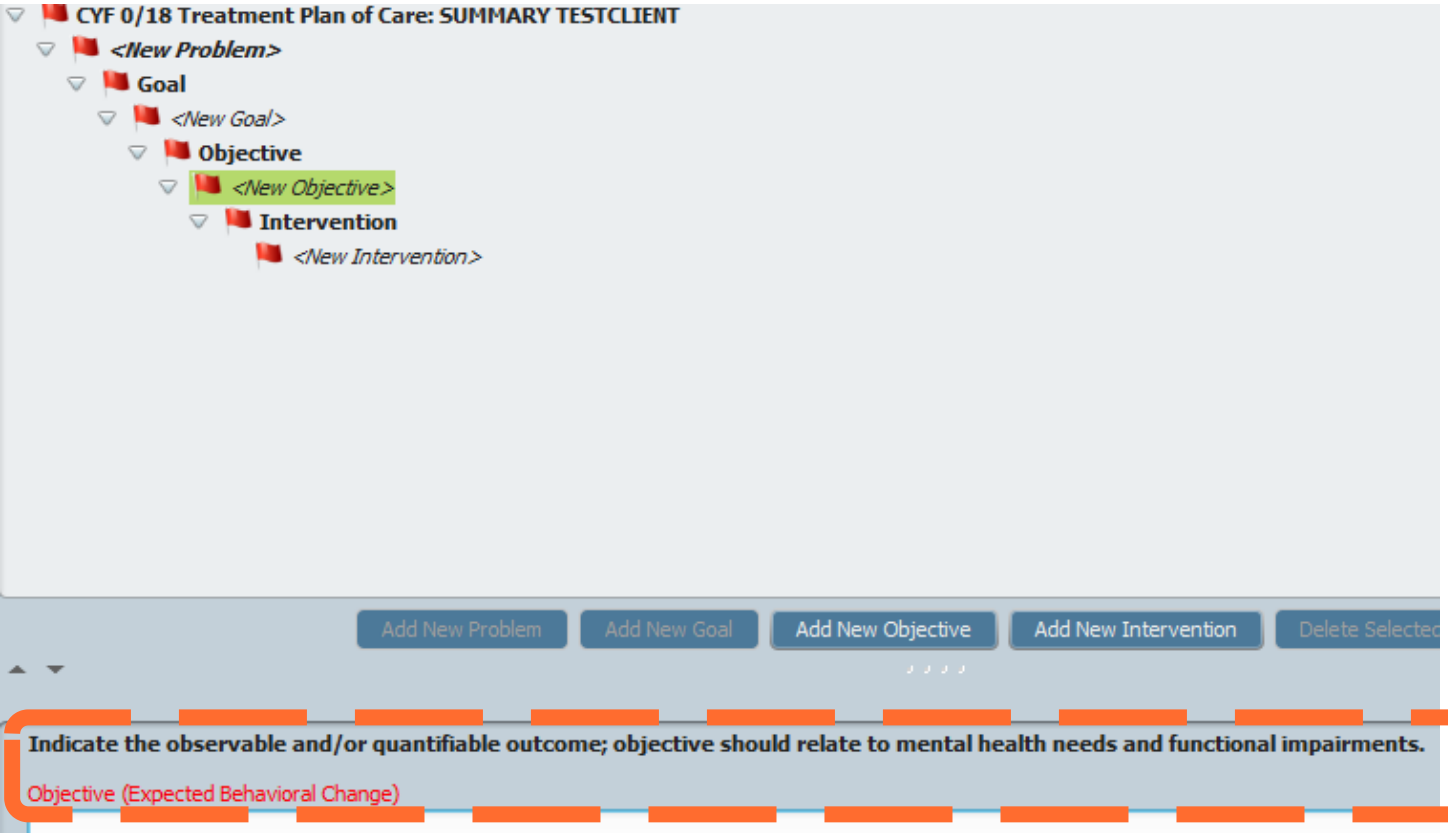
- **Adult/Older Adult-Short/Long Assessment:**
  - 11 Sections—respond to the prompts on the screen



- **Psychiatric Assessment Form:**
  - 4 Sections—respond to the prompts on the screen



- **TPOC (All Clients):**
  - 4 Levels: Respond to the prompts on the screen



Chapter 2:

Logic of Mental Health Medi-Cal Insurance

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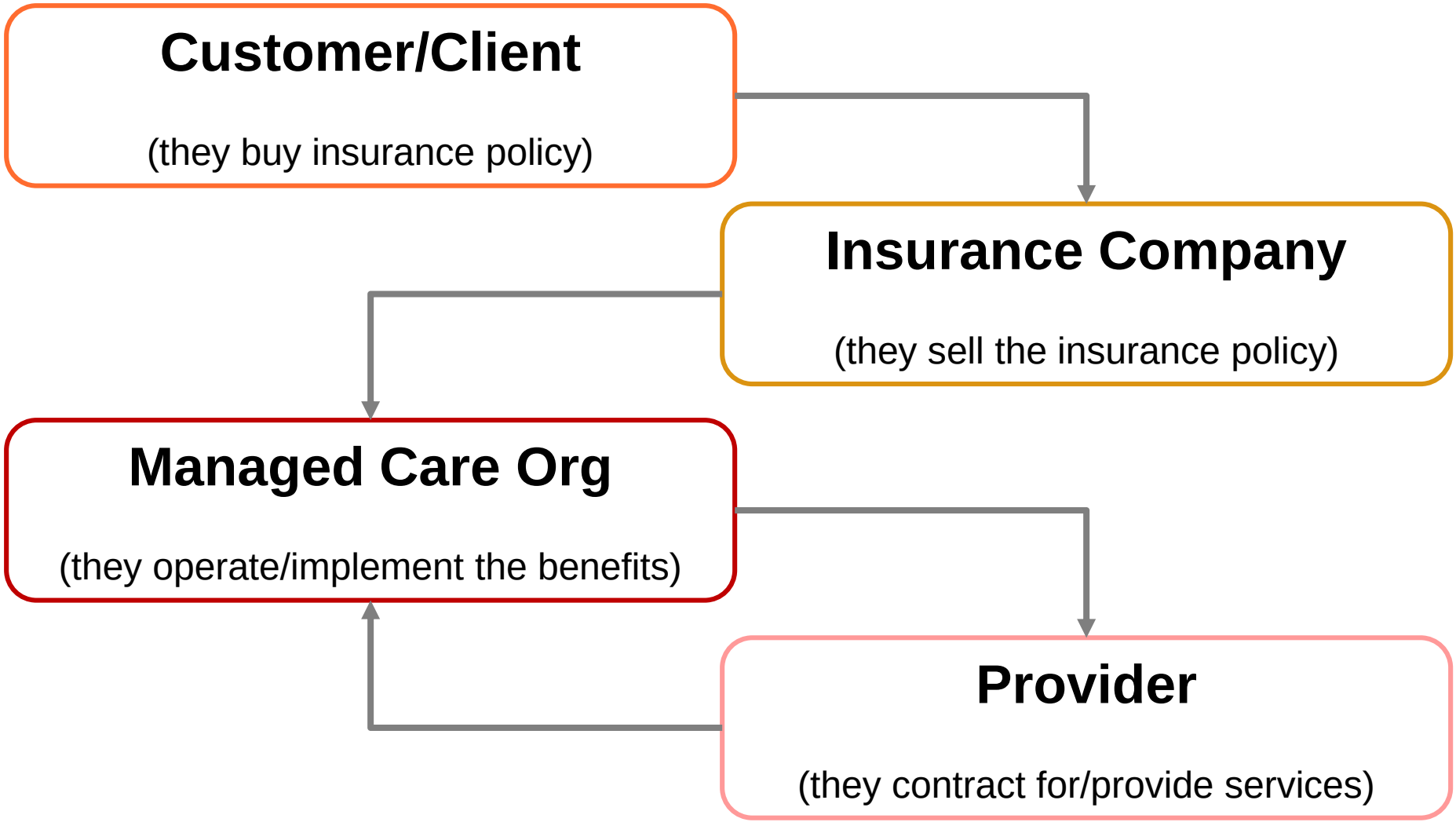
Chapter 2: Logic of Mental Health Medi-Cal



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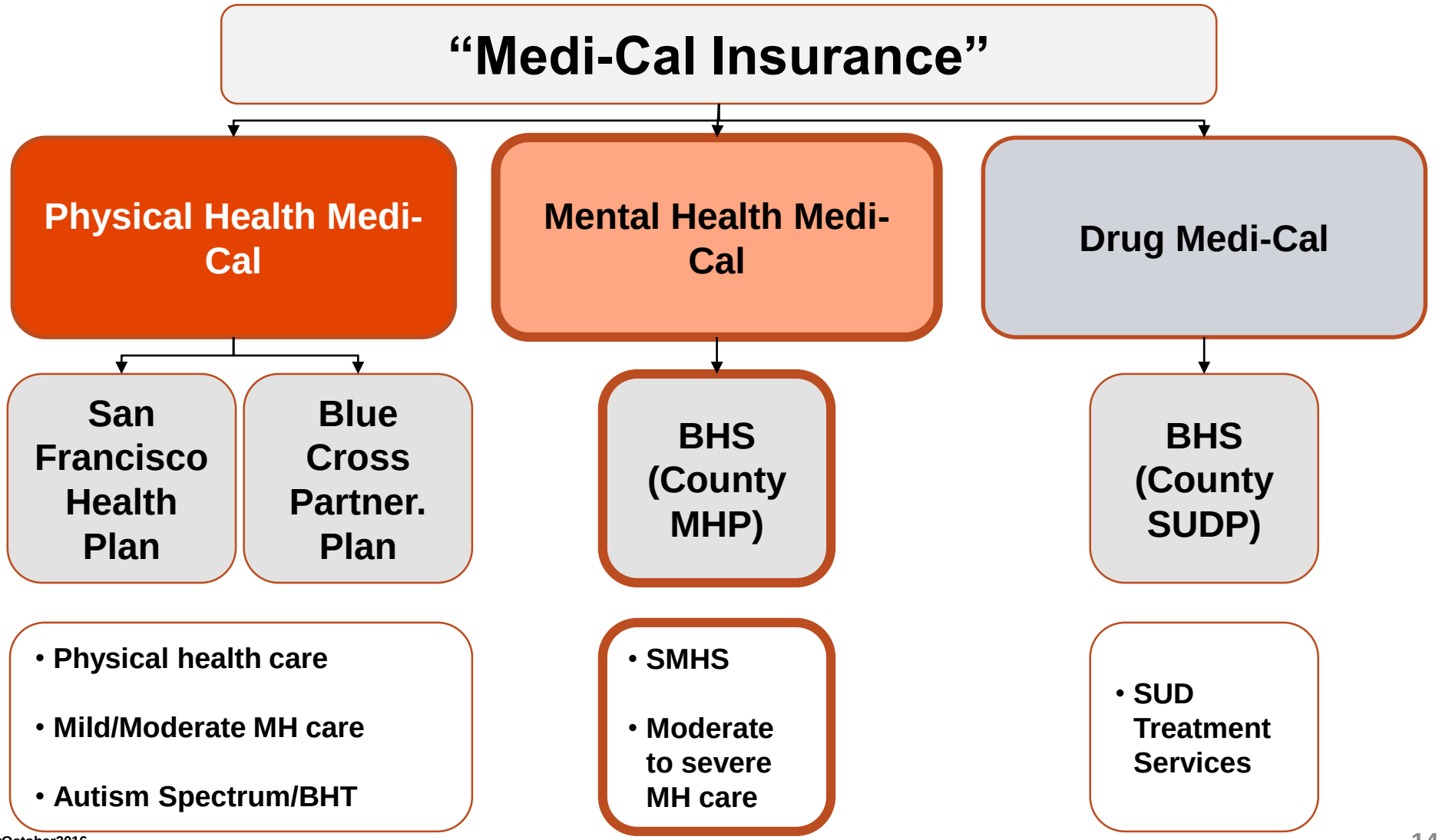
Chapter 2: Logic of Mental Health Medi-Cal



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Chapter 3:

Medical Necessity for Mental Health Medi-Cal Specialty Mental Health Services (SMHS)

Chapter 3: Medical Necessity for Outpatient SMHS

- DHCS Requirements (FY16-17 Audit Protocol)

1. Covered Mental Health **Diagnosis**
2. Functional **Impairments**
3. Treatment **Interventions**
4. **Not Responsive** to Physical Health Care Treatment

Chapter 3: Medical Necessity for Outpatient SMHS

- **Functional Impairments** as a result of the qualifying diagnosis:
  - **Symptoms** = behavioral **expressions/actions** associated with the disorder
    - **Distractibility** in client with ADHD diagnosis…
  - **Impairments** = the **consequences/outcomes** that ensue for the individual as a result of these behaviors
    - …causes poor **academic** performance (Functioning)
    - …causes loss of **friendships** (Functioning)

Chapter 3: Medical Necessity for Outpatient SMHS

- **Functional Impairments** as a result of the qualifying diagnosis (cont.):
  - DHCS Requirements (FY16-17 Audit Protocol): **Meet at least one of the following criteria**:
    - A **significant impairment** in an important area of life functioning
    - A probability of **significant deterioration**
    - A probability that the child will **not progress developmentally** as individually appropriate
    - If full-scope Medi-Cal, under age of 21 years and has a condition as a result of the **mental disorder that SMHS can correct or ameliorate**

Chapter 3: Medical Necessity for Outpatient SMHS

- DHCS Requirements (FY16-17 Audit Protocol): **Treatment Interventions meet two criteria**:
  - The focus of the proposed/actual interventions must **address the functional impairment** identified as a result of the qualifying mental health diagnosis
  - **Focus** = functional impairments
  - **Proposed** interventions = creating Client Plan
  - **Actual** interventions = creating Progress Notes

Chapter 3: Medical Necessity for Outpatient SMHS

- DHCS Requirements (FY16-17 Audit Protocol): **Treatment Interventions meet two criteria** (cont):
  - **Expectation** that proposed/actual interventions must do **one of the following**:
    - **Significantly diminish** the functional impairment
    - **Prevent** significant **deterioration** in functioning
    - Allow for a child to **progress developmentally** as individually appropriate
    - **Correct/ameliorate** the condition for FS-MC, <21 years

Chapter 3: Medical Necessity for Outpatient SMHS

- **Tip**: These are **clinical stories**…line up your functional impairments & interventions.

Functional Impairment Pathway	Treatment Interventions Pathway
#1: Client has current **significant impairments**…	…my interventions will **significantly diminish** impairments
#2: Client has **probability of significant deterioration**…	…my interventions will **prevent significant deterioration** in functioning
#3: Child client has probability of child **not progressing developmentally**…	…interventions **allow the child to progress developmentally**
#4: Child client has Full-scope Medi-Cal + <21yrs + a **condition that SMHS can correct or ameliorate**…	…interventions **correct or ameliorate the condition**

Chapter 3: Medical Necessity for Outpatient SMHS

- DHCS Requirements (FY16-17 Audit Protocol): **The Condition Would Not Be Responsive to Physical Health Care-Based Treatment:**

  - The **condition** (that exists as a result of a covered diagnosis) **would not be responsive** to physical health care based treatment.

  - **Examples**:

    - **Depression** related to a **thyroid** condition.
    - **Traumatic brain injury** that leads to **violent behaviors.**

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Chapter 4:

Credentialing, Qualifications and Billing Privileges

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Chapter 4: Credentialing/Qualifications/Privileges

- **Scope of Practice**: the health care services a physician/health care practitioner is authorized to perform by virtue of a professional license, registration or certification

- **Credentialing**: based on your education/licensure and status, the Mental Health Plan (MHP) will "credential" you with "privileges" to bill specific services

- **MH Medi-Cal**: you will be "credentialed" by the County MHP and this restricts services you provide

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Chapter 4: Credentialing/Qualifications/Privileges

- **Licensed Practitioner of the Healing Arts (LPHA)**:
  - Physician/Medical Doctor (Licensed)
  - PhD (Licensed, Registered or Waivered)
  - PsyD (Licensed, Registered or Waivered)
  - MFT (Licensed, Registered or Waivered)
  - MSW (Licensed, Registered or Waivered)
  - Professional Counselor (Licensed, Registered or Waivered)
  - Registered Nurse (if Psych Masters, CNS, or NP; Licensed, Registered or Waivered)

- **<u>Only</u> LPHA can establish diagnosis!**
- **LPHA <u>must</u> sign/co-sign Client Plan/Tx Plan!**

Chapter 4: Credentialing/Qualifications/Privileges

- **Not LPHA**:
  - 2 year/Bachelor's Registered Nurse
  - LVN
  - Mental Health Rehabilitation Specialist (MHRS)
  - "Case managers"

- Is your current **"workflow"** set up to **ensure that a LPHA establishes the diagnosis**? To **ensure that a LHPA (co)signs the Client Plan/Treatment Plan**?

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Chapter 4: Credentialing/Qualifications/Privileges

- **SFDPH-BHS; Mental Health Staffing Qualifications for Service & Billing Privileges Matrix (2016):**

Mental Health Staffing Qualifications for Service and Billing Privileges

Mental Health Services	LPHA (MD, LCSW, LMFT, NP, LPCC, Licensed PhD/ PsyD)	Staff Registered with Licensing Boards (ASW, MFTI, PCCI, Waivered PhD/ PsyD)	GRADUATE STUDENT (Unlicensed) MA/ MSW/ MD/ PCC/ MA Psychology Student/ Trainee	RN (BA or AA)/ LVN/ PT	MHRS Master 2yrs exp BA 4yrs exp AA 6yrs exp	BA Degree in a Mental Health Related Field (Unlicensed) 1 yr exp.	HS Degree/ GED (4 yrs exp in MH related field of which 1 yr MUST be in position of supervising direct care staff)	BA not in MH Related Field/ HS Degree/ GED (less than 2 yrs exp in the MH field (Unlicensed)
Collateral	X	X	LPHA must co-sign	X	X	No privilege	No privilege	No privilege
Assessment	X	X	LPHA must co-sign	Cannot establish diagnosis	Cannot establish diagnosis	No privilege	No privilege	No privilege
Individual Psychotherapy	X	X	LPHA must co-sign	No privilege	No privilege	No privilege	No privilege	No privilege
Group Psychotherapy	X	X	LPHA must co-sign	No privilege	No privilege	No privilege	No privilege	No privilege
Group Rehab-Session	X	X	LPHA must co-sign	X	X	LPHA must co-sign	LPHA must co-sign	LPHA must co-sign
Rehabilitation	X	X	LPHA must co-sign	X	X	LPHA must co-sign	LPHA must co-sign	LPHA must co-sign
Plan Development	X	X	LPHA must co-sign	LPHA must co-sign	LPHA must co-sign	No privilege	No privilege	No privilege
TBS Direct Services	X	X	LPHA must co-sign	X	X	No privilege	No privilege	No privilege
TBS Collateral	X	X	LPHA must co-sign	X	X	No privilege	No privilege	No privilege
TBS Plan Development	X	X	LPHA must co-sign	LPHA must co-sign	LPHA must co-sign	No privilege	No privilege	No privilege
Medication Support								
Group Meds – MD	MD	No privilege	MD must co-sign	No privilege	No privilege	No privilege	No privilege	No privilege
Group Meds – RN, PA	RN, PA	No privilege	No privilege	No privilege	No privilege	No privilege	No privilege	No privilege
Group Meds – Mixed	MD, RN, PA	No privilege	MD must co-sign	X	No privilege	No privilege	No privilege	No privilege
Group Meds – LVN/PT	LVN, PT	No privilege	No privilege	X	No privilege	No privilege	No privilege	No privilege
Med Support – MD	MD	No privilege	MD must co-sign	No privilege	No privilege	No privilege	No privilege	No privilege
Med Support – RN, PA	RN, PA	No privilege	No privilege	X	No privilege	No privilege	No privilege	No privilege
Med Support – LVN/PT	LVN, PT	No privilege	No privilege	X	No privilege	No privilege	No privilege	No privilege
Case Mgmt / Brokerage								
Case Management	X	X	LPHA must co-sign	X	X	LPHA must co-sign	LPHA must co-sign	LPHA must co-sign
Crisis Intervention								
Crisis Intervention	X	X	LPHA must co-sign	X	X	LPHA must co-sign	LPHA must co-sign	LPHA must co-sign
Day Treatment								
Intensive Half Day	X	X	LPHA must co-sign	**Daily Note**-No co-sign **Weekly Note**- LPHA must co-sign	**Daily Note**-No co-sign **Weekly Note** – LPHA must co-sign	LPHA must co-sign	LPHA must co-sign	LPHA must co-sign
Intensive Full Day	X	X	LPHA must co-sign	**Daily Note**- No co-sign **Weekly Note**- LPHA must co-sign	**Daily Note**- No co-sign **Weekly Note** – LPHA must co-sign	LPHA must co-sign	LPHA must co-sign	LPHA must co-sign
Rehabilitation Half Day	X	X	LPHA must co-sign	X	X	LPHA /MHRS must co-sign	LPHA/MHRS must co-sign	LPHA /MHRS must co-sign
Rehabilitation Full Day	X	X	LPHA must co-sign	X	X	LPHA /MHRS must co-sign	LPHA/MHRS must co-sign	LPHA /MHRS must co-sign
Miscellaneous Services								
Cancellation	X	X	X	X	X	X	X	X
No Show	X	X	X	X	X	X	X	X
Community Client Contact	X	X	X	X	X	X	X	X

X No restrictions

* California Psych Interns must receive a waiver from DHCS, which is granted for up to 5 yrs. Out-of-State Interns must receive a waiver from DHCS or respective board, which can be granted for up to 3 yrs. Application for the waiver must go through the DPH Compliance Office. Contact Ravi Mehta at (415) 255-3905.

Enclosures

Review of Chapter 4:

Scope of Practice

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Review of Chapter 4: Credentialing/Qualifications/Privileges

- Are **you** a LPHA? *YES or NO*
- Is your **supervisee** a LPHA? *YES or NO or N/A*
- **Only** LPHA can establish **diagnosis**? *YES or NO*
- **LPHA must sign**/co-sign **Client Plan**? *YES or NO*

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Chapter 4.5:

Consent for Medication

Chapter 4.5: Consent for Medication

- BHS Guidance on Medication Consents: posted on BHS Policies/Procedures website

Prescription and Laboratory Svcs for CBHS Patients (CBHS: Administrative Manual Holders, Direct Treatment programs)	3.01-3	5/17/2016
CBHS Clinic Medication Rooms • Attachment 1 | Attachment 2 | Attachment 3 | Attachment 4 | Attachment 5 | Attachment 6 | Attachment 7 | Attachment 8	3.01-4	5/17/2016
Medication Storage, Disposal, and Monitoring in Community Care and Substance Abuse Residential Care Facilities • Appendix A - Centrally Stored Medication and Destruction Record • Attachment 1 - Medication Room Temperature Log • Attachment 2 - Temperature Log for Refrigerator • Attachment 3 - Monthly Expired Medication Review • Attachment 4 - Medication Destruction Log • Attachment 5 - Residential Care Facility Medication Storage – Compliance Checklist	3.01-5	8/9/2016

Chapter 4.5: Consent for Medication

- More info from BHS Policies/Procedures website

BHS Psychiatric Medication Consent in Ambulatory Care (Attachment Adult Informed Consent | Attachment CYF Informed Consent)	3.05-04	2/19/2016

Chapter 4.5: Consent for Medication

- DHCS Guidance on Medication Consents: FY16-17 Audit Protocol posted on DHCS Website

CRITERIA	FINDING Y	P	N	INSTRUCTIONS TO REVIEWERS
Does the MHP have a policy and procedure in place which ensures that Forms JV-220 (Application Regarding Psychotropic Medication), JV-220(A) (Physician's Statement—Attachment), JV-221 (Proof of Notice: Application Regarding Psychotropic Medication), JV-222 (Input on Application Regarding Psychotropic Medication), and JV-223 (Order Regarding Application for Psychotropic Medication) will be completed and in the beneficiary's medical record when psychotropic medications are prescribed under the following circumstances: 1) When a child is under the jurisdiction of the juvenile court and living in an out-of-home placement and the child's physician is asking for an order: • Giving permission for the child to receive a psychotropic medication that is not currently authorized *or* • Renewing an order for a psychotropic medication that was previous authorized for the child because the order is due to expire?				**SUGGESTED DOCUMENTATION:** ☐ Policies and Procedures #_____ **GUIDANCE:** • Use of the forms is optional for a child who is a ward of the juvenile court and living in an out-of-home facility that is not considered a foster care placement as defined in *Welfare and Institutions Code* Section 727.4, unless one of the forms is required by a local rule of court. • Use of the forms is not required if the court has previously entered an order giving the child's parent the authority to approve or deny the administration of psychotropic medication to the child. • The JV220 does not replace the need for a medication consent form to be completed. A physician could review with the beneficiary the elements in the JV220 that are some of the elements required to be covered as part of the medication consent form but medication consent needs to be completed and signed. The consent could document that the JV220 information was reviewed with the beneficiary and the JV220 could be attached to the medication consent form.
2) For a child who is a ward of the juvenile court and living in a foster care placement, as defined in Welfare and Institutions Code Section 727.4?				
Judicial Council Forms, JV 219				**OUT OF COMPLIANCE:** • MHP does provide evidence of a policy or procedure to ensure Form JV-220 is completed when a child is under the jurisdiction of the juvenile court and living in an out-of-home placement and the child's physician is asking for an order or for a child who is a ward of the juvenile court and living in a foster care placement.

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Chapter 4.5: Consent for Medication

- DHCS Guidance on Medication Consents: FY16-17 Audit Protocol posted on DHCS Website

	CRITERIA	Y	P	N	INSTRUCTIONS TO REVIEWERS
3. 3a.	Regarding medication consent forms: Did the provider obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication?				**GUIDANCE:** • Review the medication orders and medication consents. • Attestation by clinician is not acceptable in lieu of medication consent. • Medication consents should be specific for each medication prescribed. • For circumstances in which a beneficiary does not have a medication history and/or current medications, reviewers should indicate "Not Applicable" in the findings.
3b.	Does the medication consent for psychiatric medications include the following required elements: 1) The reasons for taking such medications?				

Chapter 4.5: Consent for Medication

- DHCS Guidance on Medication Consents: FY16-17 Audit Protocol posted on DHCS Website

	CRITERIA	Y	P	N	INSTRUCTIONS TO REVIEWERS
	2) Reasonable alternative treatments available, if any?				**Compliance Rating:** _____% (Number of med consents meeting requirements/Total number of med consents reviewed in audit sample)
	3) Type of medication?				
	4) Range of frequency (of administration)?				
	5) Dosage?				
	6) Method of administration?				
	7) Duration of taking the medication?				
	8) Probable side effects?				
	9) Possible side effects if taken longer than 3 months?				
	10) Consent once given may be withdrawn at any time?				
3c.	Do medication consents include: 1) The date of service?				
	2) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?				
	3) The date the documentation was entered in the medical record?				
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act*					**OUT OF COMPLIANCE**: • No assessment has been completed. • The assessment or other documents in the medical record do not contain the required elements.

(Revised 08/01/2016) FY 2016-2017 Protocol

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Chapter 5: Assessments

What is the problem?

Chapter 5: Assessments ("What is the Problem")

- The **11 Required Items for Every Assessment Document** (from FY16-17 DHCS Chart Audit Protocol)**:**

1. **Presenting problem:** The beneficiary's chief complaint, history of presenting problem(s) including current level of functioning, relevant family history and current family information;

2. **Relevant conditions & psychosocial factors:** Those factors affecting the beneficiary's physical health and mental health including, as applicable; living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma;

Chapter 5: Assessments ("What is the Problem")

- The **11 Required Items for Every Assessment Document (cont.):**

3. **Mental Health History.** Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data such as previous mental health records and relevant psychological testing or consultation reports;

4. **Medical History.** Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;

Chapter 5: Assessments ("What is the Problem")

- The **11 Required Items for Every Assessment Document (cont.):**

5. **Medications.** Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The **assessment must include documentation of the absence or presence of allergies** or adverse reactions to medications **and documentation of an informed consent for medications**;

6. **Substance Exposure/Substance Use.** Past and present use of *tobacco, alcohol, caffeine, CAM* (complementary and alternative medications) and over-the-counter drugs, and illicit drugs;

Chapter 5: Assessments ("What is the Problem")

- The **11 Required Items for Every Assessment Document (cont.):**

7. **Client Strengths.** Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;

8. **Risks.** Situations that present a risk to the beneficiary and/or others, including past or current trauma;

9. **A mental status examination;**

Chapter 5: Assessments ("What is the Problem")

- The **11 Required Items for Every Assessment Document (cont.):**

10. **A Complete Diagnosis:** A diagnosis from the current ICD-code must be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; including any current medical diagnoses.

11. **Additional clarifying formulation information, as needed**

Chapter 5: Assessments ("What is the Problem")

- **Billing:** For the initial assessment/TPOC, only bill ***Assessment (90792)*** **and** ***Plan Development*** **(H0032) services until you finalize the assessment** form in Avatar. **You can bill "Crisis Intervention" if there is a crisis.**

Billable Services: 1. Assmt+Plan Devel 2. Crisis Intervention	**Billable Services:** 1. Assmt+Plan Devel 2. Crisis Intervention	**Billable Services:** 1. Planned Services 2. Crisis Intervention
Clinical Practice	**I conduct an assessment:** "*what* is the problem?"	**I create a treatment plan:** "*why* the problem exists"	**I provide interventions:** "*how* we address the problem"
M-Cal Logic	**Establish Diagnosis & Functional Impairments**	**Create Treatment Plan/Client Plan**	**Provide Treatment Interventions**

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Chapter 6:

Client Plans
(Treatment Plan of Care/TPOC)

<u>Why</u> does the problem exist?

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Chapter 6: TPOC ("Why Does the Problem Exist")

- The **Client Plan** is important!
  - The Client Plan must **address the mental health needs** identified in the **current assessment** (*The Golden Thread*…assessment→impairments).
  - The Client Plan must **have Goals/Objectives that address the functional impairments** (*The Golden Thread*…assessment→impairments).
  - The Client Plan **must be updated** when there are **significant changes in the client's condition** (at a minimum, updated **Annually**).

Chapter 6: TPOC ("Why Does the Problem Exist")

- The **11 Required Items for Every Client Plan/TPOC** (from FY16-17 DHCS Chart Audit Protocol)**:**

1. **Client Plan Updates**: The Initial Client Plan is finalized by Day 60 (for Outpatient). The client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition.

2. **Objectives**: Client Plan objectives must be specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.

Chapter 6: TPOC ("Why Does the Problem Exist")

- The **11 Required Items for Every Client Plan/TPOC** (from FY16-17 DHCS Chart Audit Protocol)**:**

3. **Interventions**: The Client Plan contains the proposed type(s) of interventions/modalities. There must be a detailed description of the intervention to be provided.

4. **Frequency of Interventions**: The Client Plan includes the proposed frequency of the intervention(s).

5. **Duration of Interventions**: The Client Plan includes the proposed duration of the intervention(s).

Chapter 6: TPOC ("Why Does the Problem Exist")

- The **11 Required Items for Every Client Plan/TPOC** (from FY16-17 DHCS Chart Audit Protocol)**:**

6. **Target of Interventions**: The Client Plan interventions focus on and address the identified functional impairments as a result of the mental disorder or emotional disturbance. .

7. **Consistency of Interventions with Objectives & Diagnosis**: The Client Plan interventions are consistent with both: (1) Client Plan goal(s)/treatment objective(s) and (2) the qualifying diagnoses.

Chapter 6: TPOC ("Why Does the Problem Exist")

- The **11 Required Items for Every Client Plan/TPOC** (from FY16-17 DHCS Chart Audit Protocol)**:**

8. Staff signatures: The Client Plan is signed by:

(1) Person providing the service(s) ***or***

(2) Person representing a team or program providing the service(s) ***or***,

(3) A person representing the MHP providing the service(s) ***or***

(4) Co-signed by a LPHA (if the Client Plan is used to establish that services are provided under the direction of a LPHA, and if the signing staff is not a LPHA

Chapter 6: TPOC ("Why Does the Problem Exist")

- The **11 Required Items for Every Client Plan/TPOC** (from FY16-17 DHCS Chart Audit Protocol)**:**

9. Client Participation & Agreement with Plan:

The client's participation in and agreement with the Client Plan is documented by one of the following: (1) reference to the client's participation in/agreement written within the body of the Client Plan, (2) the client's signature* on the client plan or (3) a description of the client's participation in/agreement documented in the medical record.

The client's signature* (or client's legal representative's signature) must appear on the Client Plan if both of the following are true: (1) the client is expected to be in long-term treatment [defined by County MHP] and (2) the Client Plan includes more than 1 type of SMHS [e.g., "Therapy" and "Collateral"].

***If the **client refuses or is unavailable to sign** the Client Plan, then the Client Plan must **include a written explanation of the refusal/unavailability of the signature**.

Chapter 6: TPOC ("Why Does the Problem Exist")

- The **11 Required Items for Every Client Plan/TPOC** (from FY16-17 DHCS Chart Audit Protocol)**:**

10. **Evidence of Offering Client Copy of Plan**: The Client Plan will include documentation that the contractor offered a copy of the client plan to the beneficiary.

11. **Dates & Staff Degree/Title**: The Client Plan must include all of the following (1) the date of service; (2) the staff's signature, professional degree and title of job/licensure; and (3) the date the documentation was entered into the medical record.

Chapter 6: TPOC ("Why Does the Problem Exist")

- Additional Details for the Client Plan

  - **Document your ongoing attempts to get the client's signature** on the Client Plan—get that signature!

  - The Client Plan is **officially "finalized" when all <u>required</u> staff signatures are in place and dated**.

  - You must finalize the Client Plan **before providing treatment services**. In other words, **you cannot bill "planned services" until the Client Plan is finalized—you will only be able to bill "Plan Development" services**.

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Chapter 7:

Outpatient Services & Progress Notes

How We Address the Problem

Chapter 7: Services ("How to Address the Problem")

- **Outpatient SMHS for SFDPH-BHS**:
  - **SFDPH-BHS certifies and authorizes** clinics and staff to provide **a limited "package"** of SMHS.
  - For every billable service you provide, **you must document the encounter in a progress note using the Avatar EHR**.
- **Outpatient SMHS for DHCS**:
  - **Eleven required elements** for every progress note!

Chapter 7: Services ("How to Address the Problem")

- The **11 Required Elements** (from FY16-17 DHCS Chart Audit Protocol):

1. **Relevant Aspects of Client Care:** Progress notes include documentation of relevant aspects of client care, including documentation of medical necessity;

2. **Details of the Encounter:** Progress notes include documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;

Chapter 7: Services ("How to Address the Problem")

- The **11 Required Elements** (from FY16-17 DHCS Chart Audit Protocol):

3. **Interventions & Details:** Progress notes include descriptions of interventions applied, client's response to the interventions, [how interventions reduced impairment/restored functioning/prevented deterioration in an important area of life functioning out lined in the Client Plan], and the location of the interventions;

4. **Date of Service:** Progress notes include the date the services were provided;

Chapter 7: Services ("How to Address the Problem")

- The **11 Required Elements** (from FY16-17 DHCS Chart Audit Protocol):

5. **Referrals:** Progress notes include documentation of referrals to community resources and other agencies, when appropriate;

6. **Follow-Up Care and/or Discharge Summary:** Progress notes include documentation of follow-up care or, as appropriate, a discharge summary (***more on this…***);

7. **Service Time**: Progress notes include documentation of the amount of time taken to provide services;

Chapter 7: Services ("How to Address the Problem")

- The **11 Required Elements** (from FY16-17 DHCS Chart Audit Protocol):

8. **Signature, Degree & Licensure/Title:** Progress notes include the signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title;

9. **Date of Documentation:** The date the documentation was entered in the medical record;

Chapter 7: Services ("How to Address the Problem")

- The **11 Required Elements** (from FY16-17 DHCS Chart Audit Protocol):

10. Timeliness, Frequency & Legibility:

a) Every outpatient service contact/encounter must be documented as a progress note and (b) finalized in the medical record within 5 days from the date of service

b) Late progress notes (i.e., not finalized in the medical record within 5 days from the date of service), staff must include the text "Late Entry" at the beginning of the note

c) All documentation is legible.

Chapter 7: Services ("How to Address the Problem")

- The **11 Required Elements** (from FY16-17 DHCS Chart Audit Protocol):

11. **Multi-Provider Notes:** When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes include:

a) Documentation of each person's involvement in the context of the mental health needs of the beneficiary?

b) The exact number of minutes used by persons providing the service?

c) Signature(s) of person(s) providing the services?

Chapter 7: Services ("How to Address the Problem")

- **Additional Details on Element #11: Multi-Provider Notes**:

  - **Principles** when **two or more providers** are rendering services:

    - Document **why multiple staff are needed** for the activity;
    - Document **the unique contribution** for each person's involvement;
    - **Prorate/apportion the staff service time across all clients in the room** (regardless if Medi-Cal or other insurance)

Chapter 7: Services ("How to Address the Problem")

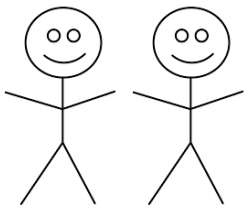
- **Additional Details on Element #6: Follow-Up Care and/or Discharge Summary**:

  - **Billable service:**
    - Conducting a **therapeutic session with a client to create a discharge plan** (and/or a **therapeutic session to review a discharge plan with client**).

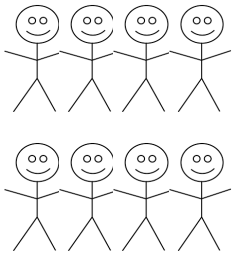
  - **Not billable:**
    - **Typing the discharge summary;**
    - Creating a discharge summary **after your last session with client**.

Chapter 7: Services ("How to Address the Problem")

- **Additional Details on Element #11: Multi-Provider Notes**:
  - **Prorating Example**: Social Skills Group (60mins) with 2 Staff and 8 Clients…**how many mins/client?**



2 Staff x 60mins = 120mins



8 clients total

Formula for Prorating Multi-Provider Services

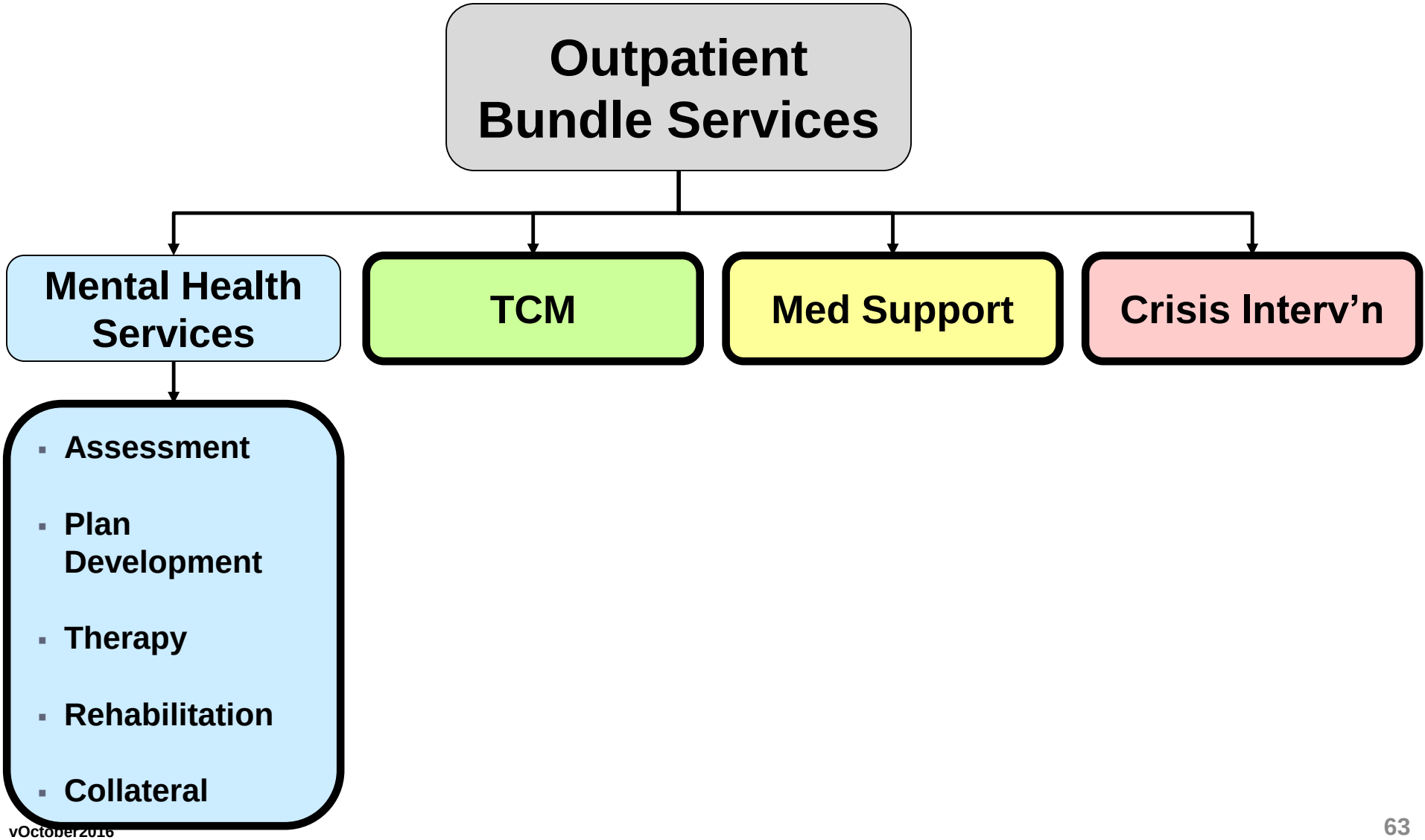
(#Staff) x (# Minutes) ÷ (# of clients)

(2 Staff) x (60mins) ÷ (8 Clients)

120 Staff Minutes ÷ 8 clients

15 Staff Minutes Per Client

Chapter 7: Services ("How to Address the Problem")



Mental Health Services: DHCS Definition

- **"Mental Health Services"** means **individual or group therapies and interventions** that are designed to **provide reduction of mental disability and restoration, improvement or maintenance of functioning** consistent with the goals of learning, development, independent living and enhanced self-sufficiency…**[s]ervice activities** may include but are not limited to ***assessment, plan development, therapy, rehabilitation and collateral***.

#1: Assessment-*Definition*

- "***Assessment***" means a service activity designed to ***evaluate the current status*** of a beneficiary's ***mental, emotional, or behavioral health***. Assessment includes but is not limited to one or more of the following: ***mental status determination***, analysis of the beneficiary's ***clinical history***; analysis of ***relevant cultural issues*** and history; ***diagnosis***; and the ***use of testing procedures***

#1: Assessment-*Example Text*

- "Initial ***meeting with client for the purposes of conducting an assessment to determine medical necessity*** for Specialty Mental Health Services."

- "***Conducted mental status exam***: client shows ***impaired Thought Processes*** (loose associations; flight of ideas) and ***Content*** (paranoid delusions) which are consistent with the reason for referral."

- "Will ***continue assessment process*** in next meeting."

#2: Plan Development-*Definition*

- "***Plan Development***" means a service activity that consists of ***development of client plans***, ***approval of client plans***, and/or ***monitoring of a beneficiary's progress***.

#2: Plan Development-*Example Text*

- "Met with client ***for the purposes of developing Client Plan objectives*** to ***address functional impairments*** (social problems) that ***result from client's mental health diagnosis*** (Schizophrenia, F20.9; inability to concentrate)."

- "The ***client identified the following goals***: 'make food at home so I can save money' and 'meet more people so I can find someone to date.'"

#3: Therapy-*Definition*

- "**Therapy**" means a service activity that is ***a therapeutic intervention*** that ***focuses primarily on symptom reduction as a means to improve functional impairments***. Therapy may be ***delivered to an individual*** or ***group of beneficiaries*** and ***may include family therapy at which the beneficiary is present***.

Chapter 7: Services ("How to Address the Problem")

#3: Therapy-*Example Text*

- "***Conducted individual therapy session*** to address Client Plan Objective ('meet more people so I can find someone to date')."
- "***Implemented behavioral rehearsal intervention*** with client. Client was ***able to introduce himself*** and ***ask an appropriate open-ended question with minimal prompts*** from therapist."
- "***Mental status exam***: no change in thought content/ processes from initial meeting. No suicidality observed."

#4: Rehabilitation-*Definition*

- "**Rehabilitation**" means a service activity which includes, but is not limited to ***assistance in improving, maintaining, or restoring*** a beneficiary's or group of beneficiaries' ***functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources***; and/or ***medication education***.

#4: Rehabilitation-*Example Text*

- "***Conducted individual rehab session*** to address Client Plan Objective ('make food at home so I can save money')."

- "***Assisted client to create a weekly calendar of food shopping activities.*** Initially, ***client was resistant*** to the activity. ***We reviewed his goals*** and he confirmed this is his current goal. ***Client agreed that he 'gets confused sometimes'*** and then created a weekly calendar and we taped the calendar to the refrigerator."

#5: Collateral-*Definition*

- "**Collateral**" means a service activity to a ***significant support person*** in a ***beneficiary's*** life for the ***purpose of meeting the needs*** of the beneficiary ***in terms of achieving the goals*** of the beneficiary's ***client plan***. Collateral may include but is not limited to ***consultation and training*** of the ***significant support person(s)*** *to* ***assist in better utilization*** of specialty mental health ***services by the beneficiary***, consultation and training of the significant support person(s) to ***assist in better understanding*** *of* ***mental illness***, and ***family counseling with the significant support person(s)***. The beneficiary ***may or may not be present*** for this service activity.

#4: Collateral-*Example Text*

- "***Conducted collateral session*** on phone ***with client's mother***, (a significant support person to the client) ***to address Client Plan Objective*** ('make food at home so I can save money')."

- "***Consulted with mother*** regarding client's weekly calendar of food shopping. ***Explained why the calendar is an important tool*** for the client. Mother agreed that when she calls the client each morning, ***she will cue him to look at the calendar***."

Targeted Case Management (TCM)-*Definition*

- *"**Targeted Case Management**"* means services that ***assist a beneficiary*** *to* ***access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services***. The service activities may include, but are not limited to, ***communication, coordination, and referral***; ***monitoring service delivery to ensure beneficiary access to service and the service delivery system***; ***monitoring of the beneficiary's progress***; ***placement services***; and ***plan development*.**

#4: TCM-*Example Text*

- "***Conducted TCM service*** on phone ***with vocational services staff to address Client Plan Objective*** ('meet more people so I can find someone to date')."

- "***Communicated with vocational program intake staff regarding referral to the program***. I was informed that client cannot begin program for 2 weeks due to staffing shortage. The intake staff member confirmed that she will call the client to introduce herself and explain the delay. ***I will confirm client's understanding of the delay in next session***."

Medication Support-*Definition*

- ***"Medication Support"*** means those services that include ***prescribing, administering, dispensing and monitoring*** of psychiatric ***medications or biologicals that are necessary to alleviate the symptoms of mental illness***. Service activities may include but are not limited to ***evaluation of the need for medication***; evaluation ***of clinical effectiveness and side effects***; the ***obtaining of informed consent; instruction in the use, risks and benefits of and alternatives*** for medication; and ***collateral and plan development related to the delivery of the service and/or assessment of the beneficiary***.

Medication Support-*Example Text*

- "***Provided Medication Support service*** to client ***to address Client Plan Objective*** ('meet more people so I can find someone to date')."

- "Medication management meeting to ***monitor client's clinical response to Risperidone***. He reports that he takes meds as directed ('my mom helps to remind me'). Minimal side effects reported. ***Client states he believes he is more 'stable*** when I take my meds.' Client also reports ***he feels more comfortable talking to people now "than I did last year."***

Crisis Intervention-*Definition*

- "***Crisis Intervention***" means a service, lasting ***less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit***. Service activities include but are not limited to one or more of the following: ***assessment, collateral and therapy***. Crisis intervention is ***distinguished from crisis stabilization*** by being ***delivered by providers who do not meet*** the crisis stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348.

Crisis Intervention-*Example Text*

- "***Provided Crisis Intervention service*** to client ***to intervene for suicidal ideation and need for safety.***

- "***Conducted Crisis Intervention session*** to client. Client called this writer to say ***he is 'feeling suicidal.' Conducted lethality assessment (low risk—client does not have a plan, is not using substances, has history of mild suicidal thoughts, but no attempts)***. Client agreed to go to his mother's house ('she will make me feel better'). Client contracted for safety and stated 'I promise I will call you if I feel bad.'"

Review of Chapter 7:

Outpatient Bundle Services & Progress Notes

Review of Chapter 7: Services ("How to Address the Problem")

- **What have we just discussed?**

  - **Specific categories of treatment interventions** which are reimbursed through MH Medi-Cal/SMHS for many **Outpatient Providers**:

    - **Assessment**
    - **Plan Development**
    - **Therapy**
    - **Collateral**
    - **Targeted Case Management**
    - **Medication Support**
    - **Crisis Intervention**

Review of Chapter 7: Services ("How to Address the Problem")

- **What have we just discussed?**
  - Each service is **defined by DHCS!**
    - **Examples of activities** as well as
    - **Specific criteria that must be addressed in every progress note**.
  - **Golden Thread!**
    - The **context for these services** is the **current Client Plan, objectives** and the **interventions described there**.

Review of Chapter 7: Services ("How to Address the Problem")

- **Service Lockouts**

  - **Service lockout** = situation/circumstance when federal financial participation (FFP) is not available for the specific SMHS.

  - See these as **logical inconsistencies!**

    - **Example:** My client is currently in a high-end placement (e.g., Adult Crisis Residential) and receiving services. I conduct a service activity while she is in Adult Crisis Residential (e.g., I speak with mother about concerns about how to support daughter's safety).

    - This is a service lockout—you cannot provide services to your client (i.e., conduct a collateral session) when you client is already receiving services!

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Chapter 8:

Special Topic-Insights from DHCS (2015)

Chapter 8: DHCS Insights (2015 Training)

- **"SMI" or "SED" ≠ Medical Necessity** for SMHS:
  - Our **Welfare & Institutions Code** (W&I Code) defines and provides criteria for **"Serious Mental Disorder"** adults **"Seriously Emotionally Disturbed"** children [W&I § 5600.3(a) and 5600.3(b) respectively].

Just because your client has been labelled "SMI" or "SED" does not mean that your client meets medical necessity for SMHS!

- **"Covered/Included" Diagnoses for Non-Hospital SMHS & Personality Disorders**

  - We tend to think about Covered/Included diagnoses as "Axis I" disorders, **but that is not entirely true...**

  - **With the exception of Antisocial Personality Disorder (F60.2), Personality Disorders are Covered/Included diagnoses for SMHS**.

  - **Reminder**—you have the list of the DHCS Outpatient SMHS Covered/Included Diagnoses!

- **"Covered/Included" Diagnoses & Personality Disorders (cont.)**

"**Personality disorder categories may be applied with children or adolescents** in those relatively unusual instances in which the individual's particular maladaptive personality traits appear to be pervasive, persistent, and unlikely to be limited to a particular developmental stage or another mental disorder. It should be recognized that the traits of a personality disorder that appear in childhood will often not persist unchanged into adult life. **For a personality disorder to be diagnosed in an individual younger than 18 years, the features must have been present for at least 1 year. The one exception to this is antisocial personality disorder, which cannot be diagnosed in individuals younger than 18 years.** Although, by definition, a personality disorder requires an onset no later than early adulthood, individuals may not come to clinical attention until relatively late in life" (*DSM-5, ps 647-648*).

Excluded Diagnoses for Outpatient SMHS

"Deferred" or "by history"	Communication Disorders	Autism Spectrum Disorder
A stand-alone "Rule Out" diagnosis	Delirium	Tic Disorders
Provisional Diagnosis (either depression or bipolar)	Dementia	Cognitive Disorders (e.g., dementia with depressed mood)
"V" codes	Amnestic Disorders	Substance-Induced Disorders
Mental Retardation (aka Intellectual Disabilities)	Sleep Disorders	Intermittent Explosive Disorder
Learning Disorders	Mental Disorders due to a General Medical Condition	Pyromania
Motor Skill Disorders	Other condition that May be a Focus of Clinical Attention	Antisocial Personality Disorder

Chapter 8: DHCS Insights (2015 Training)

- **Excluded Diagnoses:**
  - "Deferred" or "by history"
  - A stand-alone "Rule Out" diagnosis
  - Provisional Diagnosis (either depression or bipolar)
  - "V" codes
  - Mental Retardation (aka Intellectual Disabilities)
  - Learning Disorders
  - Motor Skill Disorders
  - Communication Disorders
  - Delirium
  - Autism Spectrum Disorder

- **Establishing a Diagnosis**
  - Only a LHPA can establish a diagnosis for SMHS.
  - **You cannot conduct a Mental Status Exam (a primary element of assessment/diagnosis) unless you are a LHPA!**
  - **Reminder**-you have the SFDPH-BHS Mental Health Staffing & Qualifications Matrix for Service & Billing Privileges Matrix (2016).

Chapter 8: DHCS Insights (2015 Training)

- **Client Plan Interventions**: *"Expectation that interventions significantly diminish or prevent significant deterioration…"*
  - **DHCS' Expectations = "Reasonable Mental Health Professional"**
    - "Would a ***reasonable*** mental health professional (***using community standards of care***) expect that your ***intervention would cause a significant diminishment*** of a functional impairment (or ***prevent significant deterioration*** in functioning)?"

Chapter 8: DHCS Insights (2015 Training)

- **Client Plan Interventions**: *"…the type of intervention/modality including a detailed description of the intervention to be provided"*

Modality	Intervention	Written Example
Therapy	Cognitive Reframing	Intervention #1: Therapy (including CBT interventions of cognitive reframing, pleasant activity scheduling and exposure) to improve client's Vocational and Social impairments. Will occur weekly, for 50mins by…
Rehabilitation	Behavioral Modeling	Intervention #2: Rehabilitation (including behavioral modeling and social skills training) to improve client's Social impairments. Will occur every other week for 30mins by…
Collateral	Psychoed & Family Counseling	Intervention #3: Collateral to client's mother (including psychoeducation on episodic schizophrenia) and family counseling with mother and client (developing a mutually agreed plan for mother to support son's treatment) to address Vocational and Social Impairments. Will occur weekly for 40mins by…
Targeted Care Management	Brokerage	Intervention #4: TCM for client (specifically, brokerage and service monitoring) to access Supported Vocational Program. Will occur weekly for 15mins by…
Medication Support	Prescribing & Monitoring	Intervention #5: Medication Support to client (including prescribing and monitoring) to alleviate symptoms of Schizophrenia and improve Social and Vocational functioning. Will

Chapter 8: DHCS Insights (2015 Training)

What's Up with Signatures?

Legal Documents:

- **Informed Consent:** the signature identifies the person who may legally provide consent for treatment (e.g., juvenile dependency court; conservatorship).
- **Release of Information**: the signature identifies the person who may legally control the personal health information (PHI).

"Full Disclosure" Documents:

- **Medication Consent**: the signature demonstrates the client has been advised of risks/benefits (even for dosage change!).

- **What's Up with Signatures (cont.)?**

  - **<u>Assessment Form</u>: LPHA signature/date confirms the mental status exam and differential diagnosis** was conducted by a staff member with the appropriate **scope of practice**.

  - **<u>Client Plan</u>**:

    - ***LPHA* signature/date confirms that treatment interventions are expected to significantly reduce/prevent significant decline** in functioning.

    - ***Client* signature/date confirms that the client participated in and agrees** with the Client Plan.

- **Best Practices for Progress Notes?**

  - Clear, concise and succinct;
  - Interventions are clearly linked to **mental health functional impairments and included diagnosis**;
  - **Client response to intervention is described**:
    - When you provided the intervention, what was the response?
  - **If services are provided in the home**, document **why community-based services need to be offered** to the client.

- **Collateral (Family Counseling) vs. Family Therapy?**

  - **What is the focus of treatment**—this is the key variable to consider!

    - **Collateral** = focus on the **needs of the client in meeting the goals** of their Client Plan

    - **Family Therapy** = **focus is family system (as a whole) and what goes on between individuals** in the family

Chapter 8: DHCS Insights (2015 Training)

- **Case Conferences:**
  - **Document your contribution in the meeting** (vs. listening).
  - **Document the time you participated in the meeting** (vs. claiming the entire meeting).
  - The progress note **must meet medical necessity criteria**!

Chapter 8: DHCS Insights (2015 Training)

- **Activities Not Billable to MH Medi-Cal:**
  - **Solely clerical** activities (e.g., faxing, filling out applications, leaving a voicemail)
  - **Reviewing charts** or other **paperwork**
  - Filling out **SSI forms**, **CPS reports**
  - Filling out **forms for housing needs**
  - **Grocery store trips that do not include skills training or other linkage to functional impairments**
  - No shows
  - Supervision

- **Activities Not Billable to MH Medi-Cal (cont.):**
  - **Solely payee related** activities
  - Staff provides **a service that is not in their scope of practice.**
    - **An LCSW/PhD, etc. can talk with a client about medication compliance** (e.g., barriers), **but cannot assess side effects**, the need for new meds, etc.
  - **Progress notes that have been "cloned"** (i.e., copied/pasted from another chart and **not individualized to client's functional impairments**).

- **Activities Not Billable to MH Medi-Cal (cont.):**
  - **Transportation** (vs. Billable Travel)
    - If you **must provide a service in the community** (client's home, school, work, park, etc.), **you will document the amount of time it takes to drive from your office to the community and return to the office**.
    - **"Service time"** in Mental Health Medi-Cal SMSH **= (Face-to-Face Time) + (Documentation Time) + (Travel Time)**
    - **In contrast, transporting a client (e.g., taking them to a doctor's appointment) is not a billable service.**

Chapter 8: DHCS Insights (2015 Training)

- **Activities Not Billable to MH Medi-Cal (cont.):**
  - **Transportation** (vs. Billable Travel)—**continued**
    - **Document the client's mental health need** that requires you **to travel into the community** (e.g., "client cannot access mental health services at office due to symptoms of agoraphobia"…"client does not have a car and does not have reliable access to mass transportation"…)
    - **Consider adding this to your treatment plan**

Chapter 8: DHCS Insights (2015 Training)

- **Cultural & Linguistic Requirements:**
  - Mental health **interpreter services must be offered and provided.**
  - **Refusal to accept** interpreter services must be **documented in the medical record**.
  - **When applicable**, information must be provided to clients in an **alternative format (e.g., large font; audio)**.
  - **Service-related correspondence = preferred language**

Cultural & Linguistic Requirements (cont.):

Title VI of the Civil Rights Act of 1964:

- **Prohibits the expectation** that family members provide interpreter services and minors should not be used as interpreters.
- **A client may choose** to use a family member/friend as an interpreter **after being informed** of the availability of free interpreter services.
- **In some cases, it may be necessary to use a family member or minor** for interpretation services (e.g., a paranoid client refuses to talk to anyone but the minor child). **In these instances, the justification should be documented**.

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parting thoughts, next steps…