

LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH

SA 4 QIC Minutes

Type of Meeting	QIC	Date	March 17, 2015
Place	St. Anne's Maternity Home, 155 North Occidental Blvd., Los Angeles 90026	Start Time	10:30 a.m.
Chair & Co-Chair	Anahid Assatourian and Alyssa Bray	Adjournment	Noon
Members Present	Misty Aronoff at Alma Family Services; Kanisha McReynolds at Amanecer; Silvia Yan at APCTC; Donetta Jackson at The Anne Sippi Clinic; Lisa Sumlin at Aviva Center; Efrain Marques at BHS; Nahara Martinez, Alma Bretado and Regina Esparza at CHCADA; Pattie Dilliner at CII; Rosie Garcia at Didi Hirsch Metro Center; Maribel Nieves at Dignity Health; Rebecca Okpere at DMHC Mark Borkheim at DMH QI; Elizabeth Townsend DMH-PSB; Diann Kaainoa at DMH/SFC; Jose Guerra at Eisner; Brooke Slusser at EMQ; Carmen Vargas at ENKI; Jeannette Aguilar at Exodus Recovery; Phil Wong at Gateways Hospital; Julie Feuer at Gateways Percy Village; Ruby Minassian & Judy Cardona at Hathaway-Sycamores; Beth Foster at Hillisides; Dora Escalante & Militza Avila at JFS; Nayon Kang KYCC; Connie Chung Joe at KAFS; Francisco Carrillo at LAMP; Frankie Nixon at Optimist Youth Homes; Judi Stadler & at Para Los Ninos; Crystal Carrillo at SSG Project 180; Malin Mattsson at St. Anne's Maternity Home; Martha Arechiga at Telecare Corp.; Patricia Perez at UALI; Dessiree Odom at VIP		
Absent Members	AIDS Project LA, BHS, CHLA, DMH/ASOC, DMH MAT, Aviva; DMH SA4 Navigation Team, DMH/PRO, DMH/QA, DMH/OMD, FASGI, Gateways Community MHC, IMCES, LA Child Guidance Center, LAC-USC Medical Center, LA Gay & Lesbian, Mental Health America, Northeast MHC, Pacific Clinics, SSG API Alliance ACT, Star View Children and Family Services, The Saban Free Clinic, Travelers Aid Society of LA.		
Introductions	Conducted by QIC membership		
Minutes Approval	The March minutes were reviewed and approved		
Announcements	None		

QUALITY IMPROVEMENT

<u>Agenda Item And Presenter</u>	<u>Findings and Discussion</u>	<u>Decisions/ and Recommendations Actions/Scheduled Task</u>	<u>Responsible Person/Due Date</u>
<p>Clinical Quality Improvement</p>	<p>Office of Medical Director (OMD) – Meaningful Use – all Directly Operated clinics have blood pressure machines and weight scales now (when height and weight are entered into IBHIS, body mass index [BMI] is automatically calculated). As part of meaningful use, this will become a regular procedure once a year.</p> <p>OMD – Restriction on Antipsychotics – Nothing has changed, Child Psychiatrists are getting better at it and there are not many questions at this point.</p> <p>OMD – Safety Intelligence – Working on getting the form demo completed. It's taking longer to finalize the demo, which is delaying getting DO clinics set up. For Contractors, DMH is gathering people for user roles. 67% of Contractors have not responded yet. Please see attachment breaking down user roles. The "manager" will do the review and submitting; the "designee" is the person who covers when the "manager" is out; the "consultant" is someone like a QA person who needs to access data; the "reporter" (most frequently the "manager" as well) can do the reporting as well, but will need a token to do so. There will not be special SI tokens, it will just be the usual tokens. If a "reporter" is not the "manager", nothing will be reviewed until the</p>		<p>Alyssa Bray</p>

"manager" submits the report. "Managers" and "designees" will be the people to get things started. There will be a training manual and trainings will be provided once they get closer to rolling this out.

OMD – New policy re med appointments within five business days for clients with urgent needs. Agencies are expressing much concern about this policy, as it does not seem do-able due to agencies having contracted psychiatrists that are only present on specific days. There will be revisions made to the policy stating that agencies can refer these clients to an urgent care center for immediate meds if the agency is unable to provide that service. When this occurs, agencies must report it to their District Chief. In the revision, the definition of "urgent" is going to be spelled out more specifically. The 5150 criteria will be removed. Concerns were raised by agencies in regards to the definition, as it seems to include anyone who meets medical necessity.

Patient's Rights Office
Patient's Rights Office (PRO) – They received a new shipment of 500 more posters. The Spanish NOAs have been finalized. NOA –A and NOA-E forms in English and Spanish will be available online. They are now looking into translating these two forms into the remaining threshold languages.

**Policy Update –
 Office of
 Compliance**

New/Revised Policies (see handout) – Please see attachment outlining new and updated policies.

**Cultural
 Competency
 Updates**

Cultural Competency Committee (CCC) – CRDP is focusing on capacity building. Mark Borkheim provided updates on the CCC workgroups

**Provider Directory
 – QI Project
 Findings, QI Work
 Plan & Evaluation**

QID Project Outcomes (see handout) – Outcomes are noted in specifics in the handout. There were many statistically significant findings. Bottom line of the findings is providers' increased awareness of and action taken towards engaging families in clients' treatment as a result of attending the Family Engagement Training.

Provider Directory Updates – Dennis Murata (Deputy Director) had concerns about changes being made in the Provider Directory that needed to be changed via agencies' District Chiefs and the PFAR process (Provider File Adjustment Request). He wants to be sure agencies go through the formal PFAR process and are not able to make changes to the Provider Directory without doing so. Therefore, requests for changes to the Provider Directory will now go through QIC Liaisons. Liaisons will keep an Excel spreadsheet with all requests for changes (that would not require a PFAR) and QID will download them once a month and make the changes.

QUALITY IMPROVEMENT

		<u>Decisions/ and Recommendations Actions/Scheduled Task</u>	<u>Responsible Person/Due Date</u>
<p>MHSIP Survey</p>	<p>MHSIP Survey Data (see handout) – QID provided a sample table that can be useful for agencies to analyze their MHSIP data as compared to Countywide results and other agencies. If you are interested in analyzing your agency's MHSIP survey data, QID can offer assistance as needed.</p> <p>Mental Health and Spirituality Trainings (see flyer) – One day trainings on March 23rd and 24th from 8am to 5pm at Descanso Gardens. Free to DMH staff and Providers. Limited seating – 50 people per training. CEU's offered.</p>		

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QUALITY ASSURANCE

		<u>Decisions/ and Recommendations/ Scheduled Task</u>	<u>Responsible Person/Due Date</u>
Announcements			
Recent/Upcoming Audits/Reviews	<p>State Chart Review due and expected in March 2016. Be aware of this, as they will be selecting and reviewing charts from agencies, and remember that we are in a more stringent audit climate than in the past.</p>		
State DHCS Updates	<p>State DHCS Updates – 1915b Waiver – allows DMH as a Mental Health Plan (MHP) to be the Provider for Medi-Cal, and that we must follow Medi-Cal rules. The State is working on the application for a five year renewal. Last year they were only able to get a two year renewal. The Feds (CMS) are putting a lot of pressure on the State regarding decreasing the number disallowances, improving access to services, and other things. CMS is asking the State to implement greater oversight and structure to the Counties. The State is encouraging the Counties very strongly to make the State look good to</p>		

CMS by meeting these requests of CMS. They aren't sure if they're going to receive the 5 years again due to the number of problems and because there has been concern regarding the stakeholder process as related to the waiver. They are going to have Stakeholder Forums to address this. The State is aiming to submit the application at the end of March.

TAR (Treatment Authorization Request) for Antipsychotics – There is a provision for a 72 hours dosage which can be renewed.

Documentation Training

Questionable Medi-Cal Billings (QMB) – LACDMH (and other Counties) are starting to receive QMB reports from the State. These occur when the State questions billings and wants LACDMH to investigate them. These investigations are done using the rules from the Office of the Inspector. If your agency ends up in one of these investigations, be totally honest and forthright about everything. The focus review and self-examination goes beyond the period of the audit – perhaps back to the last recertification. The State will check to be sure all QMB claims are voided. State expects County DMH to take the lead to fully investigate and be sure all inappropriate claims are voided. These QMB letters are becoming more common and have been showing up in other Counties. So far, LACDMH has received only one. These letters come to DMH (Dr. Southard and ultimately Dr. Bryant), and DMH will audit the Provider's program. QMB's are more serious. These go to Programs that the State is very concerned about, and the State has to provide CMS with how the State is going to provide more structure and more oversight to address these concerns.

	<p>LACDMH is already doing much more auditing in IBHIS (auditing in IBHIS is easier than paper charts). Also, with Contractors, they have implemented the submission of their QA processes and will be providing much closer monitoring.</p> <p>Schedule of trainings (see handout) – DMH is in the process of coordinating trainings for July, August, and September.</p> <p>Directly Operated Only – LACDMH QA has created a draft QA Chart Review Tool (the auditing process has not changed, just the tool). They tried to account for IBHIS language and new policies/protocols. There is a cheat sheet on the back of the tool that includes all Assessment requirements (data elements) and brief definitions of Service Components. They are in the process of finalizing instructions to go along with the tool (e.g., where to look to find items on the audit tool). They will update the QA guidelines for DO and then send the bulletin out, they are hoping to do this in about a week. DO clinics can use the tool immediately (which will be posted before the instructions) – you do not have to wait for the instructions to use the tool.</p> <p>90792 and M0064 – Bulletin coming out shortly. 90792 has been added as a billing code for doctors. It is the medical counterpart to 90791 and is paid at the MHS rate. How to determine which code to use with the doctor's assessment: If the purpose of the assessment is to develop a diagnosis – use 90792. If the purpose of the assessments to make determinations about medications, use the appropriate E&M code. Also, LACDMH just found out that M0064 was discontinued</p>		
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	<p>effective January 1, 2015. They will give Providers time to make the adjustment, but moving forward, only E&M codes and H2010 can be used for these services.</p> <p>Organizational Providers Manual – LACDMH QA is in the process of revising the TBS section of the Manual (Chapter 3). It should come out some time next month. They are moving TBS Services to Chapter 2. They are aiming to simplify the section. TBS gets the most attention from the State (due to Emily Q – to make TBS services more accessible). There are no changes, they are just simplifying it. There is more clarity on what TBS is NOT to be used for. Also, it will state the lockouts for TBS.</p> <p>Draft Clinical Forms Bulletin – They decided to create this Bulletin because there are a lot of revisions to forms due to IBHIS. The old bulletin is an arduous process, and changing it to a forms bulletin helps them get the information out quickly without having to create an entire bulletin. The information that would have gone into the old Clinical Records Bulletin will be melded into QA Bulletins instead. Concern was expressed by agencies that they would like more information about these forms than is provided on the new version of this bulletin. QA will discuss this concern and get back to us.</p> <p>Auditor-Controller Reports update – There was an issue in which a Provider got very bad results, but the bad results were overshadowed by conspicuous findings. In audits there are disallowances (which are more straight-forward and objective), and findings (which are more subjective). Findings have been very prominent in A/C Reports (e.g., Diagnosis not being supported by assessment, not enough specificity in treatment</p>		
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	<p>objectives). The concern about these findings is that they are based on clinical judgment, and DMH expressed this. They also discussed ethics in auditing (e.g., clinical supervision/agreement versus auditing). The Board of Supervisors (BOS) has expressed great concern over audit results, and in response, DMH QA laid out the above-mentioned concerns. DMH and A/C management met at the audit committee at the BOS, and they were in agreement that sometimes the audit process goes awry and can get off-track (clinical supervision versus auditing), and that findings appear to be quite subjective. Regarding diagnoses, DMH was not interested in going through diagnostic criteria to see they were met. Instead, they're saying a diagnosis must be "reasonable". The A/C might choose a different diagnosis, but as long as the diagnosis is reasonable, it's okay. Decision was made that <u>findings</u> will be left off of audit reports for now. DMH and A/C will be talking further about how findings might ultimately show up (for example, one agency was told by the A/C that there would be a section on their report that says "For discussion only," but DMH QA has not approved this yet). Only disallowances will be in the audit report (and therefore the BOS will see them). Subjective findings will be sent to DMH (BOS will not see findings), and DMH will contact Providers about them. There have also been concerns expressed by agencies about the discrepancies between auditors. DMH QA is aware of this.</p> <p>A/C Updates regarding training – when A/C is auditing an agency, they have been soliciting training to be provided to the agency. Although DMH sees this as a genuine wish to want to help, they believe it is inappropriate for the auditor role. There will be no more trainings by the A/C. In the Exit Interview, they can answer your</p>		
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	<p>questions. During the auditing process they may informally provide some feedback or suggestions – that’s okay and helpful, but they may not provide trainings. DMH QA is also going to look at the A/C’s auditing tool to make sure they are auditing to State standards and not beyond those requirements</p> <p>Community Functioning Evaluation form (CFE) – The CFE fit into the recent discussion they’ve been having related to TCM and Rehab services. They have drafted form that can be used to assist staff when thinking about evaluating and meeting TCM and Rehab needs. The CFE will NOT be a required document.</p> <p>Cal Medi-Connect By: Dr. Alan Lert/Program Support Bureau</p> <p>Cal Medi-Connect – (see handout) Alan Lert presented the Cal Medi-Connect Project and went through the handout provided. The key factor of this process is to integrate and coordinate all services for clients who are eligible for both Medicare and Medi-Cal benefits and services. It is important to send copies of Client Treatment Plans to the Health Plans (HP) of the client. District Chiefs will be getting (and sending out) reports of clients whose Treatment Plans have not been received by the Health Plans and will be following up with providers about this. Treatment Plans must be sent to Health Plans pro-actively. Make sure you send the Client Treatment Plan to the correct HP!</p>		
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Next Meeting: Tuesday, May 19, 2015
St. Anne's Maternity Home
155 N. Occidental Blvd.
Los Angeles, CA 90027

Respectfully submitted,

Alyssa Bray, LMFT, Chair



Anahid Assaturian, Psy.D. Co-Chair

