County of Los Angeles – Department of Mental Health
SA 4 Program Administration

SA 4

CHILD AND ADULT
INTEGRATED QUALITY IMPROVEMENT COMMITTEE

Agenda
August 18, 2015
10:30 AM – 12:00 PM

I.	**Introductions & Review of Minutes**	**10:30 -10:40am**
II.	**Service Area 4 QIC General Announcements** **Ed Vidaurri, Service Area 4 District Chief**	**10:40-10:50am**
III.	**Cultural Competency Committee Updates** **Sandra Chang-Ptasinski**	**10:51-11:10am**
IV.	**QI**	**11:11 – 11:25am**
	▪ **OMD Report** ▪ **CARE Clinic Presentation** ▪ **Patient's Rights Office (PRO) Updates** ▪ **Policy Updates** ▪ **QID Updates**	
V.	**QA**	**11:26 – 11:55 am**
	▪ **Agency Integration Update** ▪ **Certification** ▪ **State DHCS Updates** ▪ **IBHIS Updates** ▪ **Clinical Forms Bulletins** ▪ **Directly Operated Only – Meaningful Use and Treatment Plan Completions** ▪ **Treatment Plan Signatures** ▪ **Medication Appointments** ▪ **Clinical Forms Inventory** ▪ **SCAR Reports** ▪ **Assessment Information** ▪ **ICD-10 & DSM 5 Updates**	
VI.	**COMMENTS**	**11:55am**

Next meeting: September 15, 2015
St. Anne's Maternity Home
155 N. Occidental Blvd. /Classroom
LA, CA 90026
(213) 381-2931

LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH

SA 4 QIC Minutes

Type of Meeting	QIC	**Date**	August 18, 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	Crystal Carrilo, SSG Project 180; Michael Olson, Enki; Beth Foster, Hillsides; Misty Arnoff, Alma; Jose Guerra, Eisner Pediatric; Silvia Yan, SSG APCTC; Brooke Slusser, EMQ Families First; Lin Evans, El Centro Del Pueblo; Ruby Minassian, Hathaway-Sycamores; Nancy Weiner, SA 4 Admin; Kanisha McReynolds, Amanecer; Nahara Martinez, CHCADA; Jennifer Garcia, CHCADA; Annie Kim, Saban Community Clinic; Hrug Ghazarian, Aviva; Iris Rea, SSG Silver; Leslie Shrager, Children's Bureau; Dora Escalante, Jewish Family Services; Phong Tang, SSG Alliance; Elizabeth Townsend, DMH/PSB/QA; Bryan Kim, KFAM LA; Sandra Chang Ptasinski, DMH; Francisco Carrillo, LAMP Community; Jacqueline Bravo, Telecare Corp LA 4; Nayon Kang, KYCC; Dondera L., ASC; Adela Clayton, VIP; Regina Esparza, CHCADA; Jaime Chaignat, Para Los Ninos; Samantha Moss, St. Anne's; Daniel Domaguin, VAII; Christina Andrade, Amanecer		
Absent Members			
Introductions	Conducted by QIC membership		
Minutes Approval	July minutes will be forthcoming		
Announcements	None		

QUALITY IMPROVEMENT

Agenda Item And Presenter		Decisions/ and Recommendations Actions/Scheduled Task	Responsible Person/Due Date
SA 4 General Announcements	Ed Vidaurri, Service Area 4 District Chief, attended the QIC to provide the following information: 1. The Service Area 4 QIC Liaison, Anahid Assatourian, is on an unexpected extended leave of absence. The QIC Chair, Alyssa Bray, will continue to run the meeting until Anahid returns. 2. Ed shared about the collaborative workgroups that have been held every other month between DMH and Lanterman Regional Center. The goal of these workgroups are to build a better relationship between DMH and Regional Centers. As part of this collaborative, they are looking at how Regional Center staff can learn a little more about how to work with mental health issues in Regional Center clients, and how DMH Mental Health staff can learn more about how best to work on mental health issues for clients with Co-Occurring intellectual disabilities. 3. Ed announced that Dr. Lorraine Viade and Mary Bakchachyan will be presenting on these topics at the SA 4 October QIC meeting.		**Ed Vidaurri**

Cultural Competency Updates	**Cultural Competency Committee** – Sandra Chang-Ptasinski presented information and provided a printed Power Point presentation regarding the training by Debbie Innis-Ginsberg on PEI regulations and Innovations programs, and on the Mental Health and Spirituality Conference. In September, Dr. Southard will speak at the CCC about his vision of Cultural Competency and updates at the State level. CCC meetings are on the second Wednesday of the month, 1:30 to 3:30pm at 550 S. Vermont, usually held on the 3rd floor, but September will be on the 10th floor.		**Sandra Chang-Ptasinski**
QI Announcements			**Alyssa Bray**
OMD	**Office of the Medical Director** – The Columbia Suicide Severity rating scale has been approved to be implemented. It will take a while to set it up in the EHR and to provide trainings to everyone. Also, a policy will need to be written on how to implement it. Mini tool kits which contain several tools for suicide prevention have been sent out to Program Heads of Directly Operated Programs. This tool kit will be posted on the website with the policy once it's written.		
CARE Clinic Presentation	**Long Beach Mental Health Center CARE Clinic Program presentation** – Power Point included in handouts. Presentation on how the LBMHC transformed its set-up to be more conducive to full-service client care that is streamlined, client-friendly, and is closer to a		

	health neighborhood model of care. It represents a great example of how clinics can arrange their services to assist with integrated care. Will ask Emilia Ramos, Program Head to share this model at a future QIC meeting.		
PRO	**Patients' Rights Office** – The State is wanting more information regarding grievances in order to identify systemic issues. State has been asking PRO for more information, and PRO has had to call clients to obtain that information to provide to the State. The State will be utilizing NOA's to capture systemic issues as well. Agencies need to make sure grievance forms are always available to clients. The State Systems Review will be really focusing on grievances and what the trends are. DMH QID is starting to look for systemic trends. Any information found will be shared and addressed. A reminder that PRO is always available as needed to come directly to clinics to help with clients if/as needed. **Change of Provider Reports (Policy 200.05)**– There are some gaps in the data and they are needing information so they can send the COP Reports to the State. Fax or email (via encrypted if PHI is present) Jamie Walker and Theodore Cannady with COP logs (not individual forms, just logs). Contact Jamie Walker with questions or concerns via email or at (213) 738-6192. The DMH Sharefile for QIC Liaisons contains all contact numbers for each agency for the COP information. Please keep QIC Liaisons current with who the contact person is for your agency for the COP information. PRO will contact Providers directly if COP logs are missing (due by the 10th of each month). QIC		

	Liaisons will start getting lists of missing COP logs and will have one week to collect them. After one week, PRO will send a draft report to QIC Liaison to look over – anything still missing must be turned in immediately. We are in a new fiscal year, PRO has to start sending these as required by the new 1915b waiver plan. Also, these will be looked at closely for the State Systems Review in 2016.		
Policy Updates	**Policy Updates** – They updated the Change of Provider form so that it is fillable and more user- friendly. They changed the language so it is clearer on how to complete the forms. Policy 200.05 online has a link to the new forms. There are no content/procedural changes to the forms, they are just more user-friendly.		
MHSIP Surveys	**MHSIP Surveys** – QID has November 2014 and May 2015 data now. They are working on creating Provider-level reports for the seven survey domains (for Providers with at least 30 completed surveys). These should be available in about two months or so.		
Provider Directory	**Provider Directory** – A reminder that the information in the Provider Directory must match PFAR and IS information exactly. There are Providers missing in the Provider Directory, and some new Providers have not been added. Some inactive Providers are still showing up in the Provider Directory. **It is very important for agencies to update their information.** Dennis Murata uses the Provider Directory to collect information for the Board of Supervisors, and the information must be accurate. Active Providers by PFAR must match.		

QUALITY Assurance

QA Announcements		Decisions/ and Recommendations Actions/Scheduled Task	Responsible Person/Due Date
Agency Integration Update	Integration of DMH, DHCS and DPH – On August 11, the Board of Supervisors approved the plan for a single county health agency.		**Alyssa Bray**
Certification	**Certification** – State is wanting agencies to get Fire Clearances for schools that are satellites or primary certified Providers. If agencies have a difficult time obtaining them, call Liz or Tang in the Certification Department to assist – they've been very helpful in obtaining them.		
State DHCS Updates	**State DHCS Updates** - DO providers and QA attended the State Documentation Training on Aug 12th & 13th. Relevant information for LA County DMH Providers will be shared in the near future. **State Systems Review** – Scheduled for the week of February 8th, February 22nd, and February 29th. There will be chart reviews of approximately 80 cases that will be selected county-wide. The Feds/State expect no more than a 5% disallowance rate (last review was a		

	27% disallowance rate). DMH usually receives the list of chosen charts about three weeks ahead of time, and they will contact all agencies who have chosen clients when they receive the list. Providers must print everything and bring a paper chart to DMH for the State to review. If everything is printed from an EHR, be sure all Attestations for Electronic Signatures are in or the electronic signatures will not count as being signed. If there are any claims that need to be voided, do it now, because once the list of charts is received, no claims can be voided. When reviewing charts/progress notes, the State is particularly looking for what the clinician did, not just clients' behaviors. The State is paying us for the interventions we provide, so it needs to be clear in the notes what interventions were facilitated and to what end (outcome).		
IBHIS Updates	**IBHIS rollouts** – They are technically done. Regarding Juvenile Justice, they are still discussing how to share information with DHCS. Jails are under DHCS now (not Juvenile Justice, just jails), so that is part of the discussion of sharing information.		
Clinical Forms Bulletins	**Clinical Forms Bulletin 15-04**- Treatment Update to DCFS – the DCFS email address changed. **Clinical Forms Bulletin 15-07** – For Directly Operated only, but Contractors should read it. It provides a reminder of the Medi-Cal lockout for Crisis Intervention and how to document it. Crisis intervention notes, whether only one or multiple in a day, cannot go over 480 minutes in a day to be reimbursable by Medi-Cal. MHSA and Medicare do not have this lockout, only Medi-Cal, so if you have MHSA funding (e.g., FSP, Wellness,		

	FCCS) and you submit an unbillable claim to Medi-Cal, you will get the matching MHSA dollars only. Nothing stops you from using psychotherapy in crisis, but the service has to be psychotherapy.		
Directly Operated Only Meaningful Use	**Meaningful Use** – Directly Operated only. Clinical summaries and transition of care information will be produced automatically from this data – the clinician won't have to do anything to produce these summaries. It has been approved to use the Columbia Suicide Severity rating scale as a standardized suicide prevention tool. It will be a requirement for all clients be given this at admission probably starting September 1st. CSS Rating Scale will NOT be required for Contractors, but it will be a required **concept** (suicide risk assessment). It requires copyright permission to put the CSSRS on an EHR. The Pediatric version of the CSSRS starts at age 6. Also for Directly Operated only, new procedure codes (e.g. smoking cessation counseling) will be added soon. These are not billable to Med-Cal, but need to be documented.		
Directly Operated Only Treatment Plan Completion	**Treatment Plan Completion** – Directly Operated only. Recently QA developed a report that shows the percentage of clients with a Treatment Plan in place. QA will start sending this out to DO clinics regularly. The report checks for an active Treatment Plan only, not whether or not a client signature is present. It also doesn't check to see if the treatment being provided matches the interventions listed on the Tx Plan. They have excluded PMRT and Specialized Foster Care from this report because they don't always require a Tx Plan. If you receive this report and feel it is not accurate,		

	please contact QA (so far it has looked accurate). The report does NOT capture scanned Tx Plans.		
Treatment Plan Signatures	**Tx Plan signatures and Minute Orders** – For Treatment Plans, a child signature without a parent signature is acceptable (even from a very young child – e.g. 7). The State language requires "client" signature, not parent signature. However, there MUST be a date with the signature. No date equals no signature. Also, remember that Minute Orders provide consent, but do not sign off on a Tx Plan.		
Medication Appointments	**Medication Appts** – QA discussion with OMD. The intent of this policy is if the client has a foreseeable need for medications immediately, then the initial appointment needs to be a medication appt and an Intake Session . If the client is not running out of meds, then medication appointments can be scheduled appropriately. For auditing purposes, agencies will be held to the intent of the policy, not the specific language. QA is looking at the scheduling initial medication appointments policy to help with Service Request Log tracking to make sure it is in line with both the med appt policy and the walk-in policy. Reminder – if you are unable to get client a medication appointment in time with this required policy, you must tell your District Chief. An NOA-E is not needed if you are providing access to medication appts as part of other MH services, but it must be logged and given to your District Chief.		
Clinical Forms Inventory	**Clinical Forms Inventory** – If there is ever a question about whether forms are current and required or obsolete, whether they are for DO or Contractors or both,		

	or if data elements or concepts are required, the Clinical Forms Inventory has all of that information. Located on the website.		
SCAR Reports	**SCAR reports** – Should not be kept in clients' charts. They can be referenced in the charts from a clinical perspective (e.g., clinically relevant information that was shared that led to the SCAR), but not from a reporting perspective.		
Assessment Informaiton	**Assessment information gathering** – With client present - 90791, gathering assessment information from parent/family member – 90887, gathering assessment information from a non-family member – H2015. Most agencies have been using H0032 in the last instance. However, QA says there is a very narrow definition of Treatment Planning. If the information gathered and the discussion meets the definition for Treatment Planning, you can use H0032. If it is pure assessment information gathering with no technical Treatment Planning discussion as defined in the H0032 procedure code, you should use H2015. There is much discussion and confusion on this topic, so QA is looking into clarifying this further and perhaps putting out a Bulletin on this. **Notes while completing an Assessment session** – if you are meeting with a client and parent to gather Assessment information, and at some point the client leaves and you are speaking with the parent only, you should write two separate notes to capture that information – 90791 for the time with the client and parent together, and 90887 for the time gathering assessment information from the parent only.		

ICD-10 CM and DSM 5 Updates	**ICD-10 & DSM 5 Updates –** 1. For Directly Operated only, DSM 5 and ICD-10 will both be implemented on Oct 1. 2. State still hasn't decided about whether or not to require DSM 5, so far they say ICD-10 only. They will make an official decision on DSM 5 in 60 days. 3. Contractors can decide to use only ICD-10, or DSM 5 and ICD-10. Regulations state that you can treat an ICD-10 code only. All claims must have an ICD-10 code only. Do not send DMH any DSM codes, send ID-10 codes only. 4 If the State decides to require DSM 5, that would require contract and regulatory changes that would take a long time to complete. 5. State's tentative enforcement schedule says that as of Jan 1, 2016, all audits will be looking at ICD-10 codes only. DMH plans to only show ICD-10 information for audits. 6. State will decide in 60 days whether they will use the Blue Book or the DSM 5 when auditing charts (to see if diagnoses are supported in the documentation) as of Jan 1, 2016. However, the Blue Book and the DSM 5 are pretty similar – the DSM 5 just tends to be more specific. 7. Assessments can have a DSM 5 codes as long as there is an ICD-10 code as well. 8. No more Axes, including GAF.		

	9. The State has not provided a definition as to what qualifies as a significant life impairment (related to GAF), but the State has never put weight on the GAF. Their focus is looking for clear documentation that impairment is experienced due to the diagnosis. 10. All claims dated Sep 30 or earlier (the date of the actual claim, not the date submitted) must have a DSM IV diagnosis, all claims dated Oct 1 forward must have a DSM 5/ICD-10 diagnosis (claim must be ICD-10 code). All ICD-10 diagnoses must have a start date of Oct 1. 11. Directly Operated – a new diagnosis form will be available on Sep 1 that allows all codes to be captured (DSM IV, DSM 5, ICD-9, and ICD-10). All of these codes will populate automatically in IBHIS based on choosing the diagnosis description. 12. All forms that contain diagnoses in them Assessments, Diagnosis Information Form) will be updated and available at least a couple of weeks in advance so they can be in place by Oct 1. 13. DMH will be doing the conversion from DSM IV diagnoses to ICD-10 diagnoses for all easily-crosswalked diagnoses for DO and Contractors (not sure of the date yet). 14. QA will be finalizing the crosswalk soon (likely the next two weeks), so agencies should be looking closely at it now to see if there are any items they disagree with, don't understand, or would like changed/added.		

	15. Lists of what the conversion will look like when "switched on" will be sent out ahead of time in SIFT files (EFT files). The conversion itself will not happen until close to (or on) Oct 1st. 16. The three lists will be: 1) Clients whose primary and secondary diagnoses will be converted; 2) Clients whose primary diagnosis ONLY will be converted and; 3) Clients whose diagnosis will not be converted AT ALL. 17. The lists will show the diagnoses that clients were converted to. If agencies disagree with a diagnosis, they can change it (themselves) to what they want once converted. 18. It is important to note that any secondary diagnoses not converted, and ALL tertiary diagnoses will be agencies' responsibility to convert to DSM 5/ICD-10. 19. The State issued a finalized diagnosis list last week (QA doesn't have a copy of it yet), but QA is still talking to the State about diagnosis codes that were excluded that (in QA's mind) should be included. QA also feels that some of the crosswalks don't make sense. 20. Regarding excluded diagnosis codes, the State's stance so far is that they don't want to add those diagnoses because they don't want to expand the types of Specialized Mental Health Services. QA disagrees that this is the case. QA's stance is that these are already included diagnoses that have always fallen under SMHS, so they would not be adding new services. They are still in discussion.		

	21. The most current documentation from the State is that they will NOT have edits in their system to deny claims that have excluded diagnoses. 22. QA is working to update the Organizational Providers Manual to reflect the new codes. 23. DMH will provide three DSM 5 trainings for DO staff. These trainings were purchased from Gerry Grossman, so there will be no materials provided to Contractors. 24. In about two weeks, there will be a posted ICD-10 Webex for DO staff to take (hoping to have out by Aug 26th). This training will be posted in a public place where Contractors can access. 25. ICD-10 Web-ex is about 20-25 minutes, and it is only an overview of ICD-10 (not a training on coding, only on descriptors) because for DO staff, in IBHIS they will be choosing descriptions of diagnoses that will automatically be mapped to the appropriate DSM 5 and ICD-10 codes. 26. An ICD-10/DSM 5 FAQ Bulletin will be coming out in a couple of weeks that will include links to the training. 27. In creating the ICD-10 Webex, they looked at a number of ICD-10 trainings on YouTube. Providers might consider looking at those for training ideas as well. 28. Agencies need to talk to their own EHR vendors about the conversion, the new codes, and how it will be done in their system. 29. QA is creating cheat-sheets for DO staff that		

	crosswalk diagnoses. This will be posted in a public place that Contractors will be able to access. 30. Difference between Allowable Codes and Included Codes: Allowable Codes are valid ICD-10 codes that DMH's system will accept, but Included Codes are the diagnoses that Medi-Cal will pay for. DMH is listing both Allowable and Included codes so that clinicians can properly diagnose clients. Also, if clinicians find that a client meets the criteria for an allowable but excluded diagnosis, they can at least be reimbursed for completing the Assessment. 31. There is not a "no diagnosis" code for ICD-10. ICD-10 has a code that says something like "no symptoms" that DMH will use as a replacement for the "no diagnosis" code. 32. When clients diagnoses are changed from a DSM IV diagnosis to an ICD-10 diagnosis, a Diagnosis Information Form will only need to be completed if the diagnosis is different. Many of the crosswalked diagnoses read the same. When that is the case, no DIF is needed. However, if the verbiage is different, then a DIF must be completed (and dated effective Oct 1). 33. For ICD-10 codes, make sure you are using the ICD-10 CM version. That is the version for the United States and is the version that must be used. 34. The Blue Book for ICD-10 coding was not designed for the CM version, so it does not perfectly match the ICD-10 CM for diagnosing. However, the content of the symptoms is the same.		

	35. If you decide to use the DSM 5 please keep in mind: 1) Some of the ICD-10 codes listed in the DSM 5 are incorrect – be sure to double check them; and 2) Use the DSM 5 diagnoses on the website, not the published version of the DSM 5. There are a substantial number of errors in the DSM 5 published book. The corrections for these are on the website.		

Next Meeting: Tuesday, September 15, 2015
St. Anne's Maternity Home
155 N. Occidental Blvd.
Los Angeles, CA 90027

Respectfully submitted,

Alyssa Bray, LMFT, Chair

Anahid Assatourian, Psy.D. Co-Chair