ANNUAL DMC-ODS TRAINING AUGUST 18, 2022

County of San Diego Behavioral Health Services
Drug Medi-Cal Organized Delivery System

1

FY 22-23 DMC-ODS ANNUAL TRAINING

- Everyone is muted on entry
- Questions will not be answered during the training, put questions in the chat
- QA will send out a Q&A following the training
- The training is being recorded and will be available on Optum

2

BHS QI LEADERSHIP TEAM DMC-ODS

- Tabatha Lang, Operations Administrator
- Michael Blanchard, Behavioral Health Program Coordinator, SUD QA Team
  - Jan Alfred Valdes and Diana Daitch Weltsch, SUD QA Supervisors
- Erin Shapira, Program Coordinator, BHS Quality Assurance
- Alfie Gonzaga, Program Coordinator, Health Plan Administration
- AnnLouise Conlow, Senior MIS Manager
  - Cynthia Emerson, SUD MIS Manager, Principal Administrative Analyst

3

FY 22-23 DMC-ODS ANNUAL TRAINING

- "Big Picture" updates – State and County level
- Review DMC-ODS Requirements and documentation reform
- Program Quality Assurance, Program Integrity, and FWA
- New in FY22-23
- MIS updates
- Other updates

4

STATE OF THE STATE FY 2022-23

County of San Diego Health and Human Services Agency

Behavioral Health Services

5

THE STATE OF BEHAVIORAL HEALTH IN CALIFORNIA

- **Individuals who are justice-involved experience substantially higher rates of mental health conditions and substance use disorders** and often end up incarcerated because of those conditions.[1]
  - In California, close to **one in three adults in prison (30%) received mental health services** in 2017, more than doubling the rate since 2000.
- **Medi-Cal plays a major role in covering individuals** living with serious mental illness and substance use disorders.
  - Medi-Cal is the **primary source of coverage for close to half of California residents with a substance use disorder**.[2]

Sources:

1. "Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding," Californian Budget and Policy Center, March 2020. Available at https://calbudgetcenter.org/wpcontent/uploads/2020/03/CA_Budget_Center_Mental_Health_CB2020.pdf.

2. National Health Law Program. Substance use Disorders in Medi-Cal: An Overview. https://healthlaw.org/resource/substance-use-disorders-in-medi-cal-an-overview/#_ftn1.

6

The State of Behavioral Health in California (continued)

- Among Californians seeking mental health services, **more than four in ten (43%) reported that it was somewhat or very difficult to secure an appointment** with a provider who accepts their insurance.[1]

- Given the vast differences across California in the economic and demographic characteristics of county residents, there are **sizable differences in the county-level rate of behavioral health conditions**.

Sources:

1. "The 2021 CHCF California Health Policy Survey," California Health Care Foundation, January 2021. Available at https://www.chcf.org/wp-content/uploads/2021/01/CHCF2021CAHealthPolicySurvey.pdf.

7

California Priorities

- Invest in **behavioral health and community care options** that advance racial equity
- Ensure **equity** of behavioral health and community care options
- Address **urgent gaps in the care continuum** for people with behavioral health conditions, including seniors, adults with disabilities, and children and youth
- Increase **options across the life span** that serve as an alternative to incarceration, hospitalization, homelessness, and institutionalization

8

California Priorities (continued)

- Meet the needs of **vulnerable populations with the greatest barriers to access**, including people experiencing **homelessness and justice involvement**
- Ensure **robust services for children and youth**, including prevention and early intervention
- Ensure care can be provided in the **least restrictive settings** to support community integration, choice, and autonomy
- **Leverage county and Medi-Cal investments** to support ongoing sustainability
- Leverage the **historic state investments in housing and homelessness**

9

Major California Behavioral Health Initiatives

New Initiatives:

- CalAIM, including pre-release and reentry services for justice-involved
- The Children and Youth Behavioral Health Initiative
- The Behavioral Health Continuum Infrastructure Program
- Community Care Expansion Program
- Behavioral Health Integration Incentives Program
- The California Bridge Program
- Initiatives to address the Incompetent to Stand Trial population
- CalHOPE, a crisis counseling assistance and training program
- The California MAT Expansion Project
- Dyadic Treatment
- A $20 million investment in 988 network
- New Peer Support Services benefit in Medi-Cal

10

Major California Behavioral Health Initiatives
(CONTINUED)

Initiatives that are Under Development/in Planning:

- BH Care Continuum Waiver
- New mobile crisis services
- Contingency Management
- Housing and Homelessness Incentive Program
- Behavioral Health Bridge Housing

11

Services for Justice-Involved Populations

Waiver Request:

- Medi-Cal-eligible individuals will be able to receive targeted Medi-Cal pre-release services 90 days prior to release from county jails, state prisons, and youth correctional facilities with warm handoffs to community-based providers
- **Eligibility.** All youth (under age 19) in a corrections settings and adult inmates with at least one healthcare need c (e.g., serious mental illness, SUD diagnosis, HIV)

12

Services for Justice-Involved Populations (continued)

Waiver Request:

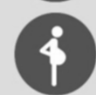
- **Covered Services.** Care management/coordination, medications and medical equipment to support re-entry, and targeted physical and behavioral health clinical consultations, medications for addiction treatment (MAT), psychotropic medications, laboratory/X-ray services pre-release, as needed.
- **PATH Funding.** Support capacity building and planning for effective pre-release care and re- entry supports for justice-involved populations and enable coordination between counties, prisons, jails, juvenile facilities, providers, and community-based organizations.

13

California Quality Strategy: Defining the Vision

BOLD GOALS:
50 x 2025

STATE LEVEL



14

CalAIM/Waivers Behavioral Health Initiatives Timelines

January 2022

Criteria for Access to SMHS

Language crafted with stakeholders and finalized in Assembly Bill 33.

- Goal to increase access: covering services during assessment period; allowing treatment without confirmed diagnosis; and expanding to include experience of trauma, such as homelessness, child welfare, or juvenile justice involvement.

DMC-ODS (2022-2026)

Transition coverage and program authority from 1115 demonstration to State Plan and 1915(b) waiver.

- Sustain recent policy updates (e.g., coverage during assessment period; remove annual residential treatment limits; require providers to offer or refer for Medication Assisted Treatment (MAT)).
- New services pending CMS approval (e.g., Contingency Management pilot; traditional healers, and natural helpers).

15

CalAIM/Waivers Behavioral Health Initiatives Timelines (continued)

July 2022

Documentation Redesign

- Rooted in discussions from 2019 CalAIM BH Workshop.
- Goal to reduce paperwork and administrative burden and increase quality care.

No Wrong Door

- Beneficiaries receive clinically appropriate and covered services regardless of the delivery system from where they seek care.
- Services rendered in good faith will be reimbursed by the provider's contracted plan during assessment.
- Beneficiaries in certain circumstances can receive unduplicated care in more than one delivery system.

Peer Support Services

- Peer Support Specialist Certification requirements, training and testing.
- Specific services for Medi-Cal billing.

16

17

18

State Planned Amendments (SPAs)

SPA 20-0006-A: Drug Medi-Cal (DMC) Substance Use Disorder Services

- Updates service descriptions, prior authorization requirements and provider qualifications
- Updates allow for services to be delivered via face-to-face, telehealth, or telephone
- Adds Medications for Addiction Treatment for Opioid Use Disorders
- Adds Peer Support Services as a DMC service and includes Peer Support Specialists as a distinct provider type of Peer Support Services

SPA 20-0006-B: MAT

- Adds Medication-Assisted Treatment (MAT) for opioid use disorders as a Medi-Cal benefit in
- Compliance with Section 1006(b) of the SUPPORT for Patients and Communities Act

SPA 21-0051: Peer Support Services

- Adds Peer Support Services as a Specialty Mental Health Service
- Includes Peer Support Specialists as a distinct provider type of Peer Support Services

SPA 21-0058: DMC-ODS Substance Use Disorder Services

- Adds DMC-ODS services in the Medi-Cal State Plan

19

NETWORK ADEQUACY: NEW REQUIREMENTS

Current elements:

Timely Access | Capacity & Composition | Time & Distance | Alternate Access Requests

New for FY 22-23:

Timely Access Data (non-urgent, non psychiatry)

- Standardized reporting with more data elements (e.g., additional appointment offer dates, reasons why a beneficiary didn't make it to an assessment or service appointment, referral information)

Timely Access Data – Psychiatry Services (both urgent and non-urgent)

274 Expansion – MHP Provider Data

- Including crisis stabilization and inpatient (meeting needs for crisis stabilization)
- Adding all required foster care services (currently measure Intensive Home Based Services (IHBS) and Intensive Care Coordination (ICC)
- Hospital and residential treatment contracts (reporting only – no minimum standards)

20

NETWORK ADEQUACY: NEW REQUIREMENTS (CONTINUED)

Current elements:

Timely Access | Capacity & Composition | Time & Distance | Alternate Access Requests

New for FY 23-24

- Add Timely Access Data reporting tools for timely access to follow-up appointments
- 274 Expansion - DMC-ODS Provider Data
- Timely access data standardized reporting

21

COMPLIANCE MONITORING FRAMEWORK

Compliance monitoring framework implements ongoing monitoring and a continuum of progressive corrective actions to ensure compliance with State and Federal requirements.

22

Compliance Monitoring Framework

(continued)

Current Compliance Monitoring:

- DMC annual audit compliance review
- Specialty Mental Health triennial review
- Drug Medi-Cal Provider review
- Corrective Action Plan Resolution
- Ongoing Compliance Monitoring Activities (new to Fiscal Year 2021/2022)

Additional Upcoming Compliance Monitoring:

- Enhanced monitoring framework (scheduled for release in 2022)
- Policies to render sanctions, fines and penalties

23

Local Goals

- Understand the complexities of these changes and recognize it's a culture shift
- Establish new standards to align with State requirements
- Enhanced focus on clinical quality with disallowances based on Fraud, Waste & Abuse
- Obtain and incorporate provider/stakeholder input when possible
- Update Management Information Systems to support required changes

24

Local Goals (continued)

- Communicate any changes in a timely manner
- Continue forums for feedback and iterative updates, as possible
- Work to increase efficiencies and streamline as we can
- Recognize the benefits to the community and the clients we serve
- Remember that we're all in this together!

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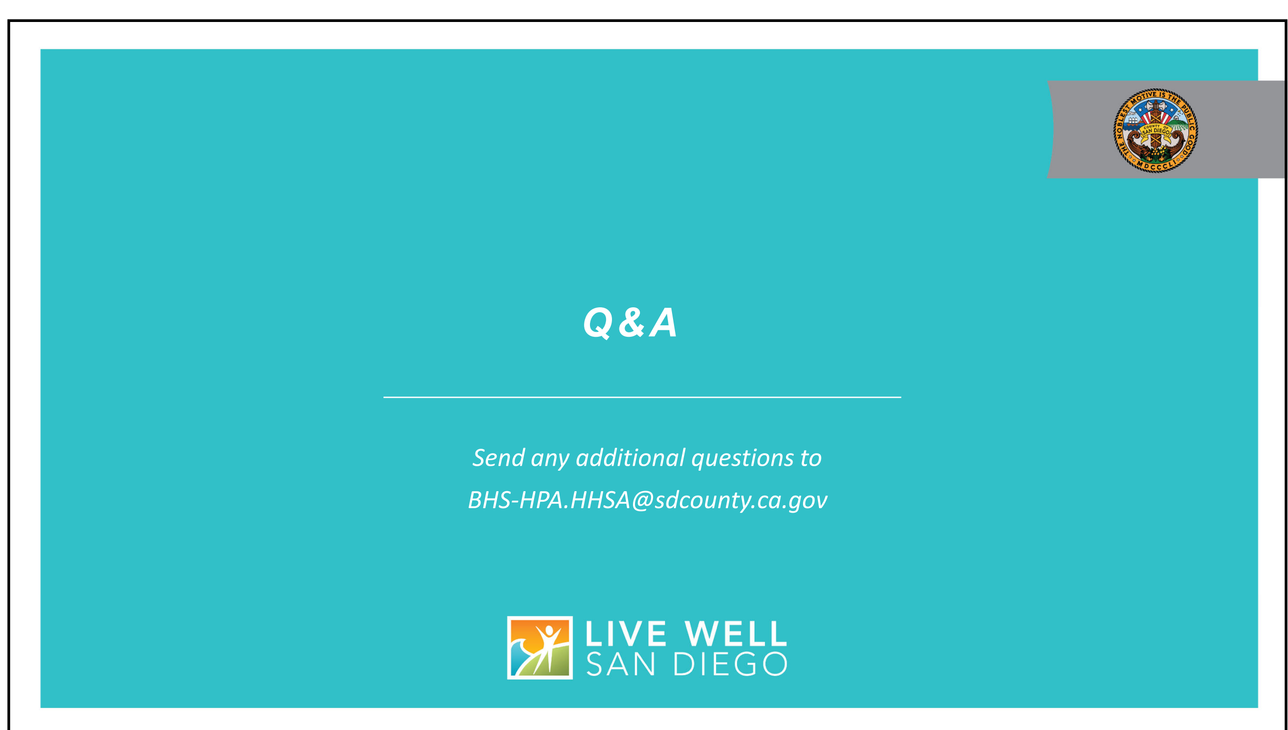

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28

ASSESSMENT OF TOBACCO USE DISORDER (BHIN 22-024)

- Requires the following:
  - Conduct an assessment of tobacco use at the time of the initial intake.
  - Provide information to the patient or client on how continued use of tobacco products could affect their long-term success in recovery
  - Recommend treatment for tobacco use disorder in the treatment plan (Problem List)
  - Offer either treatment, subject to the limitation of the license or certification issued by the department, or a referral for treatment for tobacco use disorder

29

REQUIREMENT FOR NALOXONE (BHIN 22-025

- Requires the following:
  - Maintain, at all times, at least two unexpired doses of naloxone, or any other opioid antagonist medication that is approved by the FDA for the treatment of an opioid overdose, on the premises of the licensed SUD recovery or treatment facility.
  - Have at least one staff member, at all times, on the premises who knows the specific location of the naloxone, or other FDA-approved opioid antagonist medication, and who has been trained in its administration.
  - The proof of completion of such training shall be documented in the staff member’s individual personnel file,

30

DMC-ODS REQUIREMENTS FOR 2022-2026 (BHIN 21-075)

- Covered and clinically appropriate services (except for residential treatment services) are reimbursable for up to 30 days following the first visit with an LPHA or registered/certified counselor, or up to 60 days if beneficiary is under 21, or if it's documented the client is experiencing homelessness, whether or not a DSM dx for Substance-Related and Addictive Disorders is established.
  - (Also in BHIN 21-071)

31

DMC-ODS REQUIREMENTS FOR 2022-2026 (BHIN 21-075, 21-071)

- Beneficiaries 21 years and older after assessment
  - Must have at least one dx from DSM for Substance Related and Addictive Disorder, with exception or Tobacco-Related or Non-Substance Related Disorder OR
  - Have had at least one dx prior to being incarcerated or during incarceration, determined by substance use history

32

DMC-ODS REQUIREMENTS FOR 2022-2026 (BHIN 21-075, 21-071)

- Beneficiaries under 21 years and older after assessment
  - EPSDT statues and regulations require that all coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions are furnished, regardless of whether they are covered by the State's Health Plan
    - Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered.

33

DMC-ODS REQUIREMENTS FOR 2022-2026 (BHIN 21-075)

- Medically necessary services are covered and reimbursable whether or not the beneficiary has a co-occurring mental health condition
- Recovery Services can be claimed concurrently with other levels of care or as a standalone service
- Clinician Consultation expands on previous Physician Consultation
  - LPHAs consulting with LPHAs such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists to support provision of care
  - Is not a direct service provided to DMC-ODS beneficiaries
  - More info in the SUDPOH

34

DMC-ODS REQUIREMENTS FOR 2022-2026 (BHIN 21-075)

- Care Coordination: previously referred to as Case Management
- Must be provided with all levels of treatment
- Includes coordination with medical and mental health providers, discharge planning and coordination, and referral/linkages to community-based services and support (i.e. vocational, housing, cultural sources)
- Needs a valid Consent to Release Information for care coordination or collateral

35

CARE COORDINATION

- Increased clinical focus on ensuring care coordination services are provided if a valid Consent to Release is present
- Reminder: Ensure that all attempts to provide care coordination services (i.e. leaving messages for probation or other providers) are documented, regardless if they are billable or not
- Clinically appropriate provision of care coordination services and closed loop referrals will be an increased focus of record reviews.
- Care Coordinator: Role filled by an LPHA
- Care Coordination Service: can be provided by LPHA or SUD Counselors

36

PRACTICE GUIDELINES AND 21-075

- Programs are to continue following the practice guidelines as defined in the SUDPOH and have been updated to align with BHIN 21-075
- 21-075 says that not only must Evidence Based Practices be implemented, but delivered to fidelity
  - San Diego chose Motivational Interviewing and Relapse Prevention at the beginning of DMC-ODS
  - How are you ensuring that these are being provided to fidelity at your program?

37

CODE SELECTION DURING ASSESSMENT DURING OUTPATIENT SERVICES (22-013)

- The following can be used when an SUD dx has not been established:
  - ICD-10 codes Z55-Z65, “Persons with potential health hazards related to socioeconomic and psychosocial circumstances” may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA)
  - ICD-10 code Z03.89, “Encounter for observation for other suspected diseases and conditions ruled out”
  - LPHA may use clinically appropriate ICD-20 code, including “Other specified” and “Unspecified” disorders”, or “Factors influencing health status and contact with health services.”

38

ADDITIONAL BHINS OF NOTE

- Other BHINs of note:
  - 22-033: Network Certification Requirements
  - 22-026: Peer Support Services
  - 22-023: Liability Insurance Requirements
  - 22-022: Advertising Requirements
  - 22-018: Peer Support Specialist Supervisor
  - 22-005: Reimbursable Recovery Service components
  - 22-003: SUD Treatment Services for under 21
  - 21-047: Telehealth flexibilities (will continue until 12/31/22)

39

REMINDERS

- MAT Education
  - Was added to the Program Checklist for FY 21-22
  - Client must be provided MAT Education resource (available on Optum under the Toolbox tab) and explained
    - Programs must have an effective referral mechanism in place to the most clinically appropriate MAT services

40

PAID CLAIMS VERIFICATION

- **"Paid claims verification" – Each program must develop Policy & Procedure to verify whether services reimbursed by Drug Medi-Cal were actually provided to clients.**
  - Flexibility in developing your own process
  - Can current processes be leveraged to create your paid claims verification process
  - Keep it simple (i.e. random verification)
    - i.e. random verification during specified time periods
  - Will continue to be part of the MRR Process (P&P and evidence)

41

RESIDENTIAL AND COUNSELOR COMPLAINTS

- Certain incidents must be reported by residential SUD programs to DHCS. Outpatient programs are not required to report incidents but are able to if they would like to.
  - Incidents include:
    - Death of any resident from any cause, even if death did not occur at facility.
    - Any facility related injury of any resident which requires medical treatment
    - All cases of communicable disease reportable under Section 3125 of the Health and Safety Code or Section 2500, 2502, or 2503 of Title 17, California Administrative Code shall be reported to the local health officer in addition to the Department
    - Poisonings
    - Natural disaster
    - Fires or explosions which occur in or on the premises
  - Within 24 hours of the time an alleged violation of the code of conduct specified in Section 13060 by a registrant or a certified AOD counselor becomes known to an AOD program, the program shall report it to the Department and to the registrant or counselor's certifying organization.

42

RESIDENTIAL AND COUNSELOR COMPLAINTS

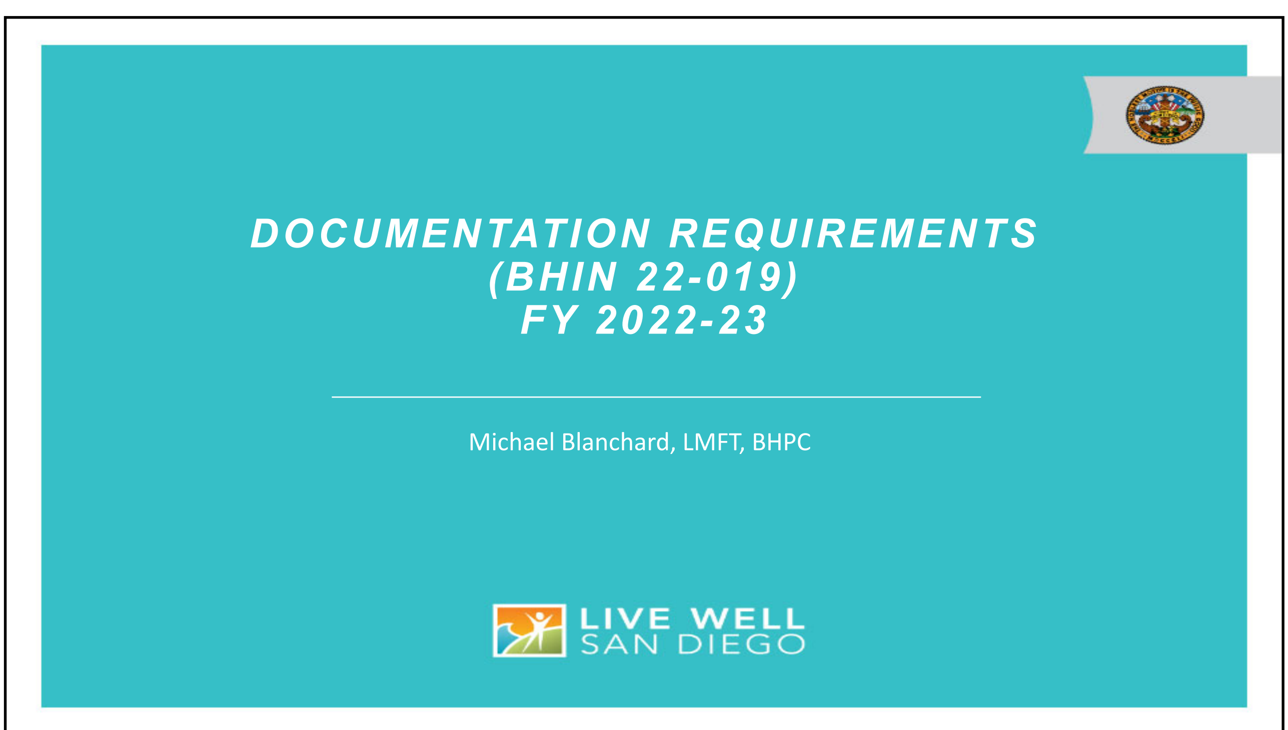
- Reporting methods include:
  - Programs must make a telephonic report to DHCS Complaints and Counselor Certification Division at (916) 322-2911 within one (1) working day.
  - The telephonic report must be followed with a written report to DHCS within seven (7) days of the event.
  - Death reports must be submitted via fax to the DHCS Complaints and Counselor Certification Division at (916) 445-5084 or by email to DHCSLCBcomp@DHCS.ca.gov.
  - Form 5079 Unusual Incident/Injury/Death Report

43

RECORD RETENTION

- Per WIC 14124.1, records are required to be kept and maintained under this section shall be retained:
  - by the provider for a period of 10 years from the final date of the contract period between the plan and the provider,
  - from the date of completion of any audit,
  - or from the date the service was rendered, whichever is later, in accordance with Section 438.3(u) of Title 42 of the Code of Federal Regulations.

44



45

ASSESSMENTS

- Programs should start using the new documentation as of 9/1/22
- We have many questions out to the state for clarification and are waiting for an official Q&A to be published by CalMHSA/DHCS
- Your assigned Specialists are available for Technical Assistance to understand and guide implementation of new documentation and standards

46

ASSESSMENTS

- ASAM Criteria assessment continues to be required
- Must include determination of medical necessity and recommendation for services
  - Problem list and progress note requirements shall support the medical necessity of each services provided
- Assessments shall be updated as clinically appropriate when the beneficiary's condition changes
- If beneficiary withdraws prior to a DSM dx being established, and later returns, the 30/60 day timeline starts over (outpatient only)

47

ASSESSMENTS

- Adult programs will use the Adult ASAM Criteria Assessment
  - Modified version of the UCLA Adult ASAM Interview Guide
    - Originally a joint effort between UCLA and ASAM
    - This takes the place of the Adult Initial LOC Assessment, LOC Recommendation Form, ASI
  - Adds items related to smoking cessation, diagnosis narrative, hx of substance use treatment, and MAT info
  - Health Questionnaire is still required
  - Outpatient: Must be completed within 30 days of the first visit with an LPHA or SUD counselor (60 days for those under 21 or documented as experiencing homelessness)

48

ASSESSMENTS

- Youth Programs will continue to use the Adolescent ILOC and YAI
  - We are anticipating a version of the UCLA/ASAM interview guide for those under 18, but no timeline has been given
  - Outpatient: Must be completed within 30 days of the first visit with an LPHA or SUD counselor (60 days for those under 21 or documented as experiencing homelessness)
  - Added smoking cessation questions and diagnosis narrative to Adolescent ILOC (will not be updated in SanWITS)
  - Health Questionnaire is still required
  - Adolescent ILOC will be used for updated assessments

49

PROBLEM LIST

- List of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other service encounters
  - This also includes the Social Determinants of Health z-codes
- The Problem List should be initiated/updated before or after providing a service to ensure something is documented on the problem list to support medical necessity and billing.
- Must include the current DSM dx with diagnosis-specific specifiers (i.e. SUD dx within the required timelines), acting within their scope of practice
  - LPHAs and MDs can document DSM dx, all providers can document other codes (i.e. Social Determinants of Health)
    - Reminder: Z03.89 can also be used by an LPHA prior to establishing an SUD DSM dx

50

PROBLEM LIST

- Must be updated on an ongoing basis to reflect the current presentation of the beneficiary
- Must add or remove problems when there's a relevant change
- Must include name and title of the provider that identified/added/removed the problem, and the date the problem was identified/added/removed
- DHCS has not specified a timeframe or requirement for how frequently the problem list should be updated. However, providers shall update the problem list withing a reasonable time and in accordance with generally accepted standards of practice.
- Problem List must be completed for new admits on or after 9/1/22
  - For current clients, a Problem list must be created no later than the expiration of the current Treatment Plan after 9/1/22.

51

PROGRESS NOTES

- Progress Notes shall include:
  - Type of service rendered
  - Date the service was provided
  - Duration of the service, including travel and documentation time
  - Location of the beneficiary at the time of receiving the service

52

PROGRESS NOTES

- Progress Notes shall include:
  - Narrative describing the service, including how the service addressed the beneficiary's behavioral health need
  - Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s), and any update to the problem list as appropriate
  - Typed or legibly printed name, signature of the service provider, and date of signature
    - Signature and date must still be a "wet" signature, or part of a valid electronic signature

53

PROGRESS NOTES

- Must be completed within 3 days (day of service + 2 days) of providing the service, or 24 hours for crisis services
- If billing on a daily basis (Residential, Withdrawal Management), must complete a daily note
- It was clarified on an All County Call on 7/20/22 that ICD and CPT/HCPCS codes are not required on progress notes if they are included on the encounter
- Telehealth consent must be documented on at least progress note, and can be withdrawn at any time

54

GROUP SERVICES

- A list of participants is required to be documented and maintained
- More than one provider can render the service, but only one progress note per beneficiary is required
  - The specific involvement and time of involvement of each provider should be clearly documented
- All other progress note requirements remain

55

PROGRESS NOTES

- A "unified" progress note template will be used for all services rendered, unless a Peer Support Specialist Plan of Care is also being documented
- Outpatient providers will continue to document a progress note for each service provided
- Those billing daily services (residential, withdrawal management), will still need to document Case Management/Care Coordination, Clinical Consultation, and Peer Support Services as separate services

56

PEER SUPPORT SERVICES PLAN OF CARE

- Uses the “unified” note template, with two additional fields:
  - Peer Support Services Plan of Care: Shall include specific, individualized goals that have measurable results
  - Co-Signature by “any treating provider who can render reimbursable Medi-Cal services” only when documenting the Peer Plan of Care. Must follow other signature requirements (printed name, “wet” or valid electronic signature and date)

57

NO LONGER REQUIRED AS OF 9/1/22

- DDN (can now be used as a tool to guide diagnosis)
- “Residential Weekly Progress Note – Services” (can now be used as a tool to track hours)
  - Programs are required to continue providing the number of clinical and structured hours per week
  - During Medical Record Reviews, QA staff will ask for P&P and evidence of the required hours.

58

NO LONGER REQUIRED AS OF 9/1/22

- Physical Exam requirement on the Treatment Plan (no requirement to be on the Problem List, but other requirements still remain)
  - Physician Direction form is being update to include all required elements related to physical exam requirements

59

ALSO UPDATED

- Brief Level of Care Screening Tool
  - Some items were streamlined, and required data elements for ASAM reporting requirements for DHCS have been added
  - Programs can use this form or their own for screening/triaging clients, but the required elements must be included
    - The updated instruction sheet highlights the required elements

60

SUNSETTING AS OF 9/1/22

- Adult Initial Level of Care
- ASI
- Treatment Plan
- Level of Care Recommendation Form
- Continuing Service Justification

61

REMAINING

- All other prior requirements, unless mentioned here, are maintained until further direction is provided by DHCS
  - Examples: Discharge plans and summaries, drug test results, use of other progress note to document never billable services (clerical, no shows, leaving phone message for probation/other providers)
- Remember: if you didn't document it, it didn't happen

62

DISALLOWANCES

- As of 7/1/22, DHCS is instructing counties to only recoup for reasons related to Fraud, Waste, and Abuse
- For FY 22-23, the following disallowance reasons will be used:
  - Note that this may change when official reasons are provided by DHCS
    - Documentation does not establish medical necessity criteria/MD or LPHA did not substantiate the basis of the SUD Diagnosis
    - No progress note for service claimed
    - The service provided was not within the scope of practice of the person delivering the service
  - No change for our OTP providers

63

DISALLOWANCES - FRAUD

- **Fraud** is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Source: Medicare Managed Care Manual

64

DISALLOWANCES - WASTE

- **Waste** is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Source: Medicare Managed Care Manual

65

DISALLOWANCES - ABUSE

- **Abuse** includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Source: Medicare Managed Care Manual

66

REPORTING FRAUD/WASTE/ABUSE

- Any concerns about ethical, legal, and billing issues (or of suspected incidents of FWA) should be reported immediately to: the HHSA Agency Compliance Office (ACO):
- By phone at 619-338-2807, or
- By email at Compliance.HHSA@sdcounty.ca.gov
- or contact the HHSA Compliance Hotline at 866-549-0004
- Additionally, contact your program COR immediately and the SUD QM team at QIMatters.HHSA@sdcounty.ca.gov

67

REPORTING FRAUD/WASTE/ABUSE

- In addition, any potential fraud, waste, or abuse shall be reported directly to DHCS' State Medicaid Fraud Control Unit. Reporting can be done:
  - By phone: 1-800-822-6222
  - Online form
  - fraud@dhcs.ca.gov
  - Medi-Cal Fraud Complaint – Intake Unit
    - Audits and Investigations
    - PO Box 997413, MS 2500
    - Sacramento, CA 95899-7413

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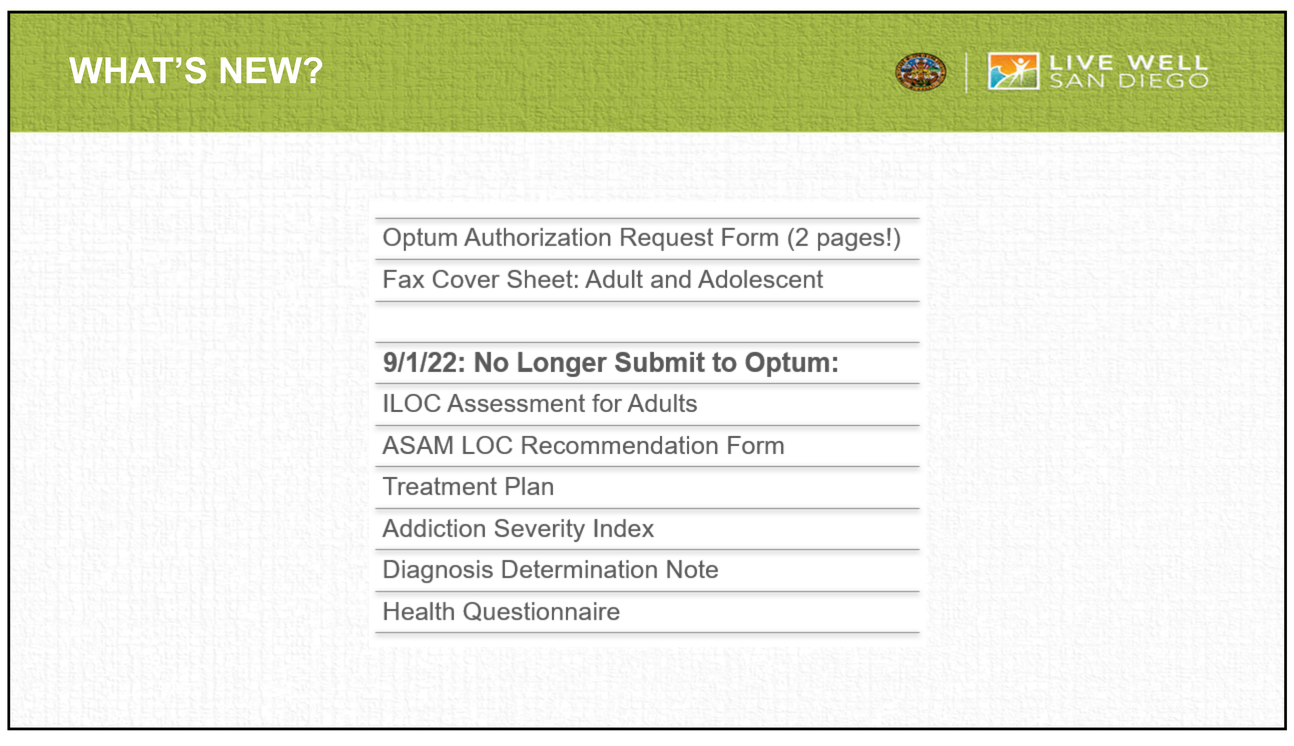


70

ADULT AUTHORIZATIONS

LIVE WELL SAN DIEGO

Optum

ADULT RSUD AUTH REQUEST
FAX COVER SHEET
(To be faxed to 855-244-9359)

Date Faxed:	Program Name:	Point of Contact:
Phone Number:	Fax Number:	# of Pages Included:

All Requests:

Requested Level of Care: 3.1 ☐ 3.5 ☐

Requested Start Date:

PO Referral for Assessment/Treatment? Yes☐ No☐

Court Order for Residential? Yes☐ No☐

☐ **Other Health Coverage:**
If this is 1st request with client having other health coverage (OHC)/ private insurance, which of the following has been included?
☐ Evidence of Coverage or Letter of Non-Coverage
OR
☐ A signed AOB and 42 CFR Part 2 compliant Release of Information (ROI) Form
OR
☐ Client refused to sign ROI to bill OHC

☐ **Initial:**
Date & Time Request Called In:
☐ Optum Authorization Request Form

☐ **Continuing:**
☐ Adult ASAM Criteria Assessment
&
☐ Date of Birth:
OR
☐ Optum Authorization Request Form

☐ **Extension:**
☐ Optum Authorization Request Form

☐ **Level of Care Change:**
☐ Adult ASAM Criteria Assessment
&
☐ Date of Birth:
OR
☐ Optum Authorization Request Form

☐ **Discharge:**
☐ Discharge Plan/Summary
☐ Discharge Date:

71

ADOLESCENT AUTHORIZATIONS

LIVE WELL SAN DIEGO

Optum

ADOLESCENT RSUD AUTH
REQUEST FAX COVER SHEET
(To be faxed to 855-244-9359)

Date Faxed:	Program Name:	Point of Contact:
Phone Number:	Fax Number:	# of Pages Included:

All Requests:

Requested Level of Care: 3.1 ☐ 3.5 ☐

Requested Start Date:

PO Referral for Assessment/Treatment? Yes☐ No☐

Court Order for Residential? Yes☐ No☐

☐ **Other Health Coverage:**
If this is 1st request with client having other health coverage (OHC)/ private insurance, which of the following has been included?
☐ Evidence of Coverage or Letter of Non-Coverage
OR
☐ A signed AOB and 42 CFR Part 2 compliant Release of Information (ROI) Form
OR
☐ Client refused to sign ROI to bill OHC

☐ **Initial:**
Date & Time Request Called In:
☐ Initial Level of Care Assessment
OR
☐ Optum Authorization Request Form

☐ **Continuing:**
☐ Initial Level of Care Assessment
OR
☐ Optum Authorization Request Form

☐ **Extension:**
☐ Initial Level of Care Assessment
OR
☐ Optum Authorization Request Form

☐ **Level of Care Change:**
☐ Initial Level of Care Assessment
OR
☐ Optum Authorization Request Form

☐ **Discharge:**
☐ Discharge Plan/Summary
☐ Discharge Date:

72

AUTHORIZATION REQUESTS

LIVE WELL SAN DIEGO

Optum

SUD Residential Authorization Request

Type of Request: Initial ☐ Continuing ☐ Extension ☐ LOC Change ☐ Requested Authorization Start Date: __________

Level of Care Requested: 3.1 ☐ 3.5 ☐

First Name: Last Name:		DOB: Age:	
Gender Identity: Male ☐ Female ☐ Other ☐ Unknown		Mailing Address:	
Medi-Cal or Social Security #: (Required at Initial or as changes occur)			
Other Health Coverage: ☐		Referral Source:	
Currently Pregnant? N/A ☐ Yes ☐ No ☐ If Yes, due date:			
Substance:	# of Days Used in Past 30 Days:	Date of Last Use:	If date of last use is more than 7 days, how was the client able to remain abstinent?
Primary SUD Diagnosis:			

AUTHORIZATION REQUESTS

LIVE WELL SAN DIEGO

ASAM DIMENSION, SCORE, EXPLANATION

DIMENSION 1 Acute Intoxication and/or Withdrawal Potential	○ 0 None	○ 1 Mild	○ 2 Moderate	○ 3 Significant	○ 4 Severe	**Comments (optional):**
DIMENSION 2 Biomedical Conditions and Complications	○ 0 None	○ 1 Mild	○ 2 Moderate	○ 3 Significant	○ 4 Severe	**Comments (optional):**
DIMENSION 3 Emotional, Behavioral, or Cognitive Conditions and Complications	○ 0 None	○ 1 Mild	○ 2 Moderate	○ 3 Significant	○ 4 Severe	

1. In last 30 days, mental health symptoms and frequency:		
2. History of SI/HI: Yes ☐ No ☐	3. History of psychiatric hospitalization or mental health treatment? Yes ☐ No ☐	4. History of physical aggression/risky behaviors? Yes ☐ No ☐
Explain Dimension Scoring:		

AUTHORIZATION REQUESTS

LIVE WELL SAN DIEGO

Optum

DIMENSION 4 Readiness to Change	0 None	1 Mild	2 Moderate	3 Significant	4 Severe

1. Client wants treatment: Yes ☐ No ☐
2. History of trying to stop drinking/using: Yes ☐ No ☐
3. Does client want to quit or cut back on alcohol and other drug use? Yes ☐ No ☐

Explain Dimension Scoring:

DIMENSION 5 Relapse, Continued Use, or Continued Problem Potential	0 None	1 Mild	2 Moderate	3 Significant	4 Severe

1. Longest period of abstinence:
   None ☐ Days ☐ Weeks ☐ Months ☐ Years ☐
2. Client can identify substance use triggers: Yes ☐ No ☐
3. Client has effective coping skills: Yes ☐ No ☐
4. Client has a relapse prevention plan: Yes ☐ No ☐

Explain Dimension Scoring:

75

AUTHORIZATION REQUESTS

LIVE WELL SAN DIEGO

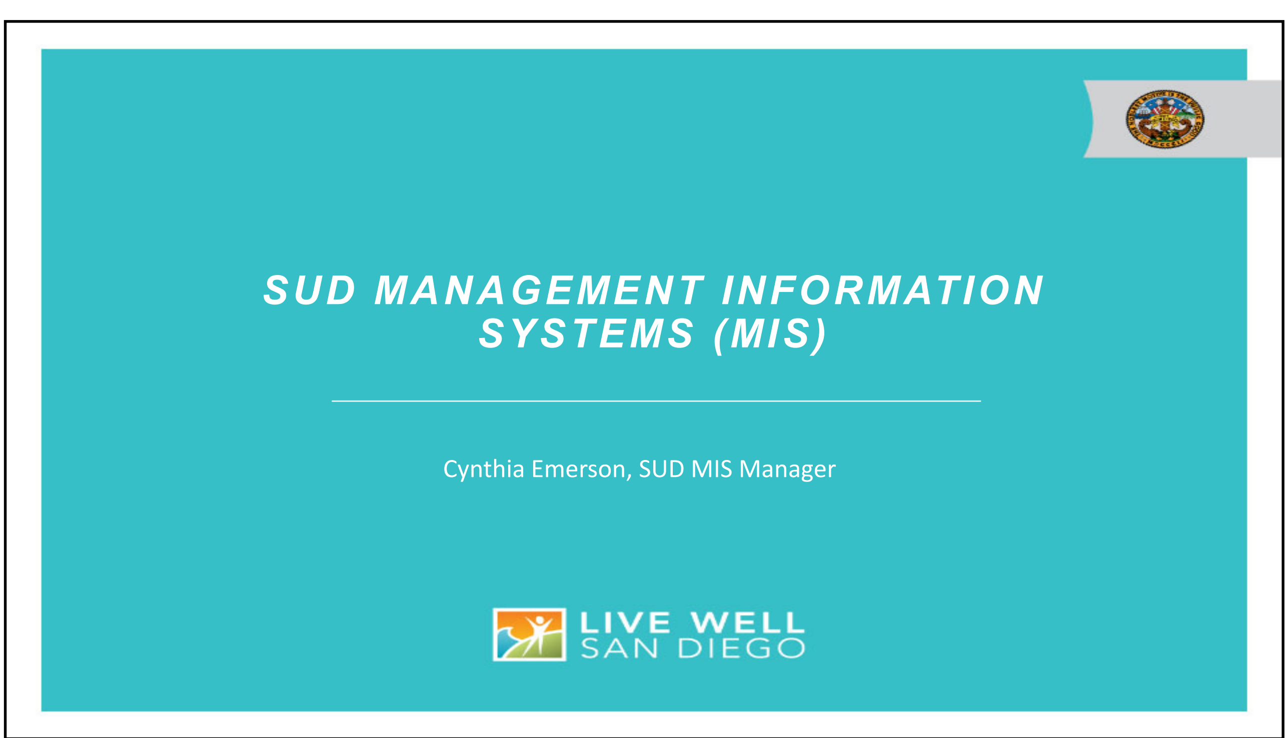
DIMENSION 6 Recovery/Living Environment	0 None	1 Mild	2 Moderate	3 Significant	4 Severe

1. Client has stable housing: Yes ☐ No ☐
2. Client lives in an environment where others are regularly using drugs or alcohol: Yes ☐ No ☐
3 History of alcohol or other drug use creating situations that are dangerous for client/threatening to others: Yes ☐ No ☐

Explain Dimension Scoring:

Name of Staff Completing Form and Credential:	Date Staff Completed Form:
LPHA Name and if Applicable Signature:	Date LPHA Completed or was Consulted:

76



77

78

SANWITS PROGRESS

DISCONTINUED SEP 1, 2022

- Diagnostic Determination Note (DDN)
- Treatment Plan
- Recommended Level of Care Assessment
- Adult Initial Level of Care Assessment

ADDITIONS IN FY 22-23

- Adult ASAM Criteria Assessment
- Problem List
- CalOMS Outcome Measures
- Modified Client Profile
- Refreshed User Interface
- New Home Page
- Lab Integration
- E-Prescribing

79

SANWITS MOVING FORWARD

FY 23-24

- Transition from SanWITS Billing to CIMS Billing Module
- Authorization Screens being updated as part of CIMS change
- New Encounter Screen with Progress Notes
- Interoperability for Providers

80

SANWITS MOVING FORWARD

FUTURE ENHANCEMENTS

- New Client Record Dashboard
- User Customizable Home Dashboard
- Additional updates to existing LPHA and Clinical Dashboards
- New Recovery Residence Screen

81

CALOMS

MEASURE CHANGE / DEMONSTRATE THE IMPACT OF SUD SERVICES

- Outcome data is necessary to identify what is working for our SUD tx clients and what is not working
- CalOMS questions are collected at three data points – admission, annual update, and discharge

82

CALOMS

ADMISSION DATA COLLECTED

- Before CalOMS tx questions are collected, a program participant must have the following:
  - ✓A SUD-related problem

    AND
  - ✓Completed Intake process to SUD Tx Program

    AND
  - ✓SUD Tx services must have commenced

83

CALOMS

TREATMENT EPISODE

- Planned series of treatment service types occurring consecutively (>30 days would be new episode)
- First treatment service in an episode would be indicated on the admission transaction type as <u>initial</u>
- Any subsequent changes in level of care or transfers to a different facility or Agency would be identified as <u>transfer</u>

84

CALOMS

SUD TX REFERRALS

- Client discharged from a SUD tx program, referred to receive additional SUD tx
- Reported on Discharge as referred
- CalOMS referrals do not include referrals to non-treatment services

85

CALOMS

ALTERNATIVE VALUES

- 99900 – Client Declined to State
  - Client declines to state
- 99901 – Unknown or Not Sure/Don't Know
  - Only available in a couple of circumstances
- 99902 – Not Applicable
  - Does not apply to that individual

86

CALOMS

ALTERNATIVE VALUES

- 99903 – Other
  - Answer not among specified values for the question
- 99904 – Client Unable to Answer
  - Service must be detoxification or developmentally disabled

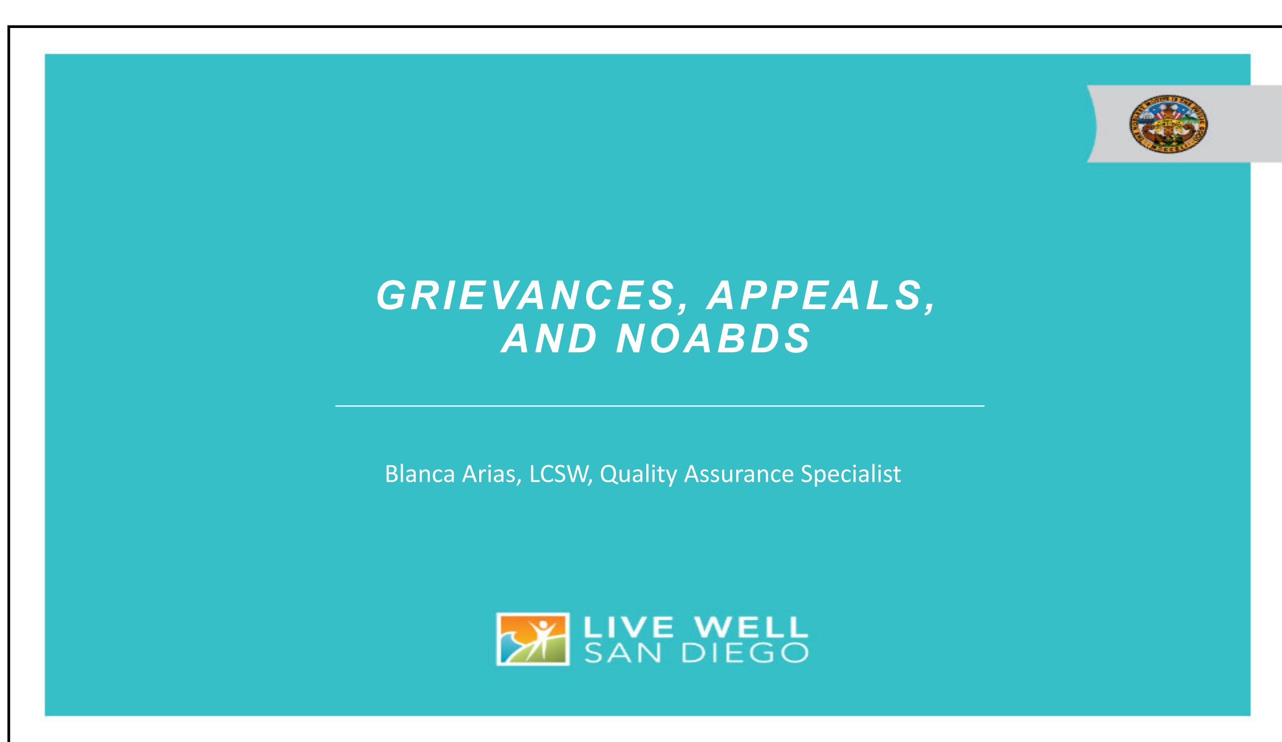
87

HELPFUL RESOURCES

- See Optum Webpage at https://www.optumsandiego.com/ for the following:
  - CalOMS Tx Data Collection Guide
  - CalOMS Tx Data Dictionary
  - CalOMS Paper Forms
  - DATAR Rewrite User Manual
  - DATAR Application Portal User Manual
  - SanWITS Tip Sheets
  - SanWITS Training Manuals & Video Tutorials
  - SanWITS User Access and Termination Forms
- See RegPacks for SanWITS Virtual Training at www.regpacks.com/dmc-ods

88

89

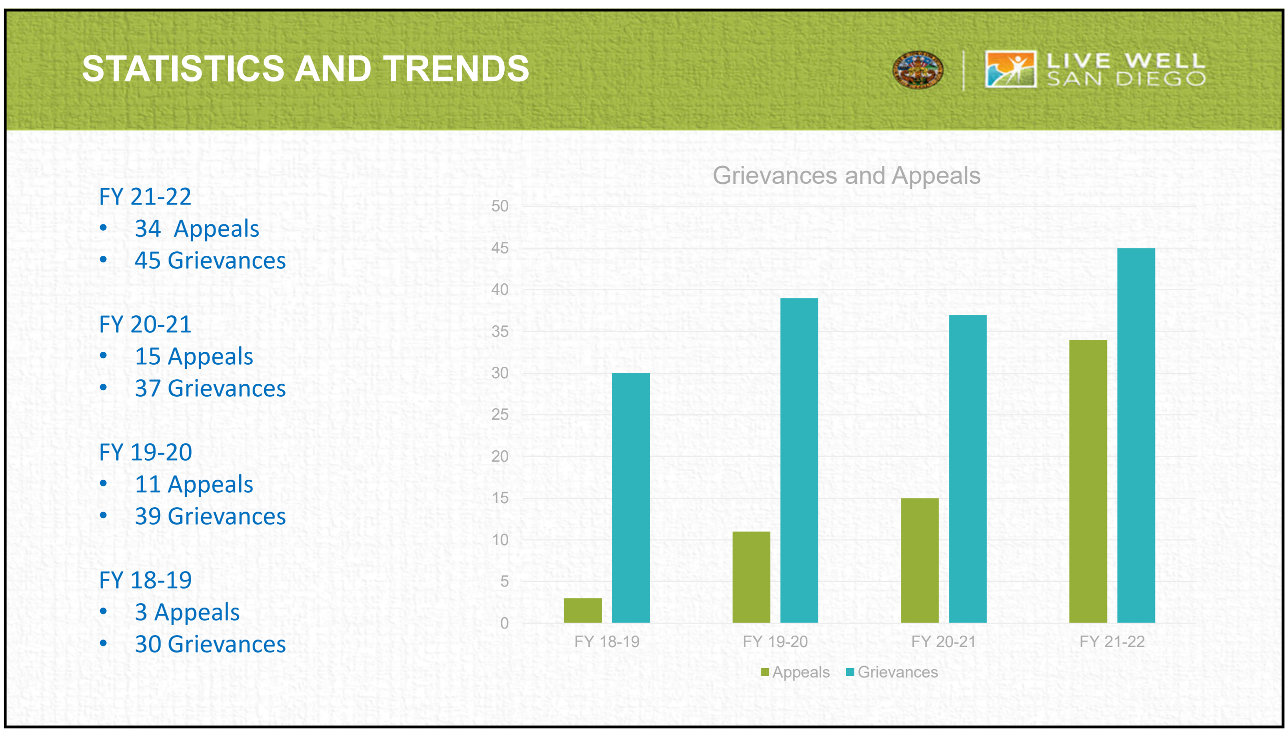


90

AGENDA

- Grievances and Appeals
- Grievance Trends: Quality of Care
- Discrimination Grievances
- NOABDs/Warm Handoff (CalAIM Care Coordination)
- 10 Day Advance Notice of Action
- Exceptions to 10 Day Advance Notice
- Documentation to clearly support discharge
- Aid paid pending
- CAPs
- Fixing deficiencies during the investigation to avoid a CAP
- Working Collaboratively with Advocacy Agencies

91



92

THE GRIEVANCE PROCESS

- Providers are encouraged to resolve grievances at the program level within 24 hours. This would be an EXEMPT grievance.
- All grievances, whether the client is a DMC beneficiary or does not have insurance, will be handled by the Patient Advocacy Contractors, CCHEA, and JFS.

93

GRIEVANCE TRENDS

- Access to Care
- Quality of Care
- Program Requirements
- Client Rights
- Other

94

GRIEVANCE TRENDS

- **Quality of Care Themes**
  - Staff Behavior Concerns
  - Treatment Issues or Concerns
  - Medication
  - Cultural Appropriateness

GRIEVANCE TRENDS

Client Rights Themes

- Not provided services they were eligible for
- Not receiving mail
- Not allowed visitors
- NOABD not documented accurately
- Not intervening when a client is bullied by peers
- Not providing language appropriate services
- Not allowing access to Advocacy Agency
- Withholding services
- Unable to receive pass to leave the facility

DISCRIMINATION GRIEVANCES

- **Discrimination Grievance**
  - A complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law:
    - Sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
  - Intergovernmental Agreement page 145

97

DISCRIMINATION GRIEVANCES

- **Discrimination Grievance**
  - When a client believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance with:
    - The County plan
    - Department's Office of Civil Rights
    - United States Department of Health and Human Services, or
    - Office for Civil Rights.
  - 45 CFR §§ 92.7 & 92.8; WIC§14029.91; SUDPOH G.24

98

DISCRIMINATION GRIEVANCES

- **Discrimination grievances are an additional monitoring requirement for SUD QA monitoring effective 7/1/21**
  - The complaint(s)
  - Providers' response to the grievance
  - Program, client, and advocacy contact information
  - Correspondence and results of the investigation
- Providers are encouraged to work with clients at the earliest opportunity and lowest levels possible to resolve discrimination grievances

NOABDS

- **Updated NOABD Chart**
  - Optum website
  - NOABD Tab
- **SUDPOH G.22-G.31** Consumer Grievances, Appeals, and State Fair Hearings

Notice of Adverse Benefit Determination (NOABD) Notices
For Medi-Cal Beneficiaries

An Adverse Benefit Determination is defined to mean any of the following actions taken by The Plan: 1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2) The reduction, suspension, or termination of a previously authorized service; 3) The denial, in whole or in part, of payment for a service; 4) The failure to provide services in a timely manner; 5) The failure to act within the required timeframes for standard resolution of grievances and appeals; or 6) The denial of a beneficiary's request to dispute financial liability. Beneficiaries must receive a written NOABD when The Plan takes any actions described above. The Plan must also communicate the decision to the affected provider within 24 hours of making the decision.

Note: All notices shall be received by either the client or the parent/legal guardian.

NOABD	Timing of Notice	Criteria	Suggested Content for Completing Forms
Denial of Authorization Notice	Within 2 business days of the decision	The Plan denies a request for service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. Use this notice for denied residential services requests (both MH and SUD).	Narrative Completion: 1. A description of the criteria or guidelines used, including a citation to the specific regulations and plan authorization procedures that support the action; a) Denial of Authorization Ex: "The reason for the denial is The Plan has reviewed your request for services and determined we are unable to provide such services based on Medi-Cal managed care guideline criteria due to…" i) … type or level of service; requirements for medical necessity; appropriateness, setting; or effectiveness of a covered benefit b) Delivery System Ex: "Our assessment is based on Medi-Cal managed care guidelines and state regulations which staff utilized to determine if medical necessity criteria are met…" i) … your diagnosis is not covered by the MHP; your MH condition does not cause problems in your daily life that are serious enough for SMH services; services are not likely to maintain or improve your MH condition; your MH condition would be responsive to treatment by a PCP. c) Modification Ex: "We cannot approve this treatment as requested. This is because The Plan has reviewed your provider's request for services and has changed the services based on…" i) … your condition has improved and you require less service less often; services are no longer appropriate for the condition
Delivery System Notice	Within 2 business days of the decision	The Plan has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health services through the Plan. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health or other services.	
Modification Notice	Within 2 business days of the decision	The Plan modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.	
Termination Notice	At least 10 days before the date of Action	The Plan terminates, reduces or suspends a previously authorized service. Notice is <u>required</u> for all clients who have unsuccessfully discharged. Unsuccessful discharge includes, but is not limited to, client AWOL, client unwilling to continue services, client terminates AMA, etc.	
Timely Access Notice	At the time of the action	When there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service.	

BHS QM NOABD Table Rv. 1/8/20

GRIEVANCES & APPEALS

- **Most Common NOABD:** ***Termination Notice***
  - Must be provided 10 days before the date of action
  - Required for all clients who have been unsuccessfully discharged
  - Examples: Instances of AWOL, unwilling to continue services, AMA, etc. For residential programs, the 10-day timeline may be exempt in rare occasions in which the health or safety of individuals in the facility are endangered
    - Consult with QA and your COR

101

NOABD APPEAL RIGHTS

All clients have the right to appeal the determination stated in their NOABD.

CONTINUATION OF SERVICES

Clients have the right to continue receiving services during the appeal process (42 CFR § 438.420). This is also known as Aid Paid Pending.

CLIENT REQUESTS

Appeals may be requested in writing or orally by the client. Client must request the appeal within 60 calendars of the date on their NOABD.

STATE FAIR HEARING

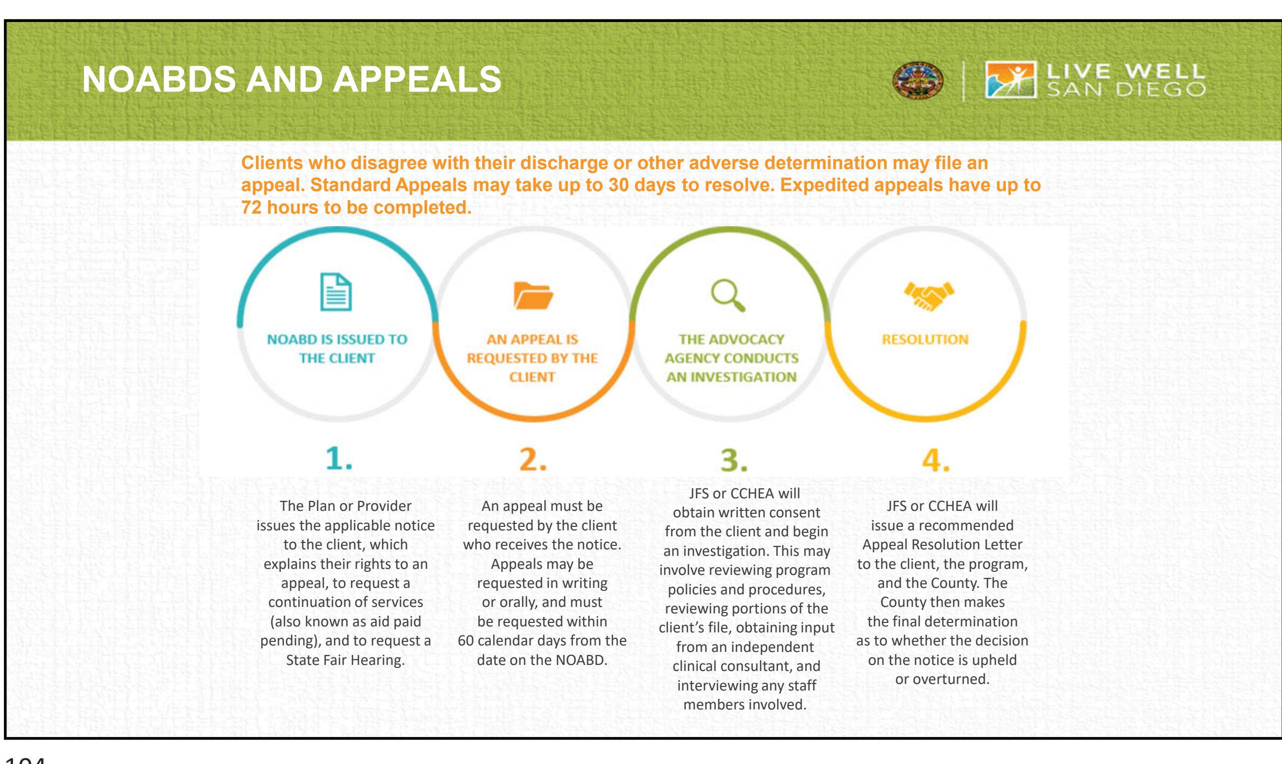
If a client disagrees with the outcome of the appeal process, they may request a State Fair Hearing. Note that clients may access State Fair Hearing processes at any point.

DOCUMENTATION

Certain documents explaining the client's rights are required to be issued with all notices and with all appeal resolutions, regardless of the outcome. These documents are available on Optum San Diego's website, NOABD Tab, in all threshold languages.

102

103



104

WHAT IS A CAP?
(CORRECTIVE ACTION PLAN)

- CAPS are issued by QA when it is identified during the investigation process by Advocacy Agency that there is a deficiency in the programs service delivery or policies and procedures that doesn't align with the SUDPOH, 42CFR, or Intergovernmental Agreement.
- The identified deficiency is pervasive
- The program has 30 days to fix the deficiency and provide evidence of the corrections to QA by providing training and submitting sign in sheets and agendas, updated policies and procedures, and updated trackers
- The CAP form needs to be completed and submitted to QA within 30 days with descriptions of plan for correction, staff responsible, how program will ensure compliance including frequency of trainings and internal updates.

County of San Diego
GRIEVANCE AND APPEAL CORRECTIVE ACTION
HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
3255 CAMINO DEL RIO SOUTH, MAIL STOP P-531
SAN DIEGO, CA 92108-3806
(619) 563-2700 • FAX (619) 563-2705

Finding	Describe how the deficiency will be corrected	Staff person responsible for correcting the deficiency	Describe how the program will ensure future compliance	Proposed Implementation Date	County Response to Provider	Implemented Yes/No

105

HOW TO AVOID CAPS

WORK COLLABORATIVELY WITH YOUR ADVOCACY AGENCY

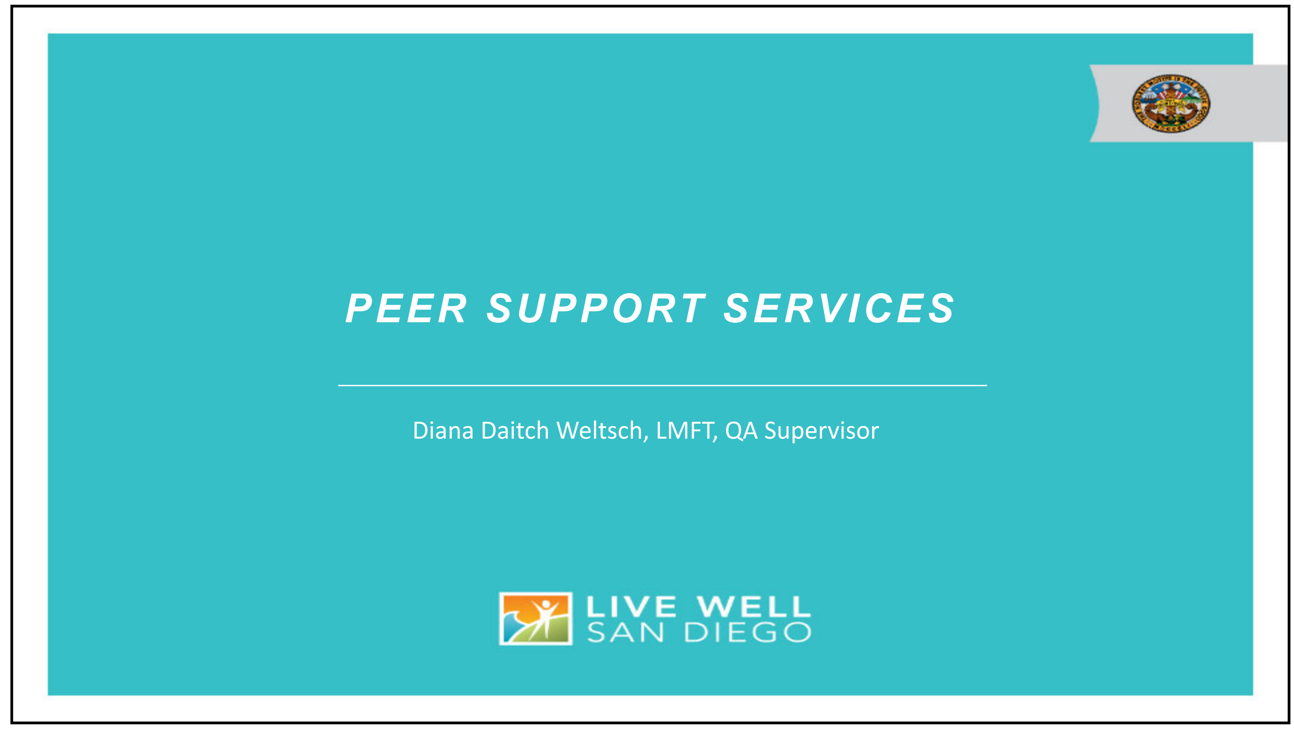
- Be proactive during the appeal or grievance investigation when deficiencies are found:
  - Update your P&Ps
  - Facilitate staff trainings
  - Provide documentation within 7 days of record requests from advocacy agency
  - Collaborative communication with the client
  - Implement changes to address the concerns highlighted during the investigation

106

GRIEVANCE & APPEAL CONTRACTORS

- **JFS Patient Advocacy Program – provided by Jewish Family Services**
  - For all inpatient or residential SUD services
  - 1-800-479-2233 or 619-282-1134
  - Email: jfsonline@jfssd.org
- **CCHEA Patient Advocacy Program provided by the Consumer Center for Health, Education, and Advocacy, a unit of Legal Aid**
  - For all Outpatient SUD services
  - 1-877-734-3258
  - TTY-1-800-735-2929
- Please provide copies of medical records to JFS or CCHEA within 7 calendar days from the date of the request. They will provide the program with a signed ROI.

107



108

PEER SUPPORT SPECIALISTS (PSS)

- What is a peer support specialist?
  - a person with "lived experience“
  - Someone who has been trained to support those who struggle with mental health, psychological trauma, or substance use.
  - Someone whose personal experience of these challenges provide peer support specialists with expertise that professional training cannot replicate.

109

MEDI-CAL CERTIFIED PEER SUPPORT SPECIALIST QUALIFICATIONS

- Be at least 18 years of age
- Possess a high school diploma or equivalent degree
- Be self-identified as having experience with the process of recovery from mental illness or substance use disorder, either as a consumer of these services or as the parent, caregiver, or family member of a consumer
- Be willing to share their experience

110

CERTIFIED PEER SUPPORT SPECIALIST

- Individual and Group Services that promote:
  - Recovery
  - Resiliency
  - Engagement
  - Socialization
  - Self-sufficiency
  - Self-advocacy
  - Development of natural supports
  - Identification of strengths

  * Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources and to educate beneficiaries and their families about their conditions and process of recovery

111

ROLES OF CERTIFIED PEER SUPPORT SPECIALISTS

- Assist peer in articulating their goals for recovery
- Assist peer in learning and practicing new skills
- Help peer monitor their progress
- Support them in their treatment
- Model effective coping techniques
- Identify self help strategies based on personal recovery experience
- Support in advocating for themselves
- Developing and implementing recovery plans
- Find and maintain community living skills
- Socialization
- Build alliances that enhance the individual's ability to function

112

CERTIFIED PEER SUPPORT SPECIALISTS

SERVICES CONSIST OF:

- Educational Skill Building Groups:
  - Providing a supportive environment to learn coping mechanisms and problem-solving skills
- Engagement:
  - Activities and coaching to encourage and support participation in treatment
- Therapeutic Activity:
  - Structured non-clinical activity such as advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to focus on the treatment needs by supporting the achievement of treatment goals

113

Program Performance Improvement

Performance Improvement Support for County of San Diego Behavioral Health Programs

PRESENTERS:

KATIE WAN (RULE)

AMY CHADWICK

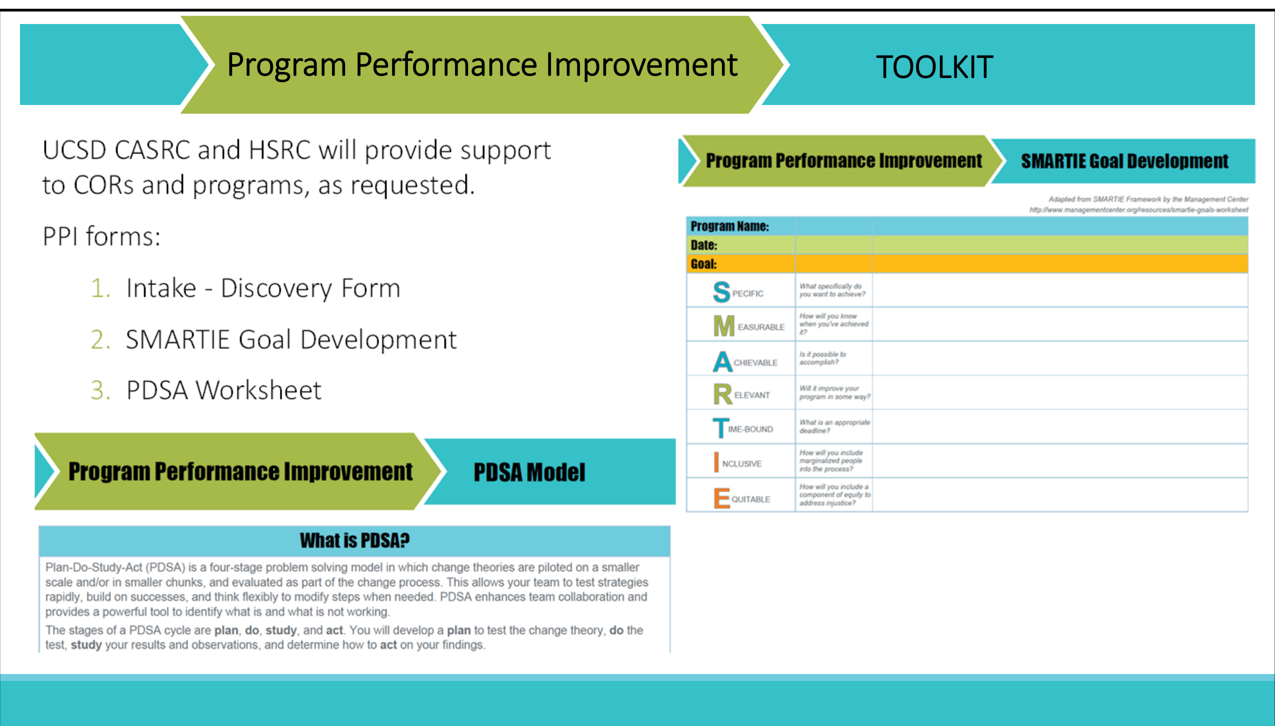
114

What is Program Performance Improvement

As part of BHS's mission to support providers, improve quality, and enhance services, UC San Diego's Research Centers (CASRC and HSRC) will engage programs in a Program Performance Improvement (PPI) review process personalized to that program's specific needs and challenges.

115

Program Performance Improvement TOOLKIT



116

Program Performance Improvement — PPI IN ACTION

Active PPI in CYFBHS

- Presenting Problem
  - Trouble recruiting bilingual staff
- Discovery
  - Identify issue/s
  - Identify barrier/s
  - Identify program strengths
- Research & Engagement
  - Literature Review
  - Expert input (staff, stakeholders)

Program Name/LOC	**Outpatient Program**
Date	**3/30/2022**
Attendees	**CASRC, BHS, Program Staff**
Program Mission/Description	Provide services to underserved youth, including health/behavioral health
Services provided	OP, school-based services to 5 schools
Clients	How many served? Primarily Spanish speaking; especially parents (~90%)
Clinical staff	How many clinicians? Just hired first non-bilingual clinician.
Administrative staff	How many admins? Primarily bilingual.
Family/Peer Support partners	Recruiting first support partner now!
GOAL	
Staff recruitment & retention	Primarily challenged to recruit and retain clinicians.
Current protocol?	1) Create position description with Hiring Manager; 2) Post at program; 3) Post on Indeed; 4) Engage contractor
How is it working?	Difficult to reach specific populations due to very high volume in central HR
Trouble attracting applicants?	YES. Looking for passionate folks who are familiar with the community. BHS positions may be less competitive due to CCBH, paperwork, pay.
Trouble retaining applicants?	Somewhat. Diverse, challenging client population. Border/documentation-divided families.
Pandemic-related challenges?	Lost two bilingual clinicians in the past year.
BARRIERS	Licensure - previously limited due to lack of supervision hours; now recruiting LCSW to open the pool to ASWs. Also now considering PCCs.
STRENGTHS	Program is a great place for clinicians to get experience working with kids in need. Strong sense of community among staff. Many clinicians grew up in the area.

117

Program Performance Improvement — PPI IN ACTION

Active PPI in CYFBHS – Bilingual Staff

- Process (PDSA)
  - Recommendations (SMARTIE)
  - Implementation
  - Outcomes & Feedback

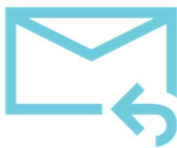
SMARTIE Goal: Retain new hires for a minimum of 2 years.

Task	Priority	Start Date	End Date	Lead Person	Key Partners	Status	Notes
Exit interviews	High	Varied	n/a	HR			Conduct exit interviews when staff resign
Stay interviews	High	Varied	n/a	Supervisors			Draft Stay Interview Conduct stay interviews as part of annual review process
Financial incentives	Medium	ASAP	n/a	HR	Leadership		Longevity bonus, loan repayment
Increase staff support	High	Immediately	n/a	PM			Regular check-ins, administrative assistance to combat burnout

Program Performance Improvement — PDSA Worksheet

Program Name	**Outpatient Program**
Start Date 5/16/2022	**End Date**
OBJECTIVE 2	
Retain new hires for a minimum of two years	
PLAN	
Plan	Survey staff and create financial incentives
Expected Result	Less staff turnover
Who	Management and HR
What	See SMARTIE worksheet
When	Ongoing
Where	N/A
Plan for collecting data	Track staff tenure
DO	
What data did you collect?	
What observations did you make?	
STUDY	
What did you learn?	
Why was this successful, or not successful?	
ACT	
Adapt, adopt, or abandon?	

118



Contact Information

Health Services Research Center
klrule@health.ucsd.edu
(858) 622-1771 ext.7011

Child and Adolescent Services Research Center
aechadwick@health.ucsd.edu
(858) 966-7703 ext.247141

119

Thank you!

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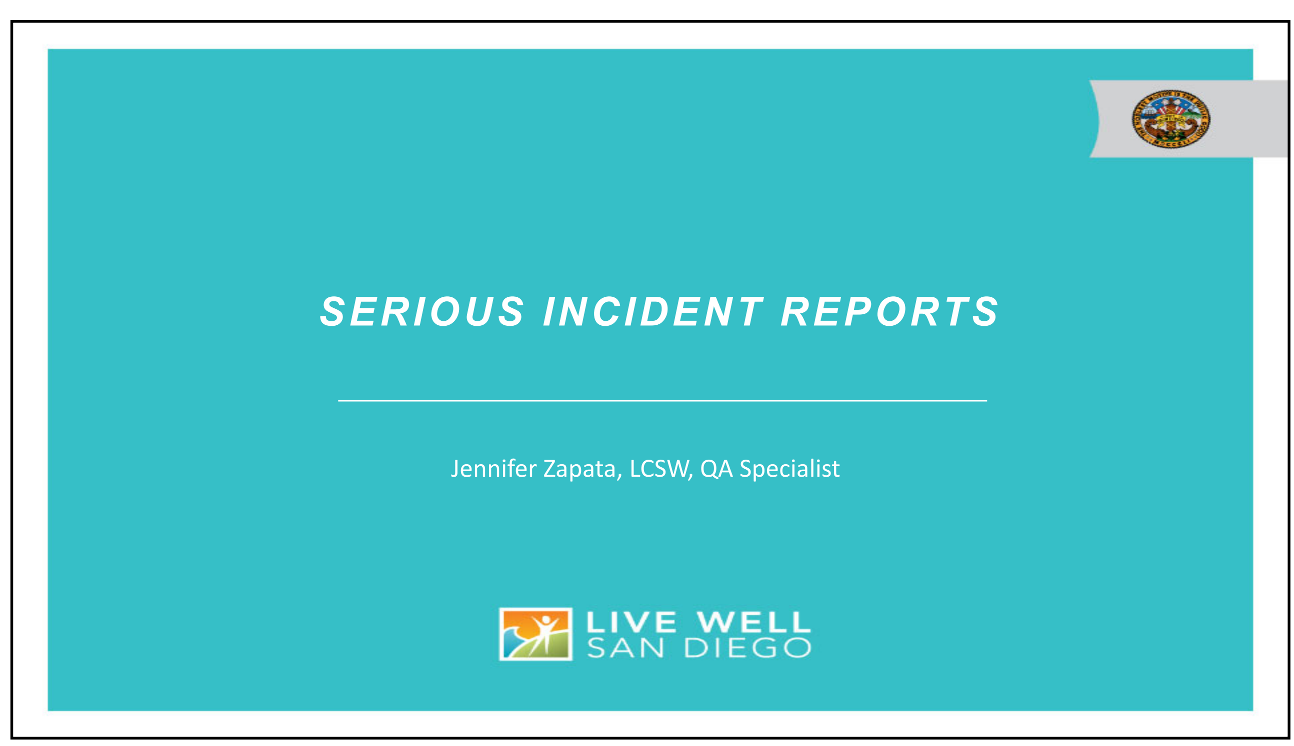


121

SERIOUS INCIDENT REPORTS

LIVE WELL SAN DIEGO

SIR Type	FY 20-21	FY 21-22
Death Under Questionable Circumstances	20	29
Apparent Overdose of Alcohol/Drugs	18	22
Other	14	22
Incident in Media	9	7
Death by Suicide	6	5
Suicide Attempt	5	5
Total	92	114

122

SERIOUS INCIDENT REPORTS

- **Level 1 SIR -The most severe type**
  - Reported in the Media (including social media)
  - Death or serious injury on the program's premises
  - Event with a significant deviation from the usual process for providing care
  - **NOTE:** Privacy Incident are no longer a part of the SIR process
- **Level 1 incident should be reported immediately to the QA SIR phone line with faxed report to follow**
  - Call and leave necessary information on secure voice mail
  - Fax Level 1 SIR within 24hours to QA
  - Note: There are updated forms on Optum for SIR (7/1/22) and SIROF (7/7/22)

123

SERIOUS INCIDENT REPORTS

- **Level 2 SIR – all other incidents**
  - Call in report to QA SIR Report phone line within 24hrs
  - Fax Level 2 SIR form within 72hours
- **SIR form must be typed**
  - Completed by Program Manger or Designee

124

SERIOUS INCIDENT REPORT OF FINDINGS

- **Serious Incident Report of Findings (SIROF)**
  - Fax SIROF within 30 days of knowledge of the incident
- **Revisions to the SIROF form was completed July 2022**
  - The following items were added:
    - Was the person in custody within the last 30 days?
    - Was Naloxone/Narcan administered? If yes, by Whom
    - Was fentanyl specific testing included in all client's urine drug screens?
    - Date and result of most recent fentanyl specific test
    - Was the client given health education about Naloxone/Narcan for overdose prevention as part of treatment plan prior to incident (i.e., intake)?
    - Was Naloxone/Narcan kit prescribed or given to the patient for overdose prevention prior to the incident (not including any staff administration of naloxone)?

125

126

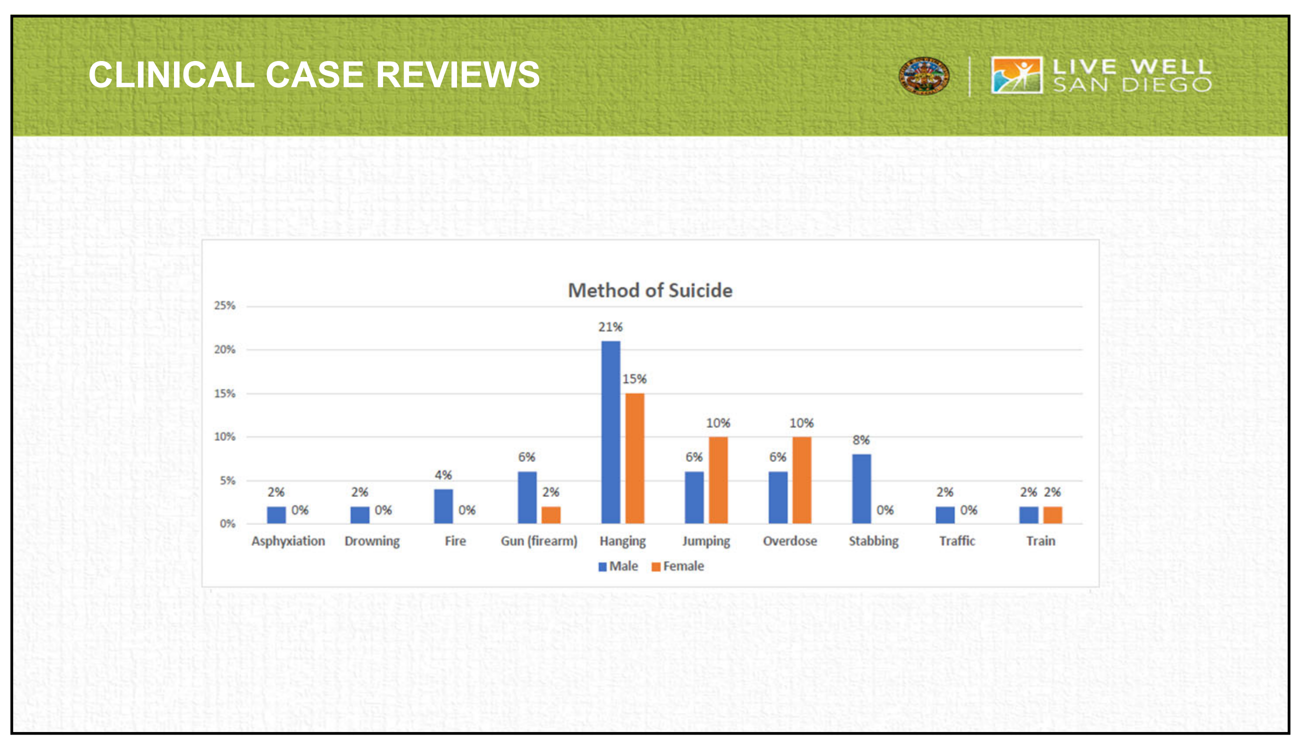
CLINICAL CASE REVIEWS

- A clinical case review convenes regularly to review cases involving a death by suicide, homicide, and other complex clinical issues
- The purpose of the review is to identify systemic trends in quality and/or operations that affect client care
- Identified trends are utilized to provide opportunities for continuous quality improvement
- Program shall comply with requests for client records that are reviewed in clinical case conference
- A serious incident that results in a death by suicide or an alleged client committed homicide will trigger a chart review and require the completion of a Root Cause Analysis (RCA) within 30 days of knowledge of the incident

127

CLINICAL CASE REVIEWS

LIVE WELL SAN DIEGO



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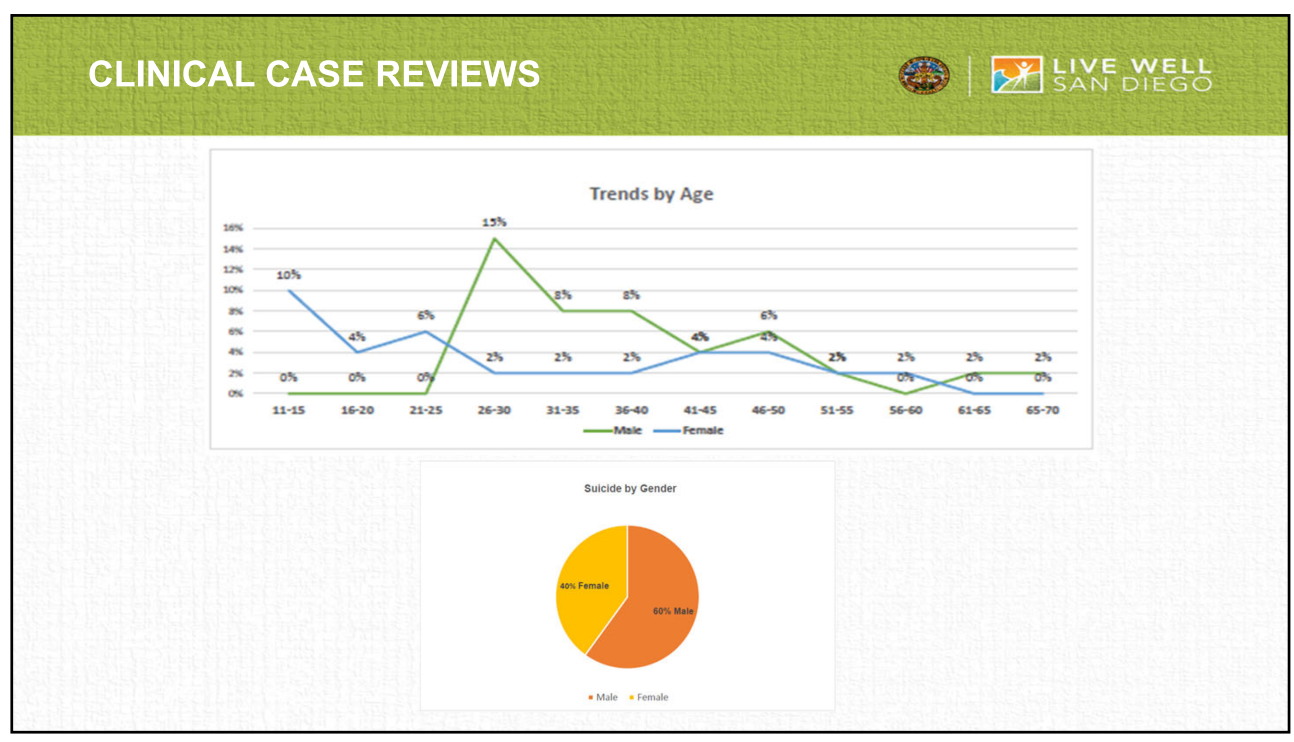

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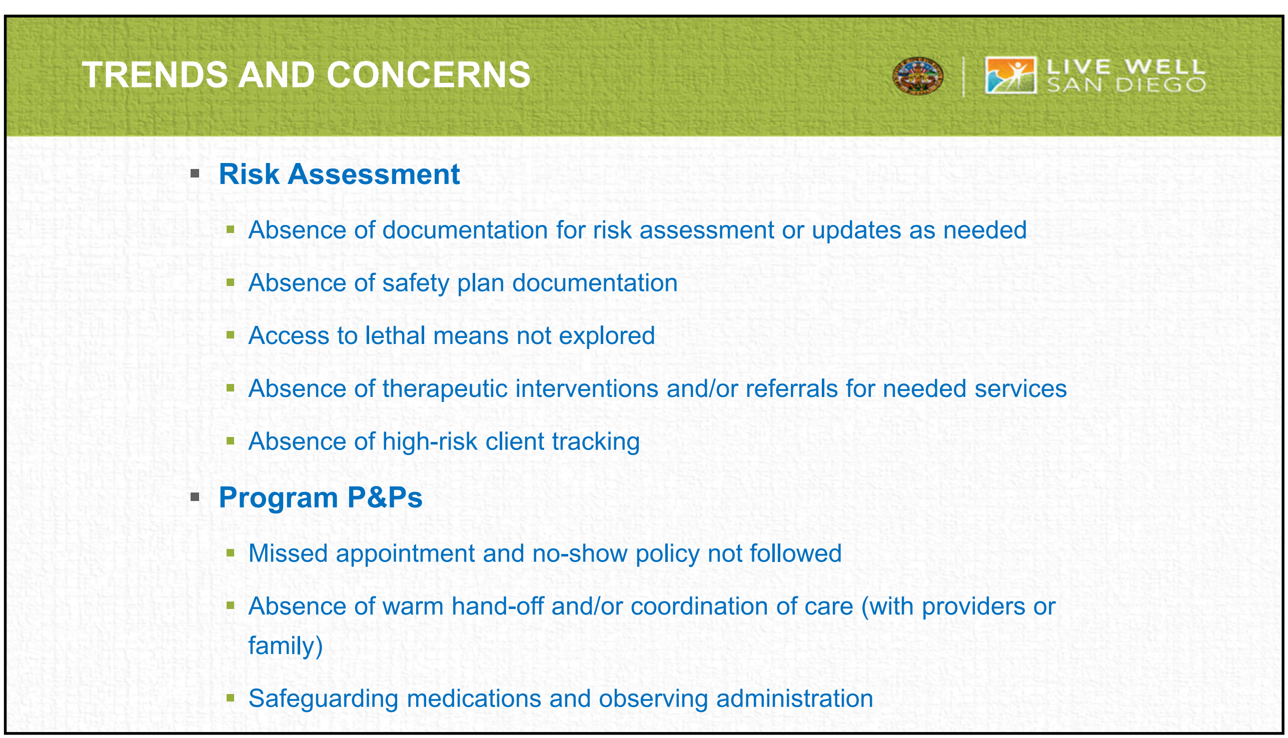


130

RECOMMENDATIONS AND FOLLOW-UPS

- **Policy & Procedures**
  - Missed Scheduled Appointments
    - All providers shall have policies and procedures in place regarding the monitoring of missed scheduled appointments for clients
    - These policies and procedures shall cover both new referrals and existing clients, and at minimum, follow timeline standards
    - The program policy needs to document next steps and outline how the program will continue to follow-up with a client who has been identified as being at an elevated risk
    - All attempts to contact a new referral and/or a current client (or caregiver, if applicable) in response to a missed scheduled appointment must be documented by the program

131

RECOMMENDATIONS AND FOLLOW-UPS

- **Coordination of Transitions in Care**
  - **Involves but is not limited to:**
  - In all cases of care transitions, the last treating SUD provider is responsible for and must coordinate transitions in care
  - Having established policies and procedures for standardizing the care transition process
  - Warm handoffs that involve interpersonal communication and ideally physically accompanying the client during the transition, rather than solely relying on written or electronic communication

132

RECOMMENDATIONS AND FOLLOW-UPS

- **Care Coordination**
  - The primary role of the staff providing care coordination services is to coordinate client services seamlessly between settings of care, including appropriate discharge planning
  - Care Coordination is a client-centered, collaborative approach
    - Focuses on reducing barriers to treatment and linking clients with necessary and appropriate services including medical, mental health, educational, social, prevocational, vocational, rehabilitative, or other community services while the client is receiving SUD treatment.

133

RECOMMENDATIONS AND FOLLOW-UPS

- Medication Assisted Treatment (MAT)
  - Best practice is to continue following-up after admission with clients on MAT education as clinically indicated
  - Programs are encouraged to complete and clearly document closed loop referrals to MAT services, as clinically indicated

134

RECOMMENDATIONS AND FOLLOW-UPS

- **Risk Assessment & Safety Management Plan**
  - Each program must develop internal guidelines for the risk assessment with regards to the Safety Management Plan as what will be the plan of action when someone is identified at the various levels of risk
    - The Safety Management Plan may include the following information:
      - Considerations of higher level of services or additional services such as Care Coordination and more frequent sessions
      - Linkage to additional resources such as providing client with referrals to 211 or Access & Crisis Line (1-888-724-7240; TDD/TTY Dial 711), 988 Suicide and Crisis Lifeline, Psychiatric Emergency Response Team (PERT), Mobile Crisis Response Team (MCRT), crisis house or psychiatric hospital
      - The documentation should also include how the use of Protective Factors and Coping Skills will be employed by the client
      - Frequency of re-assessment for risk (e.g., HRA)

135

AVAILABLE TRAININGS & RESOURCES

- **Root Cause Analysis (RCA)**
  - Upcoming virtual RCA trainings are held quarterly
- **Optum San Diego**
  - Virtual Skill Building Workshops
  - Up To The Minute (UTTM)
- **CalMHSA**
  - CalAIM Documentation Training
- **Academy for Professional Excellence**
  - COSDBHS Contracted Trainings are available through the Responsive Integrated Health Solutions (RIHS)
  - There are resources on RIHS to assist your program with various DMC-ODS topics (e.g., Relapse Prevention, Motivational Interview)

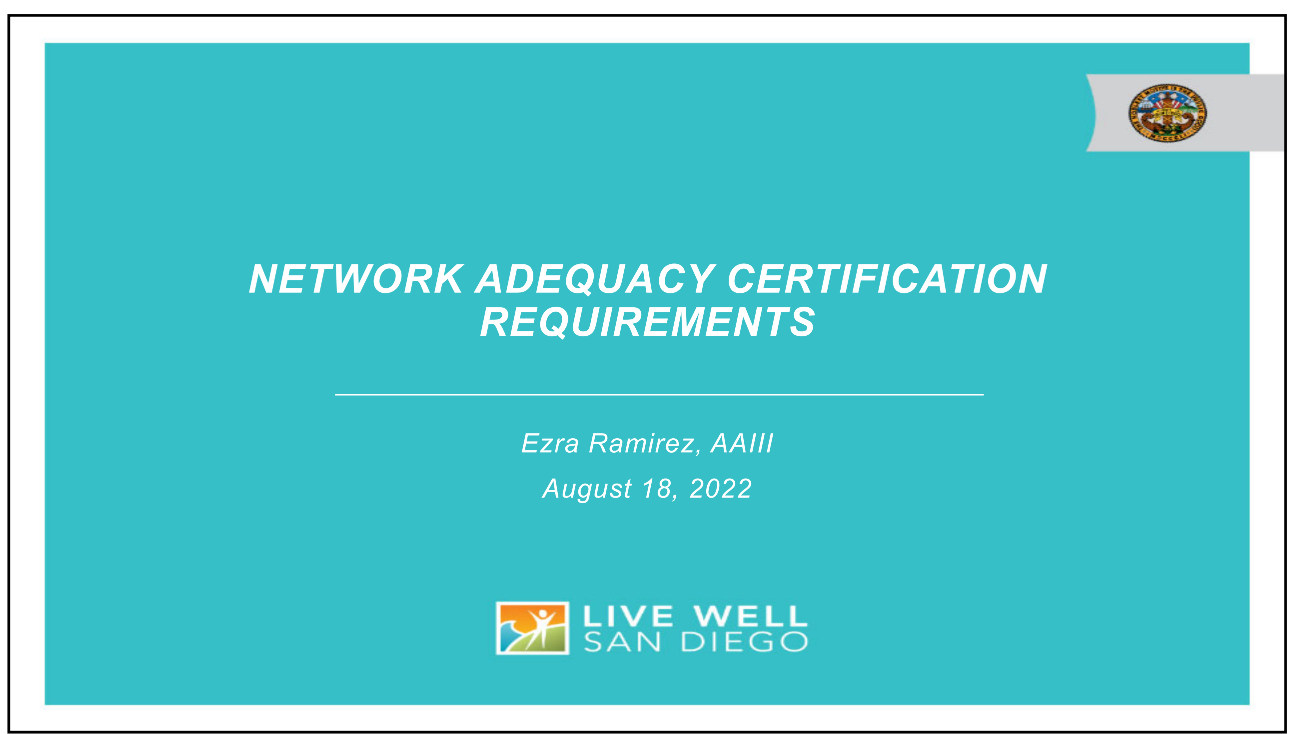
136

137

TIMELY ACCESS & URGENT REQUESTS

- **Providers shall ensure an appointment:**
  - Outpatient & Residential* – within 10 business days
  - OTP – within 3 business days
    - **DHCS clarified the residential standard as part of CalAIM*
    - ***Reminder** – NOABD for Timely Access should be issued for all contacts not meeting the access time requirements outlined.*
- **Urgent Requests**
  - Condition perceived by the client as serious but not life threatening; condition disrupts activities of daily living; requires assessment by a health care provider, and if necessary, treatment within 48 hours.
- **SanWITS**
  - Client Contact screen
  - Required for all clients (admitted or not admitted)

138



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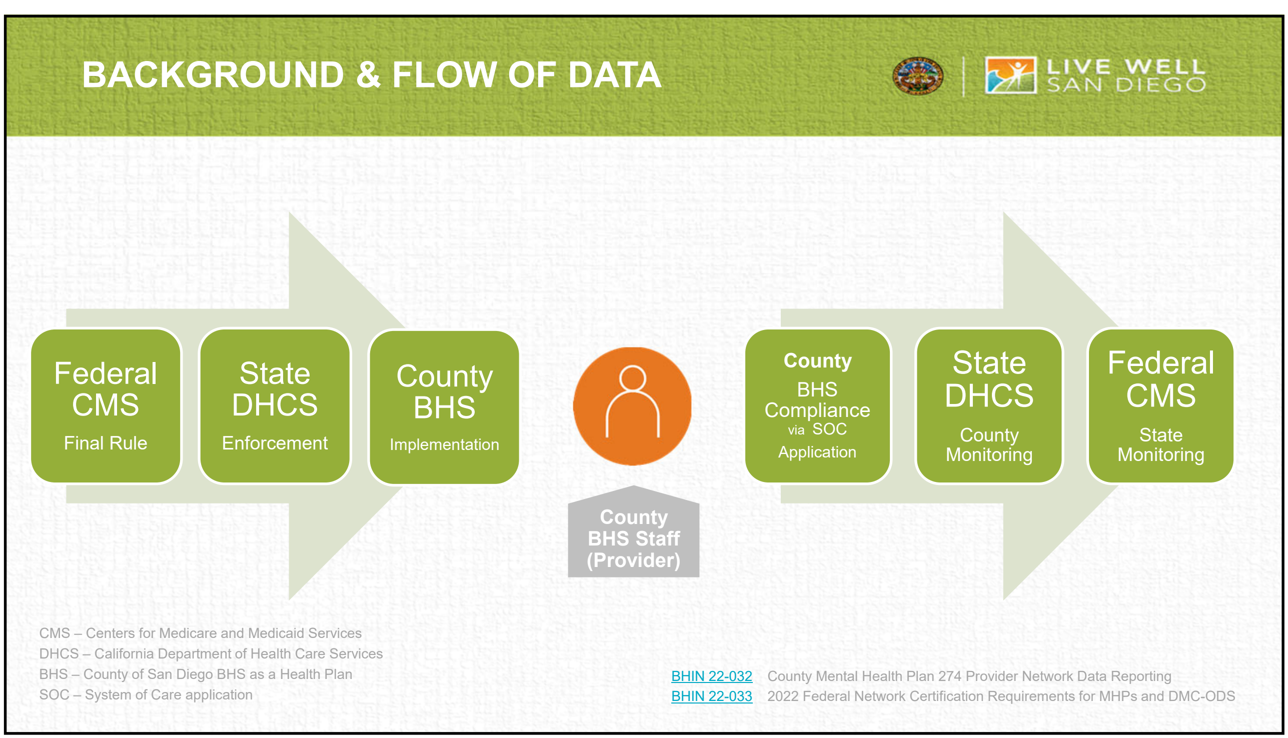


140

NEW NACT REPORTING STANDARD

- Registration
  - New hires and program transfers are required to **register promptly**, and attest to information once registration is completed.
- Monthly attestations
  - Effective immediately, Staff/Providers and Program Managers are required to attest to all SOC information **monthly**.
  - Program Managers are expected to visit the SOC app to review their programs' information and attest to information **monthly**.
  - Providers are expected to update their current profile in the SOC app **as changes occur** to show accurately on the provider directory.

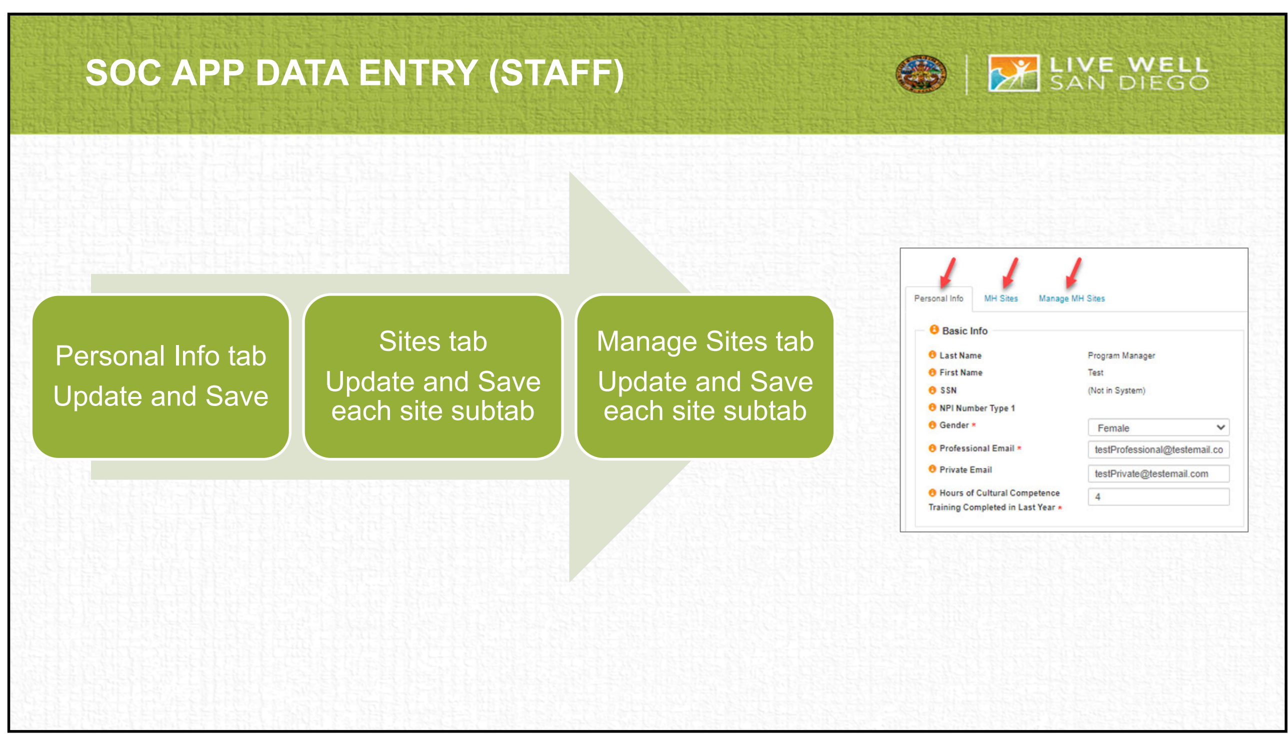
141

NEW NACT REPORTING STANDARD

- 274 Expansion Project
  - Based on X12 274 Health Provider Directory standard selected by DHCS to ensure all provider network data is consistent, uniform, and aligns with national standards. (BHIN 22-032)
  - Mental Health Providers
    - By **September 2022**, DHCS requires all County BH Plans to submit mental health services provider data using 274 reporting requirements on a **monthly** basis
  - DMC-ODS Providers
    - 274 reporting requirements for DMC-ODS are in development, rollout date TBD.

142

143



144

SOC APP DATA ENTRY (STAFF)

LIVE WELL SAN DIEGO

Personal Info | SUD Sites | Manage SUD Sites

Basic Info

- Last Name
- First Name
- Middle Name
- SSN — (Not in System)
- NPI Number Type 1
- Gender *
- Professional Email *
- Private Email
- Hours of Cultural Competence Training Completed in Last Year * — 3

Professional Info

Areas of Expertise (SUD)
- ☐ Child/Adolescent
- ☑ Adult
- ☐ Geriatric
- ☐ Mental Health

Specialized Age Groups (SUD)
- ☐ Infant 0-2

Provider Practice Focus (SUD)
- ☐ Adjustment Disorders
- ☐ Anxiety Disorders
- ☐ Bi-polar Disorders
- ☐ Delirium, Dementia, and Amnestic and other Cognitive Disorders
- ☐ Depressive Disorders
- ☐ Disorde in Infancy Adolesce
- ☐ Dissoci
- ☐ Eating
- ☐ Factitio
- ☐ Impulse Otherwis
- ☐ Mental

Licensure

- Academic Degree * — Associate
- Academic Degree Description * — Associate in Social Work
- California Practitioner License # — (Not in System)
- DEA Number — (Not in System)
- Licensure/Credentials — Certified Substance Use Disorder Counselor
- Licensing Entity
- Board Certified Psychiatrist — ☐
- California Practitioner Certification # — (Not in System)
- Type of Board Certification — Other
- Certifying Entity — CCAAP

Language Capacity

Language	Capacity
Arabic	N/A
Armenian	N/A
Cambodian	N/A
Cantonese	N/A
English	Fluent
Farsi	N/A
Hmong	N/A
Korean	N/A
Mandarin	N/A
Other Chinese	N/A
Russian	N/A
Spanish	Fluent
Tagalog	N/A
Vietnamese	N/A
American Sign Language	N/A

Save and Attest | Reset

145

SOC APP DATA ENTRY (STAFF)

LIVE WELL SAN DIEGO

Personal Info | SUD Sites | Manage SUD Sites

58 - Serial Inebriate Program(3781) | 86 - Stepping Stone of San Diego - Residential

Treatment Location Information

- Agency Name — Mental Health Systems Inc.
- Agency ID — 20
- Facility Name — Serial Inebriate Program(3781)
- Facility ID — 58
- Network — Substance Use Disorder (SUD)
- Treatment Location Address — 3340 Kemper St Ste 105
- Site-specific Email *
- Service Status

Modalities

Modalities
- ☑ Outpatient Drug Free Clinic
- ☐ Intensive Outpatient Clinic
- ☐ Residential
- ☐ Opioid Treatment Program

More Service Options

- Telehealth Services * — Both Telehealth and Non-Telehealth
- Distance Provider Travels to Field Based Services — 11 - 30 miles

Medi-Cal Age Groups and Hours

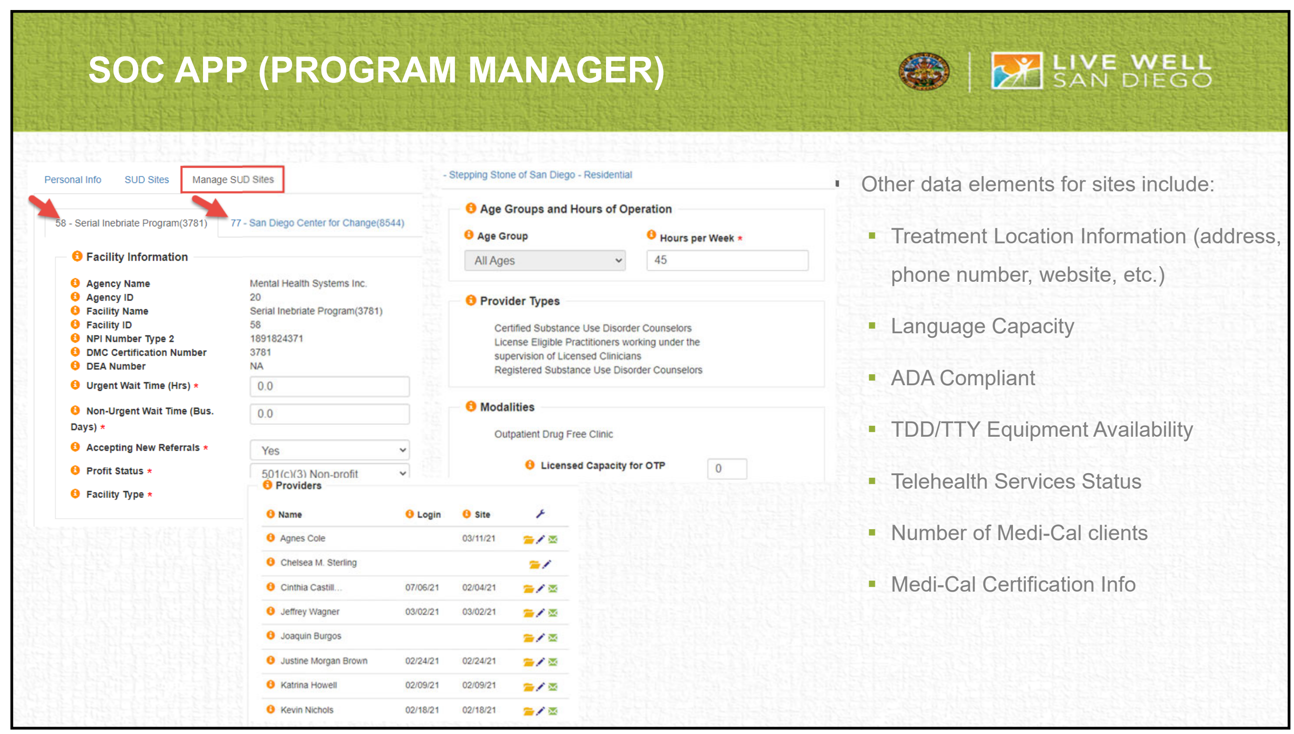
Hours per Week
- 0-20 * — 0
- 21+ * — 40

Medi-Cal Clients

- Max * — 56
- Current * — 46

Save and Attest | Reset

146



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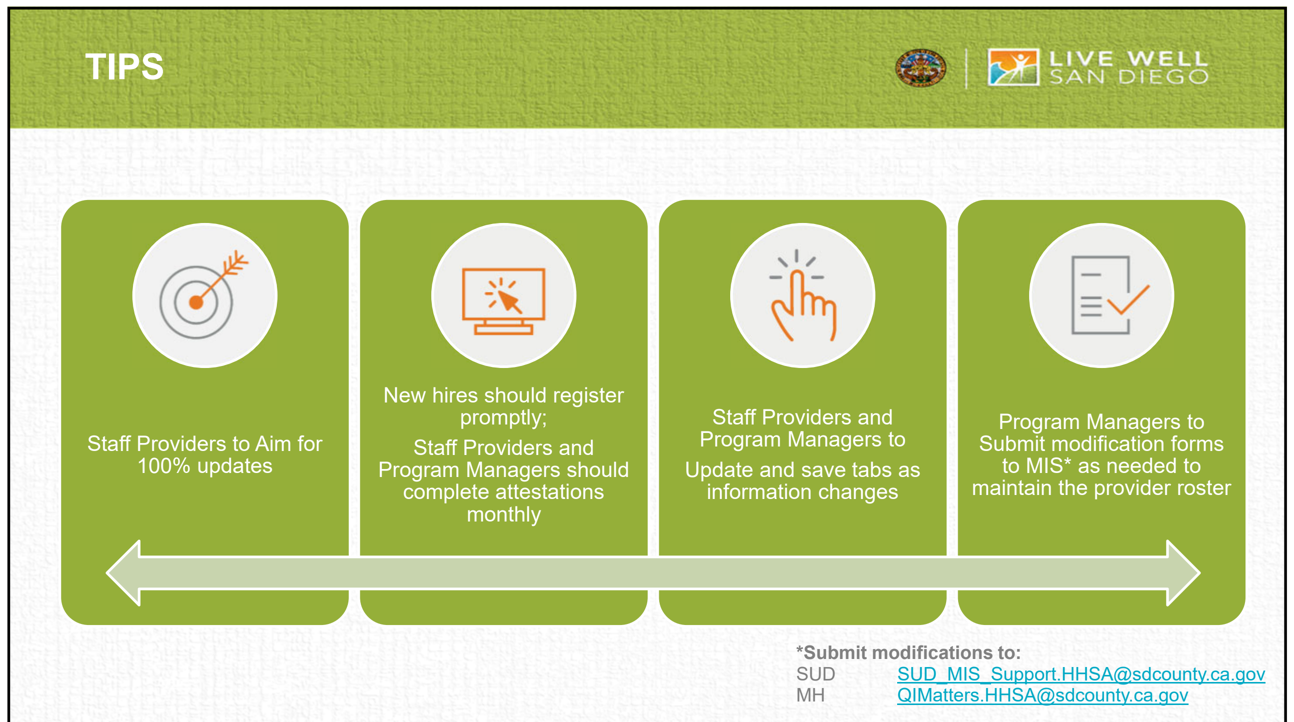

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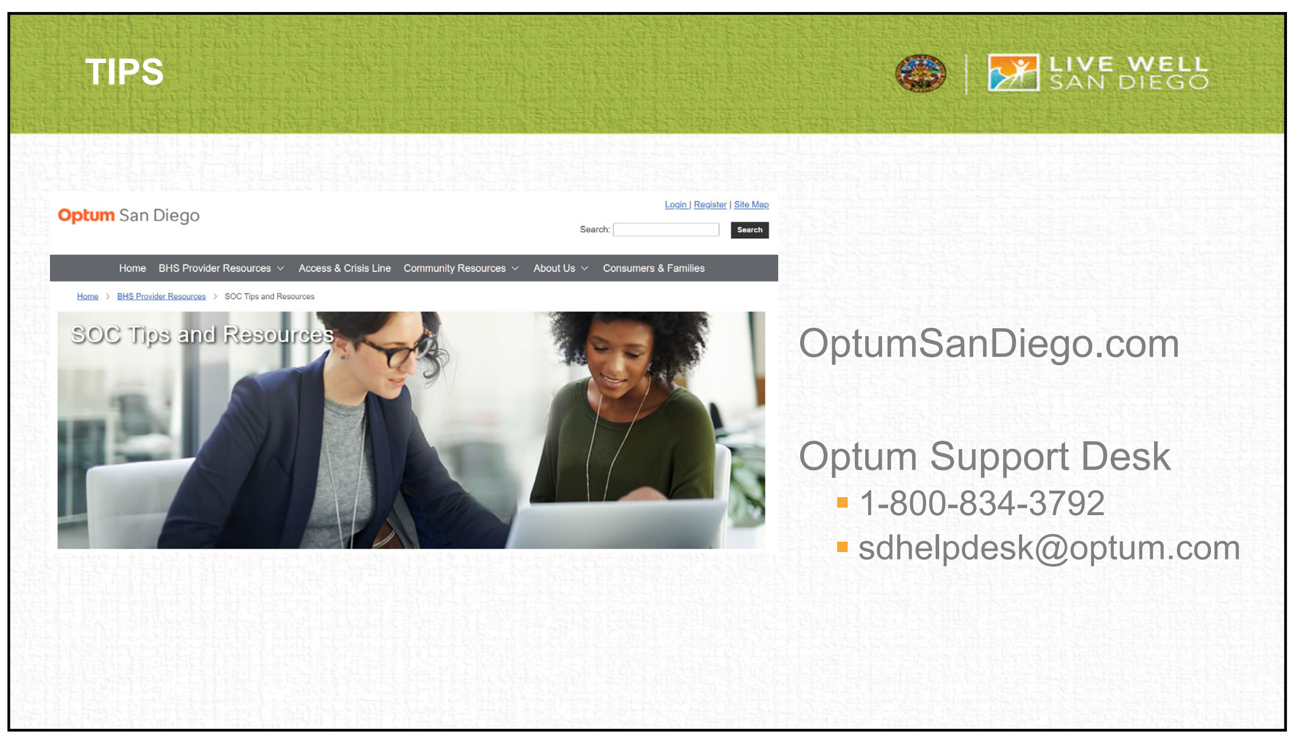


149

150

151

152

CERTIFICATE REMINDERS

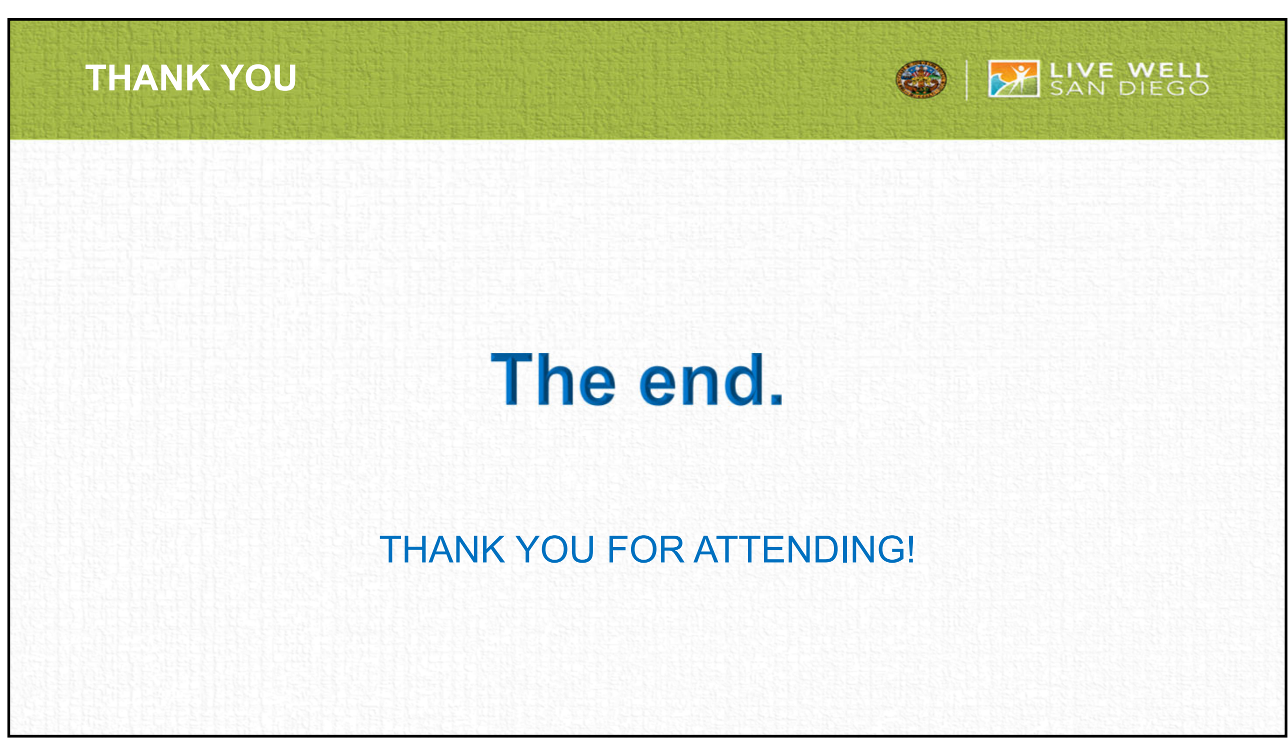
- Remember to save any and all training certificates provided to you by outside entities. This includes evidence for completion of 5 hours of addiction medicine per year for MD's and LPHA's per calendar year.
  - ASAM certificates (QA no longer provides this certificate)
  - Addiction CEU's
  - Certifications, Registrations, or Licenses
- Reminder that SUD QA no longer provides certificates of completion as of 12/1/21
- Programs are responsible for tracking trainings and maintaining appropriate records for reporting.

153

Email the SUD QA team at:

QIMatters.HHSA@sdcounty.ca.gov

154



155