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Marin County Behavioral Health and Recovery Services

January 2023

IN THIS EDITION:

Important Dates: DHCS Triennial Audit February 7-9, 2023

BHRS Documentation Training: February 28, 1-3pm

SmartCare (by Streamline®) EHR Implementation Update

New Documentation Requirements as of January 1, 2023

Reminders of Existing Documentation Requirements

CalAIM Q&A

Important Dates:

- **DHCS Triennial Audit will be February 7-9, 2023**
- **BHRS Documentation Training: February 28, 1-3pm**

SmartCare (by Streamline®) EHR Implementation Update:

Marin County Behavioral Health & Recovery Services (BHRS) is currently implementing the new semi-statewide Electronic Health Record (EHR) known as SmartCare, with a projected go-live date of July 1st, 2023! This project will deliver a breadth of benefits and features over the systems we currently have in place with the ultimate goal of improving efficiencies for users as well as outcomes for the people we serve! Below are just a few benefits we have to look forward to…

What's in it for us?

Single System of Record – SmartCare has been designed to support *all* functional areas of County Behavioral Health Plans and therefore will eliminate the need to have multiple systems in place (e.g. SC and CG) to support the business needs of BHRS and its providers!

Semi-Statewide – Having a common system amongst almost half of the counties in the State will allow member counties to pool resources, align documentation/workflow processes, and lay the foundation for improved data exchange and interoperability!

CalAIM support – The SmartCare EHR will support the transformational components of CalAIM in the areas of clinical documentation and Medi-Cal billing reform right out of the box!

Accomplishments & Next Steps

Participation Agreement - It's official! As of December 2022, Marin County has approved the "participation agreement" which formalizes the commitment to implementing SmartCare as part of the CalMHSA semi-statewide EHR. With the participation agreement in place, we can now begin technical implementation activities!

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Sandbox – In January we will get access to the SmartCare sandbox environment! The sandbox is a testing environment that we can use to gain a deeper understanding of how the system functions, configure mock-up workflows, and inform a training plan.

Data Migration – The EHR-IT team has started extracting data from our current systems to migrate into SmartCare. This is a critical process to ensuring continuity of care when going live on July 1st!
Future Demos Sessions– CalMHSA will be presenting additional SmartCare demo sessions in January on topics including Security, Consent, and Care Coordination. For more information about the demo sessions, please email Alberto Palomo at apalomo@marincounty.org.

New Documentation Requirements as of January 1, 2023:

- **Transition of Care Tool**

The transition of care tool must be used whenever a beneficiary is receiving mental health services from one delivery system (MHP or MCP) and 1) their existing service needs to be transitioned to the other delivery system or 2) services need to be added to their existing mental health treatment from the other delivery system.

Transition of Care Tool for Medi-Cal Mental Health Services

- **Adult and Youth Screening Tools for Medi-Cal Mental Health Services**

The Adult and Youth Screening Tools for Medi-Cal Mental Health Services (hereafter referred to as Screening Tools) determine the appropriate mental health delivery system referral for beneficiaries who are not currently receiving mental health services when they contact the MCP or MHP seeking mental health services. The Screening Tools are not required or intended for use with beneficiaries who are currently receiving mental health services. The Screening Tools are also not required for use with beneficiaries who contact mental health providers directly to seek mental health services. Mental health providers who are contacted directly by beneficiaries seeking mental health services are able to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy described in All Plan Letter (APL) 22-005 and BHIN 22-011, or subsequent updates.

Screening and Transition of Care Tools for Medi-Cal Mental Health Services

- **DHCS Information Notice on New Tools**: BHIN 22-065 (ca.gov)

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Reminders of Existing Documentation Requirements:

- **Telehealth Consent**

Providers are required to confirm consent prior to initiating telehealth services and a client's verbal or written consent for the telephone or telehealth visit shall be documented.

- **Treatment Plan Requirement for Targeted Case Management/Brokerage**

This treatment plan requirement for TCM/brokerage services was part of the mandatory CalMHSA online training modules and the BHRS documentation trainings and has been in effect since July 1, 2022 for all clients receiving any TCM/brokerage service. It is also covered in both the CalMHSA and BHRS documentation guides.

Please review this requirement with all direct service staff and make sure that all clients who are receiving any TCM/brokerage service have at least one treatment plan completed for these services. Please be sure that staff are aware of the BHRS documentation guide and know to review it when they have questions about documentation.

- **CalMHSA and BHRS Documentation Guides (pertinent sections highlighted on the following pages of this newsletter!):**

https://www.calmhsa.org/wp-content/uploads/CalMHSA-MHP-LPHA-Documentation-Guide-06232022.pdf

BHRS Clinical Documentation Guide July 2022 with CalAIM standards.pdf (marinbhrs.org)

Treatment Plan Requirements

In the past, treatment plans were static and complicated documents with strict start and end dates. If services were provided that were not documented on the treatment plan, they could not be claimed. Persons in care had to sign the treatment plans or they were not considered valid. Over time it has become clear that effective treatment planning involves a more dynamic process since the person's needs are dynamic and can change rapidly. As part of CalAIM, treatment plans for many types of services are moving from standalone documents to be embedded in progress notes. Exceptions to these changes can be found in Attachment 1 of BHIN 22-019[22].

A. Targeted Case Management (TCM)

Targeted case management services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment. The TCM care plan:

- Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the person in care;
- Includes activities such as ensuring the active participation of the person in care, and working with the person (or the person's authorized health care decision maker) and others to develop those goals;

22 https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf

- Identifies a course of action to respond to the assessed needs of the person in care; and
- Includes development of a transition plan when the person in care has achieved the goals of the care plan.

These required elements shall be provided in a narrative format in the person's progress notes.

4.2. Services Still Requiring a Treatment Plan.

4.2.1. Targeted Case Management (TCM)/Brokerage

Targeted Case Management services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment.

The TCM plan:

- Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the beneficiary;
- Includes activities such as ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary's authorized health care decision maker) and others to develop those goals;
- Identifies a course of action to respond to the assessed needs of the beneficiary; and
- Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.

A plan with these required elements must be provided in a narrative format in a client's progress note and do not require a client/caregiver signature. This plan should be included at the initiation of TCM/Brokerage services and updated as appropriate in the narrative of subsequent TCM/Brokerage services.

4.2.2. Peer Support Services (PSS)

Peer Support Services (PSS) must be based on approved plan of care.

The plan of care shall be documented within the progress notes in the beneficiary's clinical record and must be based on a plan of care approved by any treating provider who can render reimbursable Medi-Cal Services.

4.2.3. Other Service types: ICC, IHBS, TFC, TBS

These service types require a separate care plan with specified goals and **do require** client/caregiver signature. This care plan is in addition to the Problem List. See service description for additional information.

Intensive Care Coordination (ICC)

Intensive Home Based Services (IHBS)

Therapeutic Foster Care (TFC)

Therapeutic Behavioral Services (TBS)

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10.4. EXAMPLES OF PROGRESS NOTES

EXAMPLE BROKERAGE SERVICE

This staff provided the following case management intervention to address the client's inability to manage emotions due to their anxiety. This staff contacted Group Intervention Center and spoke with intake counselor (Susan) to obtain information about the appropriateness of their Healing Heart Program to meet client's needs. Staff completed the referral process by summarizing client's anxiety symptoms and highlighting strengths, including supportive family members. Healing Hearts indicated client seemed appropriate for their program group and provided staff with information on next steps. This staff will contact client to discuss eligibility for program and assist client in preparing to attend this support group.
Treatment Plan:
Client's goal(s) in their own words: "I need a referral to get into the Healing Hearts Program"
To meet this goal, client participated actively in the development of this plan and will receive case management/peer support services to address the below concerns: Access to Healing Hearts Program.

CalAIM Q&A

The Department of Health Care Services (DHCS) has posted additional Q&As to their CalAIM FAQ Page: https://www.dhcs.ca.gov/Pages/CalAIM-Behavioral-Health-Initiative-Frequently-Asked-Questions.aspx (new items noted as "added December 2022")

HOW TO REACH US

BHRS ACCESS Team: BHRSAccessPublic@marincounty.org

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BHRS SUS Residential Care Authorization: BHRSAuthSUS@marincounty.org

MHP Inpatient Care Authorization: BHRSQMPublic@marincounty.org

BHRS Electronic Health Record (EHR) Team: BHRSEHR@marincounty.org

BHRS Admin Team: BHRSAdmin@marincounty.org

BHRS Credentialing Public: BHRSCredentialingPub@marincounty.org

All documentation training and manuals are available here:
https://www.marinbhrs.org/providers/mental-health-providers/clinical-documentation-guide

Share with your staff so they are in the know!