# Optum Salt Lake County

## Quality Assurance and Performance Improvement Bulletin for Outpatient providers

### December 1, 2022

Dear Providers,

The following information has been gathered to guide you in your efforts to meet Utah Medicaid regulations, Office of Substance Use and Mental Health (OSUMH) mandates, Salt Lake County Division of Behavioral Health Services (DBHS) and Optum contractual requirements as you complete required documentation. Implementing these tips into your practice will positively impact the quality of services and improve your audit performance and scores. Please reach out to our team with any questions regarding the guidelines provided.

-The Optum Salt Lake County QAPI Team

## Timely access to care requirements

To ensure that all members have access to appropriate treatment as needed, we require network providers adhere to Medicaid access standards. In all cases, we expect you will respond within 24-hours to a member request for routine outpatient care for mental health/substance use treatment services.

Medicaid Timely Access Standards, within which you are expected to offer a face-to-face evaluation for members initiating services with you for the first time, are indicated in Table A – Timely Access Standards.

Additionally, mental health and substance use disorder providers must submit timely access data in PCONN when a member requests an initial service and an appointment time is offered.

This must be done regardless of whether the member:

- accepts the date and time initially offered, or
- schedules an appointment, or
- attends the appointment.

**Table A -Timely Access Standards**

| Level of care | Contact method | Time standard for initial contact |
|---|---|---|
| Emergent | Phone | Clinical screening by telephone within 30 minutes and outpatient face-to-face appt. within 1 hour of phone screening |
| Emergent | Walk-in | Outpatient face-to-face service within 1 hour |
| Urgent | | Face-to-face covered service within 5 business days from initial contact |
| Non-urgent | | Face-to-face covered service within 15 business days from the initial contact |

The data reported only relates to whether the initial appointment time offered meets timely access standards based on the identified level of acuity.

In addition to submitting timely access data to Optum SLCo, providers are required to have a standardized method for tracking timely access information for each member. During monitoring visits, providers must be able to demonstrate, for a given member, whether timely access was offered and met.

This will include the date and time of the initial contact. The time of the initial contact for circumstances deemed emergent is imperative since timely access is measured by minutes. The interval between the date of the initial contact and the date of the initial assessment will be used to measure whether timely access was met.

Providers may choose the standardized method for tracking timely access which works best for their practice. Examples are listed below:

- Documentation in the clinical record in a demographics section.
- Documentation on the intake paperwork.
- Documentation in the mental health assessment information.
- Documentation on a log of initial contacts with the ability to produce the information for specific members when requested.

In cases where a member is being discharged from acute inpatient care, urgent care appointment criteria is met, therefore a follow-up appointment must be scheduled, before the member leaves the hospital, within five business days (7 calendar days) from the inpatient discharge date.

Participating network providers must enter timely access information into PCONN for individuals requesting to initiate treatment. Providers who do not, may be required to implement a corrective action plan. If you are unable to offer services within the timely access standards, you will not be penalized, rather the data is used to help us monitor the availability of services within in the network. Please contact Optum to assist with identifying a provider who can meet the member's needs within the required timeframe. The data is also required to be reported to DHHS.

## OQ®/Y-OQ® Questionnaires

OSUMH mandates the use of OQ® Measures Questionnaires as follows:

- Offered to individuals five years and older (A guardian may complete the questionnaire for a minor.)
- Administered upon admission
- Readministered every thirty days, or every visit (whichever is less frequent)
- Completed at discharge
- Used in treatment planning
- Entered into the OQ® Analyst

When completing a treatment plan, it must reflect the member's diagnoses and the information gathered in the initial assessment as well as the OQ®/Y-OQ® questionnaire. It must be evident the individual was included in the planning process and the plan addressed the member's individual needs. For mental health treatment plan reviews, information from the OQ®/Y-OQ® Clinician Reports must be incorporated and shall be documented in the clinical record.

Optum offers semi-annual training for providers to learn how to administer the questionnaires, interpret the Clinician Reports and incorporate the information into treatment planning with the member and the guardians for youth.

## Risk assessment and safety planning

**What should I know about assessing risk factors?**

-Providers should document and address on-going safety risks, such as suicidal or homicidal ideation/plan/access to lethal means, running away from home, self-harm, taking excessive amounts of prescribed medications, driving under the influence, engaging in unprotected sex with multiple partners or any other actions which pose a safety risk to the individual or others.

-If a formal assessment tool was used, be sure to document the type of tool, the date administered, who completed the tool, the score/outcome and a clinical interpretation of the results. How this information, as well as the member's response to the results, impact the treatment plan should also be included. If a safety plan is warranted, please provide a copy of the safety plan to the member and save it to the clinical record. Consider requesting a release of information for the individuals who are to be supports as part of the safety plan. Consider encouraging the member to share the plan with those individuals too.

**Who is administered a suicide risk assessment?**

-All members 5 years of age and older must be screened for suicidal risk upon admission to treatment and any time after when suicidal risk or ideation is present.

**What if a member responds yes to suicide?**

-For example, if using the C-SSRS and a member responds "Yes" to Question #2 or any subsequent questions on the C-SSRS, endorsing suicidal ideation, a safety plan must be created or updated on the same day.

**Is the C-SSRS the only suicide risk assessment tool I can use?**

-No, you can use another risk assessment or suicide risk assessment.

- The results of all risk assessments are expected to be included and documented in the member record.
- The C-SSRS form can be located at the following link, SAFE-T with C-SSRS| The Columbia Lighthouse Project (wpengine.com)
- Entry of C-SSRS results into PCONN is no longer required, however requirements remain to assess for risk.

**What should be in a safety plan?**

-A safety plan includes identified safety concerns. It also includes:

- ✓ Warning signs
- ✓ Coping strategies
- ✓ Social contacts
- ✓ Supportive family members or friends
- ✓ Professionals and agency contacts
- ✓ Ways for the member to make their environment safe

-Be sure there is documentation of the member's participation in the plan development. Also note when the plan is reviewed with the member and updated.

**Counseling on Access to Lethal Means (CALM)**

**What is CALM?**

CALM includes evidenced-based communication strategies to communicate with members and their families about access to lethal means and how to reduce access to those means.

**Who is at risk and can benefit from Lethal Means Counseling?**

Based on information from the Suicide Prevention Resource Center (sprc.org/states/utah) there are three types of clients who may be at risk of suicide and can benefit from counseling on lethal means:

- Individuals who currently have suicidal thoughts
- Clients in distress who have attempted suicide in the past
- Those who are struggling with mental health or substance misuse issues, especially if they are also coping with painful life crises (e.g., relationship breakups, legal problems, financial crises, housing dislocation, job loss)

**What clinicians can do?**

Get trained! CALM training is available through the following site:
zerosuicidetraining.edc.org

Raise the issue

1. Motivate the family to reduce access to lethal means at home
2. Assess how guns and medications are currently stored at home

Develop a plan

1. Safely store firearms away from the client until they recover
2. Reduce availability of medication (even those still accessible, so that they would not cause serious harm if taken all at once)
3. Reduce access to any other method which has been a focus for the member

Document and follow-up

1. Agree on roles and timetables for specific steps
2. Document the plan and next steps
3. Confirm that the plan was implemented

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## Coordination of care

Optum SLCo expects network clinicians and facilities will consult and coordinate treatment with other behavioral health and/or medical care clinicians and facilities, treating members in a manner consistent with HIPAA, 42 CFR Part 2, and other applicable state law requirements. Optum expects providers to comply with applicable law in obtaining any consents or authorizations that may be required to exchange appropriate treatment information with other treating professionals, based on the nature of the information being exchanged and with whom. Some members may refuse to allow for the release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. When Optum staff reach out to providers to obtain updates regarding a member's treatment, information sharing is appropriate in these instances.

Coordination and communication should take place at the time of intake, during treatment, at the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate.

HIPAA generally does not limit disclosures of PHI between health care providers for treatment, payment or health care operations, including for case management and care coordination, except that covered entities must obtain individuals' authorization to disclose separately maintained psychotherapy session notes for such purposes. Providers should determine whether other rules, such as state law or professional practice standards place additional limitations on disclosures of PHI related to mental health.

To ensure continuity of care, if a provider terminates their contract with Optum (either voluntarily or involuntarily), it is expected that the provider will communicate with any subsequent providers (with written member consent) to ensure the member's care is not disrupted.

### Guidelines to effective communication

- ✓ During the diagnostic assessment session, request the member's written consent to exchange information with all appropriate treatment professionals who are providing treatment. Also, we recommend you request a release for a trusted person to contact in case of an emergency.
- ✓ Attempt to obtain all relevant clinical and collateral information from other treating professionals pertaining to the member's mental health, substance use or other relevant conditions.
- ✓ After the initial assessment, provide other treating professionals with the following information within two weeks:
  - Summary of the member's evaluation
  - Diagnoses
  - Treatment plan summary (including medications prescribed)
  - Contact information for the primary clinician treating the member
- ✓ Update other behavioral health and/or medical clinicians:
  - when there is a change in the member's condition or medication(s)
  - when serious medical conditions warrant closer coordination.
- ✓ Apprise primary care physicians of any sentinel event and hospitalizations, emergencies, or incarceration.
- ✓ Report transitions in levels of care.
- ✓ At the completion of treatment, send a copy of the discharge summary to the other treating professionals.

## Collateral information

Collateral information from other sources can be valuable when assessing a member's history or current presentation to formulate a diagnosis and disposition plan. It is very important to obtain and integrate collateral information into the member's treatment when available.

Examples of collateral information include, but are not limited to:

- Inpatient documentation (History and physical, Discharge Summary)

- Documentation from other behavioral health providers (assessments, medication management, discharge plans, safety plans, treatment plans, etc.).
- Documentation of phone calls and emails between providers related to care coordination, at least in a transition of care or a referral for services.
- Psychological testing results
- IEP/504 plan information
- Court orders
- Legal information related to parental custody and guardianship

Please note: Depending on HIPAA regulations, 42 CFR Part 2, and other applicable law, a release of information signed by the individual for each source may be required.

## Gaps in service

Services need to be documented in the clinical record at the time of service, to include date, exact time of service, duration, type of service, and be signed by the rendering staff with verifiable signature and credentials. Written documentation will be developed and maintained for each service or session for which billing is made and will be recorded and coded as outlined in the Utah Medicaid Provider Manual. The note must be signed, dated, and saved in the electronic health record (HER). Documentation is to be completed within 24 hours of completion of the service.

Gaps in service such as sickness, vacation, incarceration, home visits, no shows and cancellations must be documented in the HER. If using UWITS, please enter as a “Miscellaneous Note”. Documentation of efforts to contact the member and to promptly reschedule is to be included.

## Discharge summaries

At the time of discharge, a discharge summary document needs to be prepared in the clinical record that includes the following:

- The member’s level of engagement during the treatment episode to include examples.
- The member’s level of participation and response to treatment.
- The current DSM-5 or ICD-10 diagnoses.
- The extent to which the treatment plan goal, objectives and methods were achieved.
- The services provided, the reason for discharge or referral and the recommendation for additional services.
- Referrals for needed supportive services must be made and noted.

A LMHT will be involved in the discharge process and is responsible for any clinical action. At the completion of treatment, send a copy of the Discharge Summary to the other current treating professionals and the provider receiving the member to coordinate care and facilitate an efficient transition.