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Ask QM

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SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH
& RECOVERY SERVICES

Ask QM FAQs

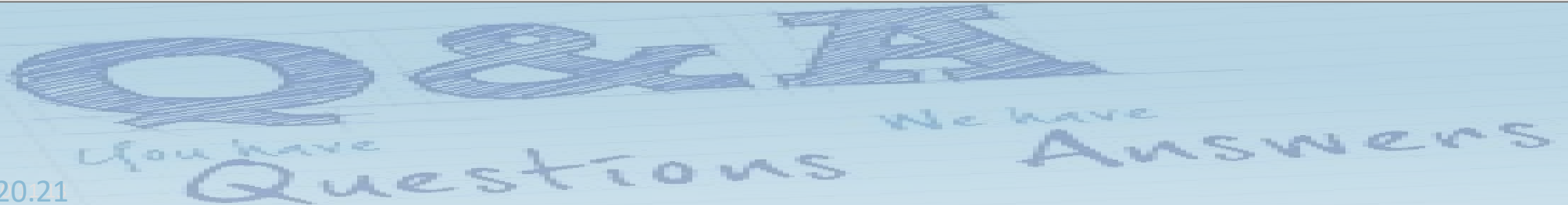
Special Topic

Working Remotely

Sharing AOD PHI (42CFR Part 2)

Updates & Alerts

January 20, 2021





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Q1: Telehealth Question:
Do we need to ask the client their physical location at the beginning of every Phone or Video Session?

A1: Yes, you should ask the client their physical location at the beginning of every Phone and Video Session and document their location in the progress note. Also, "Update Client Data" if there are changes.

TESTONE, TEST V MR (000930000)
F, 58, 05/08/62
Ht: 5' 6", Wt: 114 lbs, BMI: 18.4

Ep: -
Problem P: -
DX P: -

Chart

Overview

My Forms-CRbillingadmin
Financial Eligibility
Assign Care Coordinator
Day Treatment Authorization Appr

My Forms-CRclinical
BHRS Client Relationships
Assign Care Coordinator
Client Treatment and Recovery Pl
BHRS Client Treatment and Recov
Contractor/Field Based Treatment
Physician's Initial Assessment (PIN
CHILD / YOUTH Admission Assessn
CALOCUS
PRE TO 3 Admission Assessment
CHILD / YOUTH Annual / Update A
Authorization for Use or Disclosure
BHRS Diagnosis
Transfer/Discharge Request
Application for Services and Conse
ADULT Special Assessment
CHILD / YOUTH Special Assessment

Client Demographics

Name: TESTONE, TEST ID:930000 Next Appointment:

[Update Client Data](#)

Address 1: 1235 APPLE ST APT 12a
Address 2:
City: SAN MATEO
State: CA
Zip Code: 94403
HOME: 650-573-0000
CELL: 650-573-3400
WORK: 650-573-2525
Race 1: No Entry
Race 2: No Entry
Ethnicity: Unknown / Not Reported
Primary Language: Spanish

Answers



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Q2: I completed a Treatment Plan Addendum. I added a statement that the client agreed to the addendum but I forgot to state that due to COVID precautions, the client did not sign it. I am wondering what I should do now.

A2: You can write a progress note that states the information you did not add in the treatment plan addendum or you can complete a second addendum to add the missing information.





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Q3: Are providers able to place direct quotes from emails into a note?

A3: If a client happens to email you with content that you feel should be included in a progress note...

Yes, you may:

- 1) lift direct quotes to be included in your progress note or,**
- 2) summarize the content of the email in the progress note or,**
- 3) have the email scanned to the client's chart.**

Points to remember:

- Use clinical judgement to determine the best route.
- Email TO CLIENTS is only acceptable for tasks such as scheduling appointments, providing resources, getting consents signed, etc. Do not use email for therapy or other complex communications.
- It is preferred that you communicate delicate matters via telephone or through one of the BHRS-approved Telehealth platforms (MS Teams, doxy.me, or Facetime through County-issued phone) to protect both yourself and the client. If you must communicate via email, always send emails via encrypted email (must write #sec# in the subject line of the email).

You have
Questions

We have
Answers



Q4: Can clinicians use their personal fax machines to send CPS reports?

A4: If the only viable solution is to use your personal fax for time-sensitive matters, **you can, but with caution.** Use electronic forms and secure email whenever possible.

Current QM Recommendations:

- **Limit printing and/or completing paper PHI from home and off-site.** Do this only when necessary. Only use hard copies and print documents if no other method is available to perform your work.
- **Keep printed/paper PHI-safe.** Lock it up. Take it to the office as soon as reasonably possible.
- If you must complete CPS reports (or other documentation with PHI) on paper at home or off site, the paper PHI should be kept in a locked drawer or cabinet in your home. **Take the documents to work as soon as reasonably possible to be scanned into Avatar, then shredded. Do not throw any documents containing PHI in your home trash or recycling.**
- If the fax stores a copy of information faxed, delete that history if possible. **Please double check all fax numbers.**
- **In case of any mishandled PHI or a potential breach, please complete the BHRS incident report and submit it to QM.**

BHRS staff have had to use their personal faxes and other personal equipment for their work during the PHE. Staff have had to keep paper documents with sensitive information at their homes and on their own devices. **This ongoing is a concern and risk. But is understandable given the PHE.**



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Q5: I was under the impression we were supposed to **note verbal consent on forms**, etc. within progress notes and **also complete the actual forms noting verbal consent** and **still scan them into the chart**, but there's been some confusion within our team, **is this true?**

Yes

Is only noting verbal consent within our progress note, and not on the form, sufficient?

No

A5: It is appropriate during the COVID-19 situation to get verbal consent in lieu of client signatures on all consents and authorizations.

You would **document this clearly** on the form AND in a progress note.

You will not need to go back after Shelter in Place to obtain signatures on consents for which you have already obtained and documented verbal consent from the client.

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Q6: It was my understanding that during this Public Health Emergency, **services provided via the telephone could be billed as Telehealth. Is that true?**
Do we bill the same rate for services coded as “other billable” vs. Telehealth?

A6:
No: Phone services are not coded as location Telehealth; instead, the location code is Phone unless the client is in a lockout.
Yes: Medi-Cal rate is the same for Other Billable as Face-to-Face time, and for Phone as Telehealth.

Modality of Service	When to use	Service Minutes and Location Code
Videoconferencing (with client)	<ul style="list-style-type: none"> When you are video conferencing with the client 	<ul style="list-style-type: none"> Service minutes with client are entered in “Service to Client Present in Person” time. Location code is “Telehealth,” unless client is in a lockout location (e.g. jail, PES/Psych Hospital).
Videoconferencing (without client)	<ul style="list-style-type: none"> When you are video conferencing services with caregiver/providers <u>without client present</u> (e.g., care coordination meeting) 	<ul style="list-style-type: none"> Service minutes without client present is entered in “Other Billable” time. Location code of “Phone,” unless client is in a lockout location. This is <u>not</u> considered Telehealth.
Phone (with or without client)	<ul style="list-style-type: none"> When you are speaking with the client over the phone without video. When you are speaking to a collateral person over the phone without video. When you are speaking to another provider over the phone without video. 	<ul style="list-style-type: none"> Service minutes spent speaking to anyone* over-the-phone (without video) should be entered in “Other Billable” time. Location code of “Phone,” unless client is in a lockout location. <p>*Unlike Telehealth/Videoconferencing or in-person services, over-the-phone service time does not distinguish between time spent directly speaking with client versus speaking with someone other than the client.</p>

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Q7: What has changed under the New 42 CFR Part 2 rule related to sharing AOD information?

Does this eliminate the need to segment the AOD electronic health record from MH in Avatar, and exclude AOD episodes within other health data systems?

A7: No, the records still need to be segmented. Otherwise, all records become Part 2 records.

This final rule was effective August 14, 2020.





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Q8: What has changed under the New 42 CFR Part 2 rule related to sharing AOD information? Once an ROI consent is obtained, does this allow any treating provider to have access/share info to treat/coordinate care?

A8: Yes, once the client provides consent, those agencies can disclose PHI until the consent expires. AOD (42 CFR Part 2) programs must still obtain consent in order to disclose for treatment, payment, and certain health care operations. The change is that this allows redisclosure to mental health and other providers. Providers can share their charts with other CURRENT treating providers without re-consent each time; the original consent covers redisclosure if the information becomes part of their treatment record.

Provision	What Changed?	Why Was This Changed?
Applicability and Re-Disclosure	Treatment records created by non-Part 2 providers based on their own patient encounter(s) are explicitly not covered by Part 2, unless any SUD records previously received from a Part 2 program are incorporated into such records. Segmentation or holding a part of any Part 2 patient record previously received can be used to ensure that new records created by non-Part 2 providers will not become subject to Part 2.	To facilitate coordination of care activities by non-part-2 providers.

This final rule was effective August 14, 2020.

Questions



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Q9: What has changed under the New 42 CFR Part 2 rule related to sharing AOD information?

If the regulations are adopted per the CARES Act, how closely does this align to HIPAA?
What is still different and more restrictive?

A9: The part that is more aligned to HIPAA is that the consent to disclose may be to an **AGENCY**. It does not need to be to a specific person. But the consent form must have a space describing *why* the disclosure may be made.

What Has Changed Under the New Part 2 Rule: The revised rule modifies several major sections of Part 2, as follows:

Provision	What Changed?	Why Was This Changed?
Consent Requirements	An SUD patient may consent to disclosure of the patient's Part 2 treatment records to an entity (e.g., the Social Security Administration), without naming a specific person as the recipient for the disclosure.	To allow patients to apply for benefits and resources more easily, for example, when using online applications that do not identify a specific person as the recipient for a disclosure of Part 2 records.

This final rule was effective August 14, 2020.





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Q10: Do you restrict all notes that address AOD issues? Or only those notes pertaining to treatment facilities (inpatient or outpatient)?

For instance, if MH counselors do relapse prevention for AOD, do they need to restrict this note?

A10: Yes, you should restrict progress notes about contacts with AOD treatment facilities. This just flags the note so that a clinical staff approves its release.

MH counselors that do relapse prevention for AOD in a MH program do NOT need to restrict these notes unless there is some reason that they are concerned about the note being released.

It is always an option to restrict the note but as a reminder, all BHRS Avatar users can still see the note.

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New QM information Available at
<https://www.smchealth.org/bhrs/qm>

NEW [Medication Support Quick Guide](#)

NEW Fillable Spanish versions of ROI Consent Forms will be posted by end of day 1/22/2021 at
<https://www.smchealth.org/bhrs/qm>

Documentation Quick Guide (for Medication Services)

Contents

Telehealth vs Phone Services..... 1

Service Codes Cheat Sheet..... 2

Physician Initial Note (PIN Progress Note) versus Initial Assessment (Assessment type Physician Initial Assessment) 5

 How to determine if you need to complete a PIN Progress Note or an Initial Assessment form in Avatar:..... 5

 When to complete assessments/reassessments for returning clients:..... 6

Telehealth vs Phone Services

Modality of Service	When to use	Service Minutes and Location Code
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Phone (with or without client)	<ul style="list-style-type: none"> When you are speaking with the client over-the-phone without video. When you are speaking to a collateral over-the-phone without video. When you are speaking to another provider over-the-phone without video. 	<ul style="list-style-type: none"> Service minutes spent speaking to anyone* over-the-phone (without video) should be entered in "Other Billable" time. Location code of "Phone," unless client is in a lockout location.

*Unlike Telehealth/Videoconferencing or in person



BBS Alert

https://www.bbs.ca.gov/pdf/law_changes2021.pdf

Suicide Risk Assessment and Intervention Coursework or Experience: Under this requirement, effective January 1, 2021, both applicants for licensure and licensees are required to complete a minimum of **six hours of coursework** or applied experience under supervision in **suicide risk assessment and intervention**.



AB 1145

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1145

AB 1145: This bill makes some clarifications about what is reportable under the Child Abuse and Neglect Reporting Act (CANRA).

It specifies that **voluntary acts** of sodomy, oral copulation, and sexual penetration are **not considered acts of sexual assault that must be reported by a mandated reporter as child abuse** if there are **no indicators of abuse**, unless it is between a person age 21 or older and a minor under age 16.



