July 17, 2023

Tyler Sadwith
Deputy Director, Behavioral Health
California Department of Health Care Services

Sent via email to: BHCalAIM@dhcs.ca.gov

Re: BH Doc Redesign – Targeted Stakeholder BHIN 22-019 Feedback

Dear Deputy Director Sadwith:

The California Alliance of Child and Family Services (the California Alliance) would like to share our recommendations regarding the updated draft revisions to BHIN 22-019 (Behavioral Health Documentation Redesign). The California Alliance represents 160 nonprofit organizations serving children, youth and families through behavioral health, education, foster care, prevention, and juvenile justice programs throughout the state.

Our members are very encouraged by several updates to the recent BHIN draft. This guidance will enable behavioral health workers to spend less time completing unnecessary paperwork and more time supporting children and families. Our members strongly support, for example, the following guidance:

- provisions giving providers the discretion to determine where in the record they will document care planning elements;
- guidance that prevents counties from enforcing care plan requirements that differ from DHCS guidance; and
- efforts to standardize, as much as possible, the documentation of care planning elements for SMHS and other related services, such as Full Service Partnerships.

We encourage DHCS to build on these important advances by also issuing the guidance recommended below.

Clarify that MHPs May Not Enforce Requirements for Assessments, Problem Lists and Progress Notes that Differ from the BHIN Guidance.

Our members strongly support the guidance regarding Care Planning Requirements which states that "[c]ounties shall not enforce requirements for the location, format, or other specifications of the care plan that differ from those described within this BHIN." This guidance will greatly reduce county-specific documentation burdens and help to standardize documentation practices throughout the state. We strongly recommend that DHCS issue the same guidance regarding assessments (in paragraph (2)), problem lists (in paragraph (3)) and progress notes (in paragraph (4)).

This guidance is sorely needed because, despite current documentation streamlining guidance, individual counties have continued to issue widely varying documentation requirements, such as the requirements listed below.

- Requirements for CANS assessments administered on dates that align with the client's date of enrollment – even if the youth already received a recent CANS assessment and no update is clinically appropriate
- Blanket requirements to administer a PEARLS (Pediatric ACEs and Related Life Events Screener) for every youth (as discussed more below)
- Requirements that progress notes be submitted with a specific format, such as ACT (Activity/Action; Consumer Progress/Perspective; The Next Steps) (which often lead to additional progress note requirements)
- Requirements that, if multiple staff render a group service, each of those staff members write a note for each beneficiary

If the BHIN states clearly that counties may not enforce requirements for assessments, problem lists, and progress notes that differ from the BHIN guidance – as the draft currently states in the case of care planning elements – the BHIN will achieve great progress in eliminating a myriad of county-specific paperwork obstacles.

In addition, we would encourage DHCS to include as the guidance below.

Clarify that MHPs May Not Require Providers to Administer Additional Assessment Tools, Such as the PEARLS.

We recommend that the decision regarding whether to administer additional assessment tools (apart from the CANS) be left to the discretion of the provider. Currently, for example, at least one county requires providers to conduct a PEARLS for every youth client. In many cases, however, the information gathered in the PEARLS already has been gathered in the CANS trauma module. Moreover, because the information covered in the PEARLS can be very difficult to discuss, the need to answer the same questions multiple times can be needlessly distressing for the family and can also undermine efforts to develop a rapport with the youth and their caregivers. In order to clarify that this decision should be left to the discretion of the provider, we recommend adding the following language in bold to paragraph (1) Standardized Assessment Requirements, subparagraph C (SMHS), after the discussion of the CANS assessment in paragraph f:

> **"g. Counties shall not limit the discretion of providers to decide which, if any, additional assessment tools are appropriate for each youth beneficiary."**

Require Counties to Allow Providers to Integrate their Documentation of SMHS and Wraparound Action Plans.

In order to better integrate SMHS care planning efforts with treatment planning for child welfare services, we recommend that DHCS require MHPs to allow SMHS providers to integrate SMHS care plans with Child and Family Team (CFT)/Wraparound Action Plans. Currently, at least three MHPs already allow providers to use CFT/Wrap Action Plans as the foundation for documenting SMHS care planning elements. This has allowed providers to significantly streamline their documentation burdens. We therefore suggest that DHCS add the following language in bold at the end of paragraph (5) Care Planning Requirements, paragraph b:

For example, care plan elements may be notated within the assessment record, problem list, or progress notes, **or as part of a Child and Family Team Wraparound Action Plan that is included in the client record**, or the provider may use a dedicated care plan template within an EHR.

Clarify that Counties May Not Require Client Signatures on Care Plans.

Despite DHCS guidance indicating that client signatures are no longer required on care plans, at least one county has continued to impose this requirement. We therefore recommend that DHCS add the following language to the end of paragraph (5) Care Planning Requirements, paragraph d:

"Counties shall not require client signatures on care plans."

Eliminate the Requirement for Prior Authorization for IHBS and TBS.

We greatly appreciate DHCS's stated intention to clarify that both IHBS and TBS will no longer require "prospectively completed standalone client plans." We urge DHCS to build on this progress by also eliminating the requirement to pre-authorize IHBS and TBS services. These services are for youth who are in, or at risk of placement in, hospital or residential settings, but who could be effectively served in a home or community setting. By definition, therefore, the need for these services is urgent. Yet prior authorization requirements often delay access to these services by many days or even weeks. From a mental health parity perspective, these services are just as urgent as many physical health conditions that receive urgent care with no prior authorization.

The need to avoid the delays caused by a prior authorization requirement has been recognized since the inception of the TBS program. When DHCS began implementing the TBS litigation settlement in 2009, it removed from its county contracts the requirement for prior authorization of TBS, in order to reduce administrative requirements that limited access to care. (IN 08-38, p. 7.) This was done as part of implementing the Emily Q settlement. (See page 6 of Second Quarterly Report of Special Master.) We therefore ask that DHCS implement this important element of the Emily Q settlement.

Conclusion

We appreciate the opportunity to share these recommendations. Please do not hesitate to contact me if I can provide any further information.

Sincerely,

Adrienne Shilton
Director of Public Policy and Strategy