

Organizational Provider Operations Handbook OPOH

Adult/Older Adult (A/OA)

Children, Youth & Families (CYF)

System of Care (SOC)

Note:

- The Pro Forma and Statement of Work for each Program take precedence over the OPOH. If providers find any elements of their contract to be inconsistent with the OPOH, contact your COR.
- All providers shall adhere to the rules and regulations as stipulated in the Medicaid and CHIP Managed Care Final Rules. Information about the final rule can be found at the following link:
<https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html>
- For the next five years the County of San Diego will be identified as a managed care delivery system under the Federal Regulation waiver authority Section 1915b.
- All Forms and Manuals referenced in the OPOH can be found on the Optum Website <https://www.Optumsandiego.com>
- Documents are located under the County Staff & Providers tab. Then click on Organizational Provider Documents link.



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[Appendix to Mental Health Plan and Incorporated by Reference into Provider Contracts]

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APPENDIX N

None

APPENDIX O

None

APPENDIX P

None

APPENDIX Q

None

APPENDIX R

None

ABBREVIATIONS REFERENCE GUIDE

ACL – Access and Crisis Line
AMHS – Adult Mental Health Services
A/OAMHS – Adult/Older Adult Mental Health Services
ASP – Augmented Services Program
ASW – Associate Social Worker (registered with the BBS)
BBS – Board of Behavioral Sciences
B&C – Board and Care
CA-QOL – California Quality of Life (client survey)
CMUMC – Case Management Utilization Management Committee
CCHEA – Consumer Center for Health Education and Advocacy
CCISC – Comprehensive, Continuous Integrated System of Care
CCR – California Code of Regulations
CCRT – Cultural Competence Resource Team
CFR – Code of Federal Regulations
CMHS – Children’s Mental Health Services
CMS – County Medical Services
COR – Contracting Officer Representative
CSS – Community Services and Support
DCS – Deaf Community Services
DHS – Department of Health Services (State of California)
DMH – Department of Mental Health (State of California)
DSM-IV-TR – Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
ERMHS – Educationally Required Mental Health Services
ECR – Error Correction Reports
EPU – Emergency Psychiatric Unit
FFP – Federal Financial Participation
FFS – Fee-For-Service
FSP - Full Service Partnerships
FTE – Full-Time Equivalent
HHSA – Health and Human Services Agency
HIPAA – Health Insurance Portability and Accountability Act
HMO – Health Maintenance Organization
ICM – Intensive Case Management
IMF – Intern Marriage and Family Therapist (registered with the BBS)
IMD – Institute of Mental Disease
LCSW – Licensed Clinical Social Worker
LPS – Lanterman-Petris-Short (Conservatorship)
McFloop – Multi-Use Complete Feedback Loop
MFT – Marriage and Family Therapist
MHP – Mental Health Plan
MHS – Mental Health Services

MHSA – Mental Health Services Act
MHSIP – Mental Health Statistics Improvement Program
MIS – Management Information Systems
MSR – Monthly Status Report
NOA-A – Notice of Action – Assessment
NOA –B – Notice of Action
OIG – Office of Inspector General
OP – Outpatient
OptumHealth – Optum Health
P&T – Pharmacy and Therapeutics Standards and Oversight Committee
PEI - Prevention and Early Intervention
PCR – Program Contract Representative (Program Monitor)
PSR – Psychosocial Rehabilitation
QM – Quality Improvement
QM – Quality Management
QRC – Quality Review Council
SES – Special Education Services
SMA – Statewide Maximum Allowances
SDCMHA – San Diego County Mental Health Administration
SDCPH – San Diego County Psychiatric Hospital
SF/LTC – Secure Facility/Long-Term Care
SNF/STP – Skilled Nursing Facility/Special Treatment Program
SOC – Systems of Care
TAR – Treatment Authorization Request
TBS – Therapeutic Behavioral Services
TBI – Traumatic Brain Injuries
UBH – United Behavioral Health
UM – Utilization Management
UMDAP – Uniform Method for Determining Ability to Pay
UR – Utilization Review
URC – Utilization Review Committee
USD – University of San Diego (Patient Advocacy Program)
W&IC – Welfare & Institutions Code (State of California)
WET - Work Force Education and Training

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Customer Service

San Diego County Behavioral Health Services (SDCBHS) recognizes that its greatest strength lies in the talent of its providers and expects them to always treat clients, families and other consumers with respect, dignity and courtesy. They should be treated *without* regard to race, religion, creed, color, gender, economic status, sexual orientation, age, source of payment or any other non-treatment or non-service related characteristic.

Clients and families expect high-quality customer service and they deserve it. They want fast, efficient service and caring, professional treatment. Exceptional customer service includes:

- Treating customers with courtesy, respect, professionalism and a positive attitude
- Responding to customers in a timely manner whether in person, by phone, in writing or via e-mail
- Being aware of cultural diversity and focusing on understanding customer differences
- Providing complete, accurate and reliable information and feedback

County and contracted organizational providers are expected to ensure that they have a customer-first attitude which is instilled throughout their operations. Systems should be in place so that customers are able to voice their problems or complaints anonymously. Input should be listened to and acted upon. Programs can then use the input to look at systems and improve them. The methods your program or legal entity uses may be through informal conversations or more formal methods such as individual interviews, focus groups, surveys, and suggestion/comment cards or forms.

The recommended way to get ongoing feedback from customers is to have suggestion or comment cards available to them on site. The advantage of using brief surveys and comment cards is that they are more user friendly and convenient. That way you can receive timely input on many aspects of your services that can be reviewed and acted upon quickly. A critical element of using suggestion or comment cards is to ensure that individual's identities are held confidential so that they will feel safe to comment or respond to surveys candidly without fear of any recrimination or retaliation.

The following are the basic expectation that SDCBHS has for all County and Contracted programs:

1. Establish Customer Service Standards which may include elements such as:
 - Answering phones and email in a friendly and timely manner

- Informing clients when appointments will be cancelled
 - Having a positive attitude to clients and families.
 - Going the extra mile for clients, such as fitting in one more client when you are about to close, taking more time to explain a bill to a confused client, initiating a friendly conversation, dealing with questions instead of deflecting them to others.
 - Having a clean, neat, organized and cheerful workplace can never be undervalued. A welcoming waiting room invites visitors to feel at home and creates an expectation that services will be equally caring and accepting.
2. Ensure that all staff members are aware of the standards and are clear that adhering to Customer Service Standards is an expectation of your organization and your facility.
 3. Encourage your customers to give you input that will allow you to make changes to improve the service that you are delivering.
 4. Ensure clients and families that if they give input to you or your program about improvements that are needed that they will not face any kind of retaliation.
 5. Enhance your program based on the input you receive from customers to demonstrate that you are listening.
 6. Make Customer Service training available to all staff.
 7. Recognize great customer service

A. SYSTEMS OF CARE (SOC)

Mission of Health and Human Services Agency (HHS) Mental Health Services (MHS)

The mission of the Health and Human Services Agency is: “Through partnerships, and emphasizing prevention, assure a healthier community and access to needed services, while promoting self-reliance and personal responsibility.” Mental Health Services adds to that mission: “To provide quality, cost-effective mental health treatment, care, and prevention services by dedicated and caring staff to people in the service population.” Under Alcohol and Drug Services the mission is further enhanced: Lead the County of San Diego in reducing alcohol and other drug problems through community engagement.

Client Population Served by the Mental Health Plan (MHP)

CHILD, YOUTH & FAMILIES (CYF) SYSTEM OF CARE (SOC)

Clients who are seriously emotionally disturbed (SED), as defined below, and who are:

- Youth up to age 21,
- Clients with co-occurring mental health and substance use,
- Medi-Cal eligible and meet medical necessity,
- Indigent, and/or
- Low income/underinsured.

Seriously Emotionally Disturbed (SED) Clients:

The priority population for CYF Services, including clients seen under MHS, is seriously emotionally disturbed (SED) children and youth. SED clients must meet the criteria for medical necessity and further are defined as follows (per California Welfare & Institutions Code Section 5600.3):

Seriously emotionally disturbed children or adolescents means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

- (i) The child is at risk of removal from home or has already been removed from the home.
- (ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

CYF SOC Principles

Children, Youth and Families Services (CYFS) programs, regardless of funding source, serve a broad and diverse population of children, adolescents, transitional youth and families throughout San Diego County. An array of services is provided through Organizational Providers, Fee For Service Providers, and Juvenile Forensic Providers. CYFS San Diego is a “System of Care” County. The System of Care is based on Child and Adolescent Service System Program (CASSP) System of Care principles and the Wraparound Initiative of the State of California (All County Information Notice 1/28/99, April 17, 1999; and SB163, Wraparound Pilot Project). System of Care Principles (May 2005) shall be demonstrated by ongoing client and parent/caregiver participation and influence in the development of the program’s policy, program design, and practice demonstrated by:

- Individualized services that are responsive to the diverse populations served
- Integrates mental health and substance abuse into a behavioral health system,
- Integrates physical health for the overall advancement of health and wellness,
- Underscores the importance of natural community resources,
- Values the complexity of cultural diversity, AND
- Strengthens our commitment to youth and families

CYF SOC Values:

- **Collaboration of four sectors:** The cornerstone of the CSOC is a strong four sectors partnership between youth/families, public agencies, private organizations and education that ensure accountability to achieve System of Care (SOC) goals and quality outcomes consistent with SOC philosophy.
- **Integrated:** Among the four sector partners services are comprehensive, accessible coordinate behavioral and physical health care, provide seamless transition of care and utilize natural community supports.

- **Youth guided, family driven:** Youth and families actively participate in service delivery, planning, and program and policy development.
- **Individualized:** Services are flexible and designed to meet and build upon the unique needs, strengths and potential of each youth, and family.
- **Strength-based:** Individualized plans and services identify and utilize youth/family strengths to facilitate health and wellness.
- **Community-based:** Sector partners offer an array of services in each region and strengthen family and youth connections to neighborhood and local community resources.
- **Outcome driven:** Service delivery systems continuously improve services by measuring and evaluating outcomes and use results to modify practices.
- **Culturally Competent:** Service providers honor the diversity of cultures; address the complexities within and between cultures, and provide accessible and relevant services. Providers, Medi-Cal and Non Medi-Cal shall plan and deliver services in a manner consistent with the Children, Youth and Families System of Care philosophy and principles. Services shall be community-based and utilize family and youth functional strengths.
- **Trauma Informed:** Sector partners recognize that trauma and chronic stress influence coping strategies and behavior, respond with compassion, and commit to the prevention of re-traumatization and the promotion of self-care and resilience.

Providers shall demonstrate family partnership in the development and provision of service delivery. Providers shall also demonstrate organizational advancement of family partnership in the areas of program design, development, policies and procedures, etc.

All facilities shall comply with the requirements of the Americans with Disabilities Act (ADA) and California Title 24.

Measuring outcomes is an integral aspect of System of Care principles. Standard outcomes have been established for all CYFS providers. *Specialized programs may have individual program outcomes either in addition to or in lieu of standard outcomes measured by all programs.* These system goals are tracked and reported as system wide outcomes in an annual report.

CYF Goals

Programs shall provide developmentally appropriate clinical services described herein to accomplish the following goals:

- Maintain client safely in their school and home environment
- Reduce recidivism related to criminal habits and activities

- Increase school attendance and performance resulting in a higher rate of successful completion of their educational program (with high school diploma or equivalent)
- Improve client's mental health functioning at home, school, and in the community
- Increase the individuality and flexibility of services to help achieve the client and family's goals
- Increase the level and effectiveness of interagency coordination of services
- Increase the empowerment of families to assume a high level of decision-making in all aspects of planning, delivering, and evaluation of services and supports

Outcome Objectives

All treatment providers shall achieve the outcome objectives as found in the Data Requirements section of this handbook.

FAMILY & YOUTH PARTNERSHIPS

Family Youth Professional Partnership embodies a set of values, principles, and practices critical to achieving optimal outcomes for children, youth and their families served in the Behavioral Health Services (BHS) CYF SOC. The concept and role of Youth and Family Support Partners (Y/FSP) was developed through a community process. In various settings, family and youth serve on advisory groups, make presentations, act as trainers, and provide direct, billable service to families and youth clients within the CYF SOC. In addition, Youth/Family Partners (Y/FSP) advise Behavioral Health Administration and other agencies' leadership teams regarding policy and programmatic issues and work with CYF providers. These efforts result in improved responsiveness to family and youth and increased awareness of agency, family and youth cultures as well as family's sense of ownership of their child's treatment plans.

Y/FSPs have firsthand experience as a child or youth or a parent/caregiver of a child/youth that is receiving or has received services from *public agencies serving children* systems in delivering culturally relevant services and increase a family's and/or youth's ability to:

- Access and/or engage in services and resources.
- Foster their ability to gain greater self-sufficiency.
- Enhance navigation to community supports and relationships.
- Reduce stigma associated with behavioral health services and/or diagnosis.

Types of Youth or Family Partners:

Youth or Family Partner: An overarching term for an individual with experience as a child or youth or a parent/caregiver of a child/youth who is or has received services from a public agency serving children and families. Youth & Family Partner roles may include, but are not limited to

Administrative, Advocacy/Community Engagement, Training and Supervision, Support Partners (direct service), Peer to Peer; and Outcome and Evaluation activities.

Youth Support Partner (YSP): An individual that has experience as a child/youth receiving services from a public agency serving children, youth and families and who is employed full or part time to provide direct (potentially billable) services to a child, youth, or family receiving behavioral health services.

Family Support Partner (FSP): An individual with experience as a parent/caregiver of a child/youth that has or is currently receiving services from a public agency serving children/families and who is employed full or part time to provide direct (potentially billable) services to a child, youth, or family receiving behavioral health services.

Y/FSP AS DIRECT SERVICE PROVIDERS

Through system reform the value and benefits of Youth and Family Support Partners was identified. Support Partners do not require a professional license, but have firsthand experience in navigating a *public agency serving children* as well as specific training in the supportive role. Title 9, Chapter 11 of the California Code of Regulations governs the provision of services to Medi-Cal eligible clients and its provisions determine San Diego County Behavioral Health Services (BHS) policy regarding service provisions to all clients, however funded. Title 9 allows the provision of direct service, with appropriate billing, by staff who are unlicensed and appropriately supervised when they are providing Rehabilitation (MHS-Rehab), Case Management/Brokerage (CMBR), Intensive Care Coordination (ICC), and Intensive-Home Based Services (IHBS) to an identified client and his or her collateral persons such as family members, when these services are connected to the child/youth's Client Plan goal(s).

Y/FSP: SELECTION, TRAINING AND SUPERVISION

The process for employment and supervision of Youth/Family Support Partners (Y/FSPs) as follow:

1. Selection of Y/FSPs: YSPs must be at least 12 years of age, meet work permit requirements and be no older than 25 years of age. FSPs must be at least 18 years of age and have high school diploma or equivalent. They must have direct experience a parent or caregiver of a child and/or youth (current or past) in a public agency serving children, youth and families.

2. Training: Minimum Curriculum should include the role and function of the Y/FSP, the role of supervision, basic knowledge of Principles of Family Youth Professional/System Partnership, Pathways to Well Being / Katie A, Children's System of Care (CSOC), community and system resources to which youth/family may be referred. This also includes

the safety, cultural competency, boundaries and dual relationships, Systems' Mandate or introduction to peripheral systems on the child/youth's continuum of care Mandated Reporting confidentiality, documentation requirements, conflict resolution and effective listening. Other training as specified by employer or BHS-CYF.

3. Supervision: Y/FSP must receive individual supervision at least once a month to ensure quality services, but not less than one hour per 10 hours of direct service provided. Peer to Peer Support Partner Supervision outside of one's employer may provide mutual support, continuing education, and promote fidelity to the role of a FYSP and the Principles of Family Youth Professional Partnership.

Operational Guidelines for Youth/Family Support Partners(Y/FSPs):

- Y/FSPs shall not be employed by the agency where they or their families are currently receiving services.
- Productivity: For each full time equivalent (FTE) Y/FSPs, a minimum of 32,400 Minutes / 540 hours (30% productivity level) per year will be spent in billable services.
- Clients Choice: If client/family opts to transfer/change to different Y/FSPs, this will be recorded on the agency's Suggestion and Transfer (S&T) Log and reported in the agency's Monthly/Quarterly Status Report.
- Caseload: Y/FSPs shall carry a minimum client load of 20 unduplicated clients per FTE per fiscal year unless otherwise specified in the program's SOW.

Duties and Responsibilities of the Y/FSPs

- Attend and participate in meetings which may include Individualized Education Programs (IEP), court proceedings, and transition planning teams.
- Engage family to be active in the treatment process, attend treatment team meetings, Wrap Team Meetings, participate in Child and Family Team (CFT) meetings, assist families with referrals and locating resources, complete initial intake, needs assessment and collect outcome measures as required.
- Offer supportive counseling within scope of practice as well as facilitate skill building.
- (30% productivity level) per year of the FYSP billed services must be documented so that the activity can be tied directly to the treatment goals of the identified client leaving 70% of time.

PROVISION OF SERVICES AND CLAIMING

Services and claiming for Y/FSPs shall be classified as Rehabilitation Services (MHS-R), Case Management/Brokerage (CMBR), Intensive Care Coordination (ICC), or Intensive Home Based

Services (IHBS) and limited by the individual employee's experience. Y/FSPs with additional qualifications may be eligible to provide additional services within their scope of practice.

Claiming to Other Funding Sources

Claiming to other funding sources, such as MAA (if included in the contract budget), may be possible for a different set of activities and documentation requirements may also differ. Programs are responsible for knowing the requirements of the specific funding stream if the program receives funding from sources other than CYF. Medi-Cal payments for an eligible client receiving claimable services may not be supplemented by other funding sources except as permitted in Title 9.

YOUTH & FAMILY PARTNER ROLES OTHER THAN DIRECT SERVICES

Youth and Family Partnership in the design and monitoring of the CSOC is an integral component of BHS-CYF. The youth and family Partnership should be integrated into standard system activities through numerous strategies which include:

- Youth and Family Partners with voting authority in advisory groups, e.g., Program Advisory Groups, County BHS- CSOC Council, County BHS Quality Review Council (QRC), and advisory boards of specific programs and agencies, Youth and Family service recipients as well as Youth/Family Support Partners (Y/FSP) in system audits/reviews and focus groups such as the External Quality Review (EQR).
- Involvement of Youth/Family Partner in Source Selection Committees for BHS-CYF procurements.
- Contract, policy, procedures and guidelines language that reflect current policy and procedure regarding Youth/Family Professional Partnership.
- Identify a single entity as the County BHS-CYF liaison as a key point of contact for administration partnership, dissemination of information, feedback gathering and source of Youth/Family for administrative tasks.

In addition, Family and Youth Liaison shall be included in work groups dealing with policy and program development and Quality improvement evaluations. In instances where the process involves sensitive or confidential information, Youth/Family Partners who are not current employees/consultants may be formally enrolled as volunteers to the agency and asked to sign an oath of confidentiality. Y/FP should be trainers for a broad range of professional trainings regarding children's system of care, effective practices, wraparound, P2W and other topics. Key administrators in public and private agencies should have a formal partnership relationship with a Youth/Family Administrative Partner. Staff of BHS-CYF and contracted agencies may make themselves available for presentations and respond to the concerns of family and/or youth organizations and/or the BHS-CYF Liaison.

Youth/Family Partnership, both as direct service providers and partners for policy, program, and practice development shall be monitored. All documentation by Y/FSPs in the medical records shall be subject to annual Medical Record Reviews through the County Quality Management (QM) unit. Programs are tasked with implementing regular internal monitoring to ensure that proper documentation and claiming standards are in compliance. In addition, for items not reflected in charting, such as inclusion of Youth/Family Partners in advisory boards, planning groups, and the like, the monitoring shall be completed via review of sign-in sheets, meeting minutes and group deliverables.

ADULT/OLDER ADULT SYSTEM OF CARE

Clients who are:

- Adults ages of 18-59
- Older adults age 60 and over
- Transitional Age Youth who will be turning 18 and transitioning from the children's mental health system into the adult mental health system
- Clients with co-occurring mental health and substance use
- Medi-Cal eligible
- Indigent

and meet the following conditions may be served by the MHP:

San Diego County Adult / Older Adult Outpatient Mental Health provides recovery oriented services to promote both clinical improvement and self-sufficiency, with the goal of ultimately freeing clients of the need for our services. By definition, clients eligible for our specialty Mental Health System services are those that cannot be appropriately treated within a primary care environment, or by a primary care physician. Every effort will be made to serve clients within the Recovery oriented Mental Health System until they are either stabilized (able to function safely without Mental Health resources), or until they no longer require complex biopsychosocial services in order to maintain stability.

Individuals we serve include:

1. Individuals with a serious psychiatric illness that threatens personal or community safety, or that places the individual at significant risk of grave disability due to functional impairment.
2. People with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and / or who require unusually complex medication regimens. Required psychosocial services may include illness management; or skill development to sustain housing, social, vocational and educational goals.

Individuals we may serve, to the extent resources allow, but who otherwise may be referred to other medical providers, include:

1. Individuals with serious psychiatric illness that may be adequately addressed in a primary care practice, either by a primary care practitioner or an affiliated mental health professional within a primary care practice setting, when the acute symptoms do not place the individual at risk of danger to self or others, and do not threaten the individual's ability to sustain independent functioning and housing within the community.
2. Individuals with lesser psychiatric illness, such as adjustment reactions, anxiety and depressive syndromes that do not cause significant, functional impairment that could be addressed within the context of a primary care setting or other community resources.

Such individuals may also have their needs addressed, either alone or in combination with medication prescribed within their primary care practice, through community supports such as supportive therapy, peer and other support groups, or self-help and educational groups. When co-occurring substance abuse is a factor, Co-occurring Disorders programs might also constitute an alternative resource.

The specialty Mental Health System will provide expedited evaluation and/or access for clients who are being maintained in the community with other resources, at such time as their condition destabilizes and they meet one of the criteria for inclusion, above. We will also provide support for the primary care community for those clients referred to primary care for maintenance in the primary care system. In order to accomplish these goals, the specialty Mental Health System will make every effort to provide:

1. Crisis screening services for individuals with acute symptoms, to provide triage to appropriate services within the specialty Mental Health System when needed.
2. Psychiatric consultation, as needed, to primary care providers for clients referred to primary care for chronic disease management after treatment in the Mental Health System.

Psychosocial Rehabilitation and Recovery

Adult/Older Adult Mental Health Services (A/OAMHS) espouses the philosophy and practices of biopsychosocial rehabilitation and recovery in its system of care.

Psychosocial rehabilitation in a recovery-oriented system helps people with mental disabilities to: (1) learn to manage the symptoms of their disorder; (2) acquire and maintain the skills and resources needed to live successfully in the community; and (3) pursue their own personal goals and recognize and celebrate their individual strengths. The service focus is on normalization and recovery, and the person is at the center of the care planning process. Personal empowerment,

the ability to manage one's disorder and move toward mastery of one's personal environment, is the path to recovery.

The psychosocial rehabilitation and recovery approach includes a variety and continuum of interventions and models, including, but not limited to, peer education, family education, clubhouses, skills development, resource development, housing support, job support, money management, and relapse prevention. Integration of this approach with needed medical services results in a comprehensive approach to recovery.

Additional information on San Diego County Systems of Care and psychosocial rehabilitation can be found in the System Redesign Implementation Plan for Adult/Older Adult Mental Health Services, 1999.

Services for Dual Diagnosis (Mental Illness and Co-occurring Substance Use Disorders)

San Diego County Adult/Older Adult Mental Health, Children, Youth and Families Services and Alcohol and Drug Services, recognize that clients with a dual diagnosis, a combination of mental illness and substance use disorders, may appear in all parts of the system. These conditions are associated with poorer outcomes and higher cost of care. Integrated treatment of co-occurring substance use and mental health diagnosis is recognized evidence-based practice.

The MHP has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) model that espouses a treatment and recovery philosophy that promotes the integrated treatment of clients with mental illness and substance use issues. Individuals who meet mental health treatment eligibility criteria and who also have a secondary diagnosis of substance use shall receive treatment focused on the mental health diagnosis and the impact of the substance use issue. Upon intake to a mental health program, the presence of substance use by clients shall be assessed. During treatment, substance use is reassessed on an ongoing basis and discussed with the client in terms of its impact on and relationship to the primary mental health disorder. Client Plans shall clearly reflect any services that may be needed to address the co-occurring substance use problems. Progress notes shall meet all Medi-Cal and Title 9 documentation requirements and must list a mental health diagnosis or problem as the focus of the intervention.

To support the implementation of the Dual Diagnosis Initiative, Mental Health Services recommends the development of Dual Diagnosis Capable programs. Programs participating in the CCISC Initiative shall demonstrate the following to be considered dually capable:

- San Diego Charter adoption and implementation
- COMPASS completion
- Action Plan development
- Program Policies:
 - Welcoming Policy/Statement

- MHS Co-occurring Disorders Policy
- Other
- Training and supervision of staff in Integrated Treatment Practice Model
- Integrated Screening
- Integrated Clinical Assessment
- Integrated Psychiatric Assessment
- Implementing Stage of Change Interventions
- Measure of client progress as evidence in the client plan and in progress notes (Outcomes: stage of change level, number of relapses, reduction of alcohol/drug use by type, number of months clean and sober, other)
- QM Baseline Monitoring Tool compliance

For additional information on the Dual Diagnosis initiative, please refer to the County of San Diego Health and Human Services Agency, Adult/Older Adult Mental Health, Children, Youth and Families Services, Alcohol and Drug Services, Charter and Consensus Document for Co-occurring Psychiatric and Substance Abuse Disorders, March 2003; and the County of San Diego, Mental Health Services Policy and Procedures Specialty Mental Health Services for Clients with Co-occurring Substance Use No. BHS 01-02-202 and the HHS, Dual Diagnosis Strategic Plan, 2002.

Services to Older Adults

Older adults living with mental illness comprise a segment of the population whose co-occurring health and social problems present ongoing challenges and opportunities for providers of adult mental health services. Recognizing the compounding effects of untreated mental illness on older adults (increased risk for institutionalization, hospitalization and medical services, increased mortality and social isolation, untreated medical illnesses, as well as the barriers that prevent older adults from accessing mental health services); San Diego County has taken steps to develop the Older Adult System of Care. To that effect, an Older Adult Mental Health Strategic Plan was developed and approved by San Diego County Board of Supervisors in October 2000. The Older Adult Mental Health Strategic Plan sets forth values and principles to guide the process of implementation of this three- to five-year plan. The Older Adult Mental Health Strategic Plan describes the vision, mission, and target population and makes policy recommendations for the implementation of an integrated, coordinated Older Adult System of Care that is age appropriate, cost effective, and based on best practices.

The mission of the Older Adult System of Care is to “ensure quality, cost-effective culturally competent, age-appropriate integrated mental health treatment, care, prevention and outreach services to older adults through collaboration with consumers, advocates and other professionals and agencies working with the older adult community.” Providers will participate in ongoing training regarding meeting the unique needs of our older adult clients. In addition, providers will participate in networking efforts with providers of collateral services for older adults, in order to

continue to develop the system-wide capacity to meet these clients' mental health existent and future demands more adequately.

For additional information, please refer to the California Department of Mental Health, Older Adult System of Care Framework and the San Diego County Health and Human Services Older Adult Mental Health Strategic Plan, October 2003, President's Freedom Commission Report, Older Adults, 2004.

Peer-Supported Recovery and Rehabilitation Services

As with the fields of physical disability and alcohol and drug service, there is a long history of peer support within mental health services. The County of San Diego AMHS recognizes the value of mutual support and peer counseling and encourages programs to employ qualified people who bring consumer experience to their jobs. AMHS supports the provision of consumer-provided services throughout the system of care, including, but not limited to, outpatient clinics, case management programs and clubhouses. Volunteers also offer peer recovery services, and AMHS supports programs such as NAMI's Peer to Peer and Warm Line, which offers volunteers the opportunity to use their consumer experiences to help educate and support others.

Providers shall utilize the talents of peer staff and volunteers in working with clients, as well as informing the efforts of professional staff. Providers will integrate the role of peer self-help groups, peer advocacy groups in outpatient programs and the regional Clubhouses as part of the client support system and as an adjunct to mental health services.

Homeless Outreach Services

Homeless Outreach Services are provided to individuals who are homeless and have a serious mental illness and/or substance use problem. Homeless outreach services consist of the following services:

- Outreach and engagement
- Screening and mental health assessment
- Referral and placement in emergency homeless shelters
- Short-term care coordination and case management services
- Linkages to mental health services, health services, social services, housing, employment services, advocacy and other needed services
- Coordination and collaboration with other providers to include psychiatric hospitals and other fee-for-service (FFS) providers

Homeless Funds

Homeless incidental funds are used for client-related needs including: food, clothing, transportation, and other incidentals necessary for accessing ongoing benefits.

Emergency Shelter Beds

The homeless outreach services workers are the gatekeepers and managers of the utilization of emergency and transitional short term shelter beds located in all the regions, with the exception of the South region. Participants utilizing these beds engage with the homeless outreach workers and Peer Support Specialists to work towards identified goals. The County's program monitor reconciles the billing invoices on a monthly basis and oversees the utilization of these beds. The following is a current list of shelters utilized by the homeless outreach staff:

Broadway Home
Center for Community Solutions
Chipper's Chalet
United Homes
MPH Guest Home
North County Interfaith Council
Volunteers of America

Staff Productivity Standard:

Outpatient programs shall meet or exceed the minimum productivity standard for annual billable and non-billable time by providing at least 64,800 minutes per year (60% productivity level), unless otherwise specified in the program's Statement of Work.

Additional References:

Regional Homeless snapshot: Data source Service Point, prepared by the regional Task force on the Homeless.

Homeless Services Profile: An update on Facilities and Services for Homeless Persons throughout San Diego County.

Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and/or Co-occurring Substance Use Disorders, U.S. Department of Health and Human Services; Substance Abuse and Mental Health Services Administration Center for Mental Health Services; www.samhsa.gov.

B. COMPLIANCE AND CONFIDENTIALITY

The County of San Diego Health and Human Services Agency (HHS) shall adhere to all laws, rules, and regulations, especially those related to fraud, waste, abuse, and confidentiality.

COMPLIANCE

County Programs

As part of this commitment, all County Mental Health Services workforce members¹ shall be familiar with and adhere to Agency Compliance Office (ACO) policies and procedures. In addition, County Mental Health Programs shall have processes that ensure adherence to the HHS Code of Conduct. All ACO policies and procedures, including the Code of Conduct, may be found on the ACO website, www.cosdcompliance.org.

Contracted Programs

Contracted providers with the MHP are obligated to have an internal compliance program commensurate with the size and scope of their agency. Further, contractors with more than \$250,000 (annual) in agreements with the County must have a Compliance Program that meets the Federal Sentencing Guidelines,² including the seven elements of an effective compliance program, which are:

1. Development of a Code of Conduct and Compliance Standards.
2. Assignment of a Compliance Officer, who oversees and monitors implementation of the compliance program.
3. Design of a Communication Plan, including a Compliance Hotline, which allows workforce members to raise complaints and concerns about compliance issues without fear of retribution.
4. Creation and implementation of Training and Education for workforce members regarding compliance requirements, reporting, and procedures.
5. Development and monitoring of Auditing Systems to detect and prevent compliance issues
6. Creation of Discipline Processes to enforce the program.
7. Development of Response and Prevention mechanisms to respond to, investigate, and implement corrective action regarding compliance issues.

Compliance Standards

All County and Contracted Programs, regardless of size and scope, shall have processes in place to ensure at the least the following standards:

¹ Workforce members include employees, volunteers, trainees, and other persons whose work are under the control of the Program, and/or pertain to the applicable County contract, regardless of whether the individual is paid for their work.

² Federal Sentencing Guidelines section 8B2.1 and 42 CFR 438.608(b)(1) – (b)(7)

- All new employees shall receive a thorough employee orientation about compliance requirements prior to employment.
- Staff shall have proper credentials, experience, and expertise to provide client services.
- Staff shall document client encounters in accordance with funding source requirements and HHSa policies and procedures.
- Staff shall bill client services accurately, timely, and in compliance with all applicable regulations and HHSa policies and procedures.
- Staff shall promptly elevate concerns regarding possible deficiencies or errors in the quality of care, client services, or client billing.
- Staff shall act promptly to correct problems if errors in claims or billings are discovered.

MHP's Compliance Hotline

Concerns about ethical, legal, and billing issues, whether pertaining to a County or Contracted Program, may be raised directly to the ACO at 619-338-2807 or Compliance.HHSA@sdcounty.ca.gov, as well as Compliance Hotline at 866-549-0004.

Mandated Reporting

All County and Contracted workforce members shall comply with the Child Abuse Reporting Law (California Penal Code section 11164) and Adult Abuse Reporting Law (California Welfare and Institutions Code section 15630). For further information regarding legal and ethical reporting mandates, contact your agency's attorney, the State licensing board, or your professional association.

Documentation Requirements

All County and Contracted Programs are required to prepare and maintain appropriate medical records on all clients receiving services in compliance with Title 9, Chapter 11 and 42 CFR guidelines. Programs are expected to meet all documentation requirements and standards established by the Mental Health Plan (MHP) in the preparation of these records. The MHP has the responsibility to prepare and maintain the Uniform Clinical Record Manual (UCRM), which outlines the MHP's requirements and standards in this area. Both the UCRM and the SDCBHS Management Information System User Manual, which contains the requirements for the most commonly used services, are available at www.optumsandiego.com.

Many of the requirements present in the MHP's UCRM are derived from the SDCBHS contract with the California Department of Health Care Services (DHCS) to provide specialty mental health services (State Agreement). Other documentation requirements have been established by the MHP's Uniform Medical Record Committee, which is an ad hoc committee chaired by QM.

In order to ensure that programs are knowledgeable of documentation requirements, QM provides the following:

- Annual Quality Management Forum for all System of Care (SOC) providers presented by the QM, PIT, and MIS units. Information is presented on system wide compliance with State, Federal and County MHP requirements. Areas for continuous quality improvement are identified and implemented for the System of Care.
- Quarterly in-service documentation training for all new clinical staff, or any clinical staff that may need a documentation review;
- On-site in-service trainings tailored to program's specific documentation training needs when requested by the program or identified by QM.

Claiming and Reimbursement of Mental Health Services

All rendering providers of specialty mental health services shall have a National Provider Identification (NPI) number prior to claiming for services. All providers are required to obtain NPI number as part of their staff account set up in the electronic health record. Providers may contact the MHMIS unit for questions.

When providing reimbursable mental health services, providers are required to utilize all available payor sources appropriate for reimbursement of services. Many clients have one or more insurance sources (e.g., Medicare, indemnity, PPO, HMOs, Medi-Cal) and it is the responsibility of each program to appropriately bill and collect reimbursement from primary and secondary insurance sources. For all clients receiving mental health services, programs are required to be aware of all available payor sources, be able to verify eligibility and covered benefits, obtain an Assignment of Benefits (AOB), track and process Explanation of Benefits (EOBs) and primary insurance denials, in order to seek reimbursement from secondary payor sources. All billing and submission of claims for reimbursement must be in accordance with all applicable County, State and Federal regulations.

For detailed guidelines and procedures regarding insurance billing, claims processing, assignment of benefits, determining eligibility, and accounts collection and adjustment, please refer to the Financial Eligibility and Billing Procedures - Organizational Providers Manual.

Coding and Billing Requirements

The Health Insurance Portability and Accountability Act (HIPAA) include requirements regarding transactions and code sets to be used in recording services and claiming revenue. UCRM forms reflect the required codes, and County QM staff provide training on the use of the Service Record forms. Additional requirements come from the State Agreement; these requirements determine the nature of chart reviews during a Medi-Cal audit and the items for which financial recoupment of payment for services will be made by State or County reviewers. Following are current requirements and resources related to coding and billing:

- Services must be coded in compliance with the Management Information System User Manual, Organization Provider Operations Handbook (OPOH) and the Financial Eligibility and Billing Manual.
- Diagnoses must be coded using the International Classification of Diseases (ICD-10). In general, a diagnosis is made using the fuller descriptions of the Diagnostic and Statistical Manual, and “cross-walked” to the correct service code for CCBH by the clinician. The service code should result in the highest level of specificity in recording the diagnosis.
- Services are recorded in CCBH through progress note entry or if done on paper on the Service Record form, which includes the Service Code and the staff number. The Service Record form is used to enter services to the MIS and will reflect the range of services actually in the Program’s budget.
- Documentation standards associated with coding and billing requirements can be found in the OPOH, Section G, UCRM, Financial Eligibility and Billing Manual, and Service Code Definitions Appendix located on the Optum website, www.optumsandiego.com.

False Claims Act

The Federal False Claims Act³ (FCA) helps the government combat fraud in federal programs, purchases, and contracts. The California False Claims Act⁴ (CFCA) applies to fraud involving state, city, county or other local government funds. All workforce members shall report any suspected inappropriate activity related to these Acts, which include acts, omissions or procedures that may violate the law or HHS procedures. Some examples include:

- Billing for services not rendered or not medically necessary
- Billing separately for services that should be a single service
- Falsifying records or duplicate billing

The CFCA encourages voluntary disclosure of fraudulent activities by rewarding individuals who report fraud and allowing courts to waive penalties for organizations that voluntarily disclose false claims. Programs and legal entities may not have any rule that prevents workforce members from reporting, nor may Programs or legal entities retaliate against a workforce member because of his or her involvement in a false claims action.

Any indication that any one of these activities is occurring should be reported immediately to the ACO at 619-338-2807, Compliance.HHSA@sdcounty.ca.gov, or to the HHS Compliance hotline at (866) 549-0004.

If any County or Contracted program needs training on the False Claims Act, reach out to the ACO at 619-338-2808 or email Compliance.HHSA@sdcounty.ca.gov.

³ 31 U.S.C. §§ 3729-3733.

⁴ CA Gov’t Code §§ 12650-12655.

Program Integrity- Service Verification

San Diego County Behavioral Health Services (SDCBHS) established Program Integrity (PI) procedures to prevent fraud, waste, and abuse in the delivery, claiming and reimbursement of behavioral health services. County and Contracted Programs shall develop a process of verifying that paid claims were provided to beneficiaries and that services were medically necessary. County and Contracted Programs are expected to conduct regular PI activities and maintain records for audit purposes. Questions regarding PI can be directed to QI Matters email at QIMatters.hhsa@sdcounty.ca.gov.

PI activities will be monitored by QM at a minimum annually during site and medical record review. QM tracks and monitors results of medical record reviews and may require a program to develop a Quality Improvement Plan (QIP) to address specific documentation concerns.

CONFIDENTIALITY

Client and community trust is fundamental to the provision of quality mental health services and abiding by confidentiality rules is a basic tenet of that trust. Thus County and Contracted workforce members shall follow all applicable state and federal laws regarding the privacy and security of information.⁵

MHP Responsibilities

In order to ensure compliance with applicable privacy laws as well as the State Agreement, the MHP has the following requirements for County and Contracted Programs. Programs are responsible for ensuring compliance with the latest requirements within the State Agreement, which can be found at www.cosdcompliance.org. If any County or Contracted provider has questions about privacy or security requirements, reach out to the ACO at 619-338-2808 or privacyofficer.hhsa@sdcounty.ca.gov. As of 2018, some, but not all of the requirements include that all workforce members shall:

- Be trained on privacy and security of client data and shall sign a certification indicating the workforce member's name and date on which the training was completed. The certifications shall be kept at least six years. Training must be provided within a reasonable period of time upon hire and at least annually thereafter. If any County or Contracted program needs assistance with privacy and security training, reach out to the ACO at 619-338-2808 or privacyofficer.hhsa@sdcounty.ca.gov.
- Sign a confidentiality statement prior to provision of client information. The statement must adhere to State Agreement requirements, currently including, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies sections and retention for six years.

⁵ Applicable privacy laws include, but are not limited to, 45 CFR 164 (Health Insurance Portability and Accountability Act or HIPAA), CA Civil Code 56 (California Confidentiality of Medical Information Act), 5 U.S.C. § 552a (the Privacy Act of 1974) CA Civil Code 1798 (California Information Privacy Act), U.S.C 38 §7332 (Veterans Benefits), CA W&I Code 10850.1 (Multi-Disciplinary Teams).

- Only access client records as necessary to perform their jobs.
- Will otherwise act in accordance with good judgment, clinical and ethical standards and applicable privacy laws to ensure that all written and verbal communication regarding each client's treatment and clinical history is kept confidential.

Notice of Privacy Practices

County and Contracted Programs must provide a HIPAA-compliant Notice of Privacy Practices (NPP) to all clients, as well as those with authority⁶ to make treatment decisions on behalf of the client. A notation is made on the Behavioral Health Assessment form when the NPP has been offered. Providers should ensure clients (and those with authority) understand the NPP and address any client questions about client privacy rights and the Program's privacy requirements.

County Programs shall use the HHS A NPP and adhere to all related policies and procedures (HHS A L-06), including the NPP Acknowledgement form (HHS A 23-06), all of which are available on the ACO website at www.cosdcompliance.org. Contracted Programs may, but are not required, to use the HHS A NPP. If a Contracted Program chooses to use the HHS A NPP, it must replace the HHS A logo and contact information with its own and should also review the contents of the HHS A NPP to ensure it meets all applicable privacy requirements. Contracted Programs shall also have an NPP policy or procedure to ensure NPP requirements are followed by workforce members.

Uses and Disclosures of Records

The County of San Diego BHS manages an electronic health record (EHR) for the MHP County and Contracted providers. The EHR holds client's protected health information (PHI) which is accessible by County and Contracted providers in order to improve coordination of care across the MHP System of Care. PHI documented within the EHR is also used for internal County operation purposes.

When a third party requests client information, the Program should ensure compliance with applicable privacy laws. When accepting an authorization form from an outside source, programs shall reasonably ensure the authorization is valid and verify the identity of the requestor before providing client information. County Programs shall follow the relevant ACO policies and procedures (HHS A L-25 and HHS A L-09). County Programs shall also use the HHS A-approved authorization form (HHS A 23-09) when soliciting client records from a third party.

Contracted Programs may, but are not required, to use the HHS A Authorization form. If a Contracted Program chooses to use the HHS A form, it must replace the HHS A logo and contact information with its own and should also review the contents of the HHS A form to ensure it meets all applicable privacy requirements. Contracted programs may also use their own form so long as it complies with all applicable rules and regulations. Contracted Programs shall also have an

⁶ For County programs, a definition of Authority may be found at ACO Policy and Procedure HHS A L-27.

authorization policy and a Uses and Disclosures policy to ensure these requirements are followed by workforce members.

If the third party request solicits information from multiple legal entities, the Program that received the request should promptly inform the requestor of the contact information for the other entities so the requestor can make those subsequent requests.

Client Requests for Records

When a client (or the individual with authority of the record) requests access to or a copy of their record, all Programs shall abide by applicable privacy laws and reasonably ensure the identity of the requestor before turning over client information. Remember that client requests for records are not the same as a request for records from a third party; different rules apply. County Programs shall follow the relevant ACO policies and procedures related to record requests (HHSA L-01).

Contracted Programs may, but are not required, to use the HHSA Client Record Request Form (HHSA 23-01). If a Contracted Program chooses to use the HHSA form, it must replace the HHSA logo and contact information with its own and should also review the contents of the HHSA form to ensure it meets all applicable privacy requirements. Contracted programs may also use their own form so long as it complies with all applicable rules and regulations. Contracted Programs shall also have a Client Request for Records policy to ensure these requirements are followed by workforce members.

If the client request pertains to multiple legal entities, the Program that received the request should promptly inform the requestor of the contact information for those other entities so the requestor can make those subsequent requests.

County or Contracted provider may deny a client's request for records provided that a licensed healthcare professional has determined that the access requested is reasonably likely to endanger the life or physical safety of the client or another person. The client must be given the right to have such denials reviewed by a licensed health care professional who is designated by the MHP to act as the reviewing official and who did not participate in the original denial. The MHP delegates the independent review to each contracted legal entity. Each legal entity must provide or deny access in accordance with the determination of the reviewing official. Each contracted legal entity is required to have a policy and procedure that identifies the independent review process.

The MHP County and Contracted providers may only charge a reasonable fee which can only include costs for labor associated with copying, supplies, postage, or preparation of summary as agreed to by client. In any case, clients may not be charged more than \$.25/page for copies and \$.50/ page for microfilm.

Client Requests for Amendment and Client Requests for Accounting of Disclosure

When a Program receives a request to amend CCBH records and believes amendments need to be made, or when a Program receives a request for an accounting of disclosures of CCBH records, the program should contact the SDCBHS MIS team and the Agency Compliance Office at 619-338-2808 or privacyofficer.hhsa@sdcounty.ca.gov, to provide Program assistance as needed.

Handling/Transporting Medical Record Documents

To maintain the confidentiality and security of client records, all Programs will securely store and transport medical records, including laptops, phones, and tablets which may contain client identifying information in accordance with applicable laws and the State Agreement, including, but not limited to, the below:

- Client records must be maintained at a site that complies with Article 14 requirements, including the current State Agreement. This means no client information may be left at a site unless that site has a contract with the County that includes Article 14. If a program is unsure, they should check with their Contracting Officer's Representative (COR).
- County workforce members may, as needed, transport client records and/or keep client records overnight at a personal residence if they have completed the ACO approved data safeguarding form (HHS 23-26) and follow the applicable ACO Policy and Procedures (HHS L-26). Contracted workforce members should develop their own policies and procedures that comply with Article 14 and State Agreement requirements. Programs should only remove client information from program offices for approved business purposes, with prior management approval, and information shall be stored in an appropriate manner.
- Programs shall sign in and out records, as needed.
- When saving client contact information on an encrypted device, such as a phone or laptop, include the minimum client identifying information necessary. Remember that even identifying an individual as receiving mental health services is protected information. Client information should not be stored on a non-encrypted device (such as a flip phone).
- No workforce member may ever leave client information unattended in a car, even if the records are in a locked box, and/or inside a locked trunk, and/or it's only for a few minutes.
- When transporting client information out of the Program office or clinic, include only the minimum client identifying information needed.

Privacy Incidents

A privacy incident⁷ is an incident that involves the following:

- Unsecured protected information in any form (including paper and electronic); or

⁷ For formal definition, County Programs may see ACO Policy L-30. Contracted Programs may review their Article 14.

- Any suspected incident, intrusion, or unauthorized access, use, or disclosures of protected information; or
- Any potential loss or theft of protected information.

Common Privacy Incidents may include, but are not limited to:

- Sending emails with client information to the wrong person
- Sending unencrypted email with client information outside of your legal entity
- Giving Client A's paperwork to Client B (even if you immediately get it back)
- Lost or stolen charts, paperwork, laptops, or phones
- Unlawful or unauthorized access to client information (peeking issues)

If any Program believes a privacy incident has occurred, they must complete the applicable HHS privacy incident reporting. For Contracted Programs, this is outlined in Article 14 of your County contract. For County programs, follow ACO policies and procedure (L-24). All programs shall immediately notify the ACO Privacy Officer and COR via email, complete the ACO approved Privacy Incident Report (HHS 23-24), and send it within 1 business day to the ACO Privacy Officer and COR via email. All of these documents can be found at www.cosdcompliance.org. Contracted Programs must additionally ensure compliance with HIPAA breach requirements, such as risk analysis and federal reporting and inform the ACO of any applicable requirements.

Privacy Incident Reporting (PIR) for Staff and Management

- Staff becomes aware of a suspected or actual privacy incident.
- Staff notifies Program Manager immediately.
- Program Manager notifies County COR and County Privacy and Compliance Officer immediately upon knowledge of incident.
- Program Manager completes and returns an initial HHS Privacy Incident Report (PIR) to the County COR and County Privacy and Compliance Officer within one business day.
- Continue investigation and provide daily updates to the County Privacy and Compliance Officer.
- Provide a completed HHS Privacy Incident Report (PIR) to the County COR and County Privacy and Compliance Officer within 7 business days.
- Complete any other actions as directed by the County Privacy and Compliance Officer.

San Diego County contracted providers should work directly with their agency's legal counsel to determine external reporting and regulatory notification requirements. Additional compliance and privacy resources are available at:

https://www.sandiegocounty.gov/hhsa/programs/sd/compliance_office/

C. ACCESSING SERVICES

Consistent with the Health and Human Services Agency’s “No Wrong Door” policy, clients may access mental health services through multiple points of entry. Clients may call the Access and Crisis Line (ACL), call or walk into an organizational provider’s program directly, or walk into a County-operated program.

In accordance with Title 9, California Code of Regulations requirements, organizational providers and County-operated clinics must maintain logs of all persons requesting Specialty Mental Health Services. Required information includes the date of inquiry, client’s name, nature and degree of urgency of the request, and disposition of request. The Access to Services Journal is available and completed through the electronic health record (EHR). Should access to the EHR be unavailable, the form can also be located on the Optum Website (www.optumsandiego.com). The instructions for how and when to complete, the Access to Services Journal is located on the Optum website (www.optumsandiego.com) under the Training Tab under County Staff & Providers.

The access times listed below apply for all children, adolescents, adults and older adults accessing care under the Mental Health Plan (MHP). Program shall issue a notice of adverse benefit determination (NOABD) when access standard is not met.

Emergency Psychiatric Condition

Title 9 defines an “Emergency Psychiatric Condition” as a condition in which the client, due to a mental disorder, is an imminent danger to self or others or is immediately unable to provide for or utilize food, shelter or clothing. This situation indicates an immediate need for psychiatric services.

Access Standard: Face-to-face clinical contact with client within one (1) hour of referral.

Urgent Psychiatric Condition

Title 9 defines an “Urgent Psychiatric Condition” as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition. The County further refers to Urgent as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention

Access Standard: Face-to-face clinical contact with client within (48) hours of referral.

Routine Condition

A “Routine Condition” is defined as a relatively stable condition and there is a need for an initial assessment for Specialty Mental Health Services (SMHS).

Access Standard: Face-to-face behavioral health assessment within 10 business days from request to appointment.

Access Standard: Face-to-face psychiatric evaluation within 15 business days from request to appointment.

ACCESS AND CRISIS LINE: 1-888-724-7240

Optum, the Administrative Services Organization (ASO) for the MHP, operates the statewide San Diego County Access and Crisis Line (ACL). The ACL provides telephone crisis intervention, suicide prevention services, and behavioral health information and referral 24 hours a day, seven days a week. The ACL may be initial access point into the MHP for routine, urgent or emergency situations.

All ACL clinicians are trained in crisis intervention, with client safety as the primary concern. Staff evaluates the degree of immediate danger and determines the most appropriate intervention (e.g., immediate transportation to an appropriate treatment facility for evaluation, or notification of Child or Adult Protective Services or law enforcement in a dangerous situation). In an emergency, ACL staff makes direct contact with an appropriate emergency services provider to request immediate evaluation and/or admission for the client at risk. The ACL staff makes a follow-up call to that provider to ensure that the client was evaluated and that appropriate crisis services were provided.

The ACL provides access to interpreter services through the Language Line, which provides telephonic interpreter services for approximately 140 languages at the point of an initial ACL screening. Persons who have hearing impairment may contact the ACL via the TTY line at 711.

MHP Services Authorization Requirement Provided by Optum

- Outpatient mental health services for children, adolescents and adults delivered to beneficiaries through the Fee-for-Service (FFS) Provider Network. This is a network of contracted licensed mental health professionals.
- Acute Inpatient Mental Health Services
- Adult Residential Treatment Services
- Child/Adolescent Day Treatment Program Services
- Therapeutic Behavioral Services
- Therapeutic Foster Care

Note: Outpatient services provided through County-operated and contracted provider programs do not require authorization. Clients who first access services by calling or walking into an organizational provider site or a County-operated program do not require authorization from Optum.

The following section provides guidelines on making referrals to and receiving referrals from the

ACL:

Referrals to the ACL

It is appropriate to refer individuals to the ACL for:

- Access to publicly-funded Specialty Mental Health Services
- Crisis intervention for emergent and urgent situations
- Suicide Prevention
- Referrals for routine behavioral health services
- Information about mental health and mental illness
- Referrals to community resources for vocational, financial, medical, and other concerns.

Providers shall inform clients about the option of directly using the Access and Crisis Line by calling 1-888-724-7240.

Provider Interface with the ACL

- Use the ACL as an adjunct to provider services in emergencies and after hours. To provide the most effective emergency response and back-up to their own services, provider office voice mail messages should state, “If this is a mental health emergency or crisis, please contact the Access and Crisis Line at 1-888-724-7240.”
- If a client is high risk and may be calling the ACL for additional support, the client’s therapist or care coordinator may call (with client’s approval) the ACL in advance on behalf of the client. (Please obtain a signed Release of Information from the client). To facilitate the most effective ACL response to the high-risk client’s needs when he or she calls, please provide the ACL with all relevant clinical and demographic information.

Receiving Referrals from the ACL

The ACL considers multiple screening criteria when making referrals. Referrals take into consideration:

- Urgency
- Level of Care
- Type of treatment or services
- Geographic location
- Cultural issues
- Any specific client requests, such as provider gender, language or ethnicity.

Hours of Service Availability

In accordance with 42 CFR, providers serving Medi-Cal clients must ensure service availability by offering hours of operation that are no less than the hours of operation offered to commercial clients. If the provider serves only Medi-Cal clients, the hours of service availability must be the same for fee-for-service and managed care clients. Providers are also expected to ensure that hours of operation are convenient to the area's cultural and linguistic minorities and adhere to the specifics in the Statement of Work. The MHP QM Unit will document program service hours at annual site reviews and/or Medi-Cal Certifications/Recertifications.

Language Assistance

Provider staff encountering consumers whose service needs cannot be determined on-site because of language barriers can contact the Access and Crisis Line for linkage to brief phone interpretation service to determine the client's service needs.

According to 42 CRF, clients shall be routinely asked, at the time of accessing services, about their needs for language assistance. According to Title 9 and BHS policy, providers must document the offer and whether linkage was made to interpreter service for clients requesting or needing translation services in threshold or other languages. BHS policy prohibits the expectation that family members, including minor children will provide interpreter services; however, if clients choose to use family or friends, this choice also should be documented.

To comply with State and federal regulations, providers must be able to provide information on Mental Health Plan (MHP) services to persons with visual or hearing impairment, or other disabilities, making every effort to accommodate an individual's preferred method of communication.

If program staff are not available to meet the language needs of a client, County contracted providers must have processes in place to be able to provide outside interpreter services as needed. County operated programs can contact Hanna Interpreting Services, LLC (for language interpreting) at (619) 741-0000 or Interpreters Unlimited (for hearing impairment) at (800) 726-9891 to arrange for language assistance. To request interpreter services, County operated programs shall create an online account with Hanna Interpreting Services, LLC through their Language Services Online Portal Registration.

In addition, County operated programs can request written translation services through Hanna Interpreting Services, LLC at (619) 741-0000. A drop-box must be set up for each program that utilizes the service. This is done by submitting a Computing Service Registration Form (CSRF). Detailed instructions can be found on the reference sheet posted on the County of San Diego's Department of Purchasing and Contracting website.

Provider Selection, Terminations, Incentives

In accordance with 42 CFR 438.10 and Title 9, enrollees (all clients) have the right to choose and obtain a list of MHP providers, including name/group affiliation, location, telephone number, specialties, hours of operation, type of services, cultural and linguistic capabilities, ADA accommodation, and whether provider is accepting new enrollees. MHP Provider Directory is available on the *Network of Care* website (www.networkofcare.org), the County's website http://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/technical_resource_library.html and by calling Behavioral Health Services at (619) 563-2788. The Fee-for-Service Provider Directory is available by calling Optum at 1-888-724-7240 and online at the Optum website at www.optumsandiego.com.

When feasible and/or upon request, enrollees shall be provided with their initial choice of provider. Each enrollee shall be offered a paper copy of the MHP Provider Directory at the time of enrollment and anytime at enrollee's request within (5) five business days. If requested, staff shall assist the client or responsible adult, in reviewing the list of available options and/or obtaining an appointment. Provider shall log all requests for services prior to the onset of services on the Request for Service Log.

Providers shall make a good faith effort to give written notice of a termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

Providers shall report to the QM Unit and COR upon receiving any changes affecting the Provider Directory. The MHP shall update the paper Provider Directory monthly. The MHP shall update the electronic provider directory no later than 30 days after receiving updated provider information.

The MHP does not currently offer any physician incentive plans.

Requests for Continuity of Care

Effective July 1, 2018, Title 42 of the Code of Federal Regulations, part 438.62 requires the State (and MHP) to have in effect a transition of care policy to ensure continued access to services during a beneficiary's transition from Medi-Cal fee-for-service (FFS) to a managed care program or transition from one managed care entity to another, when the beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

All eligible Medi-Cal beneficiaries who meet medical necessity criteria for SMHS have the right to request continuity of care. Beneficiaries with pre-existing provider relationships who make a continuity of care request to the county MHP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider (i.e.,

an employee of the MHP or a contracted organizational provider, provider group, or individual practitioner).

This policy applies to all Medi-Cal beneficiaries who are transitioning as follows:

- The provider has voluntarily terminated employment or the contract with the MHP;
- The provider's employment or contract has been terminated, for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program;
- Transitioning from one county MHP to another county MHP due to a change in the beneficiary's county of residence;
- Transitioning from an MCP to an MHP; or,
- Transitioning from Medi-Cal FFS to the MHP.

A beneficiary, the beneficiary's authorized representatives, or the beneficiary's provider may make a direct request to an MHP for continuity of care. Beneficiaries may request continuity of care in person, in writing, or via telephone and shall not be required to submit an electronic or written request. MHPs must provide reasonable assistance to beneficiaries in completing requests for continuity of care, including oral interpretation and auxiliary aids and services.

Validating Pre-existing Provider Relationships

An existing relationship with a provider may be established if the beneficiary has seen the out-of-network provider at least once during the 12-months prior to the following:

- The beneficiary establishing residence in the county;
- Upon referral by another MHP or MCP; and/or,
- The MHP making a determination the beneficiary meets medical necessity criteria for SMHS.

A beneficiary or provider may make available information to the MHP that provides verification of their pre-existing relationship with a provider.

Following identification of a pre-existing relationship with an out-of-network provider, the MHP must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of formal relationship to establish continuity of care for the beneficiary.

Timeline Requirements

Each continuity of care request must be completed within the following timelines:

- Thirty calendar days from the date the MHP received the request;
- Fifteen calendar days if the beneficiary's condition requires more immediate

- attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is a risk of harm to the beneficiary.

MHPs must retroactively approve a continuity of care request and reimburse providers for services that were already provided to a beneficiary under the following circumstances:

- The provider meets the continuity of care requirements;
- Services were provided after a referral was made to the MHP (this includes self-referrals made by the beneficiary); and,
- The beneficiary is determined to meet medical necessity criteria for SMHS.

A continuity of care request is considered complete when:

- The MHP informs the beneficiary and /or the beneficiary's authorized representative, that the request has been approved; or,
- The MHP and the out-of-network provider are unable to agree to a rate and the MHP notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied; or,
- The MHP has documented quality of care issues with the provider and the MHP notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied; or,
- The MHP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days and the MHP notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied.

Requirements Following Completion of Continuity of Care Request

If the provider meets all of the required conditions and the beneficiary's request is granted, the MHP must allow the beneficiary to have access to that provider for a period of up to 12-months, depending on the needs of the beneficiary and the agreement made between the MHP and the out-of-network provider. When the continuity of care agreement has been established, the MHP must work with the provider to establish a Client Plan and transition plan for the beneficiary. Upon approval of a continuity of care request, the MHP must notify the beneficiary and/or the beneficiary's authorized representative, in writing, of the following:

- The MHPs approval of the continuity of care request;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and
- The beneficiary's right to choose a different provider from the MHPs provider network.

The written notification to the beneficiary must comply with Title 42 of the Code of Federal

Regulations, part 438.10(d) and include the following:

- The MHPs denial of the beneficiary's continuity of care request;
- A clear explanation of the reasons for the denial;
- The availability of in-network SMHS;
- How and where to access SMHS from the MHP;
- The beneficiary's right to file an appeal based on the adverse benefit determination; and,
- The MHPs beneficiary handbook and provider directory.

At any time, beneficiaries may change their provider to an in-network provider whether or not a continuity of care relationship has been established. MHPs must provide SMHS and/or refer beneficiaries to appropriate network providers without delay and within established appointment time standards.

The MHP must notify the beneficiary, and/or the beneficiary's authorized representative, 30-calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period. This process includes engaging with the beneficiary and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

Repeated Requests for Continuity of Care

After the beneficiary's continuity of care period ends, the beneficiary must choose a mental health provider in the MHPs network for SMHS. If the beneficiary later transitions to a MCP or Medi-Cal FFS for non-specialty mental health services, and subsequently transitions back to the MHP for SMHS, the 12-month continuity of care period may start over one time.

If a beneficiary changes county of residence more than once in a 12-month period, the 12-month continuity of care period may start over with the second MHP and third MHP, after which, the beneficiary may not be granted additional continuity of care requests with the same pre-existing provider. In these cases, the MHP should communicate with the MHP in the beneficiary's new county of residence to share information about the beneficiary's existing continuity of care request.

Beneficiary and Provider Outreach and Education

MHPs must inform beneficiaries of their continuity of care protections and must include information about these protections in beneficiary informing materials and handbooks. This information must include how the beneficiary and provider initiate a continuity of care request with the MHP. The MHP must translate these documents into threshold languages and make them available in alternative formats, upon request. MHPs must provide training to staff that come into regular contact with beneficiaries about continuity of care protections.

Reporting Requirements

MHPs are required to report to DHCS all requests, and approvals, for continuity of care. The

MHP must submit a continuity of care report, with the MHPs quarterly network adequacy submissions, that includes the following information:

- The date of the request;
- The beneficiary's name;
- The name of the beneficiary's pre-existing provider;
- The address/location of the provider's office; and,
- Whether the provider has agreed to the MHPs terms and conditions; and,
- The status of the request, including the deadline for making a decision regarding the beneficiary's request.

Continuity of Care Requests Processed by ASO

All continuity of care requests shall be directed to the Administrative Services Organization (ASO), Optum. Optum will manage all continuity of care requests for the Mental Health Plan (MHP). Providers shall notify all beneficiaries with existing non-MHP providers that continuity of care requests are available as the beneficiary transfers care over to the MHP. Providers are expected to assist clients and work directly with Optum to ensure a smooth transfer of care. To begin the process, instruct the beneficiary to call the Access and Crisis Line and initiate the Continuity of Care request.

Clients Who Must Transfer to a New Provider

Many clients are unable to complete an entire treatment episode with the same therapist or mental health worker. This happens because of staff resignations, program closings, client change of residence or placement, transition of youths from Children, Youth and Families Services (CYFS) to the Adult Mental Health Services (AMHS) system, and completion of internships and field placements. Good clinical practice indicates that the following should be implemented whenever possible to ease transition:

- The client and caregiver should be informed of the impending change as soon as it is clinically indicated and possible, but at least 14 days prior to the final visit with the first provider.
- The client and caregiver should be informed of the client's right to request a new provider.
- Client and caregiver should be encouraged to voice their needs regarding provider clinical and language capabilities, time of appointment, location of the new clinic or program, transportation, etc.
- Report transfers on the Suggestion and Provider Transfer Log, which is found on the required Quarterly Status Report.
- The client should be assisted in making a first appointment with the new program.
- The old and new program must communicate as completely as possible, via case consultations, phone conversations, and release of discharge summaries and other chart materials.
- A thorough discharge summary (or a transfer note, if the client will continue in the same program) should be written and incorporated into the chart.

- Final outcome tools should be administered if the client will go to another provider program.
- A written plan for emergency services should be developed with the client and caregiver, to include the ACL, the new program, and informal supports.

NON-MENTAL HEALTH PLAN SERVICES: SCREENING, REFERRAL AND COORDINATION

All providers shall give appropriate referrals and/or coordination for treatment of services provided outside of the Mental Health Plan's (MHP's) jurisdiction. When an individual contacts a provider and requests referral and coordination of services that are outside of the MHP's jurisdiction, (education, health, Regional Center, housing, transportation, vocational, , etc.), the provider will make or coordinate such referrals based on the individual's residence and specific need. Appropriate referrals will include providing necessary information such as phone numbers, addresses, etc. If the provider lacks the necessary information, they will offer the individual two options: 1) Give the individual the number to Optum's Access and Crisis line # at 1-888-724-7240 or 2) Get the individual's phone number and call them back with requested information. Requests for assistance shall be entered in the Access to Services Journal in the EHR.

URGENT WALK-IN CLINICAL STANDARDS FOR PROGRAMS WITH URGENT WALK-IN SERVICES – ADULT/OLDER ADULT MENTAL HEALTH SERVICES

Urgent Psychiatric Condition

Title 9 defines an "Urgent Psychiatric Condition" as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition. The County further refers to Urgent as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention.

Access Standard: Face-to-face clinical contact for urgent services shall be within (48) hours of initial client referral.

Exodus and Jane Westin – Full Time Access

- Individuals who walk in and who are not currently receiving services will be triaged/screened. If they are not deemed in need of urgent services they may be referred to a primary care provider with known capacity, the closest outpatient mental health provider, or a fee for service provider, via the Access and Crisis Line phone number (client should mention that your program referred them to ACL). The client's choice prevails as per DHCS regulations.
- Clients who are already receiving mental health services and walk in and request medication will be triaged/screened. If they are not deemed in need of urgent services they may be referred back to their own mental health provider, fee for service provider, or

primary care provider. Alternatively, the client may be advised/assisted to call their pharmacist to contact their prescribing physician for a refill.

- Clients who walk in after missing an appointment with their provider will be triaged/screened. If they are not deemed in need of urgent services, they may be referred back to their own mental health provider, fee for service provider, or primary care provider. If they are requesting medication, the client may be advised/assisted to call their pharmacist to contact their prescribing physician for a refill.
- Clients with urgent mental health needs and/or urgent medication needs shall be triaged/screened and offered appropriate services, regardless of where the client may actually be receiving mental health services. If a walk-in clinic staff treats a client open to another program due to urgent service needs, the assigned program should be notified within 24 hours, or the next business day, for follow-up services.
- New clients assessed as needing urgent services that are referred from Exodus or Jane Westin must be prioritized for admission at an outpatient clinic within 48 hours.
- All referrals received that indicate urgency or high risk and that do not show up to the walk-in clinic will prompt a response from the walk-in clinic to the referring party for follow up. If the referring party is a Hospital or START program, the walk in clinic will follow up with the client directly.

Outpatient Clinics with Walk-In Urgent Components

- All outpatient clinics in all HHS Regions shall accommodate their ongoing, opened clients for urgent services to prevent clients from needing to access services at Exodus and Jane Westin.
- All clients who are triaged/screened and are deemed appropriate for routine admission must be admitted in accordance with acceptable access times already established for routine services, or according to the 72-hour policy for clients leaving 24-hour settings, or known case management clients.
- Institutions and Case Managers can call a clinic to arrange for a triage day during walk-in times, within 72 hours, and individuals will be given the highest priority to be triaged/screened that day.
- New clients assessed as needing urgent services that are referred from Exodus or Jane Westin must be prioritized for admission at an outpatient clinic within 48 hours.
- Programs must have processes in place to follow up with clients who come in for walk-in services, are triaged/screened and not deemed urgent, but are in need of specialty mental health services at the clinic, and are asked to return the following day but who do not show up.

- Clinics receiving urgent or at risk referrals are responsible for ensuring clients are screened within designated timelines, and shall be responsible for contacting the client for follow up if they do not show up during walk in times. The minimum expectation for client follow up includes a phone call (if number is available) or a letter to known address and/or informing the referring party of client status.

Access to Electronic Health Record (EHR):

- In the EHR, the Initial Screening form can be used for the triage/screening contact.
- In the EHR if the assessment is not available (due to not being final approved) the provider currently attempting to access the record should call/contact the other provider/site where the record is in progress to see if they can get the assessment completed quickly. If the other provider is not available, the current provider can delete the record that has not been completed. Prior to deletion, the provider should print out a copy of the record, fax it to the initial provider, and keep a copy on file.

All programs:

- The initial site providing service shall ensure that clients do not have to go to multiple facilities for an evaluation.
- MD's/Nurse Practitioners (NP's) must be prepared to provide care to a client who is in urgent need of medications even though the client may be open at another clinic.
- MD's/NP's should be prepared to provide outpatient detox medications to COD clients entering County-contracted detox programs, if in the MD's/NP's opinion it is deemed safe. This will be evaluated on a case-by-case basis.
- All programs shall post signage to inform clients what to do after hours. E.g., "In case of an emergency after business hours please go to the nearest emergency room, call the Access and Crisis Line at-1-888-724-7240, or call 911."
- HIPAA Privacy Rule Sec. 164.506 states that a covered entity may use or disclose protected health information for treatment. This would apply in the case of a clinical referral source (another clinic, case management, hospital, IMD, etc.) inquiring whether a referred client appeared for their intake process.

Priority List

Prioritization is always based on clinical judgment regarding highest acuity and risk, however the following will generally be highest priority: A client appearing agitated in the waiting room, any

Psych hospital/START discharge, Police/PERT, jail, IMD Client/Out of County locked facility referral, Case Management client with a case manager, acute JWWR/Exodus referral, homeless or at risk of homelessness with SMI or COD client whose mental status jeopardizes ADS residential placement.

Referral Process for Strength-Based Case Management (SBCM) and Assertive Community Treatment (ACT) Services

Any person or agency can complete a referral to a SBCM or ACT program. The program receiving the referral may determine that it is best able to serve the person, and will open the case. If the program receiving the referral determines the person might be better served through another provider, contact is made with the other program and the referral may be forwarded for review. Each program maintains a log of all referrals and referral dispositions.

For more information, regarding the system of care Strength-Based Case Management (SBCM) and Assertive Community Treatment (ACT) programs, please reference the [Technical Resource Library \(TRL\)](#) for hyperlinks directly to Section 2 (Adult/Older Adult System of Care) subsection 2.3 (Case Management) where the following can be found:

- Assertive Community Treatment and Strength Based Case Management pamphlet
- Referral forms for Homeless Persons with Severe Mental Illness or Closed Referral System

ASSISTED OUTPATIENT TREATMENT/LAURA'S LAW

Laura's Law/Assisted Outpatient Treatment authorizes court-ordered outpatient treatment pursuant to Welfare and Institutions Code (WIC) Sections 5345-5349.5 for individuals who have a history of untreated mental illness and meet all nine of the following criteria stipulated in the Code:

1. The person is at least 18 years of age.
2. The person is mentally ill as defined in WIC 5600.3
3. The person is clinically determined to be unlikely to survive safely in the community without supervision.
4. The person has a history of treatment non-compliance as evidenced by one of the following:
 - Two occurrences of hospitalizations, or mental health treatment in prison or jail within the last 36 months **OR**
 - One occurrence of serious and violent behavior (including threats) within the last 48 months.
5. The person has been offered treatment (including services described in WIC Section 5348) and continues to fail to engage in treatment.
6. The person has a condition that is substantially deteriorating.
7. Assisted Outpatient Treatment must be the least restrictive placement to ensure the person's recovery and stability.

8. The treatment is needed to prevent a relapse or deterioration that would likely result in grave disability or serious harm to self or others as defined in WIC Sections 5150 *et seq.*
9. The person is expected to benefit from AOT.

A request for an assisted outpatient treatment examination is made through one of the two In Home Outreach Team (IHOT) programs (Telecare or Mental Health Systems, Inc.). The IHOT program is an outreach and engagement program for individuals who are resistant to treatment. The request may only be made by one of the following:

- Anyone at least 18 years of age living with the person
 - Any parent, spouse, sibling at least 18 years of age
 - A director of a public or private agency, treatment facility, charitable organization, or licensed residential care facility providing MH services to the person
 - A director of the hospital where the person is being hospitalized
 - The licensed MH treatment provider supervising treatment of or treating the individual
 - A peace officer, parole officer, or probation officer assigned to supervise the individual
- 1) In the event that the referred individual is not engaged in IHOT services, a clinical determination will be made to refer the individual for an assisted outpatient examination. Following the assisted outpatient examination, the individual will be provided with the opportunity to voluntarily enter into the assisted outpatient treatment program. If the individual refuses to enter the assisted outpatient treatment program voluntarily, and the individual continues to meet all nine (9) criteria as stated in Laura's Law, a request for an assisted outpatient treatment examination is made through the BHS Director or his designee. Upon receiving the request, the BHS Director or his designee must conduct an investigation into the appropriateness of the filing of the petition.
 - 2) The petition with an affidavit from the designated IHOT licensed mental health clinician (LMHC) shall state that s/he has personally evaluated the person within 10 days prior to the submission of the petition; the person meets all 9 criteria; the LMHC recommends AOT and is willing and able to testify at the hearing on the petition,
OR
The licensed mental health clinician has made within 10 days of filing the petition appropriate attempts to elicit the cooperation of the person but has not been successful in persuading the person to submit for the AOT examination and is willing and able to testify at the hearing on the petition.
 - 3) If the individual refuses to be examined by a licensed mental health clinician from IHOT, the court may request the individual's consent to the examination by a licensed MH treatment clinician appointed by the court. In the County of San Diego, the Public Conservator's Office is the designated program to conduct the AOT court order examination for individuals who refused the initial examination by IHOT.

- 4) If the individual does not consent and the court finds reasonable cause, the court may conduct the hearing in the person's absence OR order an individual to be transported to San Diego County Psychiatric Hospital for examination by a licensed mental health professional under WIC 5150. Hold may not exceed 72 hours.
- 5) In the event that the AOT examination is upheld, the County's designee, San Diego County Counsel, will file the petition with the AOT Judge and upon receipt of the petition, the court must schedule a hearing within five business days. Individuals will be personally served with the petition and notice of hearing date.
- 6) If after hearing all evidence, the court finds the individual does not meet criteria for AOT, the court may dismiss the petition.
- 7) If the court finds that all nine criteria are met, the court may order the person to AOT for an initial period not to exceed six months. The individual may voluntarily enter into a settlement agreement for services after a petition for an order of AOT is filed, but before the conclusion of the hearing. Settlement agreements may not exceed 180 days and has the same force as an order for AOT.
- 8) If the person is court ordered for AOT services and is not participating in the AOT program, and if unsuccessful attempts are made to engage the person in AOT, the person may be transported to San Diego Psychiatric Hospital for up to 72 hours to be examined to determine if the person is in need of treatment pursuant to Section 5150.

ACCESSING SECURE FACILITY/LONG-TERM CARE (SF/LTC) – ADULT MENTAL HEALTH SERVICES

Locked/secure facilities service those residents of San Diego County who experience serious psychiatric disabilities and require a secure, safe, and structured environment; these residents are not entitled to services through other systems, either public or private. SF/LTC Facilities funded by the County of San Diego include Institutes of Mental Disease, additional funds for a County SNF Patch, and State Hospitals.

Referral Process

Optum, which provides mental health administrative services to the County of San Diego Mental Health Plan, provides Utilization Management for County-funded locked/secure facilities. Referring agencies shall submit an information packet to the Optum Long-Term Care (LTC) Coordinator. The packet shall include the following:

1. Referral form for a San Diego County-funded SF/LTC
2. Court Investigative Report for San Diego County LPS Conservatorship

3. Complete Psychiatric Assessment including psychiatric history, substance abuse history and history of self-destructive or assaultive behavior, if applicable
4. Current Physical and Medical History
5. Current medications
6. One week of progress notes (including nursing, group notes, and psychiatrist notes)
7. Hospital face sheet
8. Proof of current Medi-Cal coverage (an Automated Eligibility Verification System [AEVS] strip from the hospital business office) or proof that client is Medi-Cal eligible and that Medi-Cal has been applied for.
9. Current completed Mini-Cog Exam
10. Current lab reports and toxicology screen from day of admission
11. Result of purified protein derivative (PPD) (tuberculosis [TB] test) or clean chest x-ray done within the past 30 days
12. Recommendation and information from the case manager, if client has case management services.
13. Signed payee form

If the packet is not complete, the referral shall not be processed until all of the information is available.

The Optum Long-Term Care Coordinator shall review all referrals for completeness of information and eligibility for admittance. If the Coordinator has questions or concerns, he/she shall consult with the Optum Long-Term Care Medical Director. The San Diego County Long-Term Care Manager and/or the County Adult/Older Adult Mental Health Services Medical Director shall also be available for consultation. At times, even though the referral is complete, there may be concerns about whether the individual meets admittance criteria for SF/LTC. In these cases, the Optum LTC Medical Director or his/her designee may complete an independent on-site evaluation of the referred individual. Once Optum has established that the referred individual meets the admittance requirements for SF/LTC, Optum will provide the clinical packet to SF/LTC facilities. SF/LTC facilities will determine if the client is appropriate for their facility.

Target Population

The persons served should have the potential to benefit functionally from psychiatric rehabilitation services and have the capacity to progress to a less restrictive level of care. The client must have an Axis I psychiatric diagnosis (as the primary diagnosis) and meet the Medi-Cal criteria for

psychiatric inpatient services at the time of application. The person will have been certified as gravely disabled, despite active acute care interventions and will have a temporary or permanent Lanterman-Petris-Short (LPS) Conservator. For an IMD, the age range is 18 years to 64 years old

Eligibility Criteria for Admittance to SF/LTC

To County-Funded Secure Facilities/Long-Term Care

Individuals must meet all of the following criteria:

1. Have met Title 9 medical necessity criteria for psychiatric inpatient services at time of referral.
2. Be unable to be maintained at a less restrictive level of care.
3. Have an adequately documented Axis I diagnosis of a serious, persistent, major, non-substance-abuse-related mental disorder as stated in Title 9. This diagnosis must not be primarily a manifestation of mental retardation or other developmental disorder. Clients may also have a concurrent diagnosis on Axis II or have a substance abuse diagnosis as a concurrent Axis I diagnosis. An Axis II diagnosis alone is not, however, sufficient to meet criteria.
4. Have the potential to benefit from psychiatric rehabilitation services and potential to progress to a less restrictive level of care.
5. Be gravely disabled as determined by a court's having established a temporary or permanent public or private San Diego County Lanterman-Petris-Short (LPS) Conservatorship. Grave disability is defined in the Welfare and Institutions Code 5008, Section (h) (1) (A)... "A condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic needs for food, clothing, or shelter."
6. A current resident in the State of California with Medi-Cal eligibility for the County of San Diego.
7. Not be entitled to comparable services through other systems (i.e., Veterans Administration Regional Center, private disability insurance, Forensic system, etc.).
8. Be 18 to 64 years old, although persons 65 and older may be admitted to Skilled Nursing Facilities (SNFs)
9. Have absence of a severe medical condition requiring acute or complex medical care in accordance with applicable Skilled Nursing Facility/Special Treatment Program (SNF/STP) or Mental Health Rehabilitation Center (MHRC) regulations.

10. Have current tuberculosis (TB) clearance.
11. Be on a stable, clinically appropriate medication regimen.
12. Have absence of chronic or recurrent dangerousness to self or others. This includes absence of chronic or recurrent episodes of assaultive behavior.

To San Diego County Funded SNF Patch Facilities

San Diego County provides additional funds for clients who are placed in a Skilled Nursing Facility with a SNF patch. To be considered for admittance to this program, individual must meet as 12 criteria for admittance to County-funded secure facilities. In addition, individuals must have Medi-Cal as the only source of funding. To request a SNF patch the hospital completes an SNF-LTC and submits the packet to Optum.

To Vista Knoll

San Diego County has a contract with Vista Knoll, a Skilled Nursing Facility in North County, in the specialized Neurobehavioral Health Unit for residents with Traumatic Brain Injuries (TBI). To be considered for admittance to these San Diego County-funded beds, individuals must meet all 12 criteria for admittance to County-funded secure facilities. In addition:

Individuals must have a current, adequately documented Axis I diagnosis of a serious, persistent, major, non-substance-abuse-related mental disorder as stated in Title 9, with evidence it existed prior to their Traumatic Brain Injury. Referral packets shall include complete documentation of this history.

To a State Psychiatric Hospital

Individuals must meet all of the following criteria:

1. Individual must be a current or recurrent danger to self or others, which includes chronic or recurrent episodes of assaultive or suicidal behavior. Documentation must show that assaultive behavior is a result of psychosis that has been resistant to treatment rather than antisocial behavior, Dementia or Traumatic Brain Injuries (TBI).
2. Individual cannot be admitted or maintained at an Institution for Mental Disease/Mental Health Rehabilitation Center (IMD/MHRC).
3. Admissions to state hospitals shall be approved by the County LTC Coordinator.
4. Individual shall be on LPS Permanent Conservatorship. The Lanterman-Petris-Short (LPS) Conservator must authorize A/OAMHS to provide case management services in order to monitor the individual's placement and progress.

Reviews of Determination Decisions

Situations may arise in which the referring agency does not agree with the decision regarding admittance. The attending M.D., the conservator/client or the referring agency may request a review of the decision by notifying the San Diego County Adult/Older Adult Mental Health Quality Improvement Department in writing within five business days. This request shall include submission of the following information:

1. New detailed specific information as to why the individual meets the criteria for admittance.
2. Supportive documentation, as relevant.

The San Diego County Adult/Older Adult QM Department or his/her designee shall review the information and may appoint a psychiatrist who has not had any previous involvement in the case as an independent reviewer. After review of the documentation, San Diego County shall render the final determination regarding admittance.

Placement

Individuals who meet SF/LTC Admission Criteria are placed in SF/LTC facilities that are contracted with the County of San Diego. Placement decisions are made by County Contracted SF/LTC facilities and Optum.

In some cases, the most appropriate placement may not be clear. In these situations, more information may be requested from the referring agency or the case manager. In some cases, an on-site evaluation of the referred individual may be appropriate. Optum LTC Coordinator is responsible for notifying the referral agency as to the outcome after the placement decision. At times, placement in a County-funded, out-of-County located program may be appropriate. In these cases, the following criteria shall be met:

1. Individual meets all criteria for in-County placement;
2. Individual has been refused placement by all in-County facilities, or there are compelling clinical reasons (e.g., deaf program) established that the individual would benefit from out-of-County placement;
3. The San Diego County Adult/Older Adult Long-Term Care Manager has approved the placement; and verified that funding is available for placement.

Placement in a State Hospital

1. Each client shall be approved for admission to a state hospital by the County LTC Coordinator. The case manager reviews and exhausts all possible alternatives with Optum Medical Director and LTC Coordinator prior to authorizing state hospital placement.

2. Upon approval, the LTC Coordinator at Optum sends the current information provided by the hospital and case manager to the Admissions Coordinator at one of the following State Hospitals: Atascadero, Coalinga, Napa, Patton, Salinas Valley, and Metropolitan State Hospital.
3. Once the state hospital has accepted the client, the county case manager/conservatorship designee shall ensure that all legal documents and paperwork are in order enabling transportation and admission to state hospital.
 - a) Certification must be obtained from the County LTC Optum that funds are available to support the placement, by his or her signature on the “Short/Doyle” form.
 - b) Current Letters and Orders of Conservatorship must be obtained from the Conservator.
 - c) Authorization must be obtained for the county to provide case management services if conservator is a private conservator.
 - d) The case manager shall notify the facility and the Optum LTC Coordinator of the discharge and transportation date and time.
 - e) The referring facility is responsible for arranging for transportation to the state hospital and shall have the client and the client’s belongings ready to go.

TRANSITIONAL AGE YOUTH (TAY) REFERRAL PROCESS

Youth receiving behavioral health services in the Children, Youth and Families Behavioral Health System of Care and who are between the ages of 18-21 may require system coordination to successfully transition to the Adult/Older Adult Behavioral Health System of Care when continued care is needed. Youth receiving services in other sectors and needing behavioral health services often require coordinated efforts as well. To appropriately identify those youth and to coordinate care and assist with successful linkages, including the implementation of a process when routine referrals have been unsuccessful, the following procedures are established:

Identify the appropriate level of service within CYFBHS and A/OABHS since there are different levels of services available.

1. The Children, Youth and Families Behavioral Health System of Care service array includes:
 - a. The critical care/emergency screening unit, which provides emergency psychiatric evaluation, crisis stabilization, and screening for inpatient care for families during mental health crisis.
 - b. Outpatient services which include crisis intervention, mental health assessments, medication management, family therapy, group therapy, Substance Use Disorder (SUD) issues and case management. Services are clinic based, school based, institutionally based,

- and community based and offered through contracted and Fee for Service providers. These include a number of specialized programs that focus on specific populations.
- c. Full Service Partnerships are outpatient programs which provide intensive services that comprehensively address client and family needs and “do whatever it takes” to meet those needs.
 - d. Case Management/wraparound services are for children, youth and families with complex needs and require intensive supports in addition to treatment service
 - e. Therapeutic Behavioral Services are one on one behavioral service provided by BHS contractors in conjunction with other treatment services.
 - f. Day treatment services are several hours per day and all-inclusive in terms of the mental health services provided.
 - School based day rehabilitation services are provided through the San Diego Unified, Cajon Valley, and Grossmont Union School Districts. Services are accessed through referral by the district.
 - Day Treatment is offered for Dependents of the Court residing in residential treatment and long-term placement at San Pasqual Academy.
 - g. Inpatient services which are for mental health emergencies that require a hospital setting.
 - h. Non-residential SUD programs, which provide non-residential specialized SUD services that build a more integrated and coordinated strategy to meet the unique substance abuse treatment and recovery needs of youth. Programs also provide appropriate referrals for youth and their family, if needed.
 - i. Residential SUD programs, which provide 24/7 structured residential alcohol and other drug (SUD) treatment/recovery and ancillary services.
 - j. Residential detoxification programs which provide 24/7 SUD detoxification and pre-treatment/referral services.
 - k. Case Management Juvenile Justice Programs support clients referred by the Probation Department and Juvenile Drug Court to assist in the intervention, treatment and recovery from substance abuse issues. Juvenile justice programs offer services at designated County Probation service centers and the Juvenile Drug Court.
2. The Adult/Older Adult system serves individuals living with serious psychiatric disabilities who may have alcohol and other drug induced problems and the service array includes:
- a. Clubhouses which are informal centers with employment and education supports and socialization opportunities with a focus on wellbeing
 - b. Outpatient clinics which provide individual and group therapy and medication support services
 - c. Case Management services which provide assistance with linkage to services and community supports as well as psychosocial intervention and resource management to assist individuals to obtain optimum independence.
 - d. Full Service Partnership programs which provide intensive services that comprehensively address client and family needs and “do whatever it takes” to meet those needs

- e. Residential programs, which are 24/7, structured treatment programs that may provide individual, group, family therapy and other treatment modalities as appropriate.
- f. Crisis Residential programs which are an alternative to acute hospitalization for persons in crisis of such magnitude so as not to be manageable on an outpatient basis.
- g. Inpatient services which are for mental health emergencies that require a hospital setting.
- h. Non-residential alcohol and other drug (SUD) treatment and recovery programs which provide process, educational and curriculum groups to assist individuals in recovering from substance abuse disorders on an outpatient basis. Programs may also provide specialized services for special populations including criminal justice populations (on a referral basis).
- i. Residential SUD programs which provide 24/7 structured treatment and recovery services for individuals requiring a higher level of care.
- j. Residential detoxification programs which provide 24/7 SUD detoxification and pre-treatment and referral services.
- k. Non-residential and residential women's programs, which provide gender-specific, trauma-informed SUD treatment and recovery services, designed for adult women over the age of eighteen (18), including pregnant, parenting women, and their dependent minor children from birth through and including age seventeen (17).
- l. Drug Court programs, which provide non-residential alcohol and other drug (SUD) treatment and testing program services to serve non-violent adult male and female offenders who have been referred to Adult Drug Court.
- m. Driving under the Influence (DUI) programs which provide state licensed and mandated education and counseling programs for offenders arrested and convicted of Wet Reckless or first or multiple offense DUI. Programs are funded entirely by participant fees; ADS is responsible for local administration and monitoring.
- n. Special population programs which provide SUD
- o. Treatment and recovery services to traditionally harder to reach populations, such as Gay, Lesbian, Bi-sexual, and Transgender (GLBT), serial inebriates and HIV positive adults.

Identify the System Target Population

1. CYFBHS provides services to youth up to a youth's 21 birthday who are seriously emotionally disturbed. Services are provided to clients with co-occurring mental health and substance use, Medi-Cal eligible clients that meet medical necessity, as well as Indigent, and/or low income/underinsured individuals. All specialty mental health providers will evaluate and assess the treatment needs of the client. This process will encourage and involve the active participation of the client's significant others such as: the parent/caregiver, for children and youth, family members, friends and/or advocates selected by the adult client. Orientation and education of significant others includes discussion of what services are available, treatment goals, role of the provider, and expectations of the client and provider. It also includes legal limits around confidentiality. Seriously emotionally disturbed children or adolescents means minors under the age of 21 who have a mental disorder as identified in the ICD-10, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

- a. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
 - i) The child is at risk of removal from home or has already been removed from the home.
 - ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
- A short-term model of treatment is utilized in CYFBHS.
 1. For youth who meet criteria for medically necessary services, they are eligible for 13 sessions (within a 12-month period), to include:
 - One Assessment Session
 - 12 Treatment Sessions
 - An emphasis on group and family treatment.
 2. For youth who meet Utilization Management (UM) criteria and require additional services, up to 13 additional sessions may be granted in alignment with the Organizational Provider Handbook (OPH) UM process.
 3. If a youth needs services beyond the potentially available 26 sessions and they continue to meet UM criteria, a specific request may be submitted to the COR for review and potential approval, per the OPH UM process.

In the SUD Adolescent programs, the target population is defined as adolescents aged twelve (12) through seventeen (17) years of age with alcohol and other drug-induced problems. Adolescents learn how to socialize, grow and recover in a safe and supportive, youth-focused, alcohol and drug free environment.

2. In the A/OABHS, the target population is defined as individuals with a serious psychiatric illness that threatens personal or community safety or that places the individual at significant risk of grave disability due to functional impairment. In addition, the system of care serves people with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and / or who require unusually complex medication regimens. Required psychosocial services may include illness management, or skill development to sustain housing, social, vocational and educational goals.

In the Adult SUD programs, the target population is defined as individuals in need of SUD treatment and recovery services. The goal of alcohol and other drug treatment and recovery services is to assist individuals to become and remain free of alcohol and other drug problems, which lead to improved individual and family capability, overall functioning, decrease the incidence of crime, and support the person's ability to become self-sufficient through employment. Additionally, Regional Recovery Centers and select residential programs serve

a target population of PROs (Post Release Offenders) and Probationers who are referred for services and are assigned to high-risk caseloads and supervision by the Probation Department.

3. When youth are between ages 18-21 and the most appropriate level of care is being determined, the following shall be considered:
 - System of care target population defined above, with individual needs being considered
 - Youth's goals and preference
 - Youth's functional level
 - Youth's need for shorter term or longer term services
 - Youth's relationship with current provider and impact of consistency based on youth's history

Coordinate Care Between Sectors:

1. **Child Welfare Services:** In an effort to coordinate care with CWS, a call to 858-694-5191 can be made to access the name and phone number of a San Diego County foster youth's social worker. To access the name of a youth's Independent Living Skills (ILS) worker, the ILS INFO Line can be called at 866-ILS INFO (866-457-4636). The ILS INFO Line can also be used as the starting point for an eligible former foster youth to re-enter foster care after age 18. Additional information about ILS and transitional housing opportunities can be found at www.fosteringchange.org.
2. **Probation:** If a youth has probation involvement, communication with the Probation Officer would be an important aspect of services.
3. **Education:** If a youth has been in Special Education and did not receive a diploma, they are eligible for educational services through their school district until age 22. Their last school of attendance would be able to assist with school records and educational placement. If there is any difficulty at the school site getting information it is advised to contact either the Special Education Department Chair at that school site or the Vice Principal of Special Education.

If a youth was not receiving Special Education services, they can be referred to "Adult Education" which is provided through the San Diego Community College District.

Coordinate Care When Making Referrals:

1. Planning and consultation with the youth prior to a referral is needed so that the planned services match the needs and desires of the transition aged youth. Clinical staff shall meet with the youth and their supports, including other system of care partners such as CWS & Probation as applicable, to strategize about planned services as some youth may be best served by continued services in CYFBHS and for others a referral to the A/OABHS may be indicated.

2. Involvement of the family in transition planning is integral when family is available. It is critical that the youth and family understand the differences within the CYFBHS and the A/OABHS in terms of consent to treat and expectations of support systems.
3. If a referral to the Adult/Older Adult System of Care is determined, it is recommended that a call to the selected program be made to discuss the referral process and to allow for some transition time when the youth can be introduced to the new program on a timeline that is comfortable to all parties.
4. It is also recommended that visits with the youth, their supports, the existing provider and the prospective provider occur, as this can be a helpful step in supporting a transition.

Procedures to follow if unsuccessful routine referral is below:

1. Youth who need transition planning due to their unique needs but for whom routine referrals have been unsuccessful will be identified by the CYF System of Care staff, either their Case Manager or Care Coordinator, who shall submit a referral packet containing the following information:
 - Referral Form/Cover Letter
 - 650 Children's Mental Health Assessment and most recent update
 - Current Five Axis Diagnosis
 - Youth Transition Evaluation
 - Mental Status conducted by psychiatrist within the last 45 days
 - Physical Health Information
 - Medication Sheet
 - Service Plan and other plans, e.g., Flexible Service Plan, Therapeutic Behavioral Services (TBS) Plan
 - Psychological Testing done within past year (if available)
 - Individual Education Plan and Individual Transition Plan
 - Assessment of financial needs (may need referral to apply for Supplemental Security Income (SSI) six months prior to 18th birthday if applicable)
 - Any self-evaluations recently given to youth.
2. This packet shall be submitted with releases to the Mental Health Program Coordinator (MHPC) of Adult Mental Health Services in the region where youth resides. The MHPC offices are located at 3255 Camino del Rio South, San Diego, CA 92108.
3. The MHPC will review the packet to determine medical necessity according to Title 9 and the Service Eligibility Policy for the Adult/Older Adult System of Care.
4. If the client does not meet medical necessity criteria, then the client shall be referred back to the referral source for services in the community. If the youth is 18 or over, an assessment will

be requested from an adult provider agreeable to the client and family. If the assessment indicated a Medi-Cal beneficiary does not meet medical necessity criteria, a Notice of Action Assessment (NOA-A) will be issued, advising him/her of his/her rights to appeal the decision.

5. If a transition plan is agreed upon, the client's CYFBHS Case Manager or Care Coordinator will attempt to link the client with the appropriate service.
6. If the linkage is not successful, the MHPC shall coordinate an initial meeting with a multidisciplinary support team within two weeks of the initial referral that will include relevant persons that may include, but are not limited to, the following:
 - Youth
 - Support System as defined by the youth/family (parent, social worker, family members)
 - CYFBHS Case Manager and /or Therapist
 - Current Psychiatrist
 - CYFBHS Contracting Officer's Representative (CORS), or designee
 - Adult/Older Adult BHS COR if applicable, or designee
 - Probation Officer (if applicable)
 - CWS Social Worker (if applicable)
 - Education/Vocational Specialist
7. Team will review youth defined needs and options and create a transition plan, complete a Transition Age Youth Referral form, including all signatures. The Care Coordinator will include a copy of a Transition Age Youth Referral Plan in the medical record. The plan shall identify the individual that will follow up with the transition plan. Should the youth decide this plan is not acceptable, an alternative shall be identified and same procedure followed.

ACCESSING SERVICES – CHILDREN, YOUTH and FAMILIES SERVICES (CYFS)

Organizational Provider Outpatient Services or County Operated Services

If a client first accesses services by calling or walking into an organizational provider site or a county-operated program, the client can be seen and assessed, and the organizational provider authorizes services based on medical necessity and/or the SED criteria as outlined in California Welfare & Institutions Code Section 5600.3. (See Systems of Care section of this handbook for elaboration of the content of this code.) See Authorization/Reimbursement Section of this handbook for a description of organizational provider and county-operated program responsibility for registration of clients.

Day Intensive and Day Rehabilitative Services (CYFS)

Day services are offered in school/community settings and as enhanced treatment services in residential facilities for the most severely emotionally disturbed children and youth who meet medical necessity. Referral and admission to all day services may come from Juvenile Probation,

Child Welfare Services, or schools. All programs are Medi-Cal certified and comply with Medi-Cal standards regardless of funding source.

Authorization is required for all day services. Clients referred to day services shall begin treatment services within contract guidelines. Upon admission of the client, day programs shall comply with authorization procedures for day services as set forth in the DMH Letter No.: 03-03. An Administrative Services Organization (ASO) provides authorization for all day services. Optum acts as the ASO. Reauthorization is required every three months for day intensive services and every six months for day rehabilitative services. Copies of Optum's current Specialty Mental Health Services DPR forms are available at <https://www.optumsandiego.com>

See Section D for information on Out of County clients and all other authorizations.

Service Priority for Outpatient Assessment Services – CYFS

High

- Children and adolescents requiring emergency services should be seen within one hour of contact with program. They may be seen at the program or referred to Emergency Screening Unit.
- Children and adolescents with Urgent referrals, defined as a condition that, without timely intervention, would very likely become an emergency, shall be seen within 48 hours of contact with program.
- Children and adolescents being discharged from acute psychiatric hospital care shall be assessed by program within 72 hours. If the referral is Urgent, client shall be seen within 48 hours of contact with program.
- Seriously Emotionally Disturbed (SED) children and adolescents take priority over routine admissions.

Routine

- Children and Adolescents with a relatively stable condition and a need for an initial behavioral health assessment for Specialty Mental Health Services shall be seen within 10 business days from request.
- Children and Adolescents with a relatively stable condition and a need for an initial psychiatric evaluation for Specialty Mental Health Services shall be seen within 15 business days from request.

Ongoing Services

- Children and adolescents with moderate mental health needs who meet medical necessity criteria shall be provided with appropriate services based on the client needs as well as the program's Utilization Management process. For children and adolescents with mild, non-complex mental health needs clinicians at all programs shall assist the parent/caregiver in

accessing services within the region through the Optum individual/group provider network, if the child is Medi-Cal eligible.

THERAPEUTIC BEHAVIORAL SERVICES (TBS)

Clients are referred to New Alternatives, Inc. (NA), who is the point of contact for Therapeutic Behavioral Services (TBS). The referring party may include COSD SOC, CWS and Probation Department. The referring party will complete and return a referral form and Release of Information to the Point of Contact/Referral Specialist. Referrals are then screened and assessed by Point of Contact/Referral Specialist for eligibility criteria according to California Department of Mental Health guidelines provided in DMH Letter 99-03 and DMH Notice 02-08. Purpose of screening is to ensure client/family is Medi-Cal eligible and to confirm the client/family willingness to participate in the services. Point of Contact/Referral Specialist will then assign client/family to a Case Manager and the referring party is updated in the process. The provider assigned to the client/family will conduct assessment to ensure client meet the class, service, and other TBS criteria prior to services being delivered.

TBS brochures are available in English and Spanish.

Utilization Review

Authorization management for extended Therapeutic Behavioral Services is retained by the MHP. If a client requires more than 25 hours of coaching per week of TBS, the Contractor shall contact COR for approval. However, if client requires more than 4 months of services, provider will use internal/tracking request system that does not require COR approval. Authorization is not needed for “stabilization services” where the client is receiving one to two hours a week for a couple of weeks to ensure stability of treatment gains.

Authorization for services for San Diego clients placed out of county are referred to the COR for authorization for TBS services.

DUAL DIAGNOSIS CAPABLE PROGRAMS

Clients with co-occurring mental health and substance use issues are common in the public mental health system and present with complex needs. BHS has adopted the Comprehensive, Continuous Integrated System of Care (CCISC) Model for individuals and families with co-occurring substance use and mental health disorders. Programs must organize their infrastructure to routinely welcome, identify, and address co-occurring substance use issues in the clients and families they serve. They shall provide properly matched interventions in the context of their program design and resources. For specific information regarding CCISC and dually diagnosed clients, please see **Section A** of this handbook.

MENTAL HEALTH SERVICES FOR INDIAN ENROLLEES

The contract between the State DHCS and the MHP, to the extent that the MHP has a provider network, which enroll Indians must:

- Require the MHP to demonstrate that there is sufficient Indian Health Care Providers (IHCP) participating in the provider network of the MHP to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services.
- Require that IHCPs, whether participating or not, be paid for covered services provided to Indian enrollees who are eligible to receive services from such providers.
- Permit Indian enrollees to obtain services covered under the contract from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.

The MHP shall provide behavioral health care services to Indian enrollees who choose to have their services delivered by an Indian Health Care Provider. Programs shall contact Optum to arrange for services and payment for clients referred to Indian Health Care Providers.

RESIDENCY

The Uniform Method of Determining Ability to Pay (UMDAP) does not require that a person have a specific period of residence in the county or state to qualify for services. Intent to reside in San Diego County is a necessary condition, and is established by the client's verbal declaration. This applies to foreign nationals, including individuals with immigrant or nonimmigrant status. Without intent to reside in San Diego County, any client must be billed at full cost. *See Section D for additional information on the provision of specialty mental health services to Child/Youth Out of County Medi-Cal clients.*

D. PROVIDING SPECIALTY MENTAL HEALTH SERVICES

ADULT/OLDER ADULT SYSTEM OF CARE

Coordination of Care: Creating a Seamless System of Care

Coordination of care between service providers is essential for a client's continuity of care and a mental health system to work efficiently. As a client may move between different levels of care, it is vital that service providers complete a **warm hand off** with each other to provide continuity of care for the client. This is accomplished in the following manner; Providers shall develop discharge planning to support individuals transitioning between the same or a different level of care, including those outside the BHS system of care. This includes but is not limited to the referring provider making contact with, and developing collaborative communication with *one individual staff member* responsible for intake at the receiving provider, transportation to the receiving provider, and participation in appointment fulfillment or confirmation/documentation of receiving provider achieving a face-to face linkage. This also supports the clients' efforts to return to, achieve and maintain the highest possible level of stability and independence. The MHP Systems of Care stipulates that the provider shall assign each client a care coordinator as the "single point of accountability" for his or her rehabilitation and recovery planning, through service and resource coordination. The MHP monitors coordination of care.

To this end, the MHP defines a long-term client as any individual that receives behavioral health services beyond 30 days of his/her admission to a behavioral health program. Long-term clients would be expected to have a completed behavioral health assessment and client plan.

Post Discharge Coordination of Care

Any person being discharged from a crisis residential facility, a psychiatric hospital, jail, the EPU or a locked/IMD placement that are screened as needing services urgently shall be seen within 48 hours. If after screening it is determined non-urgent services are appropriate, contact shall be made within 72 hours of discharge. Any new or current client who meets the criteria for needing urgent services shall be seen within 48 hours. A need for urgent services is defined in Title 9 as a condition, which without timely intervention, is certain to result in a person being suicidal, homicidal or gravely disabled, and in need of emergency inpatient services. Compliance to this standard is monitored through the Medical Record Review process.

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Outpatient, Case Management and Assertive Community Treatment Services

The MHP defines adult clients as those between the ages of 18-59 years. Older adults are age 60 and above. Clients may access services through organizational providers and County-operated facilities in the following ways:

- Calling the organizational provider or County-operated program directly
- Walking into an organizational provider or County-operated program directly
- Calling the Access and Crisis Line at 1-888-724-7240

When the provider conducts an assessment of a client who has called or walked into the program, that provider is responsible for entering administrative and clinical information into all the appropriate forms in Cerner Community Behavioral Health (CCBH). Providers must complete the demographic and diagnosis forms and open an Assignment in CCBH. See the Management Information Systems CCBH User Manual, Organizational Provider Operations Handbook, Volume II, for a description of how CCBH supports these provider activities.

If the Access and Crisis Line refers a client to an organizational provider or to a County-operated facility, the ACL opens a record in CCBH for each client. The provider's program staff is then responsible for recording all ongoing activity for that client into CCBH.

Medical Necessity for Outpatient, Case Management, Assertive Community Treatment Services

Title 9 (Section 1830.205) Medical Necessity criteria are summarized below. A complete description of Medical Necessity Criteria can be found on the Optum Website.

Services provided to clients by outpatient providers are reimbursed if the following medical necessity criteria are met:

1. The client must have an included Title 9 diagnosis that is reimbursable for outpatient services as described in Title 9, Section 1830.205(1).
2. The client must have at least one of the following as a result of the mental disorder(s):
 - A significant impairment in an important area of life functioning; or
 - A probability of significant deterioration in an important area of life functioning.
3. All of the following:
 - The focus of proposed intervention is to address the significant impairment or probability of significant deterioration in an important area of life functioning;
 - The proposed intervention is expected to benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life

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- functioning; and
- The condition would not be responsive to physical health care treatment.

SPECIFIC PROCEDURES AND CRITERIA FOR CASE MANAGEMENT AND ASSERTIVE COMMUNITY TREATMENT SERVICES

Brief Description of Services Available

San Diego County Adult/Older Adult Behavioral Health Services are as follows:

- Transitional Case Management provides short-term case management services (up to 90 days) for unconnected clients who suffer from severe mental illness (SMI) and are discharged from Acute Care (ex: Behavioral Health unit (BHU)). The goal is to connect clients to outpatient case management and/or Assertive Community Services as clinically indicated.
- Institutional Case Management services are provided to clients who reside in a State Hospital or in out-of-county or in-county Institutes of Mental Disease (IMD) or Skilled Nursing Facilities (SNF). Services consist primarily of linking, coordinating and monitoring functions and have a staff-to-client ratio of up to 1:60. Clients are contacted face to face at a minimum of once a quarter
- Strengths-Based Case Management (SBCM) programs are only authorized to provide case management brokerage, individual and group rehabilitation, collateral, and occasional crisis intervention services. SBCM services provide a mix of mental health, rehabilitation and case management functions and have a staff-to-client ration of approximately 1:25. Clients are typically evaluated in person at a minimum of once a month. Services may be provided on a much more frequent basis, depending on client clinical need. It is also expected that the case manager will have contact with significant others as clinically appropriate.
- Note that the evaluation completed when a client enters a case management program is designed to determine case management and rehabilitation needs and should be coded as a Rehab Evaluation. Assertive Community Treatment (ACT) programs are authorized to provide primarily case management brokerage and individual and group rehabilitation, collateral and occasional crisis intervention services. The services provided are a mix of medication, mental health, rehabilitation and case management functions and have a staff-to-client ration of approximately 1:10. Clients are typically evaluated in person at a minimum of four (4) times per week in order to meet the client's clinical needs and meet a high ACT fidelity rating. ACT programs are also authorized to provide an initial clinical

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assessment for the purposes of determining medical necessity, medication support services and some psychotherapy.

Clinical Assessment for Medical Necessity

At the time a client is admitted to a program, clinicians shall perform a face-to-face assessment to ensure that each new client meets medical necessity criteria for specialty mental health services. According to service mix outlined above, the clinician shall complete the appropriate assessment form in CCBH Electronic Health Record (EHR) and ensure that all relevant clinical information is obtained and documented. Within one month after program assignment, an Assessment and Client Plan shall be completed for clients in community setting.

The following are specific procedures and criteria for each level of care:

Strength-Based Case Management

Strengths-Based Case Management services are delivered through BHS contracted service. Programs assist clients with severe mental illness who may have a co-occurring disorder and may be justice-involved to access needed mental health, medical, educational, social, prevocational, vocational, housing supports and rehabilitative or other community services. The service activities may include, but are not limited to case management, care coordination, referral and linkage to needed services; monitoring services delivery to ensure beneficiary access to services and the services delivery system, monitoring of the client's progress, and plan development. The SBCM model emphasis is on the structure of the program, supervision and clinical services. The staff ratio is approximately 1:25.

Eligibility Criteria: Client must meet two or more of the criteria below

- Medical Necessity must be established (face to face) to determine the presence of a severe psychiatric disability and need for Strength Based Case Management (SBCM) services per LOCUS (Level 3 – High Intensity Community Based Services)
- Has current LPS Conservatorship (may be a designated County Conservator or family member (Private Conservator);
- Client is not homeless but may be at-risk of homelessness
- Minimum one hospitalization in the past year, OR multiple ER utilizations, PERT interventions, jail mental health service and/or long-term care hospitalization.
- Have major impairments in life functioning
- Person is not connected to outpatient treatment

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- Person is experiencing an acute psychiatric episode that might require SBCM level services
- Is at high risk of admission to an inpatient mental health facility
- Has a substantial need for supportive services (including care coordination and outreach mental health services) to maintain current level of functioning in the community, as evidenced by missed appointments, medication non-adherence, or inability to coordinate services from multiple agencies
- Does not have a case manager from another program who is able to address mental health needs

Services provided include, but are not limited to:

- Medication management which is coordinated outside the SBCM program in the FFS sector
- Strength Based Case Management
- Rehabilitation and recovery services
- Care Coordination to needed services
- Co-occurring services linkages
- Access and linkage to Supportive Housing
- Access to Supportive employment/vocational and educational services
- **Discharge Criteria:**
 - The goal of SBCM is to help improve the clients' mental health and quality of life to support clients to live in the least restrictive environment. A LOCUS is completed every 6 months to assist in determining if client is ready for lower level of care. Clients receiving Strength-Based Case Management services are reviewed by the program's Utilization Review Committee (URC) to determine continuation of case management services and/or changes in the level of case management.

Assertive Community Treatment (ACT) Services

ACT Services are provided in a multi-disciplinary team-based model of service that uses a comprehensive team approach and provides treatment 24 hours a day, 7 days a week, 365-days a year. The services are targeted for **homeless** persons with a severe mental illness who may have a co-occurring disorder, are unconnected to outpatient services, may be referred by the justice system, have multiple major areas of impairment, have more than one long term care episode, and multiple ER and acute care hospitalizations and justice related episodes.

The ACT programs provide **integrated** mental health and medication services, rehabilitation and

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recovery services, intensive case management and has a staff-to-client ratio of approximately 1:10. Clients are typically provided services in person at a minimum of four (4) times per week to meet ACT fidelity rating and the appropriate clinic need of the client. Services may be provided on a much more frequent basis, depending on client need.

Eligibility Criteria:

- Same as SBCM plus
- Homelessness or at risk of homelessness
- Level of acuity and need for intensive ACT services per LOCUS assessment (Level 4 – Medically Monitored Non-Residential Services)

Services provided include, but are not limited to:

- Integrated Mental Health Services and Medication Management
- Rehabilitation and recovery services
- Intensive case management
- Co-occurring services
- Access and linkage to Supportive housing
- Access to Supportive employment/vocational and educational services
- Care Coordination to needed providers
- **Discharge Criteria:**
 - Same as SBCM

CLINICAL STRENGTH-BASED CASE MANAGEMENT (SBCM) AND ASSERTIVE COMMUNITY TREATMENT (ACT) SERVICES COORDINATION WITH PUBLIC CONSERVATOR – ADULT AND OLDER ADULT MENTAL HEALTH SERVICES

Overview

For Contractors and County Case Management who provide clinical SBCM and/or ACT Services to LPS Conservatees on behalf of the Public Conservator, responsibilities include:

Ensure active and continuous clinical Strength-Based Case Management and/or Assertive Community Treatment Services responsibility, which includes, but is not limited to, ensuring the Conservatee has appropriate:

- Medical care and treatment
- Psychiatric care and treatment
- Personal care

- Food/Nutrition
 - Clothing
 - Shelter
 - Education and employment
 - Recreation and socialization
2. Ensure a clear photograph of the conservatee is taken at the initial face-to-face visit and annually thereafter. The photo must be preserved in the case file for the purpose of identifying the conservatee if he or she becomes missing (per Probate Code 2360)
 3. Collaborate/Coordinate with medical and psychiatric professionals and hospital treatment teams on behalf of the conservatee.
 4. Notify all appropriate parties, including family members and other significant parties, of the assigned Case Manager or Case Management team within 14 calendar days (see item #10 below for notification requirements for the Public Conservator's Office)
 5. Respond to routine e-mails and phone calls within 2 business days; for more urgent matters, a Supervisor/Program Manager should be available if parties are unable to reach the Case Manager.
 6. Upon request, provide case information to the Public Conservator's Office regarding grave disability, including information on the following:
 - a. Clinical presentation (psychiatric/medical, functional ability, etc.)
 - b. High-risk behaviors
 - c. Activities of daily living
 - d. Current medications and adherence
 - e. Placement history
 - f. Strengths and goals
 7. Maintain documentation regarding visits for viewing by Public Conservator Office staff.
 8. Ensure conservatee has both a psychiatrist and a primary care physician who will prepare (by a psychiatrist/psychologist) and concur with (by a primary care physician) the annually required Medical Recommendation and Declaration to Reestablish Conservatorship (see

Appendix C, A.C.5) (HSA LPS PC RE-EST). This form must be prepared/signed by both of the conservatee's physicians and submitted to the Public Conservator's Office at least 45 days prior to the end date of the current conservatorship period, which communicates their recommendation as to either the reestablishment or termination of LPS conservatorship. The case management agency must ensure the conservatee is able to see both the psychiatrist and a primary care physician 2 to 4 months prior to the end date of the current conservatorship period. The names and telephone numbers of these physicians must be provided to the Public Conservator's Office and should be kept current in Cerner.

9. Maintain involuntary clinical Strength Based Case Management and/or Assertive Community Treatment Services at all times while a conservatorship is in place. If the conservatee is being transferred to another Case Management Agency, services of the sending agency must be maintained until verification is received that the conservatee has been contacted and is prepared to receive involuntary case management services from the receiving agency. The receiving agency must notify the Public Conservator's Office of the successful transfer and start of services with the receiving agency. Services may only be provided on a voluntary basis (or closed) if the Public Conservator's Office has indicated the conservatorship has been terminated by the court.
10. Notify the Public Conservator's Office within 24 hours when any of the following situations occur for a conservatee:
 - Address changes
 - A new case manager is assigned
 - A new case management agency has been assigned
 - AWOL or in a missing person status
 - Hospitalization (medical and/or psychiatric)
 - In custody
 - Death
 - A Serious Incident Report is submitted to the BHS Quality Improvement Unit
 - Any unusual occurrences that raise risk/safety concerns
11. Notify Public Conservator's Office in writing when it is believed a change in rights or when it is believed the Conservatee is no longer gravely disabled.

12. Refer treatment providers to the Public Conservator's Office for matters requiring the consent of the Court via the Public Conservator's Office, such as surgery, non-routine medical treatment or end of life decisions.
13. Contact the Public Conservator's Office when questions arise regarding the Conservatee's desire/need to enter into contracts of any kind, obtain a driver's license, vote or participate in a research study.
14. Contact the Public Conservator's Office when there is a need to have documents signed on behalf of the Conservatee, except in cases involving assistance with Social Security and Medi-Cal applications, renewals, redeterminations, appeals, etc.
15. Ensure a report is available via the electronic health record (EHR) for the Public Conservator's Office to view monthly, including completed visits.

Initial Face-to-Face Visits

Initial Face-to-Face visits with conservatees will be conducted according to the type of case management program provided, as follows:

1. **ACT:** within 48 hours of the program formally opening the case, consistent with the OPOH standard for face-to-face visits for those deemed urgent and recently discharged from acute care
2. **SBCM:** 10 business days of the program formally opening the case, unless deemed urgent and recently discharged from acute care which would then require the urgent visit within 48 hours
3. **Institutional-In County:** within 30 days of the program formally opening the case or expedited in response to clinical need, on a case-by-case basis
4. **Institutional-Out of County:** within 90 days of the program formally opening the case or expedited in response to clinical need, on a case-by-case basis
5. **Hospital Rotation Cases:** The Public Conservator's Office has case management responsibilities during the Temporary LPS Conservatorship. During this time Strength-Based Case Management and/or Assertive Community Treatment programs will not be

responsible for face-to-face visits or discharge planning, as this will remain the responsibility of the Public Conservator. Once Permanent Conservatorship is established, as long as patient remains in acute care, the case will be opened to County Institutional Case Management services pending discharge to either long-term care or community placement.

- a) **If discharge is imminent** (planned in less than 10 business days) when the case is opened to County Institutional Case Management services, no face-to-face contact must be made unless the client is requesting such contact, or it is otherwise clinically indicated. Telephone contacts may be made as needed to facilitate discharge planning or other clinical needs during the time the patient remains in acute care.
 - b) **If discharge is not imminent** at the time the case is opened to County Institutional Case Management services, the case manager must plan to meet with the patient in the acute care setting within 10 business days of case opening, with the exception of patients in jail settings.
 - c) **For conservatees in jail settings** (where discharge is not imminent at the time Permanent Conservatorship is established), face-to-face contact must be made within 30 days of opening case to County Institutional Case Management to accommodate clearances needed and access to incarcerated individuals.
6. When a **Private Conservator** is appointed and requests the assistance of County operated Case Management Services, initial face-to-face contacts will follow the same periods as when the Public Conservator is appointed.

On-Going Face-to-Face Visits

Frequency of visitation will be conducted according to either Strength-Based Case Management (SBCM) or Assertive Community Treatment (ACT) program as follows:

1. **SBCM:** Clients are typically seen in person at a minimum of once a month. Services may be provided on a much more frequent basis, depending on client clinical need. It is also expected that the case manager will have contact with significant others as clinically appropriate.
2. **ACT:** Clients are typically evaluated in person at a minimum of four (4) times per week in order to meet the client's clinical needs and meet a high ACT fidelity rating. It is also expected that the case manager will have contact with significant others as clinically appropriate.
3. **Institutional-In County:** *routine visits to occur every 90 days.* Frequency to increase based on clinical need on a case by case basis

4. **Institutional-Out of County:** *visits to occur every 90 days.* Phone contacts to occur monthly in between face-to-face visits. Frequency of visits to increase based on clinical need on a case-by-case basis

Augmented Services Program

Designated case management providers may refer to Augmented Services Program (ASP). The goal of the Augmented Services Program is to enhance and improve client functioning through augmentation of basic Board and Care (B&C) services to specific individuals living in specific residential care facilities with which the county has an ASP contract. Emphasis is on developing client strengths, symptom management, and client self-sufficiency. Priority for ASP services is given to those persons in most need of additional services. Additional information about ASP may be found in the ASP Handbook, which is provided to all designated case management services eligible to refer to ASP.

In order to be eligible for funding from ASP, a client must:

- Have a primary diagnosis of a serious mental disorder;
- Have an active case open to A/OAMHS case management program and have been evaluated by their care coordinator to be in need of ongoing case management services. The assigned case manager is the only person who can submit a request for ASP services;
- Reside in an ASP contracted facility;
- Score of 60 and above on the ASP scoring tool – if below a score of 60 will need Behavioral Health Program Coordinator (BHPC) approval; and
- ASP funds must be available for the month(s) of service.

The client's case must remain open to the A/OAMHS program that provides ongoing monitoring, care coordination and case management services in order for the ASP facility to continue receiving ASP funds for the client. The case manager notifies the ASP and the ASP facility prior to the time that the case management program closes a client's case.

Peer Led Interventions

Peer Led Interventions provide an additional tool to assist clients in developing self-awareness and self-mastery skills. Those providing this service can be peer specialist, individuals with “lived experience” or family members of consumers. Examples of peer led interventions include but are not limited to Wellness Recovery Action Plan® and Whole Health Action Plan (WHAM). These

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services are designed to assist clients in managing day to day activities in at home and in the community. Designated staff with an understanding of the peer experience may also facilitate the structured interventions.

Telehealth Services

The purpose of this program is to assure timely access of urgent psychiatric services to reduce emergency and acute clients' hospital inpatient services Psychiatrists or Nurse Practitioners (NP); hereafter referred to as "telepsychiatry prescriber" will perform various psychiatric services via tele-video linkage when an on-site Psychiatrist or NP is unavailable; primarily due to illness or other scheduled absences or vacancies; or other special needs as arranged. The site where the telepsychiatry prescriber is located who will provide the mental health service will be termed "originating" site and the site where the mental health services are being received by the client will be termed the "distant" site. This practice also extends psychiatric services to clients in remote areas of the county.

The standards of telepsychiatric practice will be the same as for on-site psychiatric services as described in the California "Telehealth Law of 2012".

Videoconferencing Guidelines for Telepsychiatry

County contracted organizational providers connecting to their own network must follow the guidelines below in order to deliver secure telepsychiatry services.

- Use a secure, trusted platform for videoconferencing.
- Verify your devices and software use the latest security patches and updates. Install the latest antivirus, anti-malware, and firewall software to your devices. The underlying network must provide security.
- Verify your device uses security features such as passphrases and two-factor authentication. Your device preferably will not store any patient data locally, but if it must, it should be encrypted.
- Verify your audio and video transmission is encrypted. The Federal Information Processing Standard (FIPS) 140-2 is used by the United States government to accredit encryption standards. Encryption strengths and types can change. When partnering with 3rd party telepsychiatry vendors, verify if their encryption meets the FIPS 140-2 certified 256 bit standard; that any peer-to-peer videoconferencing (streamed endpoint-to-endpoint) is not

stored or intercepted by the company in any way; and that any recorded videoconferences or—if available—text-based chat sessions near the chat window are stored locally, on your own HIPAA-compliant device or electronic record keeping system, in order to safeguard any electronic protected health information or PHI.

- Choose a software solution that is HIPAA-compliant, as many popular, free products are not. Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996) is essential. HIPAA sets a minimum federal standard for the security of health information. States may also set privacy laws that can be even more strict, so be sure to check any relevant statute for the state in which you practice. Just because software says its HIPAA-compliant isn't enough. HIPAA compliance may also be dependent on the interface of your videoconferencing software with other aspects of your practice, such as EHRs, so it is best to think about HIPAA and telepsychiatry from a global, “all technologies” perspective.
- It is recommended to use a broadband internet connection that, at minimum, has a transmission speed of at least 5 MB upload/download to avoid pixilation, frequent buffering, and other video and audio difficulties associated with slow and insufficient transmission. Higher speeds might be required for newer technologies that use HD capabilities.

When reviewing software options, you will notice that many vendors require a “business associate agreement,” or a BAA, to ensure HIPAA compliance. Contact the vendor and confirm what such an agreement entails.

County operated programs shall connect to the County's secure network when providing telepsychiatry services as the network meets the above requirements and is a trusted platform for videoconferencing. Hardware shall be installed by the County's IT department.

Crisis Stabilization Services

“Crisis Stabilization” means a service lasting less than 24 hours (23.59 hours), to or on behalf of a beneficiary for a condition that required more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: Assessment, collateral and therapy. Crisis Stabilization is distinguished from crisis intervention by being delivered by providers who meet the Crisis Stabilization contract, site, and staffing requirements described in Sections 1840.338 and 1840.348 of CCR, Title 9.

Crisis Stabilization is a package program and no other specialty mental health services are reimbursable during the same time period this service is reimbursed, except for Targeted Case

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Management. Crisis Stabilization shall be provided on site at a licensed 24 hours health care facility or hospital-based outpatient program or a provider site certified by the Department or a Mental Health Plan (MHP) to perform crisis stabilization. CCR, Title 9 1840.338

Admission Criteria:

- Beneficiary must present with a mental health crisis for a condition that requires a more timely response than a regularly scheduled visit
- Must meet medical necessity

Services provided include, but are not limited to:

- Clinical Triage
- Face to Face psychiatric assessment
- Crisis Intervention
- Medication
- Collateral
- Linkage to other services as determined by Triage
- Disposition planning
- Voluntary and WI Code 5150 mental health services lasting less than 24 hours to a person in a psychiatric emergency due to a mental health condition.

Discharge Criteria:

- Discharge occurs when beneficiary no longer meets criteria for danger to others, danger to self and grave disability nor do they meet medical necessity.
- Can be discharged safely to a lower level of care.
- Must be connected to outpatient services, provided with referrals before discharge may occur.

A physician shall be on call at all times for the provision of those crisis stabilization services that may only be provided by a physician.

There shall be a minimum of one Registered Nurse, Psychiatric Technician or Licensed Vocational Nurse on site at all times beneficiaries are present.

At a minimum there shall be a ratio of at least one licensed mental health or waived/registered professional on site for each four beneficiaries or other patients receiving crisis stabilization at any given time.

If crisis stabilization services are co-located with other specialty mental health services, persons providing crisis stabilization must be separate and distinct from persons providing other services.

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Persons included in required crisis stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services. CCR, Title 9 1840.348

Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services are reimbursed.

The maximum number of hours for claimable for Crisis Stabilization in a 24-hour period is 20 hours. CCR Title 9 1840.368

Inpatient Services for Medi-Cal Beneficiaries

Pre-Authorization Through Optum

Inpatient service providers must secure pre-authorization for all inpatient services for Adults/Older Adults through the Optum Provider Line, 1-800-798-2254, option # 3, except:

- Emergencies/Urgent Services
- Clients directed by the San Diego County Psychiatric Hospital Emergency Psychiatric Unit (EPU) to the FFS Hospitals
- Intoxicated clients who will be assessed within 24 hours to determine the etiology of their symptomatology
- Medicare clients who convert to Medi-Cal on the Medi-Cal eligible date.

Medical Necessity for Adult/Older Adult Inpatient Services

Adult/Older Adult inpatient services are reimbursed by the MHP only when the following criteria are met, as outlined in Title 9, Section 1820.205.

- The client must have an included Title 9 diagnosis that is reimbursable for inpatient services as described in Title 9, Section 1830.205(1).

AND

Both of the following:

- The condition cannot be safely treated at a lower level of care;
- Psychiatric inpatient hospital services are required as a result of a mental disorder and the associated impairments listed in 1 or 2 below:
 1. The symptoms or behaviors:
 - a. Represent a current danger to self or others, or significant property destruction;
 - b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter;

- c. Present a severe risk to the beneficiary's physical health;
 - d. Represent a recent, significant deterioration in ability to function.
- OR
- 2. The symptoms or behaviors require one of the following:
 - a. Further psychiatric evaluation; or
 - b. Medication treatment; or
 - c. Other treatment that can be reasonably be provided only if the patient is hospitalized.

Inpatient Services for Non Medi-Cal Eligible Clients (Non-insured)

Clients without Medi-Cal eligibility or the means or resources to pay for inpatient services are eligible for realignment-funded services and are referred to the San Diego County Psychiatric Hospital or to the Emergency Psychiatric Unit for screening. Both facilities are located at 3853 Rosecrans Street, San Diego, California 92110. The telephone number is (619) 692-8200. These are County-operated facilities.

Crisis Residential Services

The MHP, through its contracted provider, operates Crisis Residential Services, which are considered a “step down” or diversion from inpatient services. Crisis residential services are provided to both Medi-Cal and non-Medi-Cal clients who meet medical necessity and admission criteria. Referrals for services can be made directly to the Crisis Residential intake staff and do not require pre-authorization from Optum. More information about the locations and services provided by the Crisis Residential Programs may be obtained from the Network of Care website (www.networkofcare.org) or at the contractor's website, Community Research Foundation (www.comresearch.org).

Mental Health Services to Parolees

On a regular basis, individuals are discharged on parole from California State penal institutions; the list of institutions can be located on the Optum Website. In many instances, these persons are in need of mental health services. State law requires the California Department of Corrections to establish and maintain outpatient clinics that are designed to provide a broad range of mental health services for parolees. Sometimes, parolees are not aware of the availability of these services and present themselves to the County of San Diego Mental Health Services (MHS) outpatient clinics for their mental health needs. It shall be the responsibility of staff to ensure that all parolees from California State penal institutions who present for mental health services at a San Diego County program are appropriately served, or referred for service, in accordance with

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federal, State and County regulations as set out in the following guidelines:

Parolees who fall under the Forensic Conditional Release Program (CONREP) will be provided services in accordance with the current contract between the California Department of Health Care Services and the County of San Diego.

1. Parolees who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.
2. Parolees with Medi-Cal coverage can receive inpatient services at any County-contracted acute care hospital. Indigent parolees can receive inpatient services at the San Diego Psychiatric Hospital.
3. Parolees who are Medi-Cal beneficiaries and who meet specialty mental health medical necessity requirements, as specified in CCR, Title 9, Section 1830.205, will be provided appropriate Medi-Cal covered mental health services.
4. Parolees, whether or not they are Medi-Cal beneficiaries, who do not meet specialty mental health medical necessity requirements will be referred for services at the local Department of Corrections-established outpatient mental health clinic, which is designed to meet the unique treatment needs of parolees, or to another health care provider.
5. Parolees who are not Medi-Cal beneficiaries and who do meet specialty mental health medical necessity requirements will be informed of the availability of services at the local Department of Corrections-established outpatient mental health clinic, and may choose to receive services from either County Mental Health or from the local Department of Corrections outpatient mental health clinic.
6. The California Welfare & Institutions Code, Section 5813.5 (f), explicitly prohibits the use of Mental Health Services Act (Proposition 63) funds for services to parolees. Managers of County and contracted programs which receive MHSA funding, are, therefore, responsible for ensuring that no MHSA funds are utilized for services to parolees from State prisons.

Correctional Program Checklist (CPC)

As directed by COR, contractor will fully participate in the Corrections Program Checklist (CPC) to improve treatment quality for clients who are assessed to be moderate to high risk for recidivism. Additional information regarding the CPC is found in the Technical Resource Library.

Mental Health Services to Veterans

Federal law has established the Department of Veterans Affairs (USDVA) to provide benefits to veterans of armed services. In 1996, the U.S. Congress passed the Veterans' Health Care

Eligibility Reform Act, which created the Medical Benefits Package, a standardized, enhanced health benefits plan (including mental health services) available to all enrolled veterans. A prior military service record, however, does not automatically render a person eligible for these benefits. Only veterans who have established eligibility through the USDVA and have enrolled may receive them. In recognition of the fact that there are veterans in need of mental health services who are not eligible for care by the USDVA or other federal health care providers, the legislature of the State of California in September 2005 passed AB599, which amended section 5600.3 of the California Welfare and Institutions Code (WIC). Specifically, veterans who are ineligible for federal services are now specifically listed as part of the target population to receive services under the mental health account of the local mental health trust fund (“realignment”). California veterans in need of mental health services who are not eligible for care by the USDVA or other federal health care provider and who meet the existing eligibility requirements of section 5600.3 of the WIC shall be provided services to the extent resources are available. It shall be the responsibility of staff to ensure that all veterans who present for mental health services at a San Diego County program are appropriately assessed and assisted with accessing their eligible benefits provided through the USDVA or other federal health care program or are referred and provided services through a San Diego County program.

Referral Process for Providing Mental Health Services to Veterans

1. **Adult/Older Adult Mental Health Services:** Staff will ask client if he or she is receiving veterans’ services benefits. If the client state he or she is receiving benefits or claims to have serviced in the military, the staff will be responsible for completing the following procedure:
 - a. The staff will complete “Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form” that will contain all appropriate demographic information and required client signature.
 - b. The form shall be faxed to the Veterans Service Office for verification at (858) 505-6961, or other current fax number.
 - c. If an urgent response is required, the mental health provider shall note on the Request Form in the Comment Section and contact the office by telephone after faxing the Request Form. All individuals who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.
 - d. If the client meets the eligibility criteria for seriously mentally ill persons and is receiving veteran benefits but needs mental health services not offered by the USDVA, the client can be offered mental health services.
 - e. If the client meets the eligibility criteria for seriously mentally ill persons and eligibility for veterans’ services is pending, the client can be offered mental health services until the veterans services benefit determination is completed.

2. **Veterans Service Office:** The Veterans Service Office will receive the “Request for Verification Eligibility to Counseling and Guidance Services Fax Form” confirming client’s eligibility or ineligibility for veterans’ services and mail or fax findings to the County mental health program or contracted program.
 - a. The Veterans Service Office will respond to the Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form within two to three business days upon receipt of the Fax Request.
 - b. The Veterans Service Office will make referrals for benefit determination for an individual upon verification of eligibility status for veterans’ services. The Veterans Service Office will also assist individuals in getting an appointment set up for evaluation of services if needed.

Missed Appointments and Follow Up Standard

All providers shall have policies and procedures in place regarding the monitoring of missed scheduled appointments for clients (and/or caregivers, if applicable). These policies and procedures shall cover both new referrals and existing clients, and at minimum, include the following standards:

- **For new referrals:** When a new client (and/or caregiver, if applicable) is scheduled for their first appointment and does not show up or call to reschedule, they will be contacted within 1 business day by clinical staff. If the client has been identified as being at an elevated risk¹, the client (or caregiver, if applicable) will be contacted by clinical staff on the same day as the missed appointment. Additionally, the referral source, if available, should be informed.
- **For current clients:** When a client (and/or caregiver, if applicable) is scheduled for an appointment and does not show up or call to reschedule, they will be contacted within 1 business day by clinical staff. If the client has been identified as being at an elevated risk¹, the client (or caregiver, if applicable) will be contacted by clinical staff the same day as the missed appointment. For clients who are at an elevated risk¹ and are unable to be reached on the same day, the program policy needs to document next steps, which may include consultation with a supervisor, contacting the client’s emergency contact, or initiating a welfare check. Additionally, the policy shall outline how the program will continue to follow up with the client (or caregiver, if applicable) to re-engage them in services, and should include specific timeframes and specific types of contact (e.g., phone calls, letters). Staff should continue to monitor CCBH’s Admissions report in an attempt to locate the client within the system of care (e.g., hospital, PERT or jail admissions).

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. **Elevated risk** is to be defined by the program and/or referral source.

Utilization Management

The MHP delegated responsibility to County-operated and contracted organizational providers to perform utilization management for, outpatient, crisis residential and case management services. Decisions are based on the medical necessity criteria delineated in Title 9 of the California Code of Regulations. The MHP monitors the utilization management activities of County-operated and contracted organizational providers to ensure compliance with all applicable State and federal regulations.

The Utilization Management for all service providers (outpatient, crisis residential, case management) includes procedures for establishing a Utilization Review Committee (URC), standards for participation in the URC, logs for URC activities, and standards for authorization. Although there are slight variances in the utilization review process conducted by different service providers based on level of care, all programs participating in utilization review shall adhere to the following guidelines:

- Utilization review is a “never billable activity”
- URC logs are to be maintained at each program that record the results of the UR process
- URC logs are to be made available for review as needed by the MHP
- A clinician cannot participate in the authorization decisions regarding their own client
- Questions pertaining to the UR process should be directed to the Adult QI unit.

The Utilization Review procedures for Crisis Residential, Outpatient and Case Management programs are outlined below. All applicable forms and logs necessary to perform the Utilization Review process are located on the Optum Website.

Utilization Review for Crisis Residential Programs

Each crisis residential program, referred to as Short Term Acute Residential Treatment (START) program, shall convene a Utilization Review Committee (URC) to review all admitted clients in order to authorize services on an ongoing basis. The URC shall be multi-disciplinary and shall include, at a minimum, one licensed clinician designated by the Program Director to serve as the chair of the URC, as well as a minimum of two additional staff members who provide direct services or clinical oversight. Each URC shall meet 2-3 times per week, in conjunction with the START program’s Treatment Coordination Committee (TCC) meeting. All clients will be reviewed by the program’s URC within 3 days when possible, but no later than the 5th day after admission, in order to determine initial responsiveness to the services as well as set a projected length of stay and discharge date. Additionally, at a weekly minimum, all clients will be reviewed for ongoing medical necessity by the URC. Clients will be invited to attend the TCC/URC meeting when their treatment is being discussed. Should clients not want to attend the meeting with the

URC members, staff will have input from the client prior to the meeting and will meet with the client again following the meeting in order to review the results. A “TCC/URC Record” will be created for each client and filed in the front of the progress notes section of the client’s medical record. Additionally, “URC Minutes” will be maintained.

Utilization Review for Outpatient Programs

Beginning July 1, 2010, the MHP implemented a policy change affecting the Adult/Older Adult Mental Health Services (AOAMHS) utilization review process. The purpose of this new policy is to reinforce a change of the primary focus of current County Mental Health-funded (AOAMHS) outpatient clinic practices to recovery-oriented brief treatment and establish the requirement for implementing the Utilization Management process. In connection with this policy, clients who still require services but who are stabilized and able to function safely without formal County Mental Health outpatient services will be referred to a primary care setting or other community resources for services. It is the expectation of AOAMHS that most clients shall receive brief treatment services that focus on the most critical issues identified by the clinician and client and that services will conclude when clients are stabilized.

Outpatient Guidelines:

I. Brief Solution-Focused Outpatient Services

Outpatient clinic services that shall be targeted as brief or time-limited include brief solution-focused individual and/or group treatment, individual and/or group rehabilitative services, and medication management as appropriate for stable clients who may be referred elsewhere for services. Services that may be delivered include:

- Clinical triage
- Assessment
- Possibility of up to 12 Therapy/Rehabilitative Sessions, which may include individual therapy or rehabilitation but with an emphasis on group/rehabilitation treatment as indicated. The number of services noted above (up to 12) is a recommendation and not a maximum number of services allowable.
- Group therapy
- Case Management
- Medication support as indicated
- Outpatient Biopsychosocial Rehabilitation Programs (OP/BPSR) are authorized to provide primarily individual and group rehabilitation, collateral, medication support, case management brokerage and occasional crisis intervention services.
 - OP/BPSR programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity and some psychotherapy.

Within one month after the first planned visit, an Assessment and Client Plan shall be completed. If, after completing the assessment, the clinician determines that medical necessity criteria for specialty mental health services are not met, the client will be issued an NOA-A (see more complete description of the process in the Beneficiary Rights and Issue Resolution chapter of this Handbook) and his/her beneficiary rights shall be explained.

Clients receiving services which are Evidence-Based may be exempted from the following Utilization Management process with consent form the Program or Contract Monitor. Clients will receive appropriate support and services to ensure that transition to other services are successful.

Clients who are referred elsewhere for medication or psychology services may still access County Mental Health-funded case management, peer support, and clubhouse services.

II. Initial Eligibility for Services

Initial Eligibility for Urgent and Routine Services will be based on meeting the criteria for:

- Title 9 Mental Health Medical Necessity,
- The AOAMHS Target Population-
Individuals we will serve:
 1. Individuals with a serious psychiatric illness that threatens personal or community safety, or that places the individual at significant risk of grave disability due to functional impairment.
 2. People with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and/or who require unusually complex medication regimens. Required psychosocial services may include illness management; or skill development to sustain housing social, vocational and educational goals.

This criterion applies to all clients including Medi-Cal and indigent clients

III. Eligibility for Ongoing County or Contracted Program Outpatient Services

To continue beyond limited brief sessions clients shall be reviewed through a Utilization Management process and meet the following three criteria

1. Continued Mental Health Medical Necessity, with proposed intervention/s significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning.
2. Meet Target Population Criteria
3. MORS- rating guideline of 5 or less **OR** an approved Utilization Management Form documenting justification for on-going services for clients with MORS of 6, 7, or 8 which includes at least one continuing current Risk Factor related to client's primary diagnosis:

- a. Client has been in Long-Term Care, had a psychiatric hospitalization, or was in a Crisis Residential facility in the last year.
- b. Client has been a danger to self or to others in the last six months.
- c. Client's impairment is so substantial and persistent that current living situation is in jeopardy or client is currently homeless.
- d. Client's behavior interferes with client's ability to get care elsewhere.
- e. Client's psychiatric medication regimen is very complex.
- f. Client is actively using substances.

IV. Utilization Management process for Outpatient Programs:

Clients shall meet specific criteria and be reviewed through a Utilization Management (UM) process which shall be conducted internally by a Utilization Review Committee (URC) at all County and county contracted outpatient clinics.

- **Provision of services shall be reviewed for clients based on follow criteria:**
 1. MORS rating of 6 or higher must go through Utilization Management
 - a. Clients with a MORS rating of 6 to 8 will be referred out of the County or County contracted outpatient clinic for ongoing services unless an exception is made (see exception noted below).
 - b. If a client receives a MORS rating of 6 to 8 but the primary provider believes that the client should continue to receive services at the county or contracted outpatient clinic the primary provider may request Utilization Review Committee (URC) to review client's case and justify ongoing services if applicable. [Note that someone with a MORS rating of 8 would probably be better supported at a lower level of care.]
- **While not required, the provision of services may be reviewed for clients based on one or more of the follow criteria:**
 2. Clients with unchanged MORS rating
 3. Clients who have been enrolled in program services for 2 years or longer
 4. Treatment Team recommendation.
 - a. URC may review client's that meet the above criterion in order to determine appropriateness for ongoing services or transition to a lower level of care.
- **For continued authorization of ongoing services, the following criteria must also be met:**

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- a. Continued Medical Necessity with demonstrated benefit from services.
- b. Meet Target Population Criteria.

Utilization Review Committee (URC)

Programs are required to have an internal URC in place to review records and conduct UM process. URC shall follow the guidelines below:

- a. Review quarterly a minimum of 5 clients.
- b. A review of services, treatment plan, and the Utilization Management Form shall be completed in order to support determination and document the results of the Utilization Review Committee.
- c. Client service review shall be performed through CCBH *Client Services Report*. [Note that clients who have not received services for six months or longer should be considered for discharge.]
- d. Utilization Management Form shall be reviewed by program manager or designee within 5 business days.
- e. Program manager or designee shall be licensed.
- f. Program manager or designee may agree with primary provider or may recommend a different level of service.
- g. Final determination shall be made after agreement by program manager or designee and primary provider.
- h. The Utilization Management Form shall be kept in the client record.
- i. At the time of your Medical Record Review, QM Specialists will review client Utilization Management Forms in addition to programs quarterly URC process.

Clients who have been approved for ongoing services by the URC shall remain on an UM cycle to be completed annually in order to determine continued eligibility for services.

V. Outcome Measures

The following outcome measures shall be employed in order to inform the Utilization Management process. These measures are completed at assessment (within 30 days of admission) and every 6 months thereafter by all County and County contracted outpatient providers.

1. **Recovery Markers Questionnaire (RMQ)**
2. **Illness Management and Recovery (IMR)**
3. **Milestones of Recovery Scale (MORS)**

- a. Clients with a MORS rating of 1 to 5 will be qualified to receive ongoing services at the County or Contracted outpatient clinic.

- b. The MORS rating shall be kept in the client record

Time spent with the client completing outcome measures may be claimed as part of another direct client service when the information obtained from the outcome measure is used for UM/UR review. Documentation shall demonstrate how the information was used for furthering the clinical assessment or for planning, guiding or developing treatment.

Utilization Review for Case Management Programs

Each case management program shall convene a URC to review the provision of services on a concurrent basis. The URC shall decide issues of medical necessity, continuation of treatment and level of case management services. These decisions will be based on CCR, Title 9 Medical Necessity Criteria for diagnosis, impairment and interventions and Case Management Service Level Criteria. Decisions shall be supported by chart documentation of the client's individual functioning level, symptoms, and needs.

The URC shall consist of a minimum of three staff persons. The chair of the URC shall be a licensed/registered/waivered mental health clinician. Additional members shall be two or more staff who provides direct services or clinical oversight. A clinician shall not participate in the authorization decisions of his or her client. The QI unit may identify cases for review.

Initially, all clients who have been receiving case management services for more than two years shall be reviewed by the URC. The URC may only authorize up to one year of service at the same level. Conservatees do not have to be reviewed by the URC as they are reviewed annually by the Superior Court for continuing grave disability.

Prior to the utilization review of the client, the case manager will complete the *Six Month Review and Progress Note* verifying that the client meets medical necessity and service necessity criteria. This will summarize necessary information in order to assist with the URC review. Case managers will prepare cases for URC review by the first of the month of their annual review when the admission date to the current program was two or more years ago. The Program Manager/Supervisor will develop a list of clients due for review each month and will notify the case manager and the URC of the cases to be reviewed. The URC will notify the program and case managers of the date and time of the URC and have the charts gathered accordingly.

A *Case Management URC Record* shall be created for each client reviewed and filed in the front of the progress notes of the client's chart. This URC record will provide a summary of clinical information that supports the authorization decision. The *URC Minutes for Case Management* shall summarize the outcomes of the cases reviewed. These minutes will be maintained in a designated file. The file shall be available for review as needed by the QI unit.

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CHILDREN'S SYSTEM OF CARE

All authorization requirements in this section must be completed for all treatment clients even if the services will be funded by a source other than Medi-Cal, such as SB 163 and Mental Health Services Act (MHSA).

SCREENING

All referrals shall be **screened** by a clinician for appropriate level of care. Brief screening will be conducted without an episode opening and done on the phone unless the caregiver/youth is a walk in. Screening will facilitate timely and appropriate services which are family centered and support maximizing capacity at the Organizational Provider level. Direct referrals from the Access and Crisis Line (ACL) do not require program screening as screening was completed by the ACL, and therefore an assessment appointment shall be offered. To determine level of care, clinician brief screening (non-billable activity) will consider:

- Risk of Harm
- Functional Status
- Co-Morbidity
- Environmental Stress and Support
- Resiliency and Treatment History
- Caregiver Acceptance and Engagement

Based on brief screening, the appropriate level of care will be determined and communicated to the caregiver/youth. In addition to the use of natural community resources, the **Outpatient Level of Care** consists of:

Clinical Presentation	Appropriate Provider	Session Level	Notes
Non-Complex calling for medical intervention	Primary Care Physician (PCP) Medical Home Health Plans	TBD by medical team	
Non-Complex need	Fee For Service (FFS) Network via Access and Crisis Line (ACL)	Roughly 6 to 12 sessions	Organizational Provider calls the ACL to inform of screening/recom mendation
Complex needs Medical Necessity met	Organizational Provider	Up to 13 sessions	UM is required annually, if 13 sessions are not used

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			within 12-month period.
Severely Emotionally Disturbed (SED) Pervasive impairment	Organizational Provider	Up to 26 sessions	Require program level UM
Current Risk Factors	Organizational Provider Ancillary Services	27 Sessions and beyond	Require COR UM approval
<p>Children/Youth who present with safety risk factors may require a 911 contact and/or an evaluation at the Emergency Screening Unit (ESU) to determine need for crisis stabilization or inpatient psychiatric care.</p> <p>For Medi-Cal Specialty Mental Health Services: For children and youth up to age 21, a lower threshold of severity as defined by EPSDT is applied.</p>			

For detailed information, instruction and requirements regarding authorization of outpatient services see the Optum Website. CYF Outpatient Level of Care, Brief Treatment Model.

MEDICAL NECESSITY

Provider must demonstrate that each client receiving Specialty Mental Health services meets medical necessity. Authorization is performed through the MHP Utilization Management Process, using Title 9 (Section 1830.205) Medical Necessity criteria as summarized below. A complete description of Title 9, Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services can be found on the State website at www.calregs.com. For a copy of Title 9, please call the State Office of Administrative Law at 916-323-6225. Services provided to clients are reimbursable when the following criteria are met:

Outpatient and Day Services Clients:

The client must have a diagnosis included in the current Diagnostic and Statistical Manual that is reimbursable for outpatient and day services as described in Title 9, Section 1830.205 (1).

AND

The client must have at least one of the following as a result of the mental disorder(s):

- A significant impairment in an important area of life functioning,
- A probability of significant deterioration in an important area of life functioning, or
- A probability that the client will not progress developmentally as is individually appropriate (for Medi-Cal beneficiaries under age 21).

AND

All of the following:

- The focus of proposed intervention is to address the impairment or potential impairment identified immediately above,
- The proposed intervention is expected to benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning, and
- The condition would not be responsive to physical healthcare treatment.

Seriously Emotionally Disturbed (SED) Clients:

The priority population for Children's Mental Health Services, including clients seen under MHSA, is seriously emotionally disturbed (SED) children and youth. SED clients must meet the criteria for medical necessity and further are defined as follows (per California Welfare & Institutions Code Section 5600.3):

For the purposes of this part, seriously emotionally disturbed children or adolescents are those who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

- A. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
 - The child is at risk of removal from home or has already been removed from the home.
 - The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
- B. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

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C. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

OUTPATIENT SERVICES

Outpatient Short Term Model

One of the overarching Health and Human Services Agency (HHS) principles is efficient and effective access to our target populations. CYFS clients receive brief treatment services that focus on the one or two most important issues identified by the client/family and conclude when those are stabilized. The short term, focused model shall be communicated at the onset of treatment so the client/family can maximize use of sessions and be prepared for conclusion of treatment.

Clients who meet the criteria for Title 9 medical necessity shall be eligible for up to 13 individual treatment sessions or up to 18 exclusively family and/or group treatment sessions (within a 12 month period). This will apply to Medi-Cal and MHSA (indigent) Severely Emotionally Disturbed (SED) clients. Additional sessions may be authorized as clinically indicated. Utilization Management shall be completed at the program level by a licensed clinician.

For detailed information and requirements regarding authorization of outpatient services, see the Optum Website.

Authorization for Reimbursement of Services

The San Diego County MHP defines Children, Youth and Families Services (CYFS) clients as children and youth up to 21 years of age. Providers shall evaluate TAY clients to determine if child or adult network of care would best serve their needs as well as explore TAY specific resources. Clients and families may access the services of organizational providers and county-operated facilities in the following ways:

- Calling the organizational provider or county-operated program directly
- Walking into an organizational provider or county-operated program directly
- Calling the Access and Crisis Line at 1-888-724-7240

A client/family may access services by calling or walking into an organizational provider or county-operated program; the client shall be screened and when applicable assessed by the provider. After completion of an assessment and when additional services are offered, that provider is responsible for entering administrative and clinical information into all the appropriate fields in the Management Information System (MIS). Providers must register clients, record assignment and service activities, and update the CSI information in MIS. (See the Management

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Information System section of this handbook for a description of how MIS supports these provider activities.)

If, after completing the assessment, the clinician determines that medical necessity criteria for specialty mental health services are not met, the Medi-Cal beneficiary shall be issued an **NOABD-A** and **NOABD-Back** (which must also be documented in the **NOABD-A Log** tab of the Quarterly Status Report and their beneficiary rights shall be explained. If a client will receive day services (either intensive or rehabilitative) on the same day that the client receives Mental Health Services (Individual, Group, Family, or Collateral. Etc.), authorization for the Mental Health Service must be determined in accordance with the Day Treatment Ancillary UR process applicable to outpatient providers. Authorization is obtained from Optum through the day treatment provider. (See Utilization Review.)

If the Access and Crisis Line (ACL) refers a client to an organizational provider or to a county-operated facility, ACL enters the client information in the MIS. The provider is then responsible for insuring all client information is correct and complete. The provider is also responsible for recording all ongoing activity for that client into the MIS. This information includes, but is not limited to, assignment and service activities, the primary diagnosis, the name of the single accountable individual, and all client assignment closings.

Utilization Management

The MHP has delegated initial responsibility to outpatient County operated and contracted organizational providers to perform utilization management for specialty mental health services, outpatient services, medication services, and case management services. Authorization decisions are based on the medical necessity criteria delineated in Title 9 of the California Code of Regulations. Each delegated entity shall be accountable to the Behavioral Health Services Division Director and shall follow the Utilization Management processes established for children's mental health programs.

At the time a client is admitted to a program, clinicians shall perform a face-to-face assessment to ensure that each new client meets medical necessity criteria and SED when applicable for specialty mental health services. The clinician shall complete the County's applicable Behavioral Health Assessment Form and ensure that all required domains are completed.

The Utilization Management Committee operates at the program level and must include at least one licensed clinician. The Utilization Management Committee bases its decisions on whether medical necessity is still present, whether the proposed services are likely to assist in meeting the Client Plan goals, and additional criteria from the *Utilization Review Request and Authorization*. To assist in its determination, the Utilization Management Committee or clinician receives a UM Request and Authorization form (which reports current client functioning in quadrants for various

domains) and a new Client Plan to cover the interval for which authorization is requested. Medication only clients are not included in the Utilization Management process as they are subject to medication monitoring. For detailed information and requirements regarding Utilization Management for outpatient programs see the Optum Website.

Secondary UM review is reserved for clients who demonstrate ongoing, high severity and require additional services to maintain safety. The level of review generally occurs at 26 session level and conducted by the MHP through the COR. Providers shall monitor percentage of initial and secondary UM (reported in QSR) to evaluate compliance with brief treatment philosophy.

If client is concurrently provided day and outpatient services, then ancillary authorization must occur through day program and Optum because the day services cycle supersedes outpatient UM. In these cases, the outpatient program must also complete a UR in accordance with the procedure described in CYF Outpatient Level of Care.

Medication Only Services

The MHP has delegated the responsibility to outpatient County operated programs and contracted providers to assure proper enrollment, services and monitoring of children and youth who are receiving only medication support and have no therapist or case manager involved.

Children and adolescents, as a result of their rapid development, should receive a thorough assessment as a part of any clinical service, and for most, services should include a full spectrum of treatment services, including psychotherapy, designed to reduce or ameliorate symptoms and functional impairment. However, a small number of youth may have chronic conditions for which periodic breaks in treatment are appropriate. For those that require ongoing medication treatment even during such a hiatus, outpatient providers shall leave the assignment open with the psychiatrist designated as the primary server. Such cases are not subject to utilization review/management but are subject to medication monitoring and additional peer review if the situation is unusually prolonged. Children and adolescents who have completed an assignment of psychotherapy and been retained as a medication only client must have rapid access to a resumption of therapy if a need should arise.

Procedure for Medication Only Clients:

1. Clients who have never had an open assignment in the program receiving the referral should not be opened as medication-only clients without previous approval from the Contracting Officer's Representative (COR). In these cases a complete and up to date Behavioral Health Assessment must be in the client chart. Additionally, once treatment plans are implemented

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in the Management Information Service (MIS) or Electronic Health Record (EHR) a client plan must be in place to cover medication only services.

2. When the child or adolescent has a therapist in a different organizational provider program, that program shall be contacted as to why the needed medications are not being provided by the assigned therapist's program
3. If the child's therapist is a fee-for-service provider, the child's legal representative shall be provided the number to the Access and Crisis Line for assignment to a fee-for-service psychiatrist.
4. In the event that service goals have been met, that a Utilization Review/Management (UR/UM) Committee has denied further therapy sessions, or if in the opinion of the therapist, client, and caregiver, a break in psychotherapy treatment is appropriate, the client shall be assessed for the need for ongoing medication support. Criteria for requiring such support shall include:
 - a) The client has been stabilized on a medication regime for a minimum of three (3) months under the care of the provider's staff psychiatrist;
 - b) In the opinion of the prescribing psychiatrist, the child or adolescent would experience an exacerbation of symptoms or impairment if removed from the medication;
 - c) The child's primary care physician is unable or unwilling to continue the medication, even with consultation from the program psychiatrist;
 - d) The continuation of medication support is desired by the client and caregiver; and
 - e) For School Based clients, clinician shall have the outpatient services removed from the student's Individual Education Program (IEP).
5. When the decision is to continue the case as medication-only, within the same Unit/SubUnit, the case shall remain open, but the previous therapist shall complete a discharge summary stating that continuing medication support is necessary. In the MIS, the name of the server shall be updated to reflect the name of the physician. Crisis Intervention visits may be offered by the previous therapist or other staff during a medication-only interval without utilization review/management requirements.
6. Documentation for a medication only case shall include: a complete and up to date Behavioral Health Assessment, Psychiatric Assessment (completed on initial medication evaluation and for each follow up medication management session), and an active Client Plan. Medication only cases are exempt from completion of Child and Adolescent Needs and Strengths (CANS), Pediatric Symptom Checklist (PSC) and Youth Services Survey (YSS).
7. Medication-only cases shall be billed using only the range of Medication Support service codes, except in the case of Crisis Intervention. In the event that case management or formal

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assessment is required in addition to Medication Support, the case no longer meets the criteria of medication-only and routine charting and authorization procedures shall be followed.

8. Medication-only cases are not subject to UR/UM, but cases open in this status for 12 months or more shall be reviewed annually by the Medication Monitoring Committee. When reviewed by the Medication Monitoring Committee, the reviewer shall consider:
 - a) Whether the child's age, health status, and emotional functioning continue to support the need for ongoing medication treatment.
 - b) Whether a return to active psychotherapy is indicated.
9. If a client who has been receiving medication-only services should experience an increase in symptoms or impairment, or if the course of the client's development suggests that an interval of active psychotherapy is likely to be helpful, the case shall be reviewed to determine if a current UR/UM authorization is in place.
 - a) When authorization is in place, therapy may resume, however a new Client Plan is indicated.
 - b) When authorization has expired, the UR/UM Committee must first authorize services for billing of therapy to resume.
 - c) In the MIS (EHR) the name of the server shall be updated to reflect the name of the current clinician.

SCHOOL INTERFACE

Effective 7-1-12 CYFS is no longer contracted through County Office of Education to provide Educational Related Mental Health Services (ERMHS) which is in line with repeal of AB2726/3632 in October of 2010. Students with mental health needs are assessed through the school system and when appropriate are offered related services through the school district so they can benefit from their education. Students receiving services through the school may also access CYFS services when they meet specialty mental health criteria through the County system. CYFS standard of practice is to offer a full range of services which may include medication services as well as services which are educationally related and therefore coordination of care with the school continues to be critical.

INTENSIVE SERVICES

Day Rehabilitation - a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries and is available at least four hours and less than 24 hours each day the program is open. Service activities may include,

but are not limited to, assessment, plan development, therapy, rehabilitation and collateral. See a more detailed list of required services below. Program design promotes a therapeutic milieu which is a therapeutic program with specified service components and specific activities performed by identified staff. The program must operate for more than four continuous hours for a full-day program and a minimum of three continuous hours for a half-day program. The therapeutic milieu must be made available for at least a weekly average of three hours per day for full-day programs and an average of two hours per day for half-day programs. The milieu includes staff and activities that teach, model and reinforce constructive interactions, includes peer and staff feedback to clients on strategies for symptom reduction, increased adaptive behavior, and stress reduction, and includes client involvement and behavior management interventions.

Day Intensive - a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting, with service available at least three hours for half-day programs, four hours for full-day programs and less than 24 hours each day the program is open. Service activities may include, but are not limited to assessment, plan development, therapy, rehabilitation and collateral. See a more detailed list of required services below. Program design promotes a therapeutic milieu which is a therapeutic program with specified service components and specific activities performed by identified staff. The program must operate for more than four continuous hours for a full-day program and a minimum of three continuous hours for a half-day program. The therapeutic milieu must be made available for at least a weekly average of three hours per day for full-day programs and an average of two hours per day for half-day programs. The milieu includes staff and activities that teach, model and reinforce constructive interactions, includes peer and staff feedback to clients on strategies for symptom reduction, increased adaptive behavior, and stress reduction, and includes client involvement and behavior management interventions.

Day School Services – an intensive outpatient program that includes a full range of short-term Title 9 specialty mental health services including assessment, evaluation, plan development, collateral, individual/group/family therapy, rehabilitation, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), crisis intervention, and case management services. These services are provided to children and youth identified through an IEP or school district process as needing a Special Education Classroom setting to be successful in school. Services are intensive and flexible to meet the needs of the client and assist in transitioning to a less restrictive classroom setting.

Residential OP – an intensive outpatient program within a residential milieu that includes a full range of short-term Title 9 specialty mental health services including assessment, evaluation, plan development, collateral, individual/group/family therapy, rehabilitation, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), crisis intervention, and case management services. These services are provided in a group home facility/ Short-Term

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Residential Therapeutic Program (STRTP). Services are intensive and flexible to meet the needs of the client and assist in transitioning to a less restrictive, community based or family care setting.

Authorization Process for Intensive Services

(Day Treatment Intensive, Day Rehab, Day School Services and Residential OP Services)

Prior to admission to the program, each client must have

- a face-to-face assessment to establish medical necessity,
- an assessment that documents a recommendation for applicable level of care (day or outpatient),
- documentation that lower levels of care have been tried unsuccessfully or would be unsuccessful if attempted,
- documentation that highly structured mental health program is needed to prevent admission to a more intensive level of care.

The initial Intensive Service Request (ISR) is to be completed and submitted to Optum within 3 calendar days of the start of services and re-authorized every 3 months (for Day Treatment Intensive, Day School Services, and Residential OP) or 6 months (for Day Rehab), depending on the service being requested. For continuing authorization requests, the ISR form is submitted to Optum at least 15 calendar days before the previous authorization expires. The Intensive Service Request (ISR) form is located on the Optum Website under UCRM tab.

The Intensive Service Request essentially state that the client cannot be served at a lower level of care and that a recommendation for intensive services has been made. If medical or service necessity criteria are not met, the Medi-Cal client will be issued an NOABD-A (which must also be documented in the NOABD log) and the beneficiary rights shall be explained. In the event that the provider has received a denial of authorization from Optum, a NOABD-B shall be issued by Optum.

Intensive Service Request (ISR) Information

- Initial authorizations may not be submitted prior to the opening of the assignment.
- All clients receiving services in Day Rehab, Day Treatment Intensive, Day School Services (DSS), or Residential Outpatient (OP) will require an Intensive Service Request.
- Authorization cycles are based on months and not days (i.e. for Day Treatment Intensive an authorization cycle may look like: Initial Intensive Service Request (ISR) 1/1/08-3/31/08 and Continued ISR 4/1/08-6/30/08. For Day Rehabilitation Intensive Service Request (ISR) 1/1/08- 6/31/08, Continued ISR 7/1/08 – 12/31/08, etc.).

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- Optum will review the ISR and determine authorization within 7 business days. The provider may contact Optum if there are questions. The signature page of the ISR will be faxed back to the program upon authorization.
- Authorization will include intensive services and, when applicable, ancillary services for each client. Authorizations for intensive and ancillary services are entered separately based on the timeline of the receipt of the request by Optum.
- It is the responsibility of each program to determine insurance coverage (or lack of) in order to decide which process to follow:
 - ISRs are faxed to Optum for review for the following situations:
 - Client has Medi-Cal
 - Clients with primary private insurance and secondary Medi-Cal AND the primary private insurance has provided a denial of payment (only then can Medi-Cal be billed for services)
 - ISRs are NOT sent in to Optum for the following situations:
 - Clients with no insurance
 - Clients with a primary private insurance
 - Clients with a primary private insurance and secondary Medi-Cal (AND the parents have declined to sign an Assignment of Benefits)
- Letters of denial of authorization will be sent to the program for the following reasons:
 - Client does not show as Medi-Cal eligible
 - Client has a primary private insurance
 - Client has a primary private insurance and secondary Medi-Cal – but no denial of payment has been provided by the private insurance (therefore Medi-Cal may not be billed).
- Programs are responsible to check on a monthly basis all Medi-Cal and UMDAP clients for eligibility and update the MIS as appropriate.
- ISRs should be filed in the medical record in the Plans section or be accessible upon request.
- Retroactive authorizations should not be requested for services more than 9 months in the past. Inform your COR via e-mail when submitting a retroactive authorization request.
- If any of the above is not done correctly, Optum will return the ISR for correction and services will not be authorized until the corrections are made and the form is faxed back to Optum for review.
- When the ISR Ancillary information is done incorrectly, Optum will send the ISR to the Day program with whom the outpatient program is coordinating.
- Questions regarding the ISR process may be directed to: Optum at (800) 798-2254 option #4.

Utilization Review

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Utilization review of day treatment intensive, day rehabilitation, day school services, and residential outpatient services for Medi-Cal clients is delegated to Optum.

Program Monitoring – The Quality Management Unit will monitor Day Treatment Programs in accordance with state standards. See attachments from DMH Letters and Notices for Day Treatment.

Monitoring includes but it not limited to:

- the annual collection of schedules, program descriptions and group descriptions for approval
- programs must submit any changes to the schedule, or group descriptions for review and approval

OUT OF COUNTY MEDI-CAL CLIENTS

Authorization of Reimbursement of Services

Children in foster care, Aid to Adoptive Parents (AAP), and Kinship Guardianship Assistance Payment Program (KinGAP), when placed outside their country of origin, have had difficulty receiving timely access to specialty mental health services. Assembly Bill (AB) 1299 and Senate Bill (SB) 785 intend to improve the timely access to services.

AB 1299 for Foster Youth: Establishes the presumptive transfer of responsibility and payment for providing or arranging mental health services to foster children from the county of original jurisdiction (placing county) to the foster child's county of residence.

MHSUDS Information Notice No. 17-032 (Dated 7/14/17)

SB 785 for AAP and KinGAP: Transfers the responsibility for the provision of specialty mental health services to the county of residence of foster, AAP and KinGAP children.

DMH Information Notice No. 08-24 and 09-06 (Dated 8/13/08 and 5/4/09)

Program Procedure(s) for Medi-Cal Eligible Children in Foster Care under AB1299: For foster children whose care is presumptively transferred to San Diego

1. Placing agency from the county of origin may instruct legal guardians to contact San Diego Administrative Services Organization (ASO), at 1-888-724-7240 for services referrals. The ASO makes a referral to a Fee-For-Service (FFS) or an organizational provider.
2. The placing agency informs Optum of the presumptive transfer.
3. The program providing the services submits the Service Authorization Request (SAR) to the county of origin MHP **as a notification**. The service provider shall begin to provide services

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once the notification is sent and is not required to wait until receiving the signed SAR from the county of origin.

4. If requested by the placing agency of the county of origin, the program will inform them of the services being provided, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.
5. Services shall be entered into the CCBH Management Information System (MIS) by the San Diego provider.
6. The County of San Diego will submit the claim for services directly to the State Department of Health Care Services via the MIS.
7. Intensive Service programs shall submit the notification SAR and the ISR to Optum.
8. Residential programs shall complete an AB1299 Admission and AB1299 Monthly Summary Report submitted to the COR by the 15th day of the following month.

Program Procedure(s) for Medi-Cal Eligible Children in AAP/KinGap under SB 785:

1. Placing agency from the county of origin may instruct legal guardians to contact San Diego Administrative Services Organization (ASO), at 1-888-724-7240 for services referrals. The ASO makes a referral to a Fee-For-Service (FFS) or an organizational provider.
2. The program providing the services will submit the Service Authorization Request (SAR) to the county of origin for authorization and signature.
3. For outpatient services, if county of origin SAR authorization is delayed, services may be provided when the reason for delay is administrative in nature and not a clinical denial.
4. If requested by the placing agency of the county of origin, the program will inform them of the services being provided, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.
5. Services shall be entered into the CCBH Management Information System (MIS) by the San Diego provider.
6. The County of San Diego will submit the claim for services directly to the State Department of Health Care Services via the MIS.
7. Intensive Service programs shall submit the notification SAR and the ISR to Optum.
8. Residential programs shall contact the COR for prior authorization for admission and confirm that out-of-county youth has a San Diego connection/caregiver.
9. Residential programs shall complete an AB1299 Admission and AB1299 Monthly Summary Report submitted to the COR by the 15th day of the following month which includes information about out of county KinGAP and AAP youth.

There are, in essence, two types of OOC Medi-Cal clients.

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1. OOC clients who fall under one of three aid codes (Foster Care, AAP, KinGAP). For those clients the program shall submit a SAR to the Mental Health Plan (MHP) from the County of Jurisdiction. The clients are subject to our local UM process and the services are entered into our MIS/CCBH.
2. OOC clients who do not fall under one of those codes need to have their Medi-Cal shifted to San Diego in order for programs to serve them. Programs need to get authorization from COR to serve those kids prior to Medi-Cal shifting to San Diego. When authorization is granted prior to the Medi-Cal shift it is with the expectation that program is actively and promptly working with guardian to have Medi-Cal shift to San Diego. No need to complete a SAR; follow local UM process.

Therapeutic Behavioral Services (TBS)

Clients are referred to New Alternatives, Inc. (NA), who is the point of contact for Therapeutic Behavioral Services (TBS). The referring party may include COSD SOC, CWS and Probation Department. The referring party will complete and return a referral form and Release of Information (Appendix A.D.21) to the Point of Contact/Referral Specialist. Referrals are then screened and assessed by Point of Contact/Referral Specialist for eligibility criteria according to California Department of Health Care Services guidelines provided in DMH Letter 99-03 and DMH Notice 02-08. Purpose of screening is to ensure client/family is Medi-Cal eligible and to confirm the client/family willingness to participate in the services. Point of Contact/Referral Specialist will then assign client/family to a Case Manager and the referring party is updated in the process. The provider assigned to the client/family will conduct assessment to ensure client meet the class, service, and other TBS criteria prior to services being delivered.

TBS brochures are available in English. See Optum Website under Beneficiary Tab.

Utilization Review

Authorization management for extended Therapeutic Behavioral Services is retained by the MHP. If a client requires more than 25 hours of coaching per week of TBS, the Contractor shall contact COR for approval. But if client requires more than 4 months of services, provider will use internal/tracking request system that does not require COR approval. Authorization is not needed for “stabilization services” where the client is receiving one to two hours a week for a couple of weeks to ensure stability of treatment gains.

Authorization for services for San Diego clients placed out of county are referred to the COR for authorization for TBS services.

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EARLY & PERIODIC SCREENING, DIAGNOSIS & TREATMENT (EPSDT) Brochure

In accordance to CCR, Title 9, Chapter 1, Section 1810.310 (a)(1), providers are to provide the DHCS issued **Medi-Cal Services for Children and Young Adults: Early & Periodic Screening, Diagnosis & Treatment (EPSDT) brochures**, which include information about accessing Therapeutic Behavioral Services (TBS) to children and young adults (under age 21) who qualify for Medi-Cal EPSDT services and their caregivers or guardians at the time of admission to any of the following facilities: Specialized Treatment Program (STP), Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution of Mental Diseases (IMD), Rate Classification Level (RCL) 13-14 Foster Care Group Home, Short Term Residential Therapeutic Program (STRTP) or RCL 12 Foster Care Group Home. Providers shall document in the client chart that brochure was provided to the client/family/caregiver.

See the links to the EPSDT brochures for English and Spanish.

http://www.dhcs.ca.gov/services/MH/Documents/EPSDT_TBSEng.pdf

http://www.dhcs.ca.gov/services/MH/Documents/EPSDT_TBSSpa.pdf

Pathways to Well-Being and Continuum of Care Reform

Overview

Pathways to Well-Being (PWB) was prompted by the Katie A. class action lawsuit, which was filed in 2002 against the County of Los Angeles and the State of California by a group of foster youth and their advocates, alleging violations of multiple federal laws. The lawsuit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. Katie A., the youth identified in the name of the lawsuit, was a foster youth in the County of Los Angeles who had over 30 out of home placements, including psychiatric hospitalizations and placement in residential treatment, between the ages of 4 and 14 years-old, due to unmet behavioral health needs. The State of California settled the lawsuit in December 2011, and in March 2013, issued the Core Practice Model (CPM) Guide.

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In May 2018, the CPM was revised and renamed the Integrated Core Practice Manual (ICPM) and provides practical guidance and direction to support county child welfare, juvenile probation, behavioral health and partners in the delivery of timely, effective, and collaborative services.

PWB was implemented in March 2013 in the County of San Diego as a joint partnership between Behavioral Health Services (BHS) and Child Welfare Services (CWS), in collaboration with Probation and Youth/Family Support Partners. The County of San Diego is dedicated to collaborative efforts geared toward providing safety, permanency, and well-being for youth identified as having complex or severe behavioral health needs and to establish long term permanency within a home-like setting. PWB includes services that are needs driven, strengths-based, youth and family focused, individualized, culturally competent, trauma informed, and are delivered in a well-coordinated, comprehensive, community-based approach with a central element of engagement and participation of the youth and family. These values mirror our System of Care Principles.

PWB services are available to youth up to age 21 across the System of Care, including Transitional Age Youth (TAY) who are involved in either the Children's System of Care or the Adult/Older Adult System of Care.

California's Continuum of Care Reform

California's Continuum of Care Reform (CCR) builds on the efforts made through the Katie A. class action suit. CCR is mandated through AB403 (2015) and AB1997 (2016) and integrates the positive practices identified through the implementation of PWB. CCR strives to help all children live with permanent, nurturing and committed families, and to reduce the time children spend living in congregate care. CCR adheres to fundamental principles including youth and family receiving collaborative and comprehensive supports through teaming and youth not having to change placement in order to get services and support. CWS and Probation have mandated timelines for CCR, Child and Family Team (CFT) meetings that include specific case decision making situations such as:

- Court hearing schedules
- Placement changes
- Child removed from his or her home and a plan is needed for the youth and family
- Child is in out of home care and a change in placement is required or requested
- Child returning home

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- Permanent plan for a child needs to be made
- Child/youth's mental health needs or placement in a group home should be assessed
- Any family member involved in a child's case requests to meet to talk about the child's placement or the family's service plan.

BHS providers will be invited to participate in CWS and/or Probation initiated CFT meetings in order to represent the youth's behavioral health treatment and needs. Whenever possible, CCR and PWB mandated CFT meetings shall be combined in order to create as few formalized meetings as necessary for the youth and family. It is the behavioral health provider's responsibility to ensure that behavioral health needs are discussed in the conjoint meetings.

Serving Youth with an Open Child Welfare Services Case

Upon intake and at each assessment interval, clients receiving mental health treatment are screened for CWS involvement which is captured in the Behavioral Health Assessment (BHA). When a youth has an open CWS case, the BHS provider completes the electronic Eligibility for Pathways to Well-Being and Enhanced Services form in Cerner Community Behavioral Health (CCBH) within 30 days of intake, at reassessment, at discharge and at noted changes throughout the course of treatment (such as the opening or closing of a CWS case or change in placement or treatment provider). This form indicates if a client is Pathways to Well-Being Eligible (Class) or Eligible for Enhanced Services (Subclass). Youth who are identified as Pathways to Well-Being Eligible (Class), do not meet the eligibility criteria for Enhanced Services (Subclass), are not required to receive the services mentioned below, but are identified in CCBH in Client Categories Maintenance (CCM) as Class and ongoing collaboration between the provider and CWS will occur. The services below, though not required for youth that do not meet criteria for Enhanced Services (Class), are available to all Medi-Cal beneficiaries who meet criteria for Specialty Mental Health Services. (Form located at Behavioral Health Education and Training Academy [BHETA] website, <http://theacademy.sdsu.edu/programs/BHETA/pathways.html>).

For all clients with an open CWS case, either Pathways to Well-Being Eligible (Class) or Eligible for Enhanced Services (Subclass):

- Identify in the Client Categories Maintenance (CCM) area of CCBH (aka "flip the switch") as either Class or Subclass.
- Submit the **Progress Report to Child Welfare Services** form to CWS (see secure region fax numbers on form) initially within 30 days of determining eligibility, any update (upon significant change or revised client plan), and at discharge. This form contains the client's

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diagnosis which the PSW may share with the courts. It is critical that the clinician inform and prepare the child and caregiver regarding the nature of shared information for clients with an open CWS case.

(Form located at BHETA website: <http://theacademy.sdsu.edu/programs/BHETA/pathways.html>)

Eligible for Enhanced Services (Subclass)

Youth (up to 21 years of age) are considered Eligible for Enhanced Services (Subclass) if the following criteria are met:

1. Open CWS case (including voluntary) **and**
 2. Meets the medical necessity criteria (Title IX, Section 1830.205(1) or 1830.210) **and**
 3. Has full-scope Medi-Cal (Title XIX) **and, either**
 4. Has experienced two or more placement changes within 24 months due to behavioral health needs
- or**
5. Currently being considered for, receiving, or recently discharged from a higher level behavioral health service (generally within 90 days)

If criteria 1 and 2 are met, but 3, 4, or 5 are not met, the youth will be considered Pathways to Well-Being Eligible (Class).

Child and Family Team

Under Pathways to Well-Being, all children entering the CWS system receive a mental health screening conducted by CWS and based upon need, are part of a collaborative, youth and family-centered teaming process, referred to as the **Child and Family Team (CFT)**. There is a distinction between a CFT and a CFT meeting. The CFT consists of people identified to ensure the youth has access to appropriate mental health and supportive services in order to promote safety, permanency, and well-being. The CFT meeting is just one way in which the team members communicate. The team composition is guided by the youth and family's needs and preferences. For youth **Eligible for Enhanced Services (Subclass)**, the **initial CFT meeting must occur within 30 days of determining eligibility and follow up CFT meetings shall be conducted at a minimum of every 90 days.**

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Following a CFT meeting, the CFT Meeting Facilitation Program is responsible for all members of the team receiving a copy of the **Child and Family Team Meeting Progress Summary and Action Plan** which includes specific action steps and timelines developed for the team members. If the provider has a COR-approved exemption from utilizing the CFT Meeting Facilitation Program, the BHS clinician is responsible for all members of the team receiving a copy of the CFT Meeting Summary and Action Plan. The clinician also completes the **Child and Family Team Meeting Note** which focuses on the elements associated with CFT meetings and is utilized for documenting all CFT Meetings, including Wraparound CFT meetings. Additionally, clinicians will select **ID 92 Child Family Team** under Evidence Based Practice (EBP) button (Homework/CFT) for documenting the CFT meeting.

Forms are located at BHETA website in the Tools and Forms section:

<http://theacademy.sdsu.edu/programs/BHETA/pathways.html>

The CFT is comprised of the following members (^Mindicates mandatory member):

- Child/youth/TAY^M
- Family/caregiver^M
- CWS social worker^M
- BHS provider^M
- Probation^M (when youth is a ward of the court)
- Informal supports identified by the youth and/or family
- School personnel
- Other service professionals who are working with the youth and family towards long term safety, permanency, and well-being

All youth that are Eligible for Enhanced Services (Subclass) will have a Care Coordinator. BHS and CWS will work together to identify the Care Coordinator who will take the lead in identifying CFT members with input from the youth/family. The Care Coordinator is also responsible for adherence to CFT meeting requirements, timelines and referrals to the CFT Meeting Facilitation Program. A Care Coordinator serves as the single point of accountability to ensure that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family/youth driven and culturally and linguistically relevant manner and that services and supports are guided by the needs of the youth.

CFT Meeting Facilitation Program

All mental health treatment programs (other than those with a COR-approved exception) that serve youth and families who are participating in CFT meetings, are required to utilize the CFT Meeting Facilitation Program. The CFT Meeting Facilitation Program is responsible for scheduling, organizing and facilitating CFT meetings for children/youth up to 21 years of age, within the BHS Children, Youth and Families system of care who are receiving Intensive Care Coordination (ICC). The program will also serve Child Welfare Services and Probation involved youth while closely collaborating and coordinating with all pertinent people in the youth and families life including CWS workers, Probation Officers, BHS providers, educational supports, other identified formal supports and natural supports. Providers will initiate the meeting process by completing the Child and Family Team Meeting Referral Form and faxing to the CFT Meeting Facilitation Program.

Intensive Care Coordination

Intensive Care Coordination (ICC) Service Code (SC) 82/882 is mandated for members of the Katie A Subclass and available through the EPSDT benefit to all children and youth under the age of 21 who are eligible for the full scope Medi-Cal services and who meet medical necessity for these services. ICC is provided through collaboration between the members of a CFT. **A Child and Family Team must be identified in order to provide ICC.** ICC requires active, integrated, and collaborative participation by the provider and at least one member of the CFT. ICC is a service that is used for the identification and coordination of ancillary supports and systems which promote safety, permanency, and well-being. ICC services are offered to clients with significant and complex functional impairment and/or whose treatment requires cross-agency collaboration. Examples of ICC include: facilitating or attending a collaborative team meeting or CFT Meeting, collaboration with formal and/or informal supports to ensure the complex behavioral health needs of youth are met and collaboratively developing Client Plan/Teaming Goals.

Other considerations for when to provide ICC are outlined in the California Department of Health Care Services (DHCS) Medi-Cal Manual, Second Edition (09/2016) as well as the DHCS Medi-Cal Manual Third Edition (01/2018). Both manuals provide guidelines for ICC, Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries. The Second Edition includes ICC provision considerations such as multiple mental health diagnosis, recent emergency room visits, and specifications related to the 0-5 population. The Third Edition includes how ICC differs from Targeted Case Management, a brief section on

confidentiality and information sharing practices throughout the Child and Family teaming process, guidelines for when to convene a CFT Meeting, and provides more detailed information related to TFC. Additionally, it includes the updated notice stating that ICC may be billed when provided to Medi-Cal beneficiaries, under the age of 21, who are placed in group homes or Short Term Residential Therapeutic Programs (STRTP), if medically necessary.

For more specific information, see link in the resources section for both editions of the Medi-Cal Manual.

Intensive Home-Based Services

Intensive Home-Based Services (IHBS) SC 83/883 are mental health rehabilitative services that are available to Katie A Subclass members as well as beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and meet medical necessity criteria and are receiving Intensive Care Coordination. **A Child and Family Team must be identified in order to provide IHBS.** IHBS are individualized, strength-based interventions that assist the client in building skills necessary for successful functioning in the home and community. IHBS is offered to clients with significant and complex functional impairment. These services are primarily delivered in the home, school or community and outside an office setting. Examples of IHBS include: providing support to address obstacles that interfere with being successful in the home, school and community such as maintaining housing, gaining employment and/or achieving educational goals.

For youth receiving ICC and/or IHBS, a Client Plan update needs to be completed in order to include SC 82 ICC and SC 83 IHBS. There are situations where ICC or IHBS are a lock out, including youth currently incarcerated and when the service is provided during day treatment hours, which is inclusive of these services. If a CFT meeting is provided during Day Treatment Intensive/Day Rehab hours, a CFT Meeting Note will be completed and the non-billable ICC (SC 882) will be utilized.

Therapeutic Foster Care

The Therapeutic Foster Care (TFC) service model allows for the provision of short-term, intensive, highly coordinated, trauma-informed and individualized Specialty Mental Health Services (SMHS) service activities to children and youth up to 21 years of age who have complex emotional

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and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents.

The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent will provide trauma-informed interventions that are medically necessary for the child or youth. The SMHS service activities provided through the TFC service model assist the child or youth achieve client plan goals and objectives; improve functioning and well-being; and help the child or youth to remain in a family-like home in a community setting; thereby avoiding residential, inpatient, or institutional care.

The TFC service model is intended for children and youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS service activities available under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit as a home-based alternative to high level care in institutional settings such as group homes and, in the future, as an alternative to Short-term Residential Therapeutic Programs (STRTPs). The TFC home also may serve as a step down from STRTPs. The SMHS service activities provided through the TFC service model should not be the only SMHS that a child or youth would receive. Children and youth receiving SMHS service activities through the TFC service model must receive Intensive Care Coordination (ICC) and other medically necessary SMHS, as set forth in the client plan.

Data Reporting

The county and state require data collection associated with PWB including eligibility status, ICC/IHBS services provided, and the tracking of CFT meetings. BHS providers utilize internal tracking methods such as CCBH reports to monitor Pathways to Well-Being Eligible (Class) or Eligible for Enhanced Services (Subclass) status and ICC/IHBS services that are provided in a program. In order to track CFT meetings, BHS Providers are expected to use the Evidenced Based Practice (EBP) button on the Services Encounter Screen to record all CFT meetings for youth whenever a provider attends or facilitates a CFT meeting. Providers will enter service indicator **ID 92 Child Family Team** when the service being billed has been provided within a CFT meeting. This includes CFT meetings for youth Eligible for Enhanced Services, youth that do not have an open CWS case and CWS or Probation initiated CFT meetings.

Bulletins

PWB Bulletins are used to inform and provide procedures. Bulletins are located at BHETA website in the Pathways Bulletin section: <http://theacademy.sdsu.edu/programs/BHETA/pathways.html>

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Active Bulletins:

- 2018-6 [2018-6 New Progress Report to Child Welfare Services 10-4-18](#)
- 2018-5 [Child and Family Team Meeting Facilitation Program Rollout Mandated Utilization 8-29-18](#)
- 2018-4 [Progress Note Template Update: CFT Meeting Note and ICC Note 06-20-18](#)
- 2018-3 [Integrated Core Practice Model for Children, Youth, and Families \(ICPM\) 06-07-18](#)
- 2018-2 [Medi-Cal Manual Third Edition 1-19-18](#)
- 2018-1 [Update: Tracking Child and Family Team Meetings in CCBH 1-9-18](#)
- 2017-11 [New CWS Phone Number to Obtain Current Protective Services Worker 10-25-17](#)
- 2017-10 [Revised Service Code Definitions: ICC SC 82 and IHBS SC83 10-19-17](#)
- 2017-9 [MHSUDS Information Notice: 17-055 10-19-17](#)
- 2017-8 [Tracking of All CFT Meetings in CCBH Bulletin 7-5-17](#)
- 2017-7 [CWS CCR CFT Forms Bulletin 6-15-17](#)
- 2017-6 [New Eligibility for PWB and Enhanced Services Bulletin 6-14-17](#)
- 2017-5 [Revised Individual Progress Note-ICC Note Bulletin 6-8-17](#)
- 2017-4 [PWB Progress Report to CWS bulletin 4-14-17](#)
- 2017-3 [Updated Version of the PWB CFT Progress Summary and Action Plan 3-14-17](#)
- 2017-2 [CCR and CFT Meetings 3-10-17](#)
- 2017-1 [Care Coordination of Out-of-County Katie A. Subclass Youth 2-10-17](#)
- 2016-10 [PWB- ICC and IHBS QSR Walkthrough Bulletin 12-21-16](#)
- 2016-9 [Entering End Date in CCM at Discharge](#)
- 2016-7 [Foster Youth Bill of Rights Bulletin 6-24-16](#)
- 2016-6 [ICC and IHBS Service Code Expansion Training 6-10-16](#)
- 2016-5 [Cases in Investigations Status 5-10-16](#)
- 2016-4 [Identifying the Assigned PSW 5-5-16](#)
- 2016-3 [ICC AND IHBS Information Alert 2-16-16](#)
- 2016-2 [eLearning Booster Reminder 2-01-16](#)
- 2016-1 [New Service Indicator – CFT meetings 1-26-16](#)
- 2015-11 [Client Categories Maintenance Bulletin 10-14-15](#)
- 2015-10 [eLearning Booster 10-14-15](#)
- 2015-8 [Education Letter 7-10-15](#)
- 2015-7 [CFT Meeting Time Lines 7-06-15](#)
- 2015-5 [Warm Handoff 4-23-15](#)
- 2015-4 [CWS Consent to Treat 4-16-15](#)

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- 2015-3 [Making Changes in Client Categories Maintenance 4-7-15](#)
- 2015-2 [Flipping the Switch \(Anasazi\) 1-26-15](#)
- 2015-1 [KTA Service Summary Codes 1-21-15](#)
- 2014-2 [Client Categories Maintenance 9-3-14 \(1\)](#)
- 2014-1 [Blanket Court Order 9-3-14 \(1\)](#)

Trainings

All direct service staff shall obtain the following on-line trainings from the BHETA website within 60 days of hire:

- Overview of Children Youth and Families Behavioral Health Services
- An Introduction to Pathways to Well-Being: Understanding the Katie A. Lawsuit and the Core Practice Model
- CWS 101: An Overview of Child Welfare Services in San Diego County
- San Diego County Probation Department Overview eLearning

Additionally, classroom trainings are available to all mental health treatment providers.

Forms

Client related forms specific to Pathways to Well-Being which must be completed include the following:

Form (Please always refer to BHETA website for current version)	Details
Eligibility for Pathways to Well-Being and Enhanced Services	Provider completes electronically in CCBH within 30 days of intake, at reassessment, at discharge and at noted changes throughout the course of treatment.
Child and Family Meeting Facilitation Program Child and Family Team Referral	Completed any time there is an identified need for a CFT meeting for a youth in a mental health treatment program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Intensive Care Coordination Note	Provider completes electronically in CCBH. Form is utilized for all ICC services that occur outside of the Child and Family Team (CFT) meeting.

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Child and Family Team Meeting Note	Provider completes electronically in CCBH. Form is utilized for documenting all CFT meetings, including Wraparound CFT meetings.
Child and Family Team Meeting Summary and Action Plan	Initiated by CFT Meeting Facilitation Program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Child and Family Team Meeting Confidentiality Agreement	Initiated by CFT Meeting Facilitation Program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Progress Report to Child Welfare Services	Provider completes and submits form to CWS (see secure region fax numbers on form) initially within 30 days of determining eligibility, any update (upon significant change or revised client plan), and at discharge.

Resources

DHCS Medi-Cal Manual Third Edition (2018):

http://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Katie%20A/Medi-Cal_Manual_Third_Edition.pdf

DHCS Medi-Cal Manual Second Edition (2016):

http://www.dhcs.ca.gov/services/Documents/Medi-cal_manual_9-22-16.pdf

DHCS Integrated Core Practice Model Guide (2018):

http://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-022%20Integrated%20Core%20Practice%20Model%20and%20Integrated%20Training%20Guide/Integrated_Core_Practice_Model.pdf

DHCS Core Practice Model Guide (2013):

<http://www.dhcs.ca.gov/Documents/KACorePracticeModelGuideFINAL3-1-13.pdf>

Forms referenced above are located on the **BHETA** website under the Forms and Tools tabs. The page includes general information, required forms, training, schedules, and contact information for BHS and CWS Pathways to Well-Being staff:

<http://theacademy.sdsu.edu/programs/BHETA/pathways.html>

Short Term Residential Therapeutic Programs (STRTP)

California's **Continuum of Care Reform (CCR)**, AB403 (2015) and AB1997 (2016), requires that Residential Care Level (RCL) group homes who serve foster youth and/or non-minor dependents (NMD) transition to licensure as an STRTP. The legislation ensures that youth with the most acute mental health treatment needs receive specialized, trauma informed and intensive treatment focused on stabilization to allow for a successful transition to a family setting.

IPC and CFT Meeting

Prior to placement in an STRTP, all children and youth shall participate in a **Child and Family Team meeting** and be evaluated by the **Interagency Placement Committee (IPC)** to ensure that the youth's needs cannot be met in a less restrictive environment and that they meet the criteria listed in [All County Letter No. 17-22](#), including that the child/youth:

- Does not meet criteria for inpatient care and has been assessed as requiring the level of services provided by an STRTP in order to maintain their safety and well-being, **And one** of the following:
 - Meets **medical necessity** criteria for Medi-Cal Specialty Mental Health Services,
 - is assessed as **seriously emotionally disturbed**, or
 - is assessed as **requiring the level of services** provided by the STRTP in order to meet their behavioral or therapeutic needs, or
 - meets criteria for **emergency placement** prior to determination by the IPC

The IPC consists of representatives from Child Welfare Services (CWS), Probation, and Behavioral Health Services as well as representatives from Public Health, and Educational sectors. Interagency Placement Committee meetings are held weekly by both Probation and CWS. For children 6-12 years old, placement in an STRTP shall not exceed 6 months. For children age 13 and up, placed under supervision of CWS, the placement shall not exceed 6 months. For children age 13 and up, placed under supervision of Probation, the placement in an STRTP shall not exceed 12 months. **Placement criteria and extension requests** beyond the stated timelines are outlined in **All County Letter No. 17-22**. For more information regarding **Child and Family Team meeting** requirements for youth placed in an STRTP, please reference **Section D, Child and Family Team** of the OPOH.

STRTP Services

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STRTPs shall have a contract with the MHP to provide Specialty Mental Health Services (SMHS) and shall apply for and maintain **Mental Health Program Approval for STRTP**. Children/youth placed in an STRTP shall receive intensive treatment services in a therapeutic milieu, outlined in **Section D: Intensive Services**. STRTPs shall also provide **Aftercare Services** for up to 90 days after children and youth discharge from the STRTP to promote stabilization and permanency in the new living environment. The Utilization Management process for STRTPs is outlined in **Section D: Authorization Process for Intensive Services**. The process for serving out of county Medi-Cal Clients in an STRTP is outlined in **Section D: Out of County Medi-Cal Clients**. STRTPs are required to comply with the program, documentation and staffing requirements outlined in the **Interim Mental Health Program Approval for STRTP** and the **Interim STRTP Regulations** provided in [MHSUDS Information Notice NO.: 17-016](#).

References

All County Letter No. 17-22, STRTP Placement Criteria, Interagency Placement Committee, Second Level Review for Ongoing Placements
<http://www.cdss.ca.gov/Portals/9/ACL/2017/17-122.pdf?ver=2018-01-10-151213-733>.

Interim Mental Health Program Approval:

https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Interim_Protocol_for_STRTP_Mental_Health%20Approval.pdf

Interim STRTP Regulations:

https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Interim_STRTP_Mental_Health_Regulations_Draft.pdf

https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/MHSUDS_Information_Note_17-016_STRTP.pdf

https://www.dhcs.ca.gov/formsandpubs/Documents/Joint_Info_Note_MHSUDS_IN_16-002_CDSS_ACIN%2006-16_Re_Pathways_CCR.pdf

https://www.dhcs.ca.gov/services/MH/Documents/MHSUDS_Info_Note_18-017_Participation_in_CFT_Assessments_Claiming.pdf

BHS Pathways to Well-Being and Continuum of Care Reform Programs

BHS PWB and CCR Program staff are available to provide outreach assistance to BHS providers in all aspects of PWB and CCR implementation. This includes assisting providers with utilizing

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ICC and IHBS in accordance with the DHCS Medi-Cal Manual, as well as technical assistance with group home providers who are transitioning to a STRTP. The PWB and CCR Program teams work collaboratively and in partnership with BHS providers, CWS, Probation, and Youth/Family Support Partners. Program staff can be reached through the BHETA website link below.

<http://theacademy.sdsu.edu/programs/BHETA/pathways.html>

QI PROGRAM MONITORING

The BHS Quality Improvement Unit shall monitor each organizational provider and county operated program for compliance with these requirements, to assure that activities are conducted in accordance with both State and MHP standards. If the delegated entity's activities are found not to be in compliance, the MHP shall require that a corrective action plan be formulated. Progress toward change will be effected through direct management in the case of a County operated program, or through contract monitoring in the case of a contractor. The Quality Improvement Unit will prioritize and discuss opportunities for improvement with any provider having performance problems. Corrective action plans shall be monitored for implementation and appropriateness as deemed necessary, between annual reviews. If the provider does not successfully correct the problems within the stated timeframe, the County will take appropriate remedial action.

Financial Eligibility and Billing Procedures

Each provider is responsible for specific functions related to determining client financial eligibility, billing and collections.

The *Organizational Provider Financial Eligibility and Billing Procedures Handbook* (listed as “*Financial and Eligibility User Manual*” at <https://www.Optumsandiego.com>) is provided by CYFS for providers as a guide for determining financial eligibility, billing and collection procedures. This handbook includes the following procedure categories:

- Using the MIS.
- Adding a new client.
- Assignment opening/closing and service entry.
- Determining financial eligibility.
- Claims, billing, and posting procedures.
- Training and technical assistance.

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This handbook is not intended to replace the *Management Information System CCBH User's Manual* (<https://www.Optumsandiego.com>) or intended to be a comprehensive “Insurance and Medi-Cal Billing” guide. It is meant to augment existing resource materials.

These are “living” handbook/manuals that are revised as new processes/procedures are implemented.

E. INTEGRATION WITH PHYSICAL HEALTH CARE

COORDINATION WITH PRIMARY CARE PHYSICIANS

Coordination of care between physical and behavioral health providers is necessary to optimize the overall health of a client. All providers are expected to coordinate mental health care with a client's Primary Care Physician and should have a policy and procedure in place regarding this coordination of services. Almost all of Medi-Cal beneficiaries are enrolled in one of five Health Maintenance Organizations (HMOs) that are part of Healthy San Diego. Care1st Health Plan, Community Health Group, Health Net, Kaiser Permanente, and Molina Health Care are the HMOs providing health care for Healthy San Diego. The "Healthy San Diego Health Plan Contact Information" (*Appendix A.E.2*) is a helpful tool to use for coordination of care. Included as an Attachment to this handbook is the Coordination and/or Referral of Physical & Behavioral Health Form and Coordination of Physical and Behavioral Health Update Form (*Appendix E – A.E.1*). Contracted providers are required by the MHP to complete the Coordination with Primary Care Physicians and Behavioral Health Services form with the client within 30 days of assignment opening to facilitate coordination with the client's Primary Care Physician. For clients that do not have a primary care physician, provider shall connect them to a medical home. Users of the form shall check the appropriate box at the top of the form noting the nature of the referral. If there are significant changes like an addition, change, or discontinuation of a medication, the Coordination of Physical and Behavioral Health Update Form shall be completed. The Coordination of Physical and Behavioral Health Update Form shall also be completed when the client is discharged from services in order to notify the primary care physician. Requesting client/guardian authorization to exchange information with primary care physicians is mandatory. County QM staff and/or COR will audit to this standard beginning fiscal year 2013-2014.

NOTE!

See the "**Healthy San Diego Health Plan Contact Information**" (*Appendix E – A.E.2*) for information on the Healthy San Diego Health Plans.

Note: The Coordination and/or Referral of Physical and Behavioral Form and Coordination of Physical and Behavioral Health Update Form in the threshold languages are included in *Appendix E (A.E.4-A.E.7)*

Pharmacy and Lab Services

HMO Medi-Cal Beneficiaries

Each HMO has contracts with specific pharmacies and laboratories. Providers prescribing medication or lab tests need to be aware of which pharmacy or laboratory is associated with each client's HMO in order to refer the client to the appropriate pharmacy or lab. (See the chart of such affiliations in the Attachment Section of this Handbook (*Appendix E – A.E.3*). The client's

HMO enrollment card has a phone number that providers and clients can check in order to identify the contracted pharmacy or lab. Providers must use the health plans contacted lab vendor.

Psychiatrists may order the following lab studies without obtaining authorization from the client's Primary Care Physician:

- CBC
- Liver function study
- Electrolytes
- BUN or Creatinine
- Thyroid panel
- Valproic acid
- Carbamazepine
- Tricyclic blood levels
- Lithium level.

All other lab studies require authorization from the client's Primary Care Physician. It is recommended that each provider contact the client's HMO Member Services Department or Primary Care Physician to determine which lab test(s) require authorization from the client's Primary Care Physician.

Medi-Cal Beneficiaries Not Enrolled in an HMO

Medi-Cal beneficiaries who are not members of an HMO may use any pharmacy or lab that accepts Medi-Cal reimbursement.

Non-Medi-Cal Beneficiaries

Non-Medi-Cal beneficiaries who meet financial eligibility requirements being seen at County operated clinics may have their prescriptions filled at little or no cost at a county mental health clinic, or the Health and Human Services Agency Pharmacy at the Health Services Complex, 3851 Rosecrans Street, San Diego, California, 92110.

Contracted providers shall provide medications to non-Medi-Cal clients who meet financial eligibility requirements. Contractor shall comply with the Medi-Cal Drug Formulary for Mental Health Services. Providers shall make every effort to enroll clients in low cost or free medication programs available through pharmaceutical companies or obtain free samples to offset the cost of medication.

PHYSICAL HEALTH SERVICES WHILE IN A PSYCHIATRIC HOSPITAL

Healthy San Diego Recipients

The client's Healthy San Diego HMO is responsible for the initial health history and physical assessment required for admission to a psychiatric inpatient hospital. The client's HMO also is responsible for any additional or ongoing medically necessary physical health consultations and treatments. The health plans do not require prior authorization for the initial health history and physical assessment. All other physical health services provided while a member is in a psychiatric hospital require authorization from the health plan.

The MHP contracted psychiatrist is responsible for obtaining the psychiatric history upon admission and for ordering routine laboratory services tests. If the psychiatrist identifies a physical health problem, he or she contacts the client's HMO to request an evaluation of the problem. If the psychiatrist determines further laboratory or other ancillary services are needed, the contracted hospital must obtain the necessary authorizations from the client's HMO. (See *Appendix E – A.E.1– Coordination and/or Referral of Physical & Behavioral Health Form*)

Medi-Cal Beneficiaries Not Enrolled in Healthy San Diego Health Plans

For those Medi-Cal eligible clients who are not members of a Healthy San Diego HMO, physical health services provided in a psychiatric hospital are reimbursed by Medi-Cal.

TRANSFERS FROM PSYCHIATRIC HOSPITAL TO MEDICAL HOSPITAL

Psychiatric hospitals may transfer a client to a medical hospital to address a client's medical problems. Except in an emergency, the psychiatric hospital must consult appropriate HMO staff to arrange such a transfer for physical health treatment. It is the responsibility of the HMO to pay for transportation in such cases. The Optum Health Medical Director or Liaison and the HMO Medical Director or Liaison will resolve any disputes regarding transfers.

Medical Transportation

Healthy San Diego HMOs will cover, at the Medi-Cal rate, all medically necessary emergency and non-emergency medical transportation services to access Medi-Cal covered mental health services. HMO members who call the ACL for medical transportation are referred to the Member Services Department of their HMO to arrange for such services.

HOME HEALTH CARE

Beneficiaries who are members of one of the Healthy San Diego HMOs must request in-home physical health services from their Primary Care Physician. The HMO will cover at the Medi-Cal rate home health agency services prescribed by a Plan provider when medically necessary to meet the needs of homebound members in accordance with its Medi-Cal contract with the State DHCS. The MHP will pay for services solely related to the included mental health diagnoses. The HMO case manager and the Primary Care Physician coordinate on-going in-home treatment. The HMO is responsible for lab fees resulting from in-home mental health services provided to Medi-Cal members of the HMO.

Clinical Consultation with Primary Care

Beneficiaries with less severe problems or who have been stabilized shall be referred back to their Primary Care Physician for continuing treatment. To help support treatment by the Primary Care Physician, the MHP as well as organizational providers and county operated programs shall make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving specialty mental health services from the MHP. Efforts shall be made to provide consultation and training to Medi-Cal Managed Care Providers, Primary Care Providers who do not belong to a Medi-Cal Managed Care Plan and to Federally Qualified Health Centers, Indian Health Centers, or Rural Health Centers.

F. BENEFICIARY RIGHTS, GRIEVANCE AND APPEALS

Client Rights and Protections: Code of Federal Regulations (CFR)

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule, aimed at aligning the Medicaid managed care regulations with requirements for other major sources of coverage. MHPs are classified as Prepaid Inpatient Health Plans, and therefore, must comply with all applicable federal managed care requirements. The Final Rule stipulates new requirements for the handling of grievances and appeals that became effective July 1, 2017.

According to Title 9 and 42 CFR 438.1000, the MHP is responsible for ensuring compliance with client rights and protections. Providers, as contractors of the MHP, must comply with applicable federal and state laws (such as Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR, Part 80), the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR, part 91; the Rehabilitation Act of 1973; Titles II and III of the Americans with Disabilities Act, Section 1557 of the Patient Protection and Affordable Care Act (ACA), and other laws regarding privacy and confidentiality. These rights and protections can be summarized as follows:

- *Easily understandable information.* Each managed care enrollee is guaranteed the right to receive all enrollment notices, information materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.
- *Dignity, respect, and privacy.* Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- *Receive information on the managed care plan and available treatment options.* Each managed care enrollee is guaranteed the right to receive information on the managed care plan and its benefits, enrollee rights and protections, and emergency care, as well as available treatment options and alternatives. The information should be presented in a manner appropriate to the enrollee's condition and ability to understand.
- *Participate in decisions.* Each managed care enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- *Free from restraint or seclusion.* Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulation on the use of restraints and seclusion.
- *Copy of medical records.* Each managed care enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR, 164.524 and 164.526.
- *Right to health care services.* Each enrollee has the right to be furnished health care services in accordance with CFR, Title 42, Sections 438.206-210.
- *Free exercise of rights.* Each managed care enrollee is guaranteed the right to free exercise of his/her rights in such a way that those rights do not adversely affect the way the MHP and its providers treat the enrollee.

In accordance with 42 CFR and Title 9, the MHP Quality Management Unit distributes the Guide to Medi-Cal Mental Health Services, which contains information on client rights, as well as a description of the services available through the MHP, and the avenues to obtain resolution of dissatisfaction with MHP services.

Note: New clients must receive a copy of the Guide to Medi-Cal Mental Health Services when they first obtain services from the provider and upon request, thereafter. (Handbooks are available in threshold languages.) Additional copies may be obtained from the MHP Behavioral Health Services Division at (619) 563-2700. To receive the materials in the audio or large print format contact BHSQIPIT@sdcounty.ca.gov

Additional Client Rights

- **Provider Selection**

In accordance with 42 CFR 438.6 and Title 9, providers are reminded that clients have the right to obtain a list of MHP providers, including information on their location, type of services offered, and areas of cultural and linguistic competence.

- **Second Opinion**

If the MHP or its designee determines that a client does not meet Title 9 Medical Necessity Criteria for inpatient or outpatient mental health services, a client or someone on behalf of the client, may request a second opinion. A second opinion from a mental health clinician provides the client with an opportunity to receive additional input on his or her mental health care at no extra cost. As the MHP designee, Optum is responsible for informing the treating provider of the second opinion request and for coordinating the second opinion with an MHP contracted individual provider.

The second opinion provider is required to obtain a release of information from the client in order to review the client's medical record and discuss the client's treatment. After the second opinion evaluation is completed, the second opinion provider forwards a report to the MHP Program Monitor/COR for review. If a second opinion request occurs as the result of a denial of authorization for payment, the MHP Medical Director may uphold the original denial decision or may reverse it and authorize payment.

- **Transfer from One Provider to Another**

Clients have a right to request a transfer from one Medi-Cal provider to another within or outside of a program. These transfer requests shall be recorded on the Client Suggestions and Provider Transfer Request tab of the Monthly/Quarterly Status Report. Documentation in the Log shall include the date the transfer request was received, whether the request was to a provider within or outside of the program, and the relevant code showing the reason for transfer

if specified by the client. The Log shall be submitted with the provider's Monthly/Quarterly Status Report.

- **Right to Language, Visual and Hearing Impairment Assistance**

Clients shall be routinely informed about the availability of free language assistance at the time of accessing services. The MHP prohibits the expectation that the client use family or friends for interpreter services. However, if the client so chooses, this choice should be documented in the client record. Providers must also be able to provide persons with visual or hearing impairment, or other disability, with information on Mental Health Plan Services, making every effort to accommodate individual's preferred method of communication, in accordance again with Title 9 and Behavioral Health Services policy.

- **Right to a Patient Advocate**

A client pursuant to W&I Code 5325 (h) has a right to see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services.

The rights specified in this section may not be waived by the person's parent, guardian, or conservator.

The Patient Advocate does not need to have access to the entire chart, but rather, the portions that have to do with the potential denial of rights.

Advance Health Care Directive Information

Federal Medicaid regulations (42 CFR 422.128) require the MHP to ensure that all adults and emancipated minor Medi-Cal beneficiaries are provided with information about the right to have an Advance Health Care Directive. In order to be in full compliance with this regulation, it is necessary that all eligible clients be informed of the right to have an Advance Health Care Directive at their first face-to-face contact for services, or when they become eligible (upon their 18 birthday or emancipation). An Advance Health Care Directive is defined in the 42 CFR, Chapter IV, Part 489.100 as "a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Generally, Advance Health Care Directives deal with how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for himself/herself.

In order to comply with the Federal regulations (42 CFR, Chapter IV, Section 422-128), providers shall do the following for new adult or emancipated clients:

1. Provide written information on the client right to make decisions concerning medical treatment, including the right to accept or refuse medical care and the right to formulate Advance Directives, at the first face-to-face contact with a new client, and thereafter, upon request.
2. Document in the client's medical record that this information has been given and whether or not the client has an existing Advance Directive.
3. If the client who has an Advance Directive wishes to bring in a copy, the provider shall add it to the client's current medical record.
4. If a client is incapacitated at the time of initial enrollment and unable to receive information, the provider will have a follow-up procedure in place to ensure that, the information on the right to an Advance Directive is given to the client at the appropriate time. In the interim, the provider may choose to give a copy of the information to the client's family or surrogate.
5. Not condition the provision of care or otherwise discriminate against an individual based on whether or not he or she has an Advance Directive.
6. Should the situation ever arise, provide information about the State contact point to clients who wish to complain about non-compliance with an Advance Directive.

The MHP is providing an informational brochure on Advance Directives, available in the threshold languages, which can be given out to new clients or members of the community who request it. All brochures are available on the Optum website at www.optumsandiego.com under the County Staff and Providers tab, under Organizational Provider Documents. *To receive the materials in the audio or large print format contact BHSQIPIT@sdcounty.ca.gov, or providers may duplicate their own copies.* The MHP will also be responsible for notifying providers of any changes in State law regarding Advance Directives within 90 days of the law change.

Providers are expected to formulate their own policies and procedures on Advance Health Care Directives and educate staff. Because of the legal nature of Advance Directives, providers may wish to consult with their own legal counsel regarding federal regulations.

Periodic Notice of Clients' Rights

In accordance with DHCS regulations, written and oral information explaining the grievance/appeal process and the availability of a State Fair Hearing for Medi-Cal beneficiaries shall be provided to new clients upon first admission to Mental Health Services, along with the Guide to Medi-Cal Mental Health Services. The date of this activity shall be reflected on the Behavioral Health Assessment signature page. Information on the Beneficiary and Client Problem Resolution Process and State Fair Hearing Rights must be provided annually and documented on the Behavioral Health Assessment signature page.

BENEFICIARY GRIEVANCE AND APPEAL PROCESS

San Diego County Mental Health Services is committed to honoring the rights of every client to have access to a fair, impartial, effective process through which the client can seek resolution of a grievance or adverse benefit determination by the MHP. All county operated and contracted providers are

required to participate fully in the Beneficiary and Appeal Process. Providers shall comply with all aspects of the process, including the distribution and display of the appropriate beneficiary protection materials, including posters, brochures and grievance/appeal forms as described in the process. (Beneficiary Packet Materials Order Form and Grievance/Appeal Forms are available on the Optum website: <https://www.optumsandiego.com>).

The MHP has delegated the roles and responsibilities of managing the grievance and appeal resolution process for beneficiaries to contracted advocacy organizations. When one of the contracted advocacy organizations notifies a provider of a grievance or appeal, the provider shall cooperate with the investigation and resolution of the grievance or appeal in a timely manner.

At all times, Grievance and Appeal information must be readily available for clients to access without the need for request. Each provider site shall have posters, brochures, and grievance/appeal forms in threshold languages, and addressed envelopes available to clients. These materials shall be displayed in a prominent public place. Clients shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance/appeal. The client shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to register a grievance/appeal. Additionally, the client shall be assisted in preparing a written grievance/appeal, if requested.

Written materials that are critical to obtaining services including, at a minimum, appeal and grievance notices, and denial and termination notices, shall be available to beneficiaries in threshold languages and alternative formats. These materials are available on the Optum website.

Grievance Resolution at Provider Sites

Clients are encouraged to direct their grievances directly to program staff or management for the most efficient way to resolve problems. This may be done orally or in writing at the program. In accordance with 42 CFR §438.402, a beneficiary may file a grievance at any time. The Plan shall provide to the beneficiary written acknowledgement of receipt of grievance. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the Plan representative who the beneficiary may contact about the grievance. The written acknowledgement to the beneficiary must be postmarked within five calendar days of receipt of the grievance.

Providers shall log of all grievances containing the date of receipt of the grievance, the name of the beneficiary, nature of the grievance, the resolution, and the representative's name who received and resolved the grievance in the Client Suggestions and Provider Transfer Request Log. The log shall be secured to protect client confidentiality. This log shall be submitted with the provider's Monthly/Quarterly Status Report.

Providers shall inform all clients about their right to file a grievance with one of the MHP's contracted advocacy organizations if the client has an expression of dissatisfaction about any matter, is uncomfortable approaching program staff, or the dissatisfaction has not been successfully resolved at

the program. Clients should feel equally welcomed to bring their concerns directly to the program's attention or to seek the assistance of one of the advocacy organizations.

Grievance Process

A "grievance" is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination. There is no distinction between an informal and formal grievance. A compliant is the same as a formal grievance. A compliant shall be considered a grievance unless it meets the definition of an "adverse benefit determination". Even if a beneficiary expressly declines to file a formal grievance, their complaint shall be categorized as a grievance.

JFS Patient Advocacy facilitates the grievance process for clients in inpatient and other 24-hour residential facilities. CCHEA facilitates the grievance process for outpatient and all other mental health services. These advocacy services will contact providers within two (2) business days of receiving written permission from the client to represent him/her. Securing this permission can be difficult and time consuming. To ensure compliance with the mandated federal timeline, providers shall work closely with the Advocacy organization to find a mutually agreeable solution to resolve the grievance quickly.

If a grievance or appeal is about a clinical issue, CCHEA and JFS Patient Advocacy Program, as required by 42 CFR, will be utilizing a clinician with appropriate clinical expertise in treating the client's condition to review and make a decision about the case.

Grievance Resolution

Timeline: 90 days from receipt of grievance to resolution, with a possible 14-day extension for good cause.

The MHP must resolve grievances within the established timeframes. The Plan must comply with the following requirements for resolution of grievances:

1. "Resolved" means that the Plan has reached a decision with respect to the beneficiary's grievance and notified the beneficiary of the disposition.
2. Plans shall comply with the established timeframe of 90 calendar days for resolution of grievances, except as noted below.
3. The timeframe for resolving grievances related to disputes of a Plan's decision to extend the timeframe for making an authorization decision shall not exceed 30 calendar days.
4. The Plan shall use the Notice of Grievance Resolution (NGR) to notify beneficiaries of the results of the grievance resolution. The NGR shall contain a clear and concise explanation of the Plan's decision.
5. Federal regulations allow the Plan to extend the timeframe for an additional 14 calendar days if the beneficiary requests the extension or the Plan shows (to the satisfaction of DHCS, upon request) that there is need for additional information and how the delay is in the beneficiary's

interest. In the event that resolution of a standard grievance is not reached within 90 calendar days as required, the Plan shall provide the beneficiary with the applicable NOABD, and include the status of the grievance and the estimated date of resolution, which shall not exceed 14 additional calendar days. If the Plan extends the timeframe, not at the request of the beneficiary, it must complete all of the following: (a) give the beneficiary prompt oral notice of the delay, (b) within two calendar days of making the decision, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he/she disagrees with that decision, and (c) resolve the grievance no later than the date the extension expires.

Grievance Process Exemptions

Grievances received over the telephone or in-person by the Plan, or a network provider of the Plan, that are resolved to the beneficiary's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter.

Grievances received via mail by the Plan, or a network provider of the Plan, are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If a Plan or a network provider of the Plan receives a complaint pertaining to an Adverse Benefit Determination, as defined under 42 CFR Section 438.400, the complaint is not considered a grievance and the exemption does not apply.

ADVERSE BENEFIT DETERMINATION (ABD)

The definition of an "Adverse Benefit Determination" encompasses all ~~previous~~ elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness and setting of covered benefits, and financial liability.

An Adverse Benefit Determination is defined to mean any of the following actions taken by a 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.

Written Notice of Adverse Benefit Determination (NOABD) Requirements

Beneficiaries must receive a written NOABD when the MHP takes any of the actions described above.

The Plan must give beneficiaries timely and adequate notice of an adverse benefit determination in writing, consistent with the requirements in 42 CFR §438.10. The federal regulations delineate the requirements for content of the NOABDs. The NOABD must explain all of the following:

1. The adverse benefit determination the Plan has made or intends to make;
2. A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. The Plan shall explicitly state why the beneficiary's condition does not meet specialty mental health services and/or DMC-ODS medical necessity criteria;
3. A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations;
4. The beneficiary's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination.

Decisions shall be communicated to the beneficiary in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively. For written notification to the provider, the Plan must also include the name and direct telephone number or extension of the decision-maker.

If the Plan can substantiate through documentation that effective processes are in place to allow the provider to easily contact the decision-maker through means other than a direct phone number (e.g., telephone number to the specific unit of the Utilization Management Department that handles provider appeals directly), a direct telephone number or extension is not required. However, the Plan must conduct ongoing oversight to monitor the effectiveness of this process.

Timing of the Notice

The MHP shall mail the notice to the beneficiary within the following timeframes:

1. For termination, suspension, or reduction of a previously authorized specialty mental health service, at least 10 days before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214;
2. For denial of payment, at the time of any action denying the provider's claim; or,
3. For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, within two business days of the decision.

The Plan must also communicate the decision to the affected provider within 24 hours of making the decision.

Written NOABD Templates

In accordance with the federal requirements, the MHP (providers) shall use DHCS' uniform notice templates, or the electronic equivalent of these templates generated from the Plan's Electronic Health Record System, when providing beneficiaries with a written NOABD. The notice templates include both the enclosed NOABD and "Your Rights" documents to notify beneficiaries of their rights in compliance with the federal regulations. The following is a description of adverse benefit determinations and the corresponding NOABD template, as well as instructions related to the timeframes for sending the NOABD to the beneficiary:

1. **NOABD Denial Notice** - Use this template when the Plan denies a request for a service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
2. **NOABD Payment Denial Notice** - Use this template when the Plan denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary.
3. **NOABD Delivery System Notice** - Use this template when the Plan has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health through the Plan. The beneficiary shall be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.
4. **NOABD Modification Notice** - Use this template when 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.
5. **NOABD Termination Notice** - Use this template when the Plan terminates, reduces, or suspends a previously authorized service.
6. **NOABD Delay Notice** - Use this template when there is a delay in processing a provider's request for authorization of specialty mental health service. When the Plan extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest.
7. **NOABD Timely Access Notice** - Use this template when there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service.
8. **NOABD Financial Liability Notice** - Use this template when the Plan denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.
9. **NOABD "Your Rights" Attachment** - the "Your Rights" attachment is a new form that informs beneficiaries of critical appeal and State hearing rights. There are two types of "Your Rights" attachments. One accompanies the NOABD and the other accompanies the Notice of Appeals Resolution. These attachments must be sent to beneficiaries with each NOABD or NAR.

The “**NOABD Your Rights**” attachment provides beneficiaries with the following required information pertaining to NOABD:

1. The beneficiary’s or provider’s right to request an internal appeal with the Plan within 60 calendar days from the date on the NOABD;
2. The beneficiary’s right to request a State hearing only after filing an appeal with the Plan and receiving a notice that the Adverse Benefit Determination has been upheld;
3. The beneficiary’s right to request a State hearing if the Plan fails to send a resolution notice in response to the appeal within the required timeframe;
4. Procedures for exercising the beneficiary’s rights to request an appeal;
5. Circumstances under which an expedited review is available and how to request it; and,
6. The beneficiary’s right to have benefits continue pending resolution of the appeal and how to request continuation of benefits in accordance with Title 42, CFR, Section 438.420.

APPEAL PROCESS

Timeline: 30 calendar days from receipt of appeal to resolution, with a possible 14-day extension for good cause.

An “Appeal” is a review by the MHP of an Adverse Benefit Determination regarding provision of services through an authorization process, including:

1. 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. Reduction, suspension or termination of a previously authorized service;
3. Denial of, in whole or in part, of payment for a service;
4. Failure to provide services in a timely manner;
5. Failure to act within the required timeframes of a standard resolution of grievances and appeals;
or
6. Denial of a beneficiary’s request to dispute financial liability.

Federal regulations require beneficiaries to file an appeal within 60 calendar days from the date on the NOABD. The MHP shall adopt the 60 calendar day timeframe in accordance with the federal regulations. Beneficiaries must also exhaust the Plan’s appeal process prior to requesting a State hearing. A beneficiary, or provider and/or authorized representative, may request an appeal either orally or in writing. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.

In addition, an oral appeal (excluding expedited appeals) shall be followed by a written appeal signed by the beneficiary. The date of the oral appeal establishes the filing date for the appeal. The MHP shall request that the beneficiary’s oral request for a standard appeal be followed by written confirmation unless the beneficiary or provider requests expedited resolution in accordance with federal regulations.

The MHP and its providers shall assist the beneficiary in completing forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying the beneficiary of the location of the forms on the Optum website or providing the form to the beneficiary upon request. The MHP shall also advise and assist the beneficiary in requesting continuation of benefits during an appeal of the adverse benefit determination in accordance with federal regulations. In the event that the Plan does not receive a written, signed appeal from the beneficiary, the Plan shall neither dismiss nor delay resolution of the appeal.

Authorized Representatives

With written consent of the beneficiary, a provider or authorized representative may file a grievance, request an appeal, or request a State hearing on behalf of the beneficiary. Providers and authorized representatives cannot request continuation of benefits, as specified in 42 CFR §438.420(b)(5).

Standard Resolution of Appeals

The MHP shall provide to the beneficiary written acknowledgement of receipt of the appeal. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the Plan representative who the beneficiary may contact about the appeal. The written acknowledgement to the beneficiary must be postmarked within five calendar days of receipt of the appeal.

Extension of Timeframes

The MHP may extend the resolution timeframes for appeals by up to 14 calendar days if either of the following two conditions applies:

1. The beneficiary requests the extension; or,
2. The Plan demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the beneficiary's best interest.

For any extension not requested by the beneficiary, the Plan is required to provide the beneficiary with written notice of the reason for the delay. Federal regulations delineate the following additional requirements:

- a. The Plan shall make reasonable efforts to provide the beneficiary with prompt oral notice of the extension;
- b. The Plan shall provide written notice of the extension within two calendar days of making the decision to extend the timeframe and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension;
- c. The Plan shall resolve the appeal as expeditiously as the beneficiary's health condition requires and in no event extend resolution beyond the 14 calendar day extension; and,
- d. In the event that the Plan fails to adhere to the notice and timing requirements, the

beneficiary is deemed to have exhausted the Plan's appeal process and may initiate a State hearing.

Expedited Resolution of Appeals

Timeline: 72 hours from receipt of expedited appeal request

In addition to the other logging requirements delineated in federal regulations, the MHP must log the time and date of appeal receipt when expedited resolution is requested as the specific time of receipt drives the timeframe for resolution. The Plan may extend the timeframe for expedited appeals resolution by 14 calendar days in accordance with federal regulations.

The MHP maintains an expedited review process for appeals when the Plan determines (from a beneficiary request) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking time for a standard resolution could seriously jeopardize the beneficiary's mental health or the beneficiary's ability to attain, maintain, or regain maximum function. For expedited resolution of an appeal and notice to affected parties (i.e., the beneficiary, legal representative and/or provider), the Plan shall resolve the appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, no longer than 72 hours after the Plan receives the expedited appeal request.

General Expedited Requirements

If the MHP denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution. In addition, the Plan shall complete all of the following actions:

1. The Plan shall make reasonable efforts to provide the beneficiary with prompt oral notice of the decision to transfer the appeal to the timeframe for standard resolution;
2. The Plan shall provide written notice of the decision to transfer the appeal to the timeframe for standard resolution within two calendar days of making the decision and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension; and
3. The Plan shall resolve the appeal as expeditiously as the beneficiary's health condition requires and within the timeframe for standard resolution of an appeal (i.e., within 30 days of receipt of the appeal).

Notice of Appeal Resolution (NAR) Requirements

A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld. In addition to the written NAR, the MHP is required to make reasonable efforts to provide prompt oral notice to the beneficiary of the resolution.

NAR Adverse Benefit Determination Upheld Notice

For appeals not resolved wholly in favor of the beneficiary, the MHP shall utilize the DHCS template or the electronic equivalent of that template generated from the Plan's Electronic Health Record System, for upheld decisions, which is comprised of two components:

1. NAR Adverse Benefit Determination Upheld Notice, and
2. "Your Rights" attachment.

These documents are a **"packet"** and shall be sent together to comply with all requirements of the NAR. The MHP shall send written NARs to beneficiaries. The written NAR shall include the following:

- a. The results of the resolution and the date it was completed;
- b. The reasons for the Plan's determination, including the criteria, clinical guidelines, or policies used in reaching the determination;
- c. For appeals not resolved wholly in the favor of the beneficiary, the right to request a State hearing and how to request it;
- d. For appeals not resolved wholly in the favor of the beneficiary, the right to request and receive benefits while the hearing is pending and how to make the request; and,
- e. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the Plan's adverse benefit determination.

NAR "Your Rights" Notice

The NAR "Your Rights" attachment provides beneficiaries with the following required information pertaining to NAR:

- a. The beneficiary's right to request a State hearing no later than 120 calendar days from the date of the Plan's written appeal resolution and instructions on how to request a State hearing; and,
- b. The beneficiary's right to request and receive continuation of benefits while the State hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made (i.e., within ten days from the date the letter was post-marked or delivered to the beneficiary) in accordance with Title 42, CFR, Section 438.420.

The MHP shall use the appropriate NAR form and "Your Rights" attachments.

NAR Adverse Benefit Determination Overturned Notice

For appeals resolved wholly in favor of the beneficiary, written notice to the beneficiary shall include the results of the resolution and the date it was completed. The MHP shall also ensure that the written

response contains a clear and concise explanation of the reason, including why the decision was overturned. The MHP shall utilize the DHCS template packet for appeals, which contains the NAR for overturned decisions.

Plans must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires if the Plan reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. The MHP shall authorize or provide services no later than 72 hours from the date and time it reverses the determination.

Note: A decision by a therapist to limit, reduce, or terminate a client's service is considered a clinical decision and cannot be the subject of an appeal; however, it can be grieved.

STATE FAIR HEARING (STF)

Beneficiaries must exhaust the MHP's appeal process prior to requesting a State hearing. A beneficiary has the right to request a State hearing only after receiving notice that the Plan is upholding an adverse benefit determination. If the Plan fails to adhere to the notice and timing requirements in 42 CFR§438.408, the beneficiary is deemed to have exhausted the Plan's appeals process. The enrollee may then initiate a State hearing. Beneficiaries may request a State hearing within 120 calendar days from the date of the Notice of Appeal Resolution (NAR), which informs the beneficiary that the Adverse Benefit Decision has been upheld by the Plan.

For **Standard Hearings**, the MHP shall notify beneficiaries that the State must reach its decision on the hearing within 90 calendar days of the date of the request for the hearing. For **Expedited Hearings**, the MHP shall notify beneficiaries that the State must reach its decision on the state fair hearing within three working days of the date of the request for the hearing. For **Overtured Decisions**, the MHP shall authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives notice reversing the Plan's adverse benefits determination.

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICES

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. On May 18, 2016, the United States Department of Health and Human Services, Office for Civil Rights issued the Nondiscrimination in Health Program and Activities Final Rule to implement Section 1557. Federal regulations require the MHP (and providers) to post nondiscrimination and language assistance notices in significant communications to beneficiaries.

The MHP has created a "Beneficiary Non-Discrimination Notice" and "Language Assistance Notice", which shall be sent along with each of the following significant notices sent to beneficiaries:

- NOABD,

- Grievance Acknowledgment Letter,
- Appeal Acknowledgment Letter,
- Grievance Resolution Letter, and
- Notice of Appeal Resolution Letter.

Provider Appeal Process

If the provider and advocacy organization cannot successfully resolve the client's grievance or appeal, the advocacy organization will issue a finding, to be sent to the client, provider and Mental Health Director, which may include the need for a Plan of Correction to be submitted by the provider to the Mental Health Director or designee in 10 days. In the rare instances when the provider disagrees with the disposition of the grievance/appeal and/or does not agree to write a Plan of Correction, the provider may write to the Mental Health Director within 10 days, requesting an administrative review. The Mental Health Director or his designee shall have the final decision about needed action. Please see the Beneficiary and Client Problem Resolution Process for details of this portion of the process.

Considerations for Minors

If the client is a minor, unless it is a minor consent case, the original should be sent to the minor and a copy should be sent to the minor's parent(s) or legal guardian.

In minor consent cases, only the minor shall receive the NOABD. The minor's parent/guardian shall not receive a copy or be otherwise notified of the adverse benefit determination.

Monitoring the Beneficiary Grievance and Appeal Resolution Process

The MHP, operating from a shared concern with providers about improving the quality of care and experience of beneficiaries, will monitor feedback from the grievance/appeal process to identify potential deficiencies and take actions for continuous improvement. Data is collected, analyzed and shared with the BHS System of Care and stakeholder thru system-wide meetings and councils.

G. QUALITY MANAGEMENT PROGRAM

The MHP's philosophy is that high quality mental health care is client-centered, clinically effective, accessible, integrated, outcome-driven, and culturally competent. The purpose of the MHP Quality Management Program is to ensure that all clients **regardless of funding source** receive mental health care in accordance with these principles. In order to achieve this goal, each program in the system must have internal quality improvement controls and activities in addition to those provided by the MHP. These activities may involve peer review, program manager monitoring of charts and billing activity, and/or a formal Quality Improvement department, which offers training and technical assistance to program staff. Internal monitoring and auditing are to include the provision of prompt responses to detected problems. In addition, all providers shall attend regular provider meetings, special forums, in-services/trainings as required by the Contracting Officer Representative (COR), BHS System of Care Executive Leadership and/or Quality Improvement Unit. Attendance at these meetings is essential to keep abreast of system changes and requirements as part of our continuous improvement efforts.

The quality of the MHP's care and service delivery system is ensured by continually evaluating important aspects of care and service, using reliable, consistent, and valid measurements, with the goal of maximizing each program's effectiveness. The basis of this evaluation process rests in State and Federal legislation and regulations including:

- 42 CFR, (Code of Federal Regulations)
- Title 9, Chapter 11, of the California Code of Regulations
- State Department of Health Care Services (DHCS) Letters and Notices
- the MHP Managed Care contract with the State DHCS
- the Annual DHCS State Protocol for MHPs
- Mental Health Services Act (MHSA) requirements, and
- State DHCS mandated Performance Improvement Projects (PIP)
 - The State has mandated that each MHP undertake one administrative and one clinical PIP yearly.

The evaluation process has also expanded to meet a number of new Federal regulations and legislative mandates under the **Medicaid and CHIP Managed Care Final Rules**, effective July 5, 2016. The Federal Managed Care Regulations, specifically Part 438 of title 42 Code of Federal Regulations, applies to the provision of Medicaid Managed Care (MMC) programs and managed care organizations (MCOs), Pre-paid Inpatient Health Plans (PIHPs), and Pre-paid Ambulatory Health Plans (PAHPs). Mental Health Plans are PIHPs. Key goals of the final rule are:

- To support State efforts to advance delivery system reform and improve the quality of care
- To strengthen the beneficiary experience of care and key beneficiary protections
- To strengthen program integrity by improving accountability and transparency
- To align key Medicaid and CHIP managed care requirements with other health coverage programs

All providers shall adhere to the rules and regulations as stipulated in the Medicaid and CHIP Managed Care Final Rules. Information about the final rule is available at the following link: <https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html>.

Through program monitoring, program strengths and deficiencies are identified and educational and other approaches are utilized to achieve positive change. To be maximally effective, the Quality Management Program must be a team effort. It requires the dedicated effort, responsibility, and involvement of clients, family members, clinicians, para-professionals, mental health advocates, and other stakeholders to share information on strengths and weaknesses of services.

Indicators of care and service currently being evaluated include, but are not limited to, client satisfaction, effectiveness of the service delivery system, performance and treatment outcomes, accessibility of services, cultural competency, adherence to health and safety standards, and preservation of client rights.

MEASURING CLIENT SATISFACTION

The MHP is committed to assessing client satisfaction with the quality of care and provision of mental health services. Client satisfaction is measured for the following programs as described below:

Adult/Older Adult System of Care: BHS administers semi-annual mandated client surveys to get this important feedback. The importance of provider participation in the survey process is critical to get an accurate picture of how well each provider and the mental health system as a whole are meeting client needs. It is also a contract requirement.

BHS selects a one-week time period semi-annually in the spring and fall in which all Outpatient providers, including Case Management, are required to administer the Mental Health survey. This survey consists of a Mental Health Statistics Improvement Program (MHSIP) section, which measures client satisfaction with services. This survey should be administered to **all** clients receiving services during the one-week period, **including clients receiving medications only**. UCSD Health Services Research Center (HSRC) is contracted by the MHP to handle the adult survey process. HSRC distributes the blank survey forms, collects the completed forms, and compiles provider and countywide satisfaction data. Providers will be notified by HSRC of the exact survey period. Survey returns are scanned and then tabulated, therefore, original printed forms provided by the MHP must be used. Providers are strongly requested to send in completed surveys according to HSRC instructions at the end of each survey period. Each participating provider will receive a report comparing their results on the survey with the average results for their level of care.

The criteria and guidelines for the Adult MHSIP Survey are subject to change as determined by the State. Providers will be notified of changes affecting them.

Children, Youth and Family (CYF) System of Care: A satisfaction survey is conducted semi-annually within all organizational programs (excluding detention programs, medication only cases, inpatient and crisis services) as required by the State to assess client satisfaction. The Youth Services Survey (YSS) is administered to all clients receiving services during the one-week period by the Child and Adolescent Services Research Center (CASRC). Refer to Section N of the OPOH for additional information regarding the YSS.

Provider Feedback

All providers are also encouraged to provide feedback regarding their interaction with the MHP by direct communication with the Program Monitor/COR, Quality Improvement Team, and MH Contract Administration Unit. Communication can occur at the contractor's request, at scheduled meetings, and through the status report narrative.

QM Site Reviews are scheduled on an ad hoc basis to ensure that programs remain in compliance with State Standards. However, the review of Medication Service will continue to be completed annually and will be conducted by QM staff during the Medical Record Review process.

Medi-Cal Certification and Recertification

Contracted and County providers shall be familiar with the Short-Doyle/Medi-Cal delivery system and shall become Medi-Cal certified prior to commencing services and billing Medi-Cal. Providers who bill for Medi-Cal services will be recertified every three (3) years. The re-certification review will include review of the following:

- Compliance with all pertinent State and Federal standards and requirements
- Maintenance of current licenses, permits, notices and certifications as required
- Policies & Procedures or process
- Compliance with the standards established in the Mental Health Services Quality Improvement Plan
- Physical plant/facility requirements
- Adherence to requirements for ensuring the confidentiality and safety of client records
- Medication service
- Adherence to health and safety requirements
- Fire Clearance Requirements for Short-Doyle Medi-Cal Programs

As part of the Short-Doyle Medi-Cal Certification process for new programs or Recertification of Short-Doyle Medi-Cal programs, the organizational provider will:

- Secure a new fire clearance document from their local fire code authority and submit a copy to the San Diego County Mental Health Service's Quality Management Unit prior to Certification/ Recertification site visit.
- After receipt of the fire clearance document by QM, a site visit will be scheduled. Note: All fire clearance documents must be kept at the program site and be available to reviewers.

At the Short-Doyle Certification/Recertification site visit, the organizational provider must make available to the reviewer the most recent site fire clearance document. Providers will be in compliance if the most recent fire clearance document has been completed within one (1) year of the previous fire clearance document date. If the most recent fire clearance document has not been completed within the one (1) year period or fire clearance document is not found, the program will receive a Plan of Correction (POC) requesting the appropriate action (s) to be taken by the provider. The action (s) will be included in the POC and sent to San Diego County Mental Health Service's QM Unit to review. For any questions on this process, please contact QIMatters.hhsa@sdcounty.ca.gov.

MONITORING THE SERVICE DELIVERY SYSTEM

Uniform Medical Record – Forms and Timelines

All programs are required to utilize the forms specified in the San Diego County Mental Health Services Uniform Clinical Record Manual, and any updated forms, which are issued on an interim basis. The standards for documentation shall be consistent across all clinical programs, regardless of funding source. Programs may adapt forms for specific program needs upon review and approval by the Quality Management Unit. The Hybrid Medical Record for each client must be maintained in a secure location, must be filed in the prescribed order, and must be retrievable for County, State, or Federal audit upon request, during and after the provision of services up to the limits prescribed in California law. Each legal entity shall develop forms for legal consents and other compliance related issues. **Out-of-county** mental health programs may utilize non-San Diego County medical record forms, but they must comply with all State and Federal and requested County guidelines.

County providers are to retain a medical record for 10 years after the discharge date of adult clients, or until a minor has reached the age of 23 years, but in no case less than 10 years. Organizational providers are to develop their own standard, which follows all applicable guidelines/laws, or adopt the County's. County providers are required to retain all Billing Records for a minimum of 5 years in the office, and 2 years off site (for a minimum total of 7 years) when the program is funded with State or Federal dollars. Organizational providers may seek their own legal counsel, adopt the County standard or set an internal standard, which follows all applicable guidelines, which include, but are not limited to California Code of Regulations Title 22.

Documentation and in-service trainings are offered by QM to keep providers informed of the latest County, State and Federal standards. The Uniform Clinical Record Manual may be obtained on the Optum Public Sector website.

Staff Signature Logs

All organizational providers are required to maintain an accurate and current staff signature log that includes all staff that document within the program's clinical records. The MHP requires that this staff signature log include the following elements for each staff person:

- Typed name
- Signature
- Degree and/or licensure
- Job title
- Language capability, if applicable

It is very important that the signature on the log be readily identifiable to the staff person's signature, as it appears on hard copy documents in the hybrid medical record. A staff log signature that is not readily identifiable to the staff's signature within the medical record could place the service provided at risk of disallowance.

To ensure that the log is kept current, it is the organizational provider's responsibility to update and maintain the log in a timely manner to reflect any changes, i.e. licensure, degree, job title, name, or signature. The staff signature log must be maintained onsite at the organizational provider's program location, and be made available at the request of the MHP for purposes of site visits, medical record reviews, etc. Failure to maintain a staff signature log that is accurate and current will result in a plan of corrective action being issued to the organizational provider.

Timeliness of Documentation Standard

All services provided to a client shall be documented into the client's medical record within a timely manner. Best clinical practice dictates progress notes be completed as soon as possible after a service is provided. With timely documentation, details and relevant information are captured that otherwise may be lost if too much time lapses between service provision and documentation of the service.

No service shall be claimed until the documentation for that service is complete and final approved in the electron health record. In the event a service cannot be documented within a reasonable and timely period, it must be documented within 14 days or it becomes non-billable. A service is disallowed when the documentation date is over 14 calendar days from the date of service (date of service counts as day 1 of 14-day count) and must be corrected by the program. The service would

be considered a non-billable service and would be entered into the medical record using the appropriate non-billable service code.

Medical Record Reviews

Quality improvement of documentation is an ongoing process shared between programs and County QM. As such, each plays an important role in the Medical Record Review Process.

Program Responsibility

Providers are required to conduct internal reviews of medical records on a regular basis in order to ensure that service documentation meets all County, State and Federal standards, and that all Short-Doyle Medi-Cal billing is substantiated.

If the clinical documentation does not meet documentation standards as set forth in the current California State Department of Mental Health “Reasons for Recoupment” the provider shall be responsible for addressing the issue by filing a Void-Service Request form with the Mental Health Billing Unit (MHBU).

All services that are voided will be identified as such and the units removed from the Medi-Cal and the Total units. These are automatically repaid to the State once the billing unit submits the voided request. Providers are responsible for re-entering the non-billable service code for services that are identified as a Medi-Cal billing disallowance and is voided based on the Void Reasons found on the Optum website. Corrected service information may only be entered once the provider has confirmed that the incorrect service has been voided.

Providers shall ensure that the services listed on the Void Request Form as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services listed must be listed on the form exactly as they were billed.

County Quality Management Reviews

The MHP mandates site and medical record monitoring of providers to ensure that all clients receive the highest quality clinical care at the most appropriate levels of service. The Quality Management Unit conducts program site and medical record reviews. Site visits and medical record reviews are scheduled and coordinated with the Program Manager at each provider site. A copy of the site and medical record review tool is distributed to the Program Manager prior to the scheduled review.

As part of the coordination process for a medical record review with the program, the QM Specialist will notify the program manager of the designated audit period for the billing claims review. All billings for the designated period will be reviewed on those medical records that are selected for review. Once the program manager has been informed of the designated billing claims period, no provider self-reports of disallowances will be processed for the program that fall within the billing period until completion of the medical record review and resulting final written report by the QM Specialist. At the conclusion of each medical record review, the QM Specialist will present preliminary findings of the review at an on-site exit conference.

For additional record reviews that are conducted by entities other than the MHP [i.e. Department of Mental Health Care Services (DHCS) as part of the Mental Health Plan's compliance review or for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical record reviews] the same standard will apply. Once the program or legal entity has been notified of an upcoming medical record review and the billing period has been designated, no provider self-report of disallowances will be processed for any of the designated program's medical records until completion of the review and receipt of the final report.

During the medical record review, a Quality Improvement Specialist will review clinical records for:

- Assessment/Appropriateness of Treatment
- Medical Necessity
- Clinical Quality
- Client Treatment Plan and Client Involvement
- Compliance with Medi-Cal, State, Federal, and County Documentation Standards
- Billing Compliance
- Medication Treatment/Medical Care Coordination
- Administrative/Legal Compliance
- Care Coordination
- Discharge

In addition, the QM specialist may conduct a review of the medication service at each program site.

Program Quality Improvement Plan (QIP)

If the provider's performance is found to be out-of-compliance with documentation standards, incorrect billing, or other areas of improvement are identified, a request for a Quality Improvement Plan will be issued by the MHP to the provider. After receipt of the MHP's written report of findings, the provider will have a specified timeframe in which to complete and submit the QIP to the QM Unit. The QIP must describe the interventions or processes that the provider will implement to address items that have been identified out of compliance or that were identified as

needing improvement. In some instances, the QM Unit will be making more specific process improvement recommendations to the provider that must be included in the QIP. When appropriate, the QIP must include all supporting documentation (i.e. copy of a policy and procedure that has been written, description of a system that program is implementing, copy of sign-in sheets from a training, etc.). Even when supporting documentation is not requested to be submitted with the QIP, the program is still required to keep this documentation on-file at their program. The QIP must also include identified timelines and/or dates as to when the out of compliance item or area needing improvement will be implemented or completed. Pursuant to the “Withholding of Payment” clause of the contract, failure to respond adequately and in a timely manner to a request for a QIP may result in withholding of payment on claims for non-compliance.

Upon receipt of a QIP, the QM Unit will review what has been submitted to ensure that it adequately addresses the identified items. If the determination is made that the QIP does not adequately address these items, the QM Unit may request that the QIP be re-submitted within a specified period.

Programs will be monitored for trends and patterns in any areas found out of compliance or areas needing improvement. Additional QM reviews may occur if a program has an inordinately large number of variances, certain trends and patterns are noted, or is largely out of compliance with standards or contract requirements. Determination of an additional review will be made under the direction of the QM Program Manager and may take place within 30 days, 60 days or some other identified period depending upon the severity of the noncompliance. For medical record reviews, these additional reviews will include the billing audit and will be subject to recoupment.

To track progress of QIP implementation and offer technical assistance and support toward increased quality improvement efforts, the QM Unit will request a written summary from the program on the impact of the QIP on identified deficiencies. This summary will be requested approximately three months after the QIP has been accepted. Details of this process will be discussed with the program during the on-site exit conference after the review.

When a program’s compliance issues are not improving as detailed in the program’s written QIP, QM may request that the Program COR issue a Corrective Action Notice (CAN) to the program’s Legal Entity. The CAN, given to the Legal Entity, will include a description of the noncompliance categories, history of program’s QIP actions, and a statement about insufficient improvement having been made. QM may recommend identified interventions or process changes to be implemented. If a CAN is issued to a Legal Entity, additional County Departments become involved in monitoring remedial activities. Failure to respond adequately and in a timely manner to a required Corrective Action Notice may result in a withholding of payment on the claims for non-compliance and could result in putting the contract at risk.

For billing disallowances or service corrections identified in the Medical Record review, programs will be required to submit evidence of correction as delineated in the medical record review protocol for that fiscal year as part of their QIP. Programs are responsible to follow-up on any pending corrections at QM Specialist direction. Required processes for progress note corrections/voids/deletions are outlined in the Progress Note Corrections Packet and associated Appendices, which can be located on the Optum website <https://www.optumsandiego.com/>. If there are additional billing concerns, the QM Specialist may conduct another medical record review prior to the next fiscal year.

Providers shall ensure that the services listed on the Void Request Form as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services listed must be listed on the form exactly as they were billed.

Medi-Cal Recoupment and Appeals Process

It shall be the policy of County of San Diego Mental Health Services to disallow billing by providers that do not meet the documentation standards set forth in the Uniform Clinical Record Manual and to recoup Federal Financial Participation (FFP) in accordance with the current *California State Department of Mental Health Reasons for Recoupment of Federal Financial Participation Dollars, Non-Hospital Services*.

Per the current California State DHCS Reasons for Recoupment of FFP Dollars, MHS is obligated to disallow the Medi-Cal claim under the following categories:

- Medical Necessity
- Client Plan
- Progress Notes

Located on the Optum website is the complete listing of recoupment criteria based on the above categories. Organizational and County providers shall be responsible for ensuring that all medical records comply with Federal, State and County documentation standards when billing for reimbursement of services.

At the conclusion of each medical record review, the provider will receive a Medi-Cal Recoupment Summary listing all disallowed billings based on the DHCS reasons for recoupment criteria. If the provider disagrees with a Medi-Cal recoupment, QM has developed a 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision. Providers must submit their appeals in writing to the QM Unit within required timelines. The appeal process is described in the final Medical Record Review (MRR) Report received by the program.

Site Reviews

Providers must comply with all Federal and State regulatory requirements and MHP contract requirements with DHCS. Site reviews are conducted to ensure that providers comply with necessary licenses/certification requirements, maintain a safe facility, and store and dispense medications in compliance with all pertinent Federal and State standards. During the site review visit, a Quality Improvement Specialist may review:

- Physical Plant/facility
- Health and Safety Requirements
- Licenses and Permits
- Required Program Documents
- Personnel
- Medication Service
- Cultural Competence
- Consumer Orientation
- Staff Training & Education
- Client Rights, Grievance & Appeals Process, and Advance Directives
- Staff knowledge of current Organizational Provider Operations Handbook

Medication Monitoring for CYF and AOA SOC

State and County regulations require all organizational providers with programs prescribing medication in the course of their services to have a medication monitoring system. **Out of County Providers shall adhere to their own County's Medication Monitoring process.** Current State Department of Health Care Services (DHCS) requirements for Medication Monitoring are set forth in CCR, Title 9, Chapter 11, Section 1810.440; MHP Contract with DHCS, Exhibit A, Attachment 1, Appendix A, B.4. The primary purpose of medication monitoring is to ensure the most effective treatment. Areas monitored include:

- Medication rationale and dosage consistent with community standards
- Appropriate labs
- Consideration of physical health conditions
- Effectiveness of medication(s) prescribed
- Adverse drug reactions and/or side effects
- Evidence of signed informed consent
- Client adherence with prescribed medication and usage
- Client medication education and degree of client knowledge regarding management of medications.
- Adherence to state laws and guidelines

Within the SDC BHS system of care, programs are required to review one percent (1%) of their active medication caseload each quarter, with a minimum of one chart reviewed. Closed cases, cases in which the client has not returned for recent services and clients that are not receiving medication are not to be reviewed. The sample shall include representation from all psychiatrists who prescribe.

The Medication Monitoring Committee function shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. The Medication Monitoring Committee may be comprised of two or more representatives from different disciplines but at least one of the members must be a psychiatrist or pharmacist. Psychiatrists may not review their own prescribing practices. It is the programs responsibility to assure that there is another psychiatrist to review the charts.

Contracted providers are required to perform the first-level screening of medication monitoring for their facility. Programs will use the Medication Monitoring Report, Medication Monitoring Screening tool (either Adult or Children's), and the Medication Monitoring Feedback Loop (McFloop) for their screening. If a variance is found in medication practices, a McFloop form is completed, given to the psychiatrist for action, and then returned to the Medication Monitoring Committee for approval.

Procedures for Medication Monitoring Reporting:

- Email/fax the Medication Monitoring Report to QM.
- Do not submit your Medication Monitoring tools or approved McFloop forms. Keep these forms on file at your clinic.
- If you have any unapproved McFloop forms, send in by secure email or by fax (619-236-1953) as they contain PHI.
- At the time of your Medical Record Review, QM Specialists will review your medication monitoring submissions for the last quarter.

Report Instructions: Variances are totaled by type of variance. For example, if you reviewed 10 charts, and one chart had a variance for variance #2a, then a "1" would be entered in the *variance 2a* box. If three charts had a variance for variance #6, then a "3" would be entered in *variance 6* box. Keep in mind when filling out the forms:

- Under the **Description of Activities Section**, all fields must be completed.
- Question 2a on both Adult and Children's form is for answering if labs were required. If no labs were required and it has been answered NO – this would not be a variance.

Results of medication monitoring activities are reported quarterly to the QM unit by the 15th of each month following the end of each quarter (First quarter due October 15, second quarter due January 15, third quarter due April 15 and fourth quarter due April 15). The QM Medication Monitoring Reports for the CYF and Adult's Mental Health Systems of Care are located in Appendix G. For AOA SOC be sure the criteria are met before completing the Benzodiazepine section of the Adult Medication Monitoring Tool.

Due to the number of missing signed consents and lab reports, BHS is establishing a standard for monitoring these two issues.

- All programs shall have a procedure in place to ensure the following:
 - Signed and updated consents are completed and filed in the hybrid record in a timely manner. (*See section L for Practice Guidelines*).
 - Labs are ordered and those results are returned in a timely manner. Programs shall ensure that lab results have been reviewed and filed in the hybrid record a timely manner.
 - Ensure there is sufficient follow up with clients/family members in keeping their appointments for labs.

The Health and Human Services Agency Pharmacy is responsible for performing the medication monitoring for County-operated facilities. The Chief of Pharmacy submits a written quarterly report that includes results of screening and clinical review activities to the clinic program managers and the Behavioral Health Quality Management Unit.

The QM Unit evaluates the reports from both the contractors and Chief of Pharmacy for trends, compiling a summary report submitted to the Quality Review Council (QRC), Program Monitor/COR, and the Pharmacy and Therapeutics Standards and Oversight Committee (P&T) quarterly. If a problematic variance trend is noted, the report is forwarded to the Medical Director for recommendations for remediation. Programs with severe or recurrent problems will have additional reviews and/or recommendations for a quality improvement plan.

CYF System of Care: Storage, Assisting with Self Administration, and Disposal of Medications

Only authorized California licensed personnel within the scope of their practice and in accordance with all Federal laws and regulations governing such acts shall administer medications. These licensed personnel include; physicians, physician assistants, nurse practitioners, registered nurses, licensed vocational nurses and licensed psychiatric technicians.

In instances where clients must take medications during the provision of mental health services, and licensed personnel are not present, the following procedures shall be in place:

1) *Storage of Medications*

- a) The client's parent/guardian shall bring in the prescribed medication, which is packaged and labeled in compliance with State and Federal laws.
- b) Medications shall be logged in on the "**Perpetual Inventory Medication Log**" (See *Appendix G, G.15*)
- c) All medications shall be stored in a locked, controlled and secure storage area. Access to the storage area shall be limited to authorized personnel only.
- d) The storage area shall be orderly, well-lit and sanitary. It shall have the proper temperature, light, moisture, ventilation and segregation that are required by Federal, State and County laws, rules and regulations.
- e) All controlled substances shall be double locked for security and shall only be accessible to authorized personnel.

2) *Assisting in the Self Administration*

- a) Careful staff supervision of the self-administration process is essential. Program staff shall provide the individual dose from the packaged and labeled container for client to self-administer.
- b) Staff shall record the self-administration of all medications on the **Perpetual Inventory Medication Log**.

3) *Disposal of Medications*

- a) Disposal shall occur when the medications are expired, contaminated, deteriorated, unused, abandoned, or unidentifiable. Programs may return medications to pharmacy representatives for disposal, or dispose of medications by placing them in biohazard sharps containers for transportation to incineration. If neither of these methods is available, the program can contact a pharmaceutical disposal company for transport and disposal. Examples include: Stericycle 1 (866) 783-9816 and KEM (619) 409-9292. Disposal by flushing medications into the water system or placing in the trash are both prohibited under environmental and safety regulations.
- b) Disposal shall be documented and co-signed on "**Medication Disposal Log**" (*Appendix G, G.16*).

ACCESSIBILITY OF SERVICES

The provider is responsible for preparing and maintaining appropriate records on all clients receiving services in compliance with CCR, Title 9, Chapter 11 and 42 CFR guidelines. Providers shall enter access to service requests in the EHR through the Access to Services Journal. At a minimum, the log must contain the name of the individual, the date of the request, the nature of the request, the initial disposition of the request, and whether the request was routine, urgent or an emergency.

The provider is expected to meet the MHP standards for access to emergency, urgent and routine mental health services to ensure that clients receive care in a timely manner. These access standards refer to the acceptable timelines for triage, intake, assessment, and clinical evaluation.

Access Times

Another measure of system efficiency is the amount of time that clients need to wait to receive access to services. County-operated and designated contracted providers of outpatient assessments and medication evaluations shall enter access times information in the EHR through the Access to Services Journal. For questions on the reporting for Access Times, contact BHSQIPIT@sdcounty.ca.gov.

The Access Times (for both Mental Health and Psychiatric Assessments) are defined as the time between the initial contact (which is the date of first contact with the individual or family, and would include date of walk-in, if applicable) until the first available assessment appointment, which may be for a face-to-face screening or complete Mental Health or Psychiatric Assessment.

If a client is unwilling to wait as long as necessary in a given program, the program shall refer to another provider (including emergency rooms, if needed) who can offer a more timely appointment.

The QI Performance Improvement Team (PIT) monitors program compliance for meeting access time standards. Any program that consistently exceeds the standard may be required to submit a QIP to address the deficiency.

CLIENT AND PERFORMANCE OUTCOMES

Adult System of Care:

In conjunction with new State and Federal mandates to show program effectiveness and client progress in rehabilitation and recovery, the MHP has extended the Client Outcomes tracking to almost all Outpatient and Case Management programs. If you think client outcomes tracking may not be feasible due to the special nature of your program, please contact your System of Care Monitor (COR, RPC) to discuss a possible exemption.

New outcome measures were chosen in June-2009 to better reflect the recovery orientation of the MHP. A provider advisory group, the Health Services Research Center (HSRC), and Mental Health Administration worked together for two years to select and pilot tools to make the most appropriate choice for the San Diego MHP. Beginning in July 2009, HSRC brought the new

measures to each provider. After an on-site provider staff training, each organization implemented the new measures.

In determining what indicators to select as part of the performance measurement system, San Diego County A/OAMH continued to use the following criteria: meaningfulness, applicability, availability, compatibility with California programs and priorities, and ease of use.

The A/OA outcomes measures include the Milestones of Recovery Scale (MORS). MORS is an evaluation tool used to assess clinician perception of a client's current degree of recovery. Level of Care Utilization System (LOCUS). LOCUS is a short assessment of client current level of care needs. Recovery Markers Questionnaire (RMQ). RMQ is used to assess personal recovery of the client from the perspective of the client. Illness Management and Recovery (IMR). IMR is a 15-item assessment addressing differing aspects of the client's illness management and recovery from the perspective of the clinician.

Section N details the system-wide outcome measures. Additional performance requirements are described in that section. The outcomes measures manual is available on the Optum website at: <https://www.optumsandiego.com> Go to "Organizational Providers" "County Staff & Providers" then the "Manuals" tab.

Child, Youth and Family System of Care:

In November 2017, the California Department of Health Care Services selected new statewide outcome measures for Children's Mental Health programs. These measures include the Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptom Checklist (PSC and PSC-Y). The State's primary purpose for the data obtained from the functional assessment tools is for quality improvement efforts. Section N details the system-wide outcome measures. Additional performance requirements are described in that section. The outcomes measures and data entry trainings are available on the CASRC website:

<https://medschool.ucsd.edu/som/psychiatry/research/CASRC/resources/SOCE/Pages/CYFmHOMS-DES.aspx>

Information on CANS certification, a requirement for administration, is available on the RIHS CYF Outcomes website:

<https://theacademy.sdsu.edu/programs/rihs/cyf-outcomes/>

All outcomes data will be entered in the Children, Youth and Families Mental Health Outcomes Management System (CYF mHOMS) data entry system (DES). Other data is manually collected by providers and submitted on a quarterly basis (QSR). The data is useful in determining trends

and patterns in service provision and demand, as well as, identifying opportunities for improvement.

In conjunction with new State mandates for quality improvement and monitoring client progress, the MHP is extending the Client Outcomes tracking to all programs through data reports and the QSR. See section N – Data Requirements and Section A – Systems of Care for client outcomes indicators determined by the MHP.

Participating programs shall report their outcomes data according to defined timelines. The Program Monitor/COR will review the results, check for adherence to the outcome standard, and identify if a plan of correction is needed. The QM unit will track trends for the data provided on the QSR and the quarterly CYF mHOMS DES report produced by CASRC. The specific outcomes procedures by level of care, the outcomes tools, and reporting requirements can be obtained by contacting your Program Monitor/COR and/or the Child and Adolescent Services Research Center (CASRC).

Monthly/Quarterly Status Report (M/QSR)

Providers are required to submit a monthly/quarterly status report to the COR which gives the MHP vital information about provider services. All sections of the report must be completed. Instead of twice-yearly reports on staffing for cultural competence, the new form includes a place to report monthly/quarterly on staffing and training. This report form is updated periodically in accordance with changing State, Federal and County regulations.

Mental Health Services Act (MHSA) Outcomes

Under the MHSA in San Diego, new programs are being started while others are expanding. As the MHSA is implemented across the State, new requirements for outcome reporting are anticipated to document how these funds are changing the lives of mental health clients. Providers receiving MHSA funding will be responsible for complying with any new requirements for additional outcome data. Currently, programs that have entered into Full Service Partnerships under the MHSA are required to participate in a direct State data collection program, which tracks initial specialized client assessments, ongoing key incident tracking, and quarterly assessments.

Performance Improvement Projects (PIPs)

The State has mandated that each county be engaged in one administrative and one clinical performance improvement project each year in order to improve processes and outcomes of care.

A PIP is a comprehensive, long-term quality improvement project includes a commitment to improving quality through problem identification, evaluating interventions and making adjustments as necessary. It may provide support/evidence for implementing protocols for “Best Practices”. The External Quality Review Organization (EQRO), contracted by the State, evaluates progress on each PIP annually.

The MHP may ask for your involvement in the PIP by:

- Implementing current PIP interventions/activities/procedures at your programs
- Supporting survey administration and/or focus group coordination at your programs
- Developing your own program’s PIP projects

SERIOUS INCIDENT REPORTING (SIR)

An incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community shall be reported to the BHS Quality Management Unit. There are two types of reportable incidents, 1) Serious Incidents are reported to the BHS QM Unit and 2) Unusual Occurrences are reported directly to the program’s Contracting Officer Representative (COR).

All providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less. Required reports shall be sent to the QM Unit who will review, investigate as necessary, and monitor trends. The QM team will communicate with program’s COR and BHS management. The provider shall also be responsible for reporting serious incidents to the appropriate authorities.

Serious Incident Categories: Level One and Level Two

Serious incidents shall be classified into two levels with Level One being most severe and Level Two less severe.

A Level One incident is the most severe type of incident. A level One incident must include at least one of the following:

- Any event that has been reported in the media/public domain (television, newspaper, internet), current or recent past, regardless of type of incident.
- The event has resulted in a death or serious physical injury on the program’s premises.
- The event is associated with a significant adverse deviation from the usual process for providing behavioral health care.

A Level One serious incident shall be reported to the QM SIR Line at 619-641-8800 immediately upon knowledge of the incident. The provider shall submit the Serious Incident Report to the QM Unit within 24 hours of knowledge of incident.

A Level Two serious incident shall be reported to the QM SIR Line at 619-641-8800 no later than 24 hours of knowledge of the incident. The provider shall submit the Serious Incident Report to the QM Unit within 72 hours of knowledge of incident. A level two incident is any serious incident that does not meet the criteria of a Level One serious incident.

After review of the incident, QM may request a corrective action plan. QM is responsible for working with the provider to specify and monitor the recommended corrective action plan.

The QI unit will monitor serious incidents and issue reports to the Quality Review Council and other identified stakeholders.

Serious incidents are categorized as follows:

- Incident reported in the media/public domain (e.g. on television, newspaper, internet)
- Suicide attempt by client that requires medical attention or attempt is potentially fatal and/or significantly injurious.
- Death of client by suicide (includes overdose by alcohol/drugs/medications, etc.)
- Death of client under questionable circumstances (includes overdose by alcohol, drugs, medications, etc.)
- Death of client by homicide
- Alleged homicide attempt on a client (client is victim)
- Alleged homicide attempt by a client (client is perpetrator)
- Alleged homicide committed by a client (client is perpetrator)
- Injurious assault on a client (client is victim) occurring on the premises of the program resulting in death, severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.
- Injurious assault by a client (client is perpetrator) occurring on the premises of the program resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.
- Tarasoff Notification, the duty to protect intended victim, is made to the appropriate person(s), police, or other reasonable steps have been taken to protect the intended victim. *Note: Serious Incident Report of Finding not required unless indicated.*
- Tarasoff Notification, the duty to protect intended victim, is received by the program that a credible threat of harm has been made against a staff member(s) or program and appropriate safety measures have been implemented. *Note: Serious Incident Report of Finding not required unless indicated.*
- Serious allegations of or confirmed inappropriate staff (includes volunteers, interns) behavior such as sexual relations with a client, client/staff boundary issues, financial exploitation of a client, and/or physical or verbal abuse of a client.

- Serious physical injury to a client requiring hospitalization where the injury is directly related to the client's mental health or substance use functioning and/or symptoms.
- Adverse medication reaction resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- Medication error in prescription or distribution resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- Apparent overdose of alcohol/illicit or prescriptions drugs, whether fatal or injurious, requiring medical attention.
- Use of physical restraints (prone or supine) only during program operating hours (applies only to CYF mental health clients during program operating hours and excludes SUD programs, Hospitals, Long-Term Care Facilities, San Diego County Psychiatric Hospital/EPU, ESU and PERT)
- Other

Serious Incident Reporting Procedures

1. Upon knowledge of incident, program shall report the incident and all known details to the SIR Line at 619-641-8800
2. All providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less.
3. A Level One serious incident shall be reported to the SIR Line immediately upon knowledge of the incident and followed up with the written SIR report to QM no later than 24 hours.
4. A Level Two serious incident shall be reported to the SIR Line no later than 24 hours of knowledge of the incident and followed up with the written SIR report to QM within 72 hours.
5. In the event of a serious incident, the program manager or designee will immediately safeguard the client's medical record. Program manager shall review chart as soon as possible. The client medical record shall not be accessed by unauthorized staff not involved in the incident.
6. All program staff will maintain confidentiality about client and serious incident. The serious incident should not be the subject of casual conversation among staff.
7. All serious incidents shall be investigated and reviewed by the program. The program shall submit a complete Report of Findings to QM within 30 days of knowledge of the incident.
8. Tarasoff incidents do not require a SIROF unless the Program Manager, after review, has concluded one is indicated due to a systemic or client related treatment issue.
9. An SIR is never to be filed in the client's medical record. A Serious Incident Report shall be kept in a separate secured confidential file.

10. A serious incident that results in 1) a completed suicide or 2) an alleged client committed homicide will automatically trigger a chart review by the QM Unit and require the completion of a Root Cause Analysis (RCA) within 30 days of knowledge of the incident.
11. The Action Items because of the RCA shall be summarized and submitted to the QM unit with 30 days of knowledge of the incident. Do not submit the RCA worksheet, only a summary of action items.

Clinical Case Reviews

Under the direction of the BHS Clinical Director, a clinical case review convenes regularly to review cases involving a completed 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 medical records that are reviewed in clinical case conference.

Stakeholders, including BHS Director, CORs, Deputy Directors, QI Chief, Program Managers, County or Contractor QI staff, or other designated staff may make a request at any time for a clinical case review. Specific requests for case reviews should be coordinated through the QM Unit by contacting QIMatters.hhas@sdcounty.ca.gov.

Please Note:

The Serious Incident RCA Worksheet is required for San Diego County operated programs per current HHSA/MHS General Administration Policies and Procedures. San Diego County Contracted programs may use the Serious Incident RCA Worksheet or some other process that is approved by their Legal Entity. It is recommended that programs not choosing to use the Serious Incident RCA Worksheet ensure that the process they do use incorporates best practices for their analysis of findings (see http://www.jointcommission.org/sentinel_event.aspx for more info on RCA). Technical assistance is available by request through QIMatters.hhsa@sdcounty.ca.gov RCA training is offered on a quarterly basis.

Level One Serious Incident Reporting on Weekends and Holidays

Level One Serious Incidents are required reporting for Legal Entity (LE) behavioral health programs on weekends and holidays to the QM Unit and Designated County Staff. This requirement does not apply to Level Two serious incidents.

Follow this procedure for reporting a **Level One** Serious Incident on Weekends and Holidays.

1. For a Level One Serious Incident, call the QM SIR Line and report the incident.

2. Each LE will identify key Senior Level staff (1-3) that are designated as the main contact person(s) for their programs needing to report a Level One incident on weekends and holidays. This LE designated staff will report the Level One incident by calling or leaving a message with all required information including a call back number for the County Designated Staff. Each LE will be provided the contact phone numbers of the County Designated Staff.
3. Program staff should only be reporting the Level One Serious Incident to their LE designated staff. Program staff should not be directly contacting the County Designated Staff.
4. Report Level One Serious Incidents to the County Designated Staff on weekends and holidays between the hours of 8:00am – 8:00pm (reporting hours). If you have a Serious Incident that occurs outside of reporting hours, then report the Serious Incident on the next or same day during reporting hours. This requirement is only for Level One Serious Incidents.
5. Weekend Coverage is defined as Saturday and Sunday. Holiday Coverage is defined as any designated County Holiday.
6. County designated staffs are identified in priority contact order as:
 - 1) Adult SOC Assistant Deputy Director – A/OA Providers
 - 2) CYF SOC Assistant Deputy Director – CYF Providers
 - 3) Director; BHS (third back up).

Privacy Incident Reporting (PIR) for Staff and Management

Programs shall follow the HHS A Privacy Incident Reporting Policy. When staff becomes aware of a suspected or actual privacy incident. Staff notifies Program Manager immediately. Program Manager immediately notifies COR.

If a County incident, Program Manager will:

1. If suspected or actual privacy incident involves 500 or more individuals, notify Agency Privacy Officer (APO) immediately by emailing: angie.devoss@sdcounty.ca.gov and frank.larios@sdcounty.ca.gov. For all other suspected or actual privacy incidents, follow steps below.
2. Submit an Initial HHS A Privacy Incident Report (PIR) online via the web portal: <https://www.sandiegocounty.gov/content/sdc/hhsa/hhsa-privdb-landing.html>. Complete initial PIR web-form to the best of your ability and submit within one business day. The PIR web-form landing page link is also available on the Agency Compliance Office's website: www.cosdcompliance.org.
3. Submitter will receive an email with the PIR Tracking # and an Access Code. Use this information to access your PIR via the same web link above.

4. Continue to investigate and Update the PIR online within 72 hours, including required information missing from initial report and any additional information requested by APO.
5. Provide any pending or additional information needed to submit Final completed PIR within seven business days of initial discovery.

If a Contractor incident, COR will:

1. Direct Contractor to complete HHS Privacy Incident Report Web-Form online and updates, as outlined above.
2. Direct Contractor to complete any other steps as directed by APO, including, but not limited to notifications or external reporting.

San Diego County contracted providers should work directly with their agency's legal counsel to determine external reporting and regulatory notification requirements and provide their determination to the HHS Privacy Officer.

UNUSUAL OCCURRENCE REPORTING

An unusual occurrence is reported directly to your COR/Program Monitor within 24 hours of knowledge of the incident. An unusual occurrence is defined as an incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community that does not meet the criteria of a serious incident. Unusual occurrences may include but are not limited to:

- Alleged child abuse
- Police involvement
- Inappropriate sexual behavior
- Self-injury
- Physical injury
- Physical abuse
- AWOL
- Fire setting
- Poisoning
- Major accident
- Property destruction
- Epidemic or other infectious disease outbreak
- Loss or theft of medications from facility

Safety and Security Notifications to Appropriate Agencies

When an Unusual Occurrence occurs or are identified, the appropriate agencies shall be notified within their specified timeline and format:

1. Child and Elder Abuse Reporting hotlines.
2. Tarasoff reporting to intended victim and law enforcement
3. Law enforcement (police, sheriff, school police, agency security, military security/Naval Investigative Service, etc.) for crime reporting or requiring security assistance and inquiries.
4. Every fire or explosion that occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshall.

Child, Youth and Family: Additional Reporting

CYF providers may notify other outside agencies who serve the client upon consideration of clinical, health and safety issues. Notification should be timely and within 24 hours of knowledge of the incident. The required agencies include but are not limited to:

- Children Welfare Services
- Probation Officer
- Regional Center
- School District
- Therapeutic Behavioral Services (TBS) – Both County and Contractor
- Other programs that also serve the client

Reportable issues may include:

1. Health and safety issues
2. A school suspension
3. A student is taken to a hospital due to an injury or other medical issue which occurs at the program site or when the TBS worker is present
4. A referral for acute psychiatric hospital care
5. An issue with direct service provider staff, which may lead to worker suspended or no longer providing services
6. A significant problem arising while TBS worker is with the child

QUALITY REVIEW COUNCIL (QRC)

The Quality Review Council (QRC), mandated by State regulation, is a collaborative group that is chaired by the MHP Clinical Director and consists of MHP stakeholders including clients and family members, County and contracted providers, associations and advocacy groups representing the mental health community, and hospital providers. The QRC meets regularly to review, discuss and make recommendations regarding quality improvement issues that affect the delivery of

services through the MHP. Participation in the QRC is encouraged. If you would like to participate in the QRC, email QIMatters.hhsa@sdcounty.ca.gov

NATIONAL VOTER REGISTRATION ACT (NVRA)

Per the National Voter Registration Act (NVRA) of 1993, providers are required to offer voter registration materials at intake (except in a crisis), renewal and anytime a change of address is reported. For TAY and Adult programs, voter registration services shall be provided to clients who are:

- A citizen;
- Live in California;
- At least 18 years of age by the date of the next election; and
- Not currently on parole for a felony conviction or formally judged by a court to be mentally incompetent to vote.

For Children's programs, voter registration services shall be offered to parents/guardians of clients less than 18 years of age.

Mental Health Programs shall have Voter Registration Forms and General Instruction Forms available to clients in English, Spanish and Tagalog as required by the County of San Diego Registrar of Voters. An attached Voter Registration Form, General and State Instructions Form and DSS 16-64 form shall be included in all intake/admission packets. Additionally, the same level of assistance shall be provided to mental health consumers registering to vote as is provided for completing other forms for mental health services. When a client requests a form in a language other than those available from the County's Registrar of Voters, staff shall provide the client with the Secretary of State's toll free number: 1-800-345- VOTE. Voter Registration forms in the threshold languages can be found in *Appendix A.G.18-A.G.22*.

Training on the legal requirements and County expectations under this Act is required to be taken by provider staff once each year. The NVRA training is available on the HHSA BHS webpage: <http://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/>. For more information, refer to Medi-Cal Eligibility Division Information Letter I 12-02 (<http://www.dhcs.ca.gov/services/medical/eligibility/Documents/cI12-02.pdf>). If you have additional questions about this requirement, please contact your Contracting Officer Representative (COR).

Failure to implement the NVRA may subject the agency to legal liability.

H. CULTURAL COMPETENCE

Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

History and Background

Cultural norms, values, beliefs, customs and behaviors may influence the manifestation of mental health problems, the use of appropriate levels of care/services, the course of treatment and the successful attainment of positive outcomes. The County's dynamic demographics combined with the recognition that culture is a key factor in service delivery pose an ongoing challenge for the MHP and its contracted mental health care providers. The 2010 United States Census reports a 10% population increase in San Diego County, with no single racial/ethnic group comprising a majority. Whites make up 48% of the population, Hispanics – 32%, Asians – 11%, Blacks – 5% and Native Americans/American Indians – 1%.

As the diversity of the population continues to increase, the FY 2015-16 Progress Towards Reducing Disparities Report noted an increase in the number of Medi-Cal mental health clients from various minority populations. Efforts to reduce barriers to behavioral health care across clients in different age groups and racial/ethnic minorities have been a priority for BHS. However, the demographic breakdown of individuals eligible for BHS services differs markedly from the demographic make-up of the county as a whole. For example, although individuals of Hispanic origin make up 30% of the adults in the San Diego County population, this segment accounts for 60% of the eligible client population. A disparity was also found between the number of minority clients participating in the Medi-Cal program and the number of clinicians available with self-assessed proficiency in needed ethnic, racial and cultural specialties.

The Cultural Competence Plan reports that in addition to changing demographics related to ethnicity and race, age demographics are changing in the county and will affect service demands. The number of older adults living in San Diego is one of the most rapidly increasing populations, with an estimated 23.5% being 55 years of age or older.

Cultural Competence Plan

To address these issues in the 2017 Cultural Competence Plan and the Three-Year Strategic Plan, the MHP set the following objectives to improve cultural competence in the provision of mental health services:

- 1) Continue to conduct an ongoing evaluation of the level of cultural competence of the mental health system, based on an analysis of gaps in services that are identified by

comparing the target population receiving mental health services to the target population receiving the Medi-Cal and the target population in the County as a whole.

- 2) Continue to compare the percentage of each target population with provider staffing levels.
- 3) Investigate possible methods to mitigate identified service gaps.
- 4) Enhance cultural competence training system-wide.
- 5) Evaluate the need for linguistically competent services through monitoring usage interpreter services.
- 6) Evaluate system capability for providing linguistically competent services through monitoring organizational providers and FFS capacities, compared to both threshold and non-threshold language needs.
- 7) Study and address access to care issues for underserved populations.

Current Standards and Requirements

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization and in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable about, the clients' culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

National Culturally and Linguistically Appropriate Services (CLAS) Standards:

The National Culturally and Linguistically Appropriate Services (CLAS) Standards have replaced the Culturally Competent Clinical Practice Standards. The CLAS Standards are a series of guidelines that are intended to inform and facilitate the efforts towards becoming culturally and linguistically competent across all levels of a health care continuum. The CLAS Standards were originally developed by the Health and Human Services Office of Minority Health and are comprised of 15 Standards. All Statements of Work include the language on the requirement of the programs to implement the CLAS Standards.

The Standards are as follows:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Cultural Competence Training Opportunities through the MHP

- Cultural Competence Trainings are available through the County Knowledge Center (TKC) for County operated program staff at no cost and for a small number of providers on a fee basis.

- Cultural Competence Trainings are available through some of SDCBHS's larger contractors. Community Research Foundation, New Alternatives, and Mental Health Systems, Inc. offer such trainings to their own program staff, but other providers may send staff on a fee basis.
- SDCBHS Contracted Trainings are available through the Behavioral Health Education and Training Academy (BHETA). Limited classroom training and on-line trainings are available at no cost to staff of County contracted and County operated programs. BHETA also offers a one-hour eLearning on the implementation of CLAS Standards.

Cultural Competence Monitoring and Evaluation:

The MHP QI Unit and the CORs are responsible for monitoring and evaluating compliance with cultural competence standards as outlined in the County's Cultural Competence Plan and with State and Federal requirements. The QM Unit and the CORs utilize both the medical record review and the annual Contract Review to monitor providers regarding cultural competence. In addition, provision of/usage of the tools listed below is now cultural competence requirement:

Program Level Requirements:

1. Cultural Competence Plan (CC Plan). CC Plans are required for all legal entities. If your organization does not have a CC Plan, the CC Plan Component Guidelines outlined below may be used to assist you in developing a CC Plan. They are available in the Cultural Competence Handbook (pages 12-13) on the Technical Resource Library (TRL) website at:
http://www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html
The CC Plan Component Guidelines are as follows:
 - Current Status of Program
 - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
 - Identify how program administration prioritizes cultural competence in the delivery of services.
 - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
 - Goals accomplished regarding reducing health care disparities.
 - Identify barriers to quality improvement.
 - Service Assessment Update and Data Analysis
 - Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
 - Comparison of staff to diversity in community.
 - A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.

- Use of interpreter services.
- Service utilization by ethnicity, race, language usage, and cultural groups.
- Client outcomes are meaningful to client's social ecological needs.
- Objectives
 - Goals for improvements.
 - Develop processes to assure cultural competence (language, culture, training, and surveys) is developed in systems and practiced in service delivery.
 - Trauma-informed principles and concepts integrated
 - Faith-based services

New contractors need to submit a CC Plan, as specified in their Statement of Work, unless their legal entity has already provided one. As new programs are added, legal entities are expected to address their unique needs in the CC Plan.

Plans should be sent via email to BHSQIPIT@sdcounty.ca.gov.

2. Annual Program Evaluation – every year, program managers are required to complete a cultural competence assessment of each program, using the tool which will be provided by SDCBHS electronically to each program manager. Every program manager is provided three weeks to complete the survey. The survey can be completed in approximately one hour or less. The tool is available in the CC Handbook on TRL for reference.
3. In order to present a welcoming appearance to unique communities, providers are required to ensure that their facility is comfortable and inviting to the area's special cultural and linguistic populations. Program hours of operation must be convenient to accommodate the special needs of the service's diverse populations.

Staffing Level Requirements

Biennial Staff Evaluation – every two years, staff members of the County-contracted and County-operated behavioral health programs are required to self-assess their cultural competence in providing behavioral health services. The staff are provided two weeks to complete the survey. The tool is available in the CC Handbook on TRL for reference.

A Minimum of 4 hours of Cultural Competence Training Annually. Contractors shall require that, at a minimum, all provider staff, including consultants and support staff interacting with clients or anyone who provides interpreter services must participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written coursework, a review of published articles, web training, viewed videos, or attending a conference can count the amount of time devoted to cultural competence enhancement. A record

of annual minimum four hours of training shall be maintained on the Monthly Status Report. The following conditions also apply:

- a. All new staff must meet the requirements within 90 days of hire; including temporary staff who have been on site at least 90 days.
- b. Staff hired after May 15 are exempt from the requirement for that fiscal year but must meet requirement “a”.
- c. Volunteers who have served or are expected to serve 100 or more hours at the program must meet the requirement.

Consumer Preference – Cultural/Ethnic Requirements:

Consumers must be given an initial choice of the person who will provide specialty mental health services, including the right to use culturally specific providers. Providers are also reminded that whenever feasible and at the request of the beneficiary, clients have the right to request a change of providers. Requests for transfers are to be tracked on the Suggestion and Transfer section attached to the Quarterly Status Report.

Consumer Preference – Language Requirements:

Services should be provided in the client’s preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free interpreter services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. The offer of interpreter services and the client’s response must be documented.

Progress notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the beneficiary, consumers must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers.

Some county and contracted programs are Mandated Key Points of Contact. As a Mandated Key Point of Contact, the program must have staff or interpretation available to clients during regular operating hours that are linguistically proficient in the mandated threshold languages. The Access and Crisis Line, the EPU, and the ESU are Mandated Key Points of Entry for all threshold languages. In addition the following clinics are also designated as Mandated Key Points of Entry for the languages listed:

- Spanish
 - EPU
 - All Outpatient and Case Management programs
- Vietnamese
 - UPAC
- Tagalog

- UPAC
- Arabic
 - East County Mental Health

All other County and Contracted providers must at a minimum be able to link clients with appropriate services that meet the clients language needs whether the language is a threshold language or not.

Additional Recommended Program Practices

Programs will also be encouraged to do the following:

- If there is no process currently in place, develop a process to evaluate the linguistic competency of staff that is providing service or interpretation during services, in a language other than English. This may be accomplished through a test, supervision or some other reliable method. The process should be documented. A suggested process for certification of language competence can be found on page 51 of the CC Handbook on TRL.
- Conduct a survey or client focus group every couple of years and include clients who are bi-lingual and monolingual to assess program and staff cultural competence, community needs and the success of efforts the program is making to meet those needs. Sugestions surveys and discussion questions are available on pages 53, 57, and 59 of the CC Handbook on TRL.

I. MANAGEMENT INFORMATION SYSTEM

Cerner Community Behavioral Health (CCBH)

The County of San Diego BHS manages an electronic health record (EHR) for the MHP County and Contracted providers. The electronic Mental Health Management Information System (MH MIS) utilized by the MHP is Cerner Community Behavioral Health (CCBH). All client information, including clinical documentation, is entered into CCBH allowing for improved coordination of care across the MHP System of Care.

For the complete **Management Information System: CCBH User Manual**, go to the Optum Health Public Sector Website at <https://www.optumsandiego.com>

User Account Setup and Access

The Mental Health Management Information System (MH MIS) is used by County and contract operated programs for client tracking, managed care functions, reporting and billing. An electronic health record (EHR) will replace much of what is contained in the paper medical record. Many controls are built into the software and hardware to safeguard the security and privacy of client personal health information.

CCBH Software is a web based application that is managed by Cerner. Access to CCBH is through a secure portal which requires a user to establish an account in order to obtain an identification number, menu group, and password. Access to CCBH is granted through the MH MIS Unit by completing the appropriate access and security forms. Users are required to attend and pass a CCBH training class prior to access.

System Administration for CCBH is shared between the Administrative Services Organization (ASO) and the County's Mental Health MIS Unit.

The Mental Health MIS (MH MIS) Unit is responsible for managing access, security, and menu management in CCBH in accordance with County, State and Federal HIPAA regulations. The MH MIS Unit is also the gatekeeper who ensures that staff is only given access pursuant to contract agreements. In addition, the MH MIS Unit is responsible for coordination among the County Technology Office, Cerner and the ASO.

The ASO is responsible for other system administration activities such as table management, system maintenance, updates to the application, managing the five CCBH environments, producing reports for legal entities, electronic submission of state reporting, coordination with CCBH Software, and providing the User Support Help Desk.

Technical Requirements to Access CCBH

Prior to accessing the CCBH application via the internet, there are some basic technical requirements. For questions about whether an individual user or program site meets the basic technical requirements, it is recommended that the individual or program contact their company's IT department. The ASO may also be able to provide some technical assistance.

Staff Set Up and User Account Access

All individuals who provide services or perform some other activity to be recorded CCBH as well as those who are authorized to access CCBH must have a staff account. A “staff” in CCBH is defined as an individual who is employed, contracted or otherwise authorized by his or her designated legal entity or County business group to operate within the County of San Diego public mental health System of Care and whose primary job function may include any one of the following: to provide Mental Health Services, Quality Assurance activities, enter data, view data, or run reports. This includes clinicians, doctors, nurses, office support staff, financial/billing staff, research/analyst staff and program managers/administrative staff. All Staff providing services must provide National Provider Identifier (NPI) and taxonomy numbers. All staff will be assigned a staff ID, which is a numerical ID ranging from 15 numbers. (**Note:** If a person is employed by more than one legal entity, he/she will have a unique staff ID for each legal entity.)

Staff is given access to specific Unit(s)/SubUnit(s) based upon the program(s) where they work. Staff is also given access to specific menus based on their respective job functions. A list and definition of menus is available on the CCBH Request Form.

Staff authorized to access CCBH will be given login access and a password and are considered “users”.

User Access requires the following steps:

1. Program manager completes the “CCBH Request Form” (ARF).
2. Contractor employee and employee’s supervisor must read and sign the “Staff Electronic Signature Agreement”.
3. Contractor employee and employee’s supervisor must also read and sign the County’s “Summary of Policies” (SOP) form.
4. Fax all completed forms to the **MH MIS Unit Fax at (858) 467-0411 or SCAN and EMAIL to BHS – AccountRequest.HHSA@sdcounty.ca.gov**

All forms **must** be typed, and contain all necessary information. Incomplete forms will be returned to the contact person listed on the form. Once completed correctly, the forms must be re-faxed to MH MIS Unit. Please ensure forms are completed correctly to avoid delay in user account setup.

Once all forms have been submitted, the MH MIS Unit will:

1. Set up of a Citrix User Account with ID/password
2. Set up CCBH User Account with ID/password
3. User will be provided his/her Citrix/CCBH ID/passwords at the CCBH training.

Program managers and other supervisors are responsible to:

1. Register new staff who will be users to attend the “New User CCBH Training”
2. Confirm that employee has successfully completed CCBH training

All forms with instructions are available electronically on the ASO’s (Optum) Public Sector website at <https://www.optumsandiego.com>

Staff Assignment to Unit(s) and SubUnit(s)

On the ARF, the program manager will be assigning each staff to specific Unit(s) and SubUnit(s) based upon the program(s) where the staff performs work. Staff may be assigned to a single or multiple Unit/Subunits. The Unit/SubUnit number(s) must be reflected on the CCBH Request Form. The MH MIS Unit will monitor staff access to Units/Subunits to ensure that staff has been assigned correctly. Under no circumstances, should a staff person be assigned to a Unit/Subunit if that staff person does not perform work for that program. This would constitute a violation of security and client confidentiality.

User Assignment to a Menu Group

Each user is granted restricted access to MH MIS based on his/her job requirements. One of the ways that access is restricted is through assignment to Units and Subunits described above. In addition, access is further restricted by assignment to a menu group. A menu group defines the screens and reports the user will be able to access and whether the user can add/edit or delete for each of those screens. For example, the user may only be able to view but not change data in one screen but may have rights to add data or edit previously entered data for another screen. Menu groups are created based on multiple criteria such as security, level of access to client information, staff job functions, staff credentials and state and federal privacy regulations.

On the ARF, the program manager or supervisor is responsible for requesting the menu group assignment for each user based on his/her job functions. A user may only be in one menu group at a time. Therefore, it is important for the program manager/supervisor to determine which menu group is the best match for the job functions performed by his/her staff.

For example, there will be menu groups for:

- Data entry staff with full client look up rights
- Data entry staff with limited client look up
- Clinicians
- Program managers and supervisors
- Quality Assurance
- Billing staff
- Billing only (For Billing Purposes Only – It has no views)
- Research and Analysts

Refer to the ARF Instructions for a list and definition of available menus. The MH MIS Unit will review

menu group requested by the program manager/supervisor and approve or modify the request.

Limitation of Staff Assignment to “Data Entry – Add New Clients” Menu Group

Program staff will be allowed to view information about a client currently or previously served by their program. Designated program staff will be given access to the “full client look up” in order to add new clients and assign existing clients to their subunit (program). These individuals will be allowed to view all clients in the system, including those not served by their program. This access allows for data entry, adding new clients, full client lookup; entering demographic, diagnosis, insurance, and financial information (UMDAP); opening assignments; and running reports.

Staff Access to Live Production and Training Environment in CCBH

For most users, after logging on to CCBH through the Citrix Access Gateway, two visible CCBH icons will be available for selection. One icon provides access to the Live Production environment used for data entry and reporting. The other icon provides access to the Training environment which is a copy of the setup of the live environment populated with fictitious client data. The training environment is used to train all new and returning users. Access to the training environment will remain available for ongoing training purposes. For example, on occasion, when there are upgrades to the CCBH application, it may be necessary for staff to first practice in the Training environment prior to utilizing new functionality in the Live Production environment. Program managers and staff will be notified of changes to application functionality and will be instructed as to when the training environment should be utilized.

Program Manager/Supervisor Responsibility for Staff Access and Security

The program manager/supervisor shall ensure that staff is in compliance with all County, State and Federal privacy and confidentiality regulations regarding security, providers protected health information (PHI). In addition, the program manager shall ensure that his/her staff is aware of the County’s Security Policy regarding the protection of network/application passwords and use of County systems and data as outlined when staff with in San Diego County’s “Summary of Policy”. The program manager shall immediately notify the MH MIS Unit whenever there is a change in information such as staff demographics, email, job title, credential/licensure, and jobs, or are Unit/Subunit assignment. This includes the initial staff setup, modifying or terminating existing staff accounts.

Under no circumstances shall a staff person who has terminated employment have access to the EHR through CCBH. This would constitute a serious violation of security which may lead to disciplinary actions.

Staff Termination Process

- **Routine User Termination** – In most cases, staff employment is terminated in a routine manner in which the employee gives an advanced notice. Within one business day of employee termination notice, the program manager shall fax to the MH MIS Unit (858) 467-0411 or scan and email to BHS-AccountRequest.HHSA@sdcounty.ca.gov a completed ARF with the termination date (*will be a future date*). The MH MIS Unit will enter the staff expiration date in CCBH which will inactivate the staff account at the time of termination and process the CSRF to delete the County network Citrix

account.

- **Quick User Termination** – In some situations, a staff person’s employment may be terminated immediately. In this case, the program manager must immediately call the MH MIS Unit at (619) 584-5090 to request the staff account be inactivated immediately. Within one business day, the program manager shall fax a completed ARF to the MH MIS Unit (858) 467-0411 or scan and email to BHS-AccountRequests.HHSA@sdcounty.ca.gov.

The MH MIS Unit is responsible for inactivating both the CCBH and Citrix staff accounts.

Application Training

Prior to staff obtaining access to CCBH, he/she shall successfully complete the CCBH training. Program managers are responsible for registering new and returning CCBH users for training on the CCBH application. The Quality Management (QM) Unit provides training on a regularly scheduled basis. Previous CCBH users returning to employment (including maternity leave) after more than 90 days of absence will be required to resubmit new paperwork including an updated ARF and be evaluated for a skills assessment or retraining.

User Manuals

Users should be familiar with the MH MIS User Manual and the Financial Eligibility and Billing Procedures Manual, which contain detailed information about program workflow requirements using the MH MIS. These manuals are available on line at www.optumsandiego.com

Security and Confidentiality

The County of San Diego is responsible for the protection of County technology and data and to monitor through its own policies and procedures user compliance with state and federal privacy and confidentiality regulations.

The County’s Security mandates state that access will be given to a user at the least minimum level required by the user to execute the duties or job functions and that only those individuals with a “need to know” will be given access. Protection of County data and systems is also achieved via the use of unique user identification and passwords as well as other tracking methods.

Passwords

The sharing of passwords or allowing unauthorized individuals access into the system is strictly prohibited. A user’s password is his/her electronic signature that is not to be shared or made available to anyone. Programs must ensure that the County’s Policy and Procedures regarding

security and confidentiality as stated in the Summary of Policies is complied with at all times. Failure to comply with these policies and procedures can result in the temporary or permanent denial of access privileges and/or disciplinary action.

MH MIS passwords:

- Must be changed every 90 days
- Must have a minimum of 7 characters
- Must contain a mix of letters & numbers
- May NOT be reused
- Are case sensitive
- Will be rejected if common words or acronyms are used

Unauthorized Viewing of County Data

All terminals and computer screens must be protected from the view of unauthorized persons. All confidential client information, electronic or printed, shall be protected at all times.

User Support

Users can obtain support through the Optum Support Desk. The Optum Support Desk can assist a user with the MH MIS application (technical assistance), MH MIS password issues, connectivity/access problems, printer problems, data entry questions, special requests, such as reports and Citrix access issues for contractors. For Citrix access issues (i.e. password reset), County employees must contact the County IT vendor.

In some cases, the Optum Support Desk may refer the caller for second level user support, i.e. to the Mental Health Quality Management Unit for clinical issues and to the Mental Health Billing Unit for financial eligibility and billing issues.

The Optum Support Desk may be contacted as follows:

Phone: 1-800-834-3792 Fax: (619) 641-6975

Emails: sdhelpdesk@optumhealth.com

Optum Support Desk hours: Monday through Friday, from 6:00 am to 6:00 pm except on holidays. The Optum Support Desk will provide after-hour cell phone emergency support for urgent Citrix and CCBH issues.

- For after-hour support use cell (800) 834-3792 on weekdays 4:30 am – 6:00 am and 6:00 pm – 11:00 pm and on weekends 4:30 am – 11:00 pm

For an operating system failure, contact your company's IT department. The IT department will determine the need for Optum Support Desk involvement.

NOTE: Printing issues, password resets technical and CCBH application questions are not considered an emergency and will be handled the next business day.

QUICK RESOURCE GUIDE

1. MH MIS Unit Phone: 619-584-5090
2. MH MIS Unit Email: MH_MIS_SystemAdmin.hhsa@sdcounty.ca.gov
3. MH MIS FAX (ARFs and SOPs): 858-467-0411
4. MH MIS Email (ARFs and SOPs): BHS-AccountRequest.HHSA@sdcounty.ca.gov
5. Optum Support Desk Phone: 1800-834-3792
6. Optum Support Desk 24 Hour Pager: 619-893-4839
7. Optum Support Desk email: sdhelpdesk@optumhealth.com
8. Web address to access CCBH: <https://mhmis.co.sandiego.ca.us>
9. Optum Public Sector Website: www.optumsandiego.com

J. PROVIDER CONTRACTING

Note: References to contracting do not apply to County-operated programs.

All contracted providers, including subcontractors, shall adhere to the Mental Health Plan contract executed between San Diego County and the California State Department of Health Care Services (DHCS).

All non-County-operated organizational providers must contract with the County of San Diego in order to receive reimbursement for Specialty Mental Health Services. Please read your contract carefully. It contains:

- General terms applicable to all contracts;
- Special terms specific to a particular contract;
- A description of work or services to be performed;
- Payment Schedule and/or budget; and
- Statutes and/or regulations particular to the Medi-Cal managed mental health care programs as well as programs supported by other funds.

Selection and monitoring of organizational agencies is governed by contracting procedures, which require a review of the organization's fiscal soundness, resumes of principal administrators and supervisors, the agency's experience with similar services, and a proposed staffing plan. All contracted providers will be expected to adhere to these requirements. Please contact your Behavioral Health Services Contracting Officer's Representative (COR) if you have any questions regarding your contract.

Disclosure Requirements

The Managed Care Plan (MCP) providers and contractors shall disclose to the state any persons or corporations with an ownership or control interest that:

- Has direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Legal Entity's equity;
- Owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Legal Entity if that interest equals at least 5% of the value of the MCP's assets;
- Is an officer or director of an Legal Entity organized as a corporation; or
- Is a partner in a Legal Entity organized as a partnership.

Any person with a 5% or more direct or indirect ownership of the Legal Entity's equity must submit to a criminal background check, including submitting fingerprints. See section 42 CFR 455.434(b)(1).

The contract requires the MCP to submit:

- The name and address of any person (individual or corporation) with an ownership or control interest in the managed care entity and its subcontractors.
- The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
- The date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the MCP and its subcontractors.
- Other tax identification number of any corporation with an ownership or control interest in the MCP and any subcontractor in which the MCP has a 5 percent or more interest.
- Information on whether an individual or corporation with an ownership or control interest in the MCP is related to another person with ownership or control interest in the MCP as a spouse, parent, child, or sibling.
- Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the MCP has a 5 percent or more interest is related to another person with ownership or control interest in the MCP as a spouse, parent, child, or sibling.
- The name of any other disclosing entity in which an owner of the MCP has an ownership or control interest.
- The name, address, date of birth, and SSN of any managing employee of the MCP.

Disclosure to the State shall be done during the following:

- When the Legal Entity submits a proposal in accordance with the County's procurement process or when the contractor submits a provider application.
- When the Legal Entity executes a contract with the County or when the provider executes a provider agreement with the state.
- When the County renews or extends the Legal Entity contract.
- Within 35 days after any change in ownership of the Legal Entity or contractor/disclosing entity.
- Upon request of the state during the revalidation of the provider enrollment.
- Within 35 days after any change in ownership of the disclosing entity.

See Section 1124(a)(2)(A) of the Act; section 1903(m)(2)(A)(viii) of the Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 104]

Program Monitoring

Each provider will have assigned to their program a Program Monitor (also known as Contracting Officer's Representative - COR), who will monitor compliance with outcome measures, productivity requirements and other performance indicators, analyze reports from providers, and provide programmatic review for budgets and budget variances in accordance with contract terms and conditions. Program monitors/CORs hold regular providers meeting to keep providers informed on the System of Care. All provider contract questions should be directed to the assigned Program Monitor/COR.

Contractor Orientation

All new contracts require a contractor orientation meeting within 45 days of contract execution. The COR, in conjunction with the BHS Contract Support Services Unit and Agency Contract Support shall, be responsible for contractor orientation. Contractor will designate a contact person to coordinate attendance of necessary contractor staff at the orientation.

Notification in Writing of Status Changes

Providers are required to notify BHS Contract Support, (BHSCS) COR and QM in writing if any of the following changes occurs:

- Change in office address, phone number or fax;
- Addition or deletion of a program site;
- Change of tax ID number or check payable name (only to BHSCS);
- Additions or deletions from your roster of Medi-Cal billing personnel (BHSCS& MIS); or
- Proposed change in Program Manager or Head of Service.

Site Visits

The County MHP will conduct, at a minimum, an annual site visit to all organizational providers. The County MHP includes BHS Program Monitor/COR/Designee, MHS Administrative Services Unit, BHS Quality Improvement (QM) Unit, and the Health and Human Services Agency (HHS) Contract Support. The site visit may include, but is not limited to, a review of:

- Compliance with contractual statement of work;
- Client medical records (where applicable);
- Building and safety issues;
- Staff turnover rates;
- Insurance, licensure, NPI, and certification validation;
- Fiscal and accounting policies and procedures;
- Beneficiary informing materials requirement;

- Compliance with standard terms and conditions.

Information from the QM site visit will be included in the contract monitoring process. When a Medi-Cal certification or re-certification is due, an in-depth site review will be completed. Please see Section G of this handbook for a more detailed discussion of Medi-Cal provider site visits.

An additional note: Contractor's Program Manager shall be available during regular business hours and respond to the Program Monitor/COR or designee within 2 business days. Contractor shall have the technological capability to communicate, interface and comply with all County requirements electronically using compatible systems, hardware and software.

Corrective Action Notice

Corrective Action Notice (CAN) is a tool identifying deficiencies in compliance with contractual obligations and requires corrective actions within a specified time frame. A CAN may result from site visits or information derived from reports. Contractors are required to respond to the CAN specifying course of actions initiated/implemented to comply within the specified time frame.

Monthly and Quarterly Status Reports

Contracted providers are required to submit a completed Monthly Status Report (MSR) and/or Quarterly Status Report (QSR) within 20 calendar days after the end of the report month. The COR reviews the status report for needed information on compliance and contractual requirements. The Quality Improvement Unit (QI) tracks and trends data, provides analysis and issues reports as needed for the Department of Health Care Services (DHCS), BHS Administration, the Quality Review Council and other groups =. The status reports include: 1) A narrative (including General Information, Program Description, Activities/Events, Community Outreach, Emerging Issues, Quality Improvement Activities), 2) Outcomes, 3) Data Summaries for Units/Subunits, 4) Staffing & Personnel, 5) Client Suggestions & Transfer Requests, 6) Notices of Action, and 7) Additional Information Requested by the COR. It is important to become familiar with the status reports to document pertinent information as required. The Status Report templates offers drop-down boxes including codes to make data entry collection easier. Please see Section C on Accessing Services on Clients who must transfer to a new provider for more detail on Provider Transfers.

Contract Issue Resolution

Issues, problems or questions about your contract shall be addressed to your COR.

Local Emergency Response

In the event that a local health emergency or local emergency is declared, or when the State or federal government has declared an emergency that includes areas within the County of San Diego, the prompt and effective utilization of Contractor resources essential to the safety, care and welfare of the public shall occur at the direction of the County, to the extent possible. Contractors shall provide assistance in the prevention of, response to, and recovery from, any public health emergency, as applicable. Contractors' staff shall be available upon request of BHS to assist in any necessary tasks during a public health disaster or County emergency state of alert. Providers shall work with the County to initiate processes and develop and implement plans, guidelines and procedures as required. As relevant, Contractors shall also refer to disaster preparedness and disaster response language outlined in this section of the Handbook.

Disaster Response

- In the event that a local, state, or federal emergency is proclaimed within San Diego County, contractors shall cooperate with the County in the implementation of a Behavioral Health Services response plan. Response may include staff being deployed to provide services in the community, out of county under mutual aid Contracts, in shelters, and/or other designated areas.
- Contractors' staff shall be available upon request of BHS to assist in any necessary tasks during a disaster or County emergency state of alert.
- Contractor shall provide BHS with a roster of key administrative personnel's after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional emergency or local disaster. These numbers will be held confidential and never given out to other than authorized personnel.
- Contractor shall identify 25% of direct service staff to prepare for and deploy (if needed and available) to a critical incident. These staff shall participate in County provided Disaster Training (or other approved training) and provide personal contact information to be included in the Disaster Personnel Roster maintained by the County. Contractor shall advise COR of subsequent year training needs to maintain 25% trained direct service staff in the event of staff turnover. Contractor shall maintain 25% staff deployment capability at all times.
- In the event that contractor's program site is closed due to disaster or emergency, contractor shall call the Access and Crisis Line and their COR to inform them of this.

Transportation of Clients

Contractors shall not use taxi cabs to transport unescorted minors who receive services funded by the County of San Diego.

CLAIMS AND BILLING FOR CONTRACT PROVIDERS

Contractor Payments

Contractors will be paid in arrears. After the month for which service has been given, the BHS Administrative Services Unit (ASU) will process claims (invoice) in accordance with the contract terms.

Budgets, Cost Reports and Supplemental Data Sheets and Claims (Invoices)

- Budgets, cost reports, supplemental data sheets, and claims (invoices) must comply with the established procedures in the State of California, Department of Mental Health, Cost Reporting/Data Collection Manual.
- Year-end Cost report is due by August 31.
- Quarterly claims for MAA, QA and Admin - 45 days after quarter end as shown below:
 1. Q1 ending September 30 – submission is November 15
 2. Q2 ending December 31 – submission is February 15
 3. Q3 ending March 31 – submission is May 15
 4. Q4 ending June 30 – submission is August 15
- Short Doyle annual cost report is due December 31 following the end of the previous fiscal year.
- Reconciled cost report is due 18 months after the end of the Fiscal Year

Medi-Cal Billing to the State

- Direct service claims can be submitted to the State up to a year from the date of service. Replacement of a denied service can be submitted up to 15 months.
- If the service was denied and the error is with the State's system, services can be replaced up to 36 months with a DRC 9. Voids can be process at any time and no limitation.

Submitting Claims (Invoice) for Services

Please submit all claims (invoice) for payment to:

Behavioral Health Services Contract Support, (BHSCS) (P531K)
P O Box 85524

San Diego, CA 92186-5524
Fax to: (619) 563-2730, Attn: Lead Fiscal Analyst

Overpayment

In the event of overpayments, excess funds must be returned or offset against future claim payments.

Certification on Disbarment or Exclusion

All claims for reimbursement submitted must contain a certification about staff freedom from federal debarment, exclusion, suspension or ineligibility from services. In order to be in compliance with these federal regulations, all organizational providers must verify monthly the status of employees with the Government Services Agency (GSA) Federal System for Award Management (SAM) list, the Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), and the State of California Medi-Cal Suspended and Ineligible (S&I) list. Providers will report immediately to their COR any individual or entity that appears on any government excluded list and take the appropriate corrective action. Providers shall maintain documentation that evidences the required monthly verification.

To verify online if someone is on the federal System for Award Management (SAM) list go to <http://SAM.gov> the OIG Exclusion list and the GSA debarment list go to: <https://exclusions.oig.hhs.gov>. To view the list of what will get someone placed on the OIG list, go to: <https://oig.hhs.gov/exclusions/authorities.asp>.

To verify if a provider of health care services is subject to suspension from participation in the Medi-Cal program, go to: <https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp>. This would be due to:

- Been convicted of a felony;
- Been convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;
- Been suspended from the federal Medicare or Medicaid programs for any reasons;
- Lost or surrendered a license, certificate, or approval to provide health care; or
- Breached a contractual agreement with the Department that explicitly specifies inclusion on this list as a consequence of the breach, verification can be access by clicking on the link

Social Security Death Master File Verification

Prior to executing a contract with a provider, the MHP is required to verify that the provider (individual) is not listed within the Social Security Death Master File (DMF) upon enrollment. Should a contract provider appear on the list, the MHP will notify the County's Department of Purchasing and Contracts (DPC) to take the appropriate action regarding enrollment or disenrollment from the MHP and notify the appropriate regulatory authority.

National Provider Identification Verification

All HHSA contractors are required to verify that all clinical staff, licensed or not, have an active National Provider Identification (NPI) number. For new employees, contracted programs are to provide employee with necessary paperwork needed to apply for an NPI number, should they not already have one. If the new employee has an NPI number, the contractor shall verify in the National Plan and Provider Enumeration System (NPPES) for accuracy. Contractors must update the NPPES system as needed when the employee's information changes. The MHP is required to complete the same verification process for the contracted providers. When contractor submits their Access Request Form (ARF) for staff account set up in the electronic health record, the MHP MHMIS unit performs validation through the NPPES database. Staff shall not have access to the electronic health record without a valid NPI number.

License Verifications

All HHSA contractors are required to verify the license status of all employees who are required by the contract Statement of Work to have and maintain professional licenses. The verification must be submitted at the time of contract execution, renewal or extension. In order to ensure the license is valid and current, the appropriate website(s) shall be checked. For county operated programs, license verification is completed by the Human Resource department. All providers are responsible for ensuring that all staff licenses are active and valid. Providers shall keep documentation that evidences active licensure for staff.

SHORT-DOYLE MEDI-CAL

Per Cost Reporting/Data Collection Manual the "policy of the State Agency is that reimbursement for Short-Doyle Medi-Cal services shall be limited to the lowest of published charges and actual costs.

I. Definitions

Provider means the program providing the mental health services. It is part of a legal entity on file with the State Department of Mental Health.

Published Charge or Published Rate is a “term used in CFR Title 42 to define provider cost reimbursement mechanisms from third party sources. This generally means that customary charges throughout the year should be as close to actual (cost) as possible to avoid a lesser of costs or charges audit exception circumstance.”

Published rates for services provided by organizational providers must be updated at the beginning of each fiscal year to ensure the County’s MIS has the accurate information as well as ensuring no potential loss of Medi-Cal revenue.

The published rate for a specific service should, at a minimum, reflect the total cost for providing that service to ensure no loss of Medi-Cal revenue.

Published rates are to be submitted to Optum and MHS CAU no later than June 14 of each year.

Actual Cost is reasonable and allowable cost based on year-end cost reports and Medicare principles of reimbursement per 42 CFR Part 413 and HCFA Publication 15-1.

Federal Financial Participation per Title 9 CCR Chapter 11 means the federal matching funds available for services provided to Medi-Cal beneficiaries under the Medi-Cal program.

II. Medi-Cal Revenue

The Fiscal Services Unit will bill Medi-Cal for covered services provided to Medi-Cal beneficiaries by Short-Doyle Medi-Cal certified programs. The State will deny services that do not clear the billing edits, programs have 15 months from the date of service to fix denied services. Once the program has fixed the error, in order to rebill for the service, the program must complete the current Replace Service Request form located on the Optum Website at <https://www.optumsandiego.com/> and email the form to the email addresses stated on the form. After the form has been received and the replace processed, the program will be faxed back the form, this serves as notification that the replace was processed. If the reason for the denial is for Other Health Coverage or Medicare, the explanation of benefits (EOB) must be faxed to the billing unit with a copy of the denial report – fax to BHSBU/F (858) 467-9682.

County of San Diego HHSA – Mills Bldg.

Behavioral Health Services Billing Unit Fiscal Services (BHSBU/F)

1255 Imperial Ave.

San Diego, CA 92101

Attn: Fiscal Services 6th Floor Rm. 633

III. Medi-Cal Disallowance/Recoupment of Federal Financial Participation (FFP) Dollars

BHS is obligated to disallow Specialty Mental Health Services (SMHS) for Medi-Cal reimbursement per the current California State DHCS Reasons for Recoupment of FFP dollars categories:

- Medical Necessity
- Client Plan
- Progress Notes

Organizational providers shall be responsible for ensuring that all medical records comply with federal, state and county documentation standards when billing for reimbursement of services.

The federal share of the Medi-Cal claims for the above circumstances will be deducted from your contract payment.

In accordance with State guidelines, these disallowances may be subject to future change.

Contractor shall reimburse BHS for any disallowance of Short-Doyle/Medi-Cal payments, and reimbursement shall be based on the disallowed units of service at the Contractor's approved budgeted unit cost. The Federal share of the Medi-Cal claims for the above circumstances will be deducted from your contract payment.

The State announced that the State (non-Federal) share of EPSDT claims will also be subject to recoupment if any current or new recoupment criteria issued by the Department of Mental Health are met.

IV. Billing Disallowances – Provider Self Report

The policy of San Diego County Behavioral Health Services Administration (SDCBHS) is to recoup Federal Financial Participation (FFP) and Early Periodic Screening and Diagnostic Treatment (EPSDT) dollars by disallowing billing which has been identified and reported to the SDCBHS by the Contracted Organizational Providers and County Owned and Operated Clinics in accordance with documentation standards as set forth in the current California State Department of Mental Health "Reasons for Recoupment of Federal Financial Participation Dollars."

Procedures

The following are the procedures to be followed for Self-Reporting of Billing Disallowances to ensure consistent procedures are used when the information is reported to Behavioral Health Services Administration by providers.

Provider Requirements

1. Providers are required to conduct internal review of medical records on a regular basis (i.e. monthly) in order to ensure that the documentation meets all County, State and Federal standards and that billing is substantiated.
2. If the review of a Medi-Cal client's chart results in a finding that the clinical documentation does not meet the documentation standards as set forth in the current California State Department of Health "Reasons for Recoupment of Federal Financial Participation Dollars" the provider shall be responsible for addressing the issue by filing a self-report of billing disallowances with SDCBHS.
3. To file a self-report of billing disallowances request with SDCMH, providers shall fill out the Provider Self-Report Billing Disallowance and a Void Service Request form if the service was billed and paid. E-mail the applicable form to MH Admin email addresses as directed on the form, who will forward the form to BHSBU. Providers shall ensure that the services listed on the form as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services must be listed on the form exactly as they were billed.
4. All services that are disallowed will also be voided from CCBH. Providers are responsible for re-entering corrected service information; services can be re-entered as non-billable or no re-entry as applicable based on the void/replace reasons (found on the CCBH Void -Replace Service Forms document located on the Optum San Diego Website at <https://www.optumsandiego.com/>). Services that are submitted for corrections because of clerical errors may be replaced and programs will need to complete the replacement service request form and submit to MH Admin who forwards to the BHSBU.
5. Providers will need to check if applicable, see disallowance instructions and re-enter the services.

BHS Contract Support Procedures

1. On a quarterly basis, BHS Administrative Services Unit (ASU) staff will prepare a letter pertaining to disallowances that will be sent to Contractors indicating that the County shall be entitled to recoup the disallowances.
2. Within 90 days of the end of the fiscal year, ASU staff will ensure that all disallowances are included in the calculation of the year-end provider payment settlement. Notices will be sent to all Contractors that are entitled to additional payment or are subject to recoupment because of overpayment to the Contractor.
3. Contractors that have been overpaid may elect to repay the recoupment via check or an offset from future payments.

- If the contractor pays by check, the check is received by ASU staff and forwarded to Financial Management staff for deposit. The payment is logged in the contract file along with a copy of the payment.
- If no check is received by ASU within 15 business days from the date of the letter to the Contractor; the recoupment amount is deducted from the next scheduled provider payment.

Billing Inquiries

Questions regarding claims (invoice) for payment should be directed in writing to:
BHS Contract Support (P531K)
PO Box 85524
San Diego, CA 92186-5524
Attn: Lead Fiscal Analyst

Questions can also be addressed by calling the Contract Support Unit Fiscal Analyst

Inventory Guidelines for County Contracts

All Capital (Fixed) Assets/Equipment, Minor Equipment, and Consumable Supplies purchases shall be included in Cost Reimbursement contract budgets and shall be approved by the Contracting Officer's Representative (COR) upon budget submission. The equipment and supplies shall directly benefit clients and program's objectives.

County retains title to all non-expendable property provided to Contractor by County, or which Contractor may acquire with contract Agreement funds if payment is on a cost reimbursement basis, including property acquired by lease purchase Agreement. Internal Controls and Procedures below provide guidelines on handling Capital (Fixed) Assets and Minor Equipment.

The Contractor shall repair or replace, at the Contractor's expense, any County owned property damaged or lost as a result of Contractor negligence. Further, the Contractor shall exonerate, indemnify and hold harmless the County from and against any and all claims for any damage resulting from the use, misuse, or failure of County-owned property/equipment, whether such damage be to an employee or property of the Contractor, other contractors or other persons or property.

1. Definitions

- a) **Capital (Fixed) Assets/Equipment:** Tangible non-expendable property that has been purchased with County funds and has a normal life expectancy of ***more than one year*** and a unit cost of \$5,000 or more. Prior written approval from the COR is required for

the acquisition of Capital (Fixed) Assets/Equipment. Examples of Capital (Fixed) Assets/Equipment include, but are not limited to: building improvements, vehicles, machinery, furnaces, air conditioners, multifunction copy machines, furnishings, etc.

- b) **Minor Equipment:** Any non-consumable implement, tool, or device that has a useful life of more than one year and an acquisition amount of \$100 to \$4,999. Examples of Minor Equipment include, but are not limited to: televisions, video recorders and players, computer monitors, therapy equipment, refrigerators, hand-held electronic devices, electronic games, modular furniture, desks, chairs, conference tables, etc.
- c) **Consumable Supplies:** Goods that have a useful life of one year or less and an acquisition value under \$500. Examples of consumable supplies include, but are not limited to: pens, pencils, paper, notepads, file folders, post-it notes, toner or ink cartridges, waiting room supplies, etc.

2. Internal Controls and Procedures

Contractors shall have the following internal controls and procedures in place for managing Capital (Fixed) Assets/Equipment and Minor Equipment, whether acquired in whole or in part with County funds, until disposition takes place:

- a) Prior written approval from the COR is required for the acquisition of Capital (Fixed) Assets/Equipment through budget development requests or Administrative Adjustment Requests.
- b) Contractors shall place *County of San Diego Property* tags on Capital (Fixed) Assets/Equipment and Minor Equipment to identify items purchased with County funds. These tags can be requested through the COR.
- c) Contractors shall include the expenditure of Capital (Fixed) Assets/Equipment and Minor Equipment on the monthly invoice/cost report that immediately follows the acquisition.
- d) Contractors shall maintain inventory records that include a description of the item, a serial number or other identification number (if applicable), the acquisition date, the acquisition cost, location of the item, condition of the item, program funding for the item, and any ultimate disposition data including the date of disposal.
- e) Contractors shall submit an Inventory Report of Capital (Fixed) Assets/Equipment and Minor Equipment purchased using County funds at the end of each fiscal year. The inventory report is due to the COR no later than thirty (30) days after the end of the fiscal year. The COR will review the Inventory Report to determine if the information is reasonable and complete based on their knowledge of the contract and approval of invoices containing charges for equipment.
- f) The Inventory Report is to include all Capital (Fixed) Assets/Equipment and Minor Equipment items purchased since inception of the cost reimbursement contract.

- g) Inventory records on non-expendable equipment shall be retained and shall be made available to the County upon request, for at least three years following date of disposition.
- h) Contractors may choose to utilize their own Inventory Report as long as the required information above is included. Otherwise, contractors can utilize the BHS Inventory Form.
- i) Contractors shall include in the Inventory Report any items that were transferred from one County program to another and note the transfer date and program. A DPC 203 form shall be completed.
- j) Contractors shall make all purchased items available to the COR (or their designee) for inspection at any time.
- k) Contractors shall be responsible for accounting of all items purchased with County funds.
- l) Contractors that are required to work with computers, laptops, portable devices or media that contain personal information relating to clients, patients and residents shall have a duty to protect this data from loss, theft or misuse (refer to [Article 14 Information Privacy and Security Provisions](#) in the contract). For all Electronic Property and Information Technology (IT) related items capable of storing information, regardless of acquisition price and useful life, please refer to the Organizational Provider Operations Handbook page J.16 for appropriate inventory guidelines. Examples of Electronic Property and IT related items capable of storing information include, but are not limited to: cellphones, laptops, tablets, USB memory devices, cameras, etc.
- m) Contractors do not need to include in the Inventory Report consumable supplies valued under \$500.

3. Disposition

- a) Contractors should not remove the items previously listed on their Inventory Report submitted to the County, unless the COR approved the salvage or transfer of those items, or a County Behavioral Health Services policy provided such instructions.
- b) Minor Equipment not meeting the requirement to be listed on the Inventory Report and Consumable Supplies do not need to be disposed through the County process.
- c) Non-expendable property that has value at the end of a contract (e.g. has not been depreciated so that its value is zero), and which the County may retain title, shall be disposed of at the end of the contract Agreement as follows:

At County's option, it may:

- i) Have Contractor deliver to another County contractor or have another County contractor pick up the non-expendable property;
- ii) Allow the Contractor to retain the non-expendable property provided that the Contractor submits to the County a written statement in the format directed by the County of how the non-expendable property will be used for the public good; or

iii) Direct the Contractor to return to the County the non-expendable property.

4. Stolen, Damaged or Missing Equipment

- a) Contractor shall inform the COR in writing within 48 hours of any stolen, damaged or missing equipment purchased with County funds. *Exception:* Any lost or missing item that contains personal information shall be reported in writing to the COR within 24 hours. [Article 14 Information Privacy and Security Provisions](#) requirements shall be followed when appropriate.
- b) Contractor may be responsible for reimbursing the County for any stolen, damaged or missing equipment at the current book value of the asset.

5. Vehicles

- a) The preferred method for Contractor to acquire vehicles is through a lease arrangement. If purchase is necessary, vehicles shall be registered with the Contractor as the lien holder and registered owner. Contractor shall maintain appropriate insurance on vehicles.
- b) At contract termination, or when the original or replacement equipment/vehicle is no longer needed, or has become obsolete, or is inoperable and impractical to repair, a formal disposition process will be required (refer to BHS Property Transfer/Disposal Process). Contractors shall work with the COR, who will determine the final disposition of the item(s).

6. Inventory Disposition:

- a) Contact the COR before disposing of property purchased with County funds, and which the County may retain title under this paragraph, shall be disposed of at the end of the Contract Agreement as follows:
 - i. Contact the COR before disposing of property purchased with County funds, and which the County may retain title under this paragraph, shall be disposed of at the end of the Contract Agreement as follows:
 - ii. At County's option, it may:
 1. Have contractor deliver to another County contractor or have another County contractor pick up the non-expendable property;
 2. Allow the contractor to retain the non-expendable property provided that the contractor submits to the County a written statement in the format directed by the County of how the non-expendable property will be used for the public good;
 3. Direct the Contractor to return to the County the non-expendable property.
- b) **BHS Property Inventory Form: *Appendix J (A.J.1)*:**
 - i. As the contractor disposes of equipment the following columns on the BHS Inventory form must be completed and a copy provided to the COR.

- ii. “Date of Disposition of Capital/Fixed Assets or Minor Equipment”: This is the actual date the item was delivered and accepted by County Salvage.
 - iii. “Date form AUD253 completed”: This is the date the COR signs and returns AUD253 form to the contractor.
- c) **DPC 203 Transfer or Disposition of Minor Equipment Form(s) and Procedures:**

NOTE: Procedure for Property Transfer to the County of San Diego – Property Disposal or Transfer to another contractor. *For purposes of this section on disposal of minor equipment, “contractor” refers to the specific numbered County contract, and that contract’s County-owned property, not to the combined County-owned assets of multiple County contracts held by a parent organization/organizational provider.* Both versions of form DPC 203 and the Mobile Devices SUPPLEMENTAL can be:

- Downloaded from links in the Technical Resource Library (TRL);
- Provided to the contractor by BHS staff; or
- Downloaded from links under the Forms tab on the Organizational Provider Public Documents Optum Website:
(<https://www.optumsandiego.com>).

BHS Contract Support administrators will keep an internal record of any County-owned property and conduct an inventory of all County-owned property during selected site visits.

There are three distinct transfer/disposition procedures in place for minor equipment. These are for disposal of Non-IT items that do not have memory, IT items containing memory, and Mobile Devices. All minor equipment salvage requests are to be completed by the contractor on the appropriate version of the DPC 203 form and forwarded to their Contracting Officer’s Representative (COR) who will review, approve, sign and forward the DPC 203 form to the appropriate County staff. Once processed and approved by BHS and/or the Department of Purchasing and Contracting (DPC), the COR will notify the contractor of further steps. All DPC 203 forms must include the program name, contract number, COR name, address (with Zip Code) identifying the physical location of the items, and full site contact information including name, phone number and email. Directions for transfers between contracts are included below for each procedure. *A new fillable .pdf version of the basic DPC 203 and the Mobile Devices cover DPC 203 are now available for use. The DPC 203 Mobile Devices SUPPLEMENTAL, an Excel file, is still required for Mobile Devices. Contractors are not to make changes to the DPC 203 forms, including changing*

pre-filled wording or making any entries in the forms' boxes #7 through #16. Non-IT equipment, IT equipment and Mobile Devices cannot be listed on the same DPC 203 form.

Links to the DPC 203 forms used for minor equipment disposal are located on the Optum Website (<https://www.optumsandiego.com>) under the Forms tab.

Flowcharts for the three procedures are also located in the TRL and the Optum Website.

- i. **Non-IT Disposal Requests** (furniture, office equipment without memory: printers, most copiers, non-memory-containing computer accessories (computer monitors, keyboards, mice), routers, docking stations, wireless access points, DVD players, etc.):
 - **Requests** are to be completed on the basic DPC 203 form, checking the Non-IT box, and sent to the COR for review, approval, signature and forwarding.
 - Non-IT requests require the condition of the items to be noted and must be accompanied by photos in .jpg format, preferably with items grouped but individually identifiable in the photos.
 - Once DPC's approval is final, the COR will provide the program with the approved DPC 203 form (with a Control No.) and directions for delivery by the program, per pre-scheduled appointment, accompanied by the approved DPC 203 form, to the County's disposal contractor.
 - *[Transfers of Non-IT items between contracts/programs require the sending program to complete the DPC 203, entering both the sending and receiving programs' names, contract numbers, COR names, current and future addresses of property, the site contact names, phone numbers and email addresses, and forward to the sending COR. The sending COR reviews, approves, signs the form, and secures the receiving COR's approval and signature (if different). The COR then forwards the approved form to BHS staff for further processing. Transfers of Non-IT items do not require photos or condition.]*
- ii. **IT Disposal Requests** (those items with memory: computers, laptops, notebooks, servers, zip drives, higher-end copiers with memory, etc.)
 - **Requests** are to be completed on the basic DPC 203 form, checking the IT box, and then sent to the COR for review, approval, signature and forwarding. The basic DPC 203 form includes a section for Wipe

Certification for use with IT disposals. (HHS only recognizes Department of Defense (DoD) level wiping done by its approved IT Wipe Vendor.)

- For IT items, the serial numbers must be provided, using the “Serial No./Listing No.” column. Contractors list type, make and model of items in the “DESCRIPTION” column. Pictures and condition are not required for IT items. IT items must be physically located at the address provided on the DPC 203 and retained at that site for pick up.
- Following receipt of the disposal form with COR approval, the contractor will be contacted by HHS IT’s Wipe Vendor (currently Perspecta), to arrange for pick up for disposal. (*Include the power cords for all types of computers at point of pick-up.*) The contractor must ensure that the IT Wipe Vendor completes the first box of the Wipe Certification of the DPC 203 form at point of pick-up.
- Once the equipment is picked up, the contractor will send a copy of the DPC 203 form with the completed wipe pick-up confirmation to the COR.
- *[Transfers of IT items between contracts/programs following DoD wiping, require the sending program to complete the DPC 203, entering both the sending and receiving programs’ names, contract numbers, COR names, current and future addresses of property, the site contact names, phone numbers and email addresses, and forward to the sending COR. The sending COR reviews, approves, signs the form and secures the receiving COR’s approval and signature (if different), and forwards the DPC 203 form to BHS staff. BHS staff then arrange for HHS IT’s Wipe Vendor to pick up the items, do the DoD wipe, and return the wiped items to the contractor at the pick-up location. The contractor secures the DoD Wipe Vendor’s signature on the DPC 203 at point of pick up (first box of Wipe Certification) and again when wiped items are returned (second box of Wipe Certification). Following DoD wiping, the sending program sends the COR the DPC 203 with both sections of the Wipe Certification completed. The sending and receiving programs then coordinate transfer of wiped equipment. Contractors should discuss situations with their CORs when wiping requirement may potentially be waived, for example certain same-provider reprocured contracts, or when a new provider will be serving the identical client base and providing identical services.]*

- iii. **Mobile Devices Disposal Requests** (cell phones, flip phones, smart phones, hotspots, Wi-Fi cards, tablets, etc.)
- **Requests** are to be completed using two DPC 203 forms, the Mobile Devices DPC 203 and the Excel-format Mobile Devices SUPPLEMENTAL DPC 203, and sent to the COR for review, approval and forwarding.
 - The Mobile Devices DPC 203 form is similar to the basic DPC 203 form but with the notation “Please See Attached for Mobile Devices” entered instead of a list of items.
 - The Mobile Devices SUPPLEMENTAL DPC 203 form is to be completed, listing individual items by brand, model and type, providing serial numbers (NOT model numbers) and passwords for unlocking items, and indicating “N” (for No) in the “GRANT FUNDED” column. (The DPC 203 SUPPLEMENTAL must be submitted in its Excel file format to meet a technical requirement of the Mobile Devices Salvaging Vendor.)
 - This salvage process requires a group photo, in .jpg format, of the listed Mobile Devices, and results in a FedEx barcode emailed by the COR to the contractor along with the approved DPC 203 forms to use for shipping the package of Mobile Devices to the County’s Mobile Devices Salvaging Vendor.
 - NOTE: DPC requires that all Mobile Devices be reset to their factory default setting prior to shipping.
 - *[Transfers of Mobile Devices are limited to situations where the provider, program and services remain the same and only the contract number changes.]*

7. Electronic Property/IT:

Contractors Inventory Minimum Guidelines on A Cost Reimbursement and Fixed PRICE Contract

Inventory responsibility includes these minimum guidelines for the security of client information and portable electronic and data storage devices. This responsibility exists whether the information is in paper or electronic form. Additionally, all Contractor employees have the duty to protect any County assets assigned to them or in their possession, including desktop computers, portable devices and portable media.

Definitions

K. PROVIDER ISSUE RESOLUTION

The MHP recognizes that at times providers may have or be made aware of complaints, problems or issues with Fee-For-Service Individual Providers. Providers are encouraged to communicate any complaints, problems or issues to OptumHealth which provides oversight for Fee-For-Service Providers. Please report any complaints to OptumHealth Provider Services at 800-798-2254 option 7.

The MHP recognizes that at times providers may disagree with the MHP over an administrative or fiscal issue and will be happy to work with them to solve the problem. There is both an informal and formal Provider Problem Resolution Process for providers who have concerns or complaints about the MHP.

Informal Process

Providers are encouraged to communicate any concerns or complaints to the Program Monitor or designee. The Program Monitor or designee shall respond in an objective and timely manner, attempting through direct contact with the provider to resolve the issue. When issues are not resolved to the provider's satisfaction informally, a formal process is available. A copy of complaint materials will be sent to the County Mental Health QI Unit.

If the provider is not satisfied with the result or the informal process or any time, the formal process below is available:

Formal Provider Problem Resolution Process

1. Providers shall submit in writing any unresolved concerns or complaints to the MHS Contracts Manager Chief, Behavioral Health Services Contracts Support or designee, using the Formal Complaint by Provider form (located in *Appendix K- A.K.1*).
2. Written narration shall include all relevant data, as well as attachment of any documents which support the provider's issue(s).
3. Formal complaint shall be submitted within 90 calendar days of original attempt to resolve issue(s) informally.
4. The Contracts Manager Chief, BHS Contracts Support or designee shall have 60 calendar days from the receipt of the written complaint to inform the provider in writing of the decision, using the Formal Response to Complaint form (see *Appendix K – A.K.2*).
5. The written response from the Contracts Manager, Chief, BHS Contracts Support or designee shall include a statement of the reason(s) for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

6. Formal Provider Problem Resolution documentation is to be directed to:

Mental Health Services Contracts Manager Chief, BHS Contracts Support
P.O. Box 85524
San Diego, CA 92186-5524
Mail Stop: P531-K

7. A copy of all complaint materials shall be sent to the County Mental Health QI Unit.

Formal Provider Appeal Process

1. Provider may submit an appeal within 30 calendar days of written decision to the Formal Complaint.
2. Formal Provider Appeals from an adult services provider shall be submitted in writing, using the Formal Appeal by Provider form (see *Appendix K – A.K.3*), to the Assistant Deputy Director (ADD) for AMHS. Formal Provider Appeals from CYFS shall be submitted in writing to the Assistant Deputy Director of CYFS.
3. The Appeal Form shall summarize the issue(s) and outline support for appeal. Previous documents on the issue(s) shall be attached.
4. The ADD shall notify the provider, in writing, of the decision within 60 calendar days from the receipt of the appeal and supporting documents, using the Formal Appeal Response Complaint Form (see *Appendix K – A.K.4*).
5. The written response from the ADD shall include a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.
6. Formal Provider Appeal documentation is to be directed to:

Assistant Deputy Director of
Adult Mental Health Services
P.O. Box 85524
San Diego, CA 92186-5524
Mail Stop: P531-A

Assistant Deputy Director of
Children, Youth and Families Services
P.O. Box 85524
San Diego, CA 92186-5524
Mail Stop: P531-C

7. A copy of all appeals materials should be sent to the County Mental Health QI Unit:

Quality Improvement Unit
P.O. Box 85524
San Diego, CA 92186-5524
Fax: (619) 236-1953
Mail Stop: P531-Q (Children)
Mail Stop: P531-G (Adults)

Quality Improvement Process

1. The Quality Improvement Unit shall gather, track and analyze all formal provider problem resolution issues.
2. All Organizational Providers who submit a formal complaint, and/or formal appeal, shall send a copy to the Quality Improvement Unit.
3. All Program Monitors or designees, the Chief, BHS Contracts Support who obtains a formal complaint, and/or the ADD who handles an appeal shall forward a copy to the Quality Improvement Unit, attaching the response.
4. The Quality Improvement Unit will log all formal complaints and appeals as it pertains to issue, timeline compliance, resolution disposition and action plan. This unit will identify opportunities for improvement and decide which opportunities to pursue, design and implement interventions to improve performance, and measure the effectiveness of any interventions.

Contract Administration and Fiscal Issues with MHP Contracts

Please see the Provider Contracting section of this Handbook.

L. PRACTICE GUIDELINES

Practice guidelines refer to methods and standards for providing clinical services to clients. The MHP applies guidelines that comply with 42 C.F.R. 438.236(b) and Cal. Code Regs., Title 9 1810.326. They are based on clinical consensus and research findings as to the most effective best practices and evidence-based practices available. Because they reflect current best practices, the guidelines may change as new information and/or technology becomes available. As these changes occur, the MHP is responsible for disseminating the guidelines to Providers, as well as ensuring that changes being made are done so with consideration to the needs of the consumers. Special efforts must be given in respect to the unique values, culture, spiritual beliefs, lifestyles and personal experience in the provision of mental health services to individual consumers. The MHP and providers have created the Clinical Standards Committee as a means for collaboration within the MHP and Contracted Providers. Providers shall comply with standards that may be adopted by the Mental Health Clinical Standards Committee. This Committee sets standards of care for Mental Health within the county, develops system-wide guidelines, and includes representatives from County and Contract programs.

Treatment of Co-Occurring Substance Abuse and Mental Health Disorders Comprehensive, Continuous, Integrated System of Care (CCISC) Model

Clients with co-occurring mental health and substance use issues are common in the public mental health system and present with complex needs. Consequently, the presence of substance use should be explored with all clients and caretakers as part of routine screening at the point of initial evaluation, as well as during the course of ongoing treatment. San Diego County has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) Model, which is an integrated treatment approach for individuals with co-occurring psychiatric and substance disorders. The presence of substance use should be explored with all clients and caretakers as part of routine screening at the point of initial evaluation, as well as during the course of ongoing treatment.

For adults clients with serious mental illness who meet eligibility criteria, integrated treatment of a co-occurring substance use disorder and the mental health diagnosis is nationally recognized as evidenced based practice.

For children/youth clients know that they may be impacted by substance use or abuse on the part of their caretakers. Be aware that some children in San Diego have been identified as beginning to use substances as early as age 6 and this must be assessed, particularly in high risk family situations.

When serving adults, children, adolescents, or their families that meet the criteria for co-occurring disorders these guidelines are to be implemented:

- Document on the Admission Checklist that the client and/or family was given a copy of your program's Welcoming Statement, if any.
- Include substance use and abuse issues in your initial screening, assessment and assessment updates, included on the Behavioral Health Assessment. In addition, use any screening tools that may be adopted or required.

- If both types of disorders are indicated for the client at diagnostic levels, list the mental health diagnosis as the primary disorder and the substance use diagnosis as the secondary disorder. This indicates that the mental health diagnosis will be the primary focus of treatment, not necessarily that the mental health disorder is the more important disorder or the cause of the substance use.
 - **For adult clients** who do not meet the specialty mental health medical necessity criteria, but do have an identified substance use issue, the provider will make appropriate services referrals and document actions taken.
- Treatment services and documentation shall focus on the primary mental health diagnosis and the identified functional impairment(s). Treatment planning should deal with the substance use issue, either by referral or direct treatment. The co-occurring substance use issue may be integrated into treatment interventions in terms of how it impacts the functional impairment related to the mental health diagnosis. Even if the client or family is referred for substance abuse treatment, the client plan should document how that treatment will be coordinated or integrated into mental health treatment.
- Documentation of treatment services and interventions must meet the federal and CCR Title 9 requirements if mental health services are to be claimed to Medi-Cal. Progress notes should be carefully stated to remain within Medi-Cal guidelines. If the substance use is in a collateral person, the progress note must focus on the impact of the substance use on the identified client. In most instances, it is preferable to approach the substance use in the context of the mental health disorder, and create an integrated note and treatment regime.
 - **For child/youth clients** though notes may focus solely on substance use in an EPSDT client, this is permissible only if treatment for the substance use disorder is not otherwise available.
- It is not appropriate to exclude a client from services solely because of the presence of a substance use disorder or a current state of intoxication. This decision should be made based on the client's accessibility for treatment, as well as client and provider safety concerns.

For more information, please reference HHSA's MHS Policy and Procedure: Specialty Mental Health Services for Clients with Co-occurring Substance Use Problems No: [01-02-205](#) This resource is available by contacting your Program Monitor.

Dual Diagnosis Capable Programs

Certain programs within the HHSA/BHS system are certified as Dual Diagnosis Capable or Dual Diagnosis Enhanced. These certifications refer to program and staff competence with clients with co-occurring disorders. In general, Dual Diagnosis Capable programs will welcome clients

with both types of diagnosis, make an assessment that accounts for both disorders, and may provide treatment for the substance use within the context of the mental health treatment. Enhanced programs will be able to provide comprehensive, integrated treatment for both disorders. Following are the characteristics of Dual Diagnosis Capable Mental Health Programs when fully developed:

- Welcomes people with active substance use
- Policies and procedures address dual assessment, treatment and discharge planning
- Assessment includes integrated mental health/substance abuse history, substance diagnosis, and phase-specific needs
- Treatment plan: 2 primary problems/goals
- Discharge plan identifies substance specific skills
- Staff competencies: assessment, motivational enhancement, treatment planning, continuity of engagement
- Continuous integrated case management/phase-specific groups provided: standard staffing levels

For participating programs, the following describes criteria for these characteristics in both the Adult/Older Adult (A/OA) and Children, Youth and Family (CYF) programs. These criteria will become more demanding as the system develops its capability.

- The program's Administrator has signed the CCISC Charter
- The program has self-surveyed by annual use of the COMPASS survey
- The program has developed an action plan after completing the COMPASS, which incorporates:
 - ✓ Screening
 - ✓ Assessment
 - ✓ Treatment Plan
 - ✓ Progress Notes
 - ✓ Discharge summary
 - ✓ Medication planning when appropriate
 - ✓ Referrals
- The program has identified leads responsible for implementation of Dual Diagnosis Capability
- The program's CADRE staff are available for trainings
- Each clinician has completed the CODECAT
- The program has developed Mission and/or Welcoming Statements that reflect dual diagnosis capability

- The program has a Policy and Procedure to support Mission and Welcoming statements, including visible materials such as posters and referral brochures

Drug Formulary for HHS Mental Health Services

All contracted provider programs and physicians shall adopt the Medi-Cal Formulary as the San Diego County Mental Health Services (MHS) formulary. All clients, regardless of funding, must receive appropriate and adequate levels of care at all MHS programs. This includes the medications prescribed. The guidelines below allow for clinical and cost effectiveness.

The criteria for choosing a specific medication to prescribe shall be:

- The likelihood of efficacy, based on clinical experience and evidence-based practice
- Client preference
- The likelihood of adequate compliance with the medication regime
- Minimal risks from medication side-effects and drug interactions

If two or more medications are equal in their satisfaction of the four criteria, choose the medication available to the client and/or the system at the lowest cost. Programs shall provide information to all appropriate staff as to the typical cost for all drugs listed on the Medi-Cal Formulary, at least annually.

For all initial prescriptions, consideration should be given to prescribing generic medication rather than brand name medication unless there is superior efficacy for the brand name medication or the side-effect profile favors the brand name medication.

Providers shall follow the requirements for preparing a Treatment Authorization Request (TAR) as stated in the Medi-Cal Drug Formulary.

- County-operated programs shall send TARs to the County Pharmacy for any non-formulary medication
- Contractor operated programs shall develop an internal review and approval process for dispensing non-formulary medication for both Medi-Cal and non-Medi-Cal eligible clients

There shall be an appeal process for TARs that are not accepted.

Monitoring Psychotropic Medications

The following recommendations are not intended to interfere with or replace clinical judgment of the clinician when assessing patients on psychotropic medications. Rather, they are intended to

provide guidelines and to assist clinicians with decisions in providing high quality care, ensuring that patients receive the intended benefit of the medications, and to minimize unwanted side effects from the medications.

Antipsychotic Medications

- Typical Antipsychotics: also known as First Generation Antipsychotics: such as chlorpromazine (Thorazine), fluphenazine (Prolixin), haloperidol (Haldol), perphenazine (Trilafon), prochlorperazine (Compazine), thiothixene (Navane), thioridazine (Mellaril), and trifluoperazine (Stelazine).
- Atypical Antipsychotics: also known as Second Generation Antipsychotics: aripiprazole (Abilify), asenapine (Saphris), clozapine (Clozaril), iloperidone (Fanapt), lurasidone (Latuda), olanzapine (Zyprexa), paliperidone, quetiapine (Seroquel), risperidone (Risperdal), ziprasidone (Geodon) and any derivatives of these medications (i.e. long acting injectable formulations, extended release formulation, etc.)

Clinical Advisory on Monitoring Antipsychotic Medications:

- Ordering labs and monitoring should be tailored to each patient. Patients may require more or less monitoring than these recommendations.
- All antipsychotic medications carry a Black box warning for increased risk of mortality for older adult patients with dementia-related psychosis.
- Geriatric patients may require more frequent monitoring due to changes in metabolism and renal function.
- Obtain baseline assessment for Tardive Dyskinesia and Abnormal Involuntary Movement Scale prior to initiate of antipsychotic and every 6 months.
- Atypical antipsychotics are associated with abnormal blood work such as elevated serum glucose and lipid levels, and increased prolactin levels. They are also associated with weight gain, increased risk of type 2 diabetes, diabetic ketoacidosis, and cardiovascular side effects.
- Avoid using ziprasidone (Geodon), haloperidol (Haldol), thioridazine (Mellaril), and chlorpromazine (Thorazine) in patients with known history of QT_c prolongation, recent Acute Myocardial Infarction, uncompensated heart failure, taking other medications with prolong QT, and alcoholic patients on diuretics or having diarrhea which may alter electrolytes.
- All patients should be assessed for cardiovascular disease before initiating antipsychotic therapy.
- Refer to Clozapine REMS Program for monitoring Clozaril.
- An initial comprehensive baseline assessment should include a thorough personal and family medical history, including risk factors for diabetes, vital signs, weight, body mass index, waist circumference, metabolic laboratory analysis such as fasting glucose, and lipid profile.
- Fasting blood glucose is preferred, but HgA_{1c} is acceptable if fasting glucose test is not feasible.

- Neutropenia uncommonly occurs in patients taking antipsychotic medications. It is recommended to obtain baseline Complete Blood Count and annually.
- Patients with a history of a clinically significant low white blood cell count (WBC) or a drug-induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and discontinuation of medication should be considered at the first sign of a clinically significant decline in WBC in the absence of other causative factors (package insert).

Children Youth and Families

There are continued active legislative changes around the use/monitoring of psychotropic medication in youth. The County of San Diego has and will continue to disseminate information about legislative changes to the Children's System of Care.

In April 2015, Department of Health Care Services published "California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care" (CA Guidelines). These guidelines target youth involved in county child welfare and probation agencies and is specific to those children and youth who are placed in foster care. Foster Care is defined as 24-hour substitute care for children placed away from their parents or guardians and for whom the State and/or county agency has placement care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes. County of San Diego prescribers should be familiar with the CA Guidelines as they shall serve as the guideline for provision of care locally to all youth.

<http://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/QIPFCP/Clinical.aspx>

Appendix A of this document "Prescribing Standards with Children and Youth in Foster Care" provides guidelines regarding the number of allowable medication for youth in specific age groups. County of San Diego prescribers should be familiar with Appendix A as this shall serve as the guideline for provision of care locally.

This document includes as Appendix B the Los Angeles "Department of Mental Health Parameters 3.8 For Use of Psychotropic Medication in Children and Adolescents." DHCS has recognized this living document as the guideline for provision of psychotropic medication. County of San Diego prescribers should be familiar with Appendix B as this shall serve as the guideline for provision of care locally.

The Department of Social Services (CDSS), in collaboration with stakeholders, developed measures to track youth in foster care who received a paid claim for psychotropic medication from the California Department of Health Care Services. These measures will be publicly posted with a goal of improving the health and well-being of youth in care. Those measures include

select Healthcare Effectiveness Data and Information Set (HEDIS) measures and Child Welfare Psychotropic Medication Measures. County of San Diego providers shall be familiar with these measures as they shall serve as the guideline for provision of care locally to all youth

For recommended monitoring parameters please check Attachment A.L.1.

Monitoring Controlled Substance Prescriptions

For the past number of years, abuse of prescription drugs has become increasingly prevalent. In September 2016, Senate Bill 482 pertaining to controlled substances and the CURES database was enacted. This law requires a health care practitioner to consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, III or IV controlled substance for the first time to that patient and at least once every four months thereafter, if the prescribed controlled substance remains part of the patient's treatment, with specified exemptions. The County of San Diego expects prescribers to document monitoring efforts consistent with this law.

Client/Family Education Program

Client and family education and involvement with treatment are essential to achieving successful outcomes. A Road Map to Recovery client/family education/program exists for this purpose. A complete description of this effective client and family education program can be found on the BHETA website at <https://theacademy.sdsu.edu/programs/bheta/roadmap-to-recovery/>.

M. STAFF QUALIFICATIONS

Each provider is responsible for ensuring that all staff meets the requirements of Federal, State, and County regulations regarding licensure, training, clinician/client ratios and staff qualifications for providing direct client care and billing for treatment services. Documentation of staff qualifications shall be kept on file at the program site. Provider shall adhere to staff qualification standards and must obtain approval from their Program Monitor or designee for any exceptions.

Provider shall comply with the licensing requirements of the California Welfare and Institutions Code Section 5751.2. Provider shall have on file a copy of all staff licenses and relevant certificates of registration with the Board of Behavioral Sciences. For staff positions requiring licensure, all licenses and registrations must be kept current and be in active status in good standing with the Board of Behavioral Sciences.

County-operated programs may undergo Medi-Cal site certifications by the California DHCS and/or SDCBHS. This process includes a review of provider licenses where required. County hiring procedures shall include extensive background checks, including but not limited to, a review of license status, work history and references. Providers shall not be discriminated against on the basis of moral or religious beliefs or their practice of high-cost procedures.

ADULT AND CYF SYSTEMS OF CARE

PROFESSIONAL LICENSING WAIVER REQUIREMENTS

Professional Licensing Waiver Guidelines -Welfare and Institutions Code (W&IC) Section 5751.2.

Complete professional licensing waiver requirements and instructions on how to request these waivers are available in DMH Letter 10-03:
<http://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr10-03.pdf>. This document is also posted on the OPTUM website.

A summarized text (five paragraphs) of W&IC Section 5751.2(a-e) appears below in italics. Department of Health Care Services (DHCS) comments follow each paragraph as dot points.

Section 5751.2 (a): Both county employees and contract providers providing Mental Health Services, regardless of payer source, are subject to all applicable requirements of law regarding professional licensure.

- This applies to all psychologists, clinical social workers, professional clinical counselors

or marriage and family therapists employed by, or under contract to, local mental health programs.

- This does not apply to persons employed by or under contract to health facilities licensed by the California Department of Public Health. Waiver requests for these persons should be directed to the California Department of Public Health.
- The phrase “Mental Health Services” in this section refers to those types of treatment and services that require the practitioner to hold a license.

Section 5751.2.(b): Persons employed as psychologists and clinical social workers, while continuing in their employment in the same class as of January 1, 1979, in the same program or facility, including those persons on authorized leave, but not including intermittent personnel, shall be exempt from the requirements of subdivision (a).

- In order to qualify under this section, an individual would need to be employed in the same position and facility in which she/he was employed on January 1, 1979.

Section 5751.2. (c): While registered for the purpose of acquiring the experience required for licensure, persons employed or under contract to provide mental health services pursuant to this part as clinical social workers, marriage and family therapists, or professional clinical counselors shall be exempt from subdivision (a). Registration shall be subject to regulations adopted by the appropriate licensing board.

- Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Licensed Professional Clinical Counselor (LPCC) candidates do not need a waiver. (See the exception to this statement under Section 5751.2 (e) below for license-ready persons recruited from outside California.)
- Each LCSW, LMFT and LPCC candidate is to remain registered with her/his licensing board until such time as the candidate is licensed. As stated in the statute, such registration shall be subject to regulations adopted by the appropriate licensing board. The candidate must remain registered even though he/she is no longer accumulating hours.

Section 5751.2. (d): The requirements of subdivision (a) shall be waived by the State Department of Health Care Services for persons employed or under contract to provide mental health services pursuant to this part as psychologists who are gaining the experience required for licensure. A waiver granted under this subdivision may not exceed five years from the date of employment by, or contract with, a local mental health program for persons in the profession of psychology.

- Each psychologist candidate must obtain a waiver – even if he/she is registered with his/hers licensing board.
- In order to be eligible for such a waiver, the psychologist candidate must have successfully completed 48 semester/trimester or 72 quarter units of graduate coursework, not including thesis, internship or dissertation. An official copy of a transcript reflecting completion of this coursework requirement must be submitted with the waiver application.
- There is no statutory provision for extension of psychologist candidate waivers beyond the five-year limit.

Section 5751.2. (e): The requirements of subdivision (a) shall be waived by the State Department of Health Care Services for persons who have been recruited for employment from outside this state as psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors and whose experience is sufficient to gain admission to a licensing examination. A waiver granted under this subdivision may not exceed three years from the date of employment by, or contract with, a local mental health program for persons in these four professions who are recruited from outside this state

- To be eligible, the psychologist, LCSW, LPCC or LMFT candidate must be recruited from outside California and have sufficient experience to gain admission to the appropriate licensing examination. For applicants in this category, a letter from the appropriate California licensing board which states that the applicant has sufficient experience to gain admission to the licensing examination must be included with the waiver application.

The following general points should be noted:

- Mental Health Plans (MHPs) should submit and receive approval for waivers under subdivisions 5751.2(d) [psychologist candidates] and 5751.2(e) [candidates recruited from outside California whose experience is sufficient to gain admission to the appropriate licensing examination] prior to allowing candidates to begin work for which a license or waiver is required.
- Waivers are not transferable from one MHP to another. If an individual who obtained a waiver while working for one MHP terminates employment and is subsequently hired by a second MHP, an application for a new waiver must be submitted by the second MHP prior to allowing the candidate to begin work for which a license or waiver is required.
- Once a waiver is granted, the waiver period runs continuously to its expiration point unless the MHP requests that it be terminated earlier.

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Use the “Mental Health Professional Licensing Waiver Request” form (and instruction sheet) included in Appendix M (A.M.1). Please review the instructions prior to faxing the waiver requests to the QM Unit, Attn: Waiver Requests at (619) 236-1953 or email documents to QIMatters.hhsa@sdcounty.ca.gov. For additional questions, please contact your QM Specialist.

Clearances for Work with Minors

Contractor’s employees, consultants, and volunteers, who work under given contract and work directly with minors, shall have clearances completed by the contractor prior to employment and annually thereafter.

- Employees, consultants, and volunteers shall successfully register with and receive an appropriate clearance by “Trustline” (<http://www.trustline.org/>) or equivalent organization or service that conducts criminal background checks for persons who work with minors. Equivalent organizations or services must be approved by the COR prior to use by contractor.
- Employees, consultants, and volunteers shall provide personal and prior employment references. Contractor shall verify reference information, and employees, consultants, and volunteers shall not have any unresolved negative references for working with minors.
- Contractor shall immediately remove an employee, consultant, or volunteer with an unresolved negative clearance.

LICENSED PROFESSIONAL COUNSELORS (LPCCs) AND PCC INTERNS

The scope of practice for LPCCs includes assessment and treatment of individuals and groups. It does not include the assessment or treatment of couples or families unless specific qualifications defined in California law have been met. For complete details, select this link to be taken to the Board of Behavioral Sciences notice:

http://www.bbs.ca.gov/pdf/forms/lpc/lpc_scope_practice.pdf

Documentation and Co-Signature Requirements

Staff that provide mental health services are required to adhere to certain documentation and co-signature requirements. For the most current information on co-signature requirements, please refer to the Uniform Clinical Record Manual. This manual will instruct staff on form completion timeframes, licensure and co-signature requirements, and staff qualifications necessary for completion and documentation of certain forms.

In general, staff that hold the license of an M.D., D.O., N.P., R.N., Ph.D., LCSW, LPCC, or MFT do not require a co-signature on any documentation in the medical record. This also holds true for registered associates with the

Organizational Provider Operations Handbook

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Board of Behavioral Sciences (ASW, PCI or IMF), or staff waived according to State guidelines. These above referenced staff may also provide the co-signature that is required for other staff. Staff that does not meet the minimum qualifications of an MHRS shall have adequate clinical supervision and co-signatures from a licensed/registered/waivered staff. CO-SIGNATURE REQUIREMENTS (From Documentation and Uniform Clinical Record Manual)			
YES - co-signature required NO - co-signature <u>not</u> required N/A - credential cannot provide service			
STAFF DISCIPLINE	Behavioral Health Assessment	Client Plan	Discharge Summary
M.D.	NO	NO	NO
Doctor of Osteopathic Medicine (D.O. or DO)	NO	NO	NO
Ph.D. Psy.D licensed/waivered	NO	NO	NO
Ph.D. Psy.D registered	YES	YES	YES
LCSW, MFT licensed/registered/waivered	NO	NO	NO
Licensed Professional Clinical Counselor (LPCC) Associate Professional Clinical Counselor (APCC)	NO	NO	NO
Nurse Practitioner (NP)	NO	NO	NO
Registered Nurse (RN) **See consideration below	NO	NO	NO
Licensed Vocational Nurse (LVN)	YES	YES	YES
Licensed Psychiatric Technician (LPT)	YES	YES	YES
Mental Health Rehab Specialist (MHRS) <i>ADULT programs</i>	YES	YES	YES
Mental Health Rehab Specialist (MHRS) <i>CYF programs</i>	N/A	YES	N/A
Masters Level Student Interns	Yes	Yes	Yes
Staff not meeting minimum qualifications for MHRS	N/A	N/A	N/A
** According to DHCS guidelines, providing a mental health diagnosis is out of the scope of practice of R.N., LVN, MHRS and LPT staff.			

Masters Level Student Interns must be under formal agreement between the Master's program and the Provider to serve as interns. This agreement allows for the Masters Level Student Intern staff, at the program's discretion, to complete documentation such as the Behavioral Health

Assessment, Client Plan, Discharge Summary, and Progress notes with a co-signature.

Staff Supervision and Management Requirements

- Programs must provide supervision in amount and type that is adequate to insure client safety, maximize gains in functioning, and meet the standards of the professions of those staff employed in the program.
- Programs who employ waived/registered staff receiving supervision for licensure must offer experience and supervision that meet the requirements of the licensing board to which the person is registered.
- Contractor shall ensure provision of required supervision for Nurse Practitioner staff or intern.
- Supervisors may supervise up to 8 clinical staff (licensed, registered, waived, and Masters Level Student Interns) and up to 12 total staff, to include clinical staff.
- Programs must provide adequate training, supervision, and co-signatures by a licensed/registered/waived staff for staff that does not meet the minimum qualifications of an MHRS.
- Any exceptions to these requirements must be approved by the COR.
- Contractor shall notify COR prior to personnel change in the Program Manager position. A written plan for program coverage and personnel transition shall be submitted to COR at least 72 hours prior to any personnel change in the Program Manager position. In addition, the resume of candidate for replacement shall be submitted to the COR for review and comment at least 72 hours prior to hiring.
- Program shall provide the COR an organizational chart identifying key personnel and reporting relationships within 72 hours of any changes to organizational structure.

Staffing Requirements

- All providers shall have staff in numbers and training adequate to meet the needs of the program's target population.
- Psychiatry time: Day Treatment programs, including Intensive and Rehabilitation, shall have psychiatry time sufficient to provide psychiatrist participation in treatment reviews, plus one hour per week for medication management per 8 clients on medication (Intensive) or 10 clients on medication (Rehab). Outpatient programs must also have psychiatry time sufficient to allow the psychiatrist's participation in treatment reviews, especially where medications may be discussed, plus up to one hour per month for each new client to be assessed and one half hour per month per client on medications, for medication follow up.
- Head of Service and providing clinical direction: Most programs' contracts require that the Program Manager (Head of Service) be licensed. If the Program Manager is not

licensed, there must be a Clinical Lead who can provide clinical supervision and perform certain tasks, such as diagnosing, that are within the scope of practice of licensed and waived persons.

- Day Treatment staffing: per the requirements of Title 9, the program must maintain a client to staff ratio of 8:1 (for Intensive programs) and 10:1 (for Rehab programs) at all times. Staff counted in the ratio must be Qualified Mental Health Professionals or licensed or waived. In addition, County guidelines require that at least half the clinical staff in Intensive programs be licensed/waived.
- Outpatient providers' ratio of clinicians/therapists to Masters Level Student Interns shall be no more than 1:3 FTE, i.e., there must be at least one FTE licensed clinician per 3 FTE Masters Level Student Interns. Masters Level Student Interns may provide psychotherapy services, under the close supervision of the clinician/therapist.
- Interdisciplinary Team: Programs must have an interdisciplinary team that includes psychiatrists that meet the "psychiatry standards." Psychiatrists must participate in the regularly scheduled interdisciplinary team meetings where cases are reviewed. A goal of 3-4 hours of licensed psychiatry time weekly is established for Outpatient programs, a goal of 4 hours for Day Treatment (Intensive) and a goal of 3 hours for Day Treatment (Rehab).
- Any exceptions to these requirements must be approved by the COR.

Use of Volunteers and Masters Level Student Interns

- Provider shall utilize family and community members as volunteers in as many aspects of the programming as possible, including teaching a special skill and providing one-on-one assistance to clients. Particular emphasis shall be made to recruit volunteers from diverse communities within program region.
- Provider shall have policies and procedures surrounding both the use of volunteers and the use of employees who are also clients/caregivers.
- Licensed staff shall supervise volunteers, students, interns, mental health clients and unlicensed staff involved in direct client care.
- Masters Level Student Interns assigned to a program must have on file the written agreement between the school and agency with specific time lines which will act to demonstrate the official intern status of the student which determines scope of practice. Copy of document can be maintained in the Signature Log which often stores copies of staff qualifications.
- Signature Log and Documentation of Qualifications
- Each program shall maintain a signature log of all individuals who document in the medical record.

- Signature log contains the individual's typed/printed name, credentials/job title and signature.
- Included with the signature log, or in another accessible location, a copy of each individual's qualifications shall be stored (license, registration, waiver, resume, school contract, high school or bachelor's degree, documentation of COR waiver, etc.). This documentation is used to verify scope of practice.
- Program is responsible to insure that current copy of qualifications (i.e. license, registration, etc.) is kept on file. Expired documents are to be maintained as they demonstrate qualifications for a given timeframe.
- Signature entries and copies of qualifications of staff that are no longer employed by the program are to be maintained, as they documented in the medical record.

ADULT /OLDER ADULT SYSTEM OF CARE

Staffing

Commensurate with scope of practice, mental health and rehabilitation services may be provided by any of the following staff:

- Physician
- Licensed/Registered/Waivered Psychologist
- Licensed/Registered/Waivered Clinical Social Worker
- Licensed/Registered/Waivered Marriage and Family Therapist
- Licensed/Registered/Waivered Professional Clinical Counselor
- Nurse Practitioner
- Registered Nurse
- Licensed Vocational Nurse
- Licensed Psychiatric Technician
- Mental Health Rehabilitation Specialist (*see definition below*)
- Staff with a bachelor's degree in a mental health related field (see supervision and co-signature requirements)
- Staff with two years of full-time equivalent experience (paid or unpaid) in delivering mental health services (see supervision and co-signature requirements)
- Staff without bachelor's degree in a mental health field or two years of experience (see supervision and co-signature requirements)

Mental Health Rehabilitation Specialist (MHRS). A mental health rehabilitation specialist is an individual who has a baccalaureate degree and four years of experience in a mental health setting

as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis. Up to two years of post-associate arts clinical experience may be substituted for the required educational experience (as defined in Title 9) in addition to the requirement of four years of experience in a mental health setting.

CYF SYSTEM OF CARE

Staffing

- Contractor's program staff shall meet the requirements of Title 9, Division 1, Article 8 and Title 9, Chapter 11 of the California Code of Regulations as to training, licensure, and clinician/client ratios. All staff shall operate within the guidelines of ethics, scope of practice, training and experience, job duties, and all applicable State, Federal, and County standards. Contractor shall provide sufficient staffing to provide necessary services and Medicare approved services to Medicare covered clients. Current and previous documentation of staff qualifications shall be kept on file at program site.
- Psychotherapy shall be performed by licensed, registered, waived, or Masters Level Student Intern (with co-signature by LPHA) staff in accordance with State law.
- Psychiatrists shall have completed a training program in a child or adolescent specialty (must be Board eligible in child and adolescent or adolescent psychiatry), for programs that serve youngsters under 13 years of age, or have 5 years of experience offering psychiatric services to children and adolescents. Any exception to this must be approved by the Mental Health Services Clinical Director and the COR.
- Nurses and Psychiatric Technicians may bill Medication Support to Medi-Cal under the non-MD service code 20, as long as the service provided is within the individual's scope of practice and experience and documentation supports the service claimed. Qualified Mental Health Professionals (QMHP) / Mental Health Rehabilitation Specialist who provide direct, billable service must hold a BA and 4 years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirements on a year for year basis. Up to two years of post-associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years of experience in a mental health setting. Staff work under the direction of a licensed or waived staff member.
- Rehabilitation Staff (non-licensed, non-waiverable, also referred to as Para Professionals) who provide direct, billable service at a minimum must have a high school diploma/GED, be 18 years old, have at least one-year full time (or equivalent) experience working with children or youth, a positive reference by a supervisor from that work experience, and must work under the direction of a licensed or waived staff member.

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- Family / Youth Support Partners who provide direct, billable service must have direct experience as the parent, care giver, or consumer in a public agency serving children, and demonstrate education and/or life experience commensurate with job duties. Youth (at least 12 years of age and up to 25 years of age) must meet work permit requirements when applicable. Partners must receive ongoing training and work under the direction of a licensed or waived staff member.
- All direct service staff shall have had one year of supervised experience with children and adolescents.
- Any exceptions to these requirements must be approved by the COR.

N. DATA REQUIREMENTS

Data Collection and Retention

Contractor shall maintain daily records of services provided, including dates of service, times of service, total time of service, types of services provided, persons served, and progress of clients in meeting the objectives of the case plan. Data shall be recorded in accordance with the specifications in the CCBH User's Manual. Service entry shall be kept up to date and the data shall be entered into the SDMHS MIS (CCBH) and the mHOMS and CYF mHOMS data entry systems within a timely manner.

Accuracy of Data

Providers are responsible for ensuring that all client information is accurate including addresses and all demographic data that is required for State reporting for Client Statistical Information (CSI). Providers must have processes in place for checking/updating client data and making the necessary corrections.

Full Service Partnership programs are required to ensure that all required data that are to be tracked for their clients are correct and up to date in both the MH MIS and State Databases.

Financial Eligibility and Billing Procedures

Each provider is responsible for specific functions related to determining client financial eligibility, billing and collections. The **Financial Eligibility and Billing Procedures - Organizational Providers Manual** is available on the Optum Public Sector website (<https://www.optumsandiego.com>) for providers as a guide for determining financial eligibility, billing and collection procedures. This manual includes the following procedure categories:

- Determining financial eligibility
- Billing, collections and payment procedures
- Corrections, adjustments and special requirements

This manual is not intended to replace the CCBH User's Manual or intended to be a comprehensive "Insurance and Medicare Billing" guide. It is meant to augment existing resource materials.

Medi-Cal Administrative Activities (MAA)

Federal and State regulations (Welfare and Institutions Code, Section 14132.47, Medi-Cal Administrative Activities) permit counties to earn federal Medi-Cal reimbursement for activities that are necessary for the proper and efficient administration of a State's Medicaid (Medi-Cal) plan. These MAA activities are focused on assisting individuals to access the Medi-Cal Program

and the services it covers through such functions as Medi-Cal and mental health outreach, facilitating Medi-Cal eligibility determinations, MAA coordination and claims activities and other designated activities.

Organizational providers may be permitted to provide MAA services and claim them. The MHP requires that each organizational provider have a County approved MAA Claiming Plan prior to claiming MAA services, and that each provider complies with all applicable State and federal regulations. To claim for MAA activities, a provider must follow a set of procedures, which are described in detail in the *MAA Instruction Manual* developed by the State Department of Health Care Services.

To assist providers, technical assistance and training on MAA is available through the MAA Coordinator. The MAA Coordinator can provide assistance with claiming and procedural questions or provide MAA training to staff.

There is a Medi-Cal Administrative Activities Procedures Handout for providers claiming MAA activities with an approved MAA claiming plan. This handout may be used for reference and training purposes. The handout along with the MAA Community Outreach Service Record can be found on the Optum website <https://www.optumsandiego.com>.

Additional Outcome Measures

Additional statistical data may be required in your specific contract. This may involve the use of additional tools for Evidence Based Programs or for specific parts of the system. Your contract may also require manual collection of data on certain outcomes from client charts, such as number of hospitalizations, readmissions, arrests, or changes in level of placement/living situation. The data collected should be submitted on your QSR or as directed by your Program's COR or QM unit.

MENTAL HEALTH SERVICES ACT (MHSA)

MHSA – Community Services and Support (CSS)

CSS providers are tasked with gathering program specific information as outlined in their contract, and data tracking on the Quarterly Status Report (QSR). Additionally, CSS providers administer applicable treatment outcome data and responses are recorded by Contractor's staff in CYF mHOMS a web-based data entry system or as otherwise directed by the County. This database permits client results to be compiled for individual cases and by program.

MHSA - Prevention and Early Intervention (PEI)

PEI providers are tasked with gathering specific demographic data, and a four question general survey which is entered into mHOMS. The mHOMS database is utilized for gathering the data and managed by the County's Data Centers (HSRC in conjunction with CASRC). Data can be entered directly into the mHOMS database or the Data Centers will set up for extracts from contractor's database into the mHOMS. Program specific outcome and process data as outlined in contract is captured in the Quarterly Status Report (QSR).

MHSA - Innovation

Innovation providers are tasked with gathering specific demographic data, and a general question survey which is entered into mHOMS. The mHOMS database is utilized for gathering the data and managed by the County's Data Centers (HSRC in conjunction with CASRC). Data can be entered directly into the mHOMS database or the Data Centers will set up for extracts from contractor's database into the mHOMS. Program specific data as outlined in contract is captured in the Quarterly Status Reports (QSR).

MHSA Work Force Education and Training (WET)

WET providers are tasked with gathering specific demographic data. The mHOMS database is utilized for gathering the data and managed by the County's Data Centers (HSRC in conjunction with CASRC). Data can be entered directly into the mHOMS database or the Data Centers will set up for extracts from contractor's database into the mHOMS. Program specific data as outlined in contract is captured in the Quarterly Status Reports (QSR).

MHSA - Full Service Partnerships (FSP)

A number of providers participate in MHSA Full Service Partnerships, which both provide mental health services to clients and link them with a variety of community supports, designed to increase self-sufficiency and stability. These providers are required to participate in a State data collection program (DCR) which tracks initial, specialized client assessments, ongoing key incident tracking and quarterly assessments. The State has set timeframes for provisions of each type of data.

Outcome Measures - Adult System of Care

Milestones of Recovery Scale (MORS)

MORS is a single item evaluation tool used to assess clinician perception of a client's current degree of recovery. Ratings are determined by considering three factors: their level of risk, their level of engagement within the mental health system, and their level of skills and support. Completion of the MORS form is required within 30 days of client's admission, every 6 months thereafter, and at discharge. MORS is completed by outpatient programs by clinicians.

Level of Care Utilization System (LOCUS)

The LOCUS is a short assessment of client current level of care needs and is completed by program staff. Program staff should complete a LOCUS for all clients within 30 days of their initial intake assessment, every 6 months thereafter, and at discharge.

Recovery Markers Questionnaire (RMQ)

A consumer-driven assessment of the client's own state of mind and body and life, and involvement in the recovery process. The RMQ is used to assess personal recovery of the client from the perspective of the client. Program staff must collect the intake RMQ during the client's first 30 days in the program. All clients should complete follow-up RMQs every 6 months and at discharge.

Illness Management and Recovery (IMR)

The IMR is used to assess personal recovery of the client from the perspective of the clinician. It ranks a client's biological vulnerability and socio environmental stressors. The IMR also includes questions about changes in a person's residential, employment, or education status. Staff must complete the IMR within 30 days of their initial intake assessment. Follow-up IMRs should be completed every 6 months after intake, and at discharge for all clients.

Outcome Measures Manual

For more information about outcomes measures, the Outcome Measures Manual is available on the Optum website <https://www.optumsandiego.com>

Outcome Measures - Children's System of Care

Data Collection and Retention

All treatment programs shall enter outcomes into the Children, Youth and Families Mental Health Outcomes Management System (CYF mHOMS) data entry system for all clients. CYF mHOMS data entry shall be completed promptly upon collection of data at designated intervals, including intake, UM/UR authorization cycle or every 6 months (whichever occurs first) and discharge.

Outcome Tools and Requirements

Measuring outcomes is an integral aspect of System of Care principles. Standard outcomes have been established for all CYF treatment providers. Specialized programs may have individual program outcomes either in addition to or in lieu of standard outcomes measured by all programs.

- Pediatric Symptom Checklist – Youth (Y-PSC) – 11-18 years of age
- Pediatric Symptom Checklist - Parent/Caregiver (PSC) – 3-18 years of age
- San Diego Child and Adolescents Needs and Strengths-50 (SD-CANS) 6-21years of age
- Youth Services Survey – Youth (YSS-Y) – 13 years of age or older
- Youth Services Survey – Family (YSS-F) – caregivers of youth up to age 18
- CRAFFT- all ages (completed at intake only- used as an assessment tool)

- Personal Experience Screening Questionnaire (PESQ) – Youth receiving services from AOD counselor at a CYF FSP Sub Unit
- Satisfaction Questionnaire – Youth receiving services from AOD counselor at a CYF FSP Sub Unit

Symptoms/Functioning Outcomes:

Pediatric Symptom Checklist (PSC)

- a) Youth 11 years of age and over shall complete the Y-PSC at intake into the program, UM/UR cycle (session based for outpatient clients, 3 months for Day Treatment intensive, Day School Services and Residential OP, 6 months for Day Rehab) or every six months (whichever occurs first) and at discharge from program.
- b) Parents/Caregivers of all children and youth 3-18 years of age shall be administered the parent PSC on the same cycle. When no parent/guardian is available, an individual in a caretaking capacity (i.e. residential staff, social worker, relative, etc.) may complete the measure.
- c) Most current PSC scores above clinical cutoff should be considered during UM/UR Authorization supporting medical necessity and clinical effectiveness.
- d) All responses shall be recorded by program staff in the web-based CYF-mHOMS database or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
- e) Medication only cases are excluded from the PSC measure.
- f) Programs exempt from completing the PSC (such as TBS or DEC) shall maintain written exception documentation from COR on file.

Child and Adolescent Needs and Strengths (SD-CANS)

- a) As part of Behavioral Health Assessment (BHA), CYF clients shall have a SD-CANS completed at intake and updated at UM/UR cycle (session based for outpatient clients, 3 months for Day Treatment intensive, Day School Services and Residential OP, 6 months for Day Rehab) or very six months (whichever occurs first) and at discharge from program. SD-CANS results should be used to support medical necessity and clinical effectiveness.
- b) The CANS' results shall be recorded by program staff in CYF mHOMS, a web-based data entry system. or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
- c) Data recorded in the database shall be supplied to CASRC via direct drop off or traceable mailing to ensure HIPAA regulations are followed.
- d) CANS results are interrelated to the BHA and shall also be utilized as Service Necessity Criteria for Intensive Service Requests (ISR) and Specialty Mental Health DPRs.
- e) Medication only cases are excluded from the SD- CANS measure.

CRAFFT

- a) All CYF clients shall be assessed for substance use at intake into the program and the CRAFFT shall be administered. The CRAFFT measure is included in the Behavioral Health Assessment in CCBH.
- b) Medication only cases are excluded from the CRAFFT measure.

Personal Experience Screening Questionnaire (PESQ)

- a) Effective 1-1-13, Clinics enhanced with Alcohol and Drug Counselors through MHSA-FSP component on 7-1-12, shall administer the PESQ at intake and discharge to clients receiving services from an AOD counselor
- b) All responses shall be recorded by program staff in the web-based CYF mHOMS database, or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program
- c) Data shall be utilized to evaluate individual treatment and program effectiveness.

Discharge Outcomes Objectives:

SD-CANS

- At Discharge, 95% of clients ages 6-21 whose episode lasted 60 days or longer have CANS data available for both initial and discharge assessment. At Discharge, 100% of clients ages 6-21 whose episode lasted 60 days or longer, their initial CANS shall have at least one actionable need (2 or 3) on the Child Behavioral and Emotional Needs, Risk Behaviors OR Life Functioning domains.
- For 80% of clients ages 6-21 whose episode lasted 60 days or longer, with an actionable need (rating of 2 or 3) on the Child Behavioral and Emotional Needs, Risk Behaviors or Life Functioning domains, their number of needs shall go down by at least 3 from initial to discharge assessment indicating improvement.
- For 80% of clients ages 6-21 whose episode lasted 60 days or longer, with an actionable need (rating of 2 or 3) on the Child Behavioral and Emotional Needs, Risk Behaviors or Life Functioning domains, their number of strengths shall increase by at least 1 from initial to discharge assessment, indicating development of a strength.

PSC

- At Discharge, 75% of clients ages 3-18 whose episode lasted 60 days or longer have Parent PSC data available for both Initial and Discharge assessments demonstrating completion rate.
- For 80% of discharged clients ages 3-18 whose episode lasted 60 days or longer, the Parent PSC total score shall show a 3-point improvement (reduction in symptoms) between Initial and Discharge assessments.

- Report the number of clients ages 3-18 who scored at or above the clinical cutoff on the initial PSC assessment.
- 80% of discharged clients whose episode lasted 60 days or longer, shall show improvement on the PSC by either falling below the clinical cutoff or having a 3-point reduction in symptoms.
- Report the number of discharged clients ages 3-18 whose episode lasted 60 days or longer, whose Initial Parent PSC total score was above the clinical cutoff, that have a total score below the clinical cutoff at discharge demonstrating improvement.
- Report the number of clients ages 3-18 whose episode lasted 60 days or longer, with a 3-point improvement (reduction in symptoms) between Initial and Discharge assessments, demonstrating improvement.

Youth Services Survey (YSS): Client Satisfaction:

Currently administered twice annually to all clients and families who receive services during a selected one-week interval specified by the County MHP (excluding detention programs, medication only cases, inpatient and crisis services). The twice annual survey will be conducted in the Spring and Fall of each year. The survey returns are scanned in to facilitate tabulation, therefore original printed forms provided by the MHP must be used.

- a) Youth aged 13 and over complete the Youth Services Survey with attached comments page.
- b) Parents/caregivers of children and youth up to age 18 complete the Youth Services Survey-Family.
- c) Surveys are to be administered in a manner that ensures full confidentiality and as directed by the Child and Adolescent Services Research Center (CASRC).
- d) Completed surveys shall be delivered by hand adhering to HIPAA regulations to CASRC within 3 business days after the completion of each survey period
- e) Medication only cases are excluded from the YSS measure.

Alcohol and Drug Counselor Satisfaction Survey

- a) Only for youth receiving services from an AOD counselor enrolled in a Clinic FSP Sub Unit.
- b) Youth shall complete the four item satisfaction questionnaire upon discharge from the AD FSP Sub Unit.
- c) Surveys are to be administered in a manner that ensures full confidentiality.
- d) All responses shall be recorded by program staff in the web-based CYF mHOMS database, or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program.

Satisfaction Outcomes:

- Submission rate of YSS-Y and YSS-F shall meet or exceed the 80% standard established by the County of San Diego Children’s Mental Health.
- Aggregated scores on the YSS-Y and the YSS-F shall show an average of 80% or more respondents responding “Agree” or “Strongly Agree” for at least 75% of the individual survey items.
- Clients receiving services from an AOD counselor at an FSP Sub Unit shall show an average of 80% or more respondents responding “Agree” or “Strongly Agree” on each of the 7 supplemental items.

Medication Only Clients

Outcome measures identify the effects of mental health treatment. Once clients transition from “Meds Plus” to “Meds Only”, they will not be required to have outcome measures entered in the CYF-mHOMS database.

- Administer and record SD-CANS and PSC as a discharge assessment upon transition to meds only and close client in CYF mHOMS this is the discharge measure.
- Administer and record SD-CANS and PSC as an intake assessment if client is returning to treatment services (Meds Plus) from meds only as a new episode in CYF mHOMS.

Additional outcome objectives:

All providers:

- 100% of all clients shall be assessed for substance use during the assessment period as evidenced by documentation in the medical record and completion of the CRAFFT measure.
- 100% of all clients, ages 16 and older, shall be assessed for transitional service needs as evidenced by documentation in the medical record.
- 100% of all clients shall be assessed for domestic violence issues as evidenced by documentation in the medical record.
- 100% of all clients shall be assessed to determine the need for referral to a primary care physician as evidenced by documentation in the medical record.
- 80% or more of all clients shall receive a minimum of one face-to-face family treatment contact/session per month with the client’s biological, surrogate, or extended families, that are able.

Outpatient providers

- 90% of clients will avoid psychiatric hospitalization or re-hospitalization during the outpatient episode.

- Outpatient programs shall maintain an average waiting time of less than 5 days for the client's initial appointment.
- Outpatient programs shall meet or exceed the minimum productivity standard for annual billable time by providing at least 54,000 minutes per year (50% productivity level) for clinic, school and community based programs per FTE, unless otherwise specified in the program's Statement of Work.
- Psychiatrist shall maintain a minimum of 75% productivity level.
- RN shall maintain a minimum of 55% productivity level.
- Case Management services provided by a case manager shall meet or exceed the minimum productivity for annual billable time by providing at least 32,400 minutes per year (30% productivity level) per FTE, unless otherwise specified in the program's Statement of Work.
- Clinical staff shall carry a minimum client load of 40 unduplicated clients per FTE per year unless otherwise specified in the program's Statement of Work.
- Case Managers shall carry a minimum client load of 20 unduplicated clients per FTE per year unless otherwise specified in the program's Statement of Work.

Day Treatment providers

- Contractor shall ensure that billable client days shall be produced for 90% of the annual available client days, based upon five (5) days per week or 230-day year.
- 95% of clients will be discharged to a lower level of care unless otherwise specified in the contract.
- 95% of clients will avoid psychiatric hospitalization or re-hospitalization during the Day Treatment episode.

Research Projects Involving Children's Mental Health Clients

Some providers may develop research projects or test additional outcome tools with methods that utilize MHP clients. All such projects must be reviewed by the MHP's Research Committee as well as the organization's Internal Review Board, if any. Approval is required prior to implementation of the project.

O. TRAINING

The increasing focus on cultural sensitivity, outcome measures, practice guidelines, and evidence-based practice necessitates the need for ongoing training. Many providers have a contractual obligation to participate in identified trainings within 60 days of hire or when training becomes available. Some trainings are to be tracked on MSR/QSR:

- Cultural Competency Training – Minimum of four hours annual requirement for all staff. When an in-service is conducted, program shall keep on file a training agenda and a sign-in sheet for all those in attendance with sign-in/out times. For outside trainings, certificate of completion shall be kept on file at the program. Cultural Competency Trainings are also available through BHETA e-learning at: (<http://theacademy.sdsu.edu/programs/BHETA/index.htm>). Contractor shall maintain and submit a Cultural Competence Training Log annually.
- BHS Disaster Training is available through BHETA e-learning. A minimum of 25% of contracted staff need to be disaster trained.
- System of Care training is available through BHETA e-learning. All direct service staff shall complete e-learning about BHS System, CWS System, and Pathways to Well-being.
- Continuing Education Units (CEUs) -- Contractor shall require clinical staff to meet their licensing requirement. Other paraprofessional staff shall have a minimum of sixteen (16) hours of clinical training per year.
- Contractor shall attend trainings as specified in their Contract.
- Contractor shall obtain training on the DES database, which captures outcome data, as well as the DCR System for FSP programs. Trainings are available through CASRC (<http://www.casrc.org>)
- Family and Youth Support Partners trainings are available through NAMI San Diego. Contact the Peer & Family Support Helpline at 1-800-523-5933.

The Quality Management Unit

The Quality Management Unit provides training and technical assistance on topics related to the provision of services in the Adult/Older Adult & Children Systems of Care.

Training and information is disseminated through:

- Basic Documentation Training
- Root Cause Analysis Training
- CCBH User Trainings
- QM Specialized Trainings
- Regular QM Communications
- Organizational Provider Operations Handbook

- Regular Provider Meetings
- TKC—The Knowledge Center
- BHETA e-learning

For information on upcoming trainings or in-services, or if you require technical assistance, please contact QM at: www.QIMatters.hhsa@sdcounty.ca.gov

Electronic Health Record Trainings

Various trainings are available for the electronic health record, CCBH.

All clerical staff are required to attend CCBH Admin Data Entry training in order to have access to the system for entering data and pulling reports.

Any staff entering billing for services are required to attend CCBH Service Entry Training.

Specialized staff are required to attend CCBH Scheduler training in order to be able to enter staff into the scheduling system and to set appointments for clients.

All clinicians are required to have training in CCBH in order to complete assessments, client plans, and progress notes. Clinicians will also learn how Scheduler will work for their caseload.

Psychiatrists and nurses are also required to have training in CCBH, specifically the Doctor's Home Page (DHP) training. In the Doctor's Homepage trainings, prescribers (MDs) and Clinical Support Staff (nurses) are trained to enter Medical Conditions Reviews (vitals, medical conditions, and allergies), pre-existing physical health medications, sample medications, on-site injectables, and over-the-counter medications. They are also trained to e-prescribe psychotropic medications to the client's pharmacy of choice, as well as to renew, edit, discontinue, void, and delete medications (as necessary).

Reports training is available for managers and staff who need to be able to access reports in the CCBH system.

Information about CCBH trainings may be found on the Optum Public Sector website.

P. MENTAL HEALTH SERVICES ACT - MHSA

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). MHSA was designed to provide funds to counties to expand services, develop innovative programs, and integrate service plans for children, adults and older adults with a serious mental illness.

The MHSA work plan consists of five components:

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Innovations (INN)
- Capital Facilities and Technological Needs (CFTN)
- Workforce Education and Training (WET)

MHSA System Transformation

Under the MHSA, community based services and treatment options in San Diego County have been improved, expanded, and transformed by:

1. Increasing Client and Family Participation
2. Serving More Clients
3. Improving Outcomes for Clients
4. Decreasing Stigmatization
5. Minimizing Barriers to Services
6. Increasing Planning and Use of Data
7. Increasing Prevention Programming
8. Including Primary Care in the Continuum of Care
9. Using of Proven, Innovative, Values-Driven and Evidence-Based Programs

The Mental Health Services Oversight and Accountability Commission (MHSOAC) is responsible for oversight of MHSA implementation. MHSOAC holds counties accountable for a number of outcomes. The outcomes include decreases in racial disparities, hospitalizations, incarcerations, out-of-home placements and homelessness while increasing timely access to care. Other outcomes may be required as the State and County evaluate MHSA services. Contractors receiving MHSA funding are responsible for complying with any new MHSA requirements.

MHSA Full Service Partnerships

A number of providers are participating in MHSA Full Service Partnerships, which provide mental health services to clients and link them with a variety of community supports, designed to increase self-sufficiency and stability.

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MENTAL HEALTH SERVICES ACT - MHSA

These providers are required to participate in a State data collection program which tracks initial assessments, specialized client assessments, ongoing key incident tracking and quarterly assessments. The State has set timeframes for provisions of each type of data.

For current information on MHSA visit: <http://sandiego.camhsa.org/>

For current MHSOAC information visit:
<http://www.mhsoac.ca.gov/>

Q. Payment Schedule Budget Guidelines for Cost Reimbursement Contract

This document includes additional instructions (*in italics*) to help clarify the intent of the requirements and guidelines.

Contractors prepare program budgets for County review and approval. The approved budget for each fiscal year serves as objectives and guidelines for contract performance, and determination of allowable and appropriate expenditures. The budget guidelines allow for flexibility within specified dollar limits, and states conditions when prior written County approval must be obtained before contractors are allowed to exceed the specified limits for discretionary variance from the approved budget. It is expected that budgets submitted by providers will include all expenses that are needed to support the program during the fiscal year. Do not submit the previous year's budget if you anticipate additional expenditures in expense line items that previously have a \$0 budget or an asterisked line item.

The clauses expanded upon below are only those that have been subject to inquiry or that have been recently modified or updated.

Budget Guidelines

The annual contract amount is specified in the contract and supported by an annual budget developed by the contractor. Contractor must obtain written prior approval from the County and a Contract Amendment must be executed before exceeding the fiscal year's approved budget. Unspent funds from one fiscal year may not be applied to subsequent fiscal year's expenditures unless authorized and supported by a Contract Amendment.

If expenses are within the allowable limits stated below, no prior approval or change to the budget is required, though all expenses must always be reasonable and appropriate for the contracted services, and are subject to subsequent review and disallowance. Any expenditures requiring written approval must be requested in advance and approved by the COR. Approval is not effective, and contractor should not incur any requested expense, until notified.

Total Direct Labor Cost

Reimbursable direct labor cost for direct labor and program management staff incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such cost in Exhibit C, Contractor's Budget. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Salaries and Benefits category plus any allowable unexpended Operating Expenses without the prior written approval of the COR.

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The contract does provide some flexibility to transfer funds between Direct Labor Costs and Other Direct Costs. An adjustment to Direct Labor costs is allowed if it results in no net change to the total annual contract maximum. Guidance for allowed budget adjustments is listed below.

- Unexpended Salaries and Benefits (S&B), up to 10% of total annual S&B budgeted amounts, may be applied to Operating Expenses.

Budget adjustments greater than 10% to Direct Labor cost require prior approval from the COR. Only budget adjustments up to 10% to Direct Labor cost do not require prior approval from the COR. Example:

Example 1: The total Salaries and Benefits amount for a program budget equals \$500,000, and contractor expects to spend less than \$430,000. Of the \$70,000 in projected unspent funds for this category, up to \$50,000 (10% of the \$500,000 Total Approved Budget), may be applied to Operating Expenses without requiring prior approval or change to the budget.

Example 2: The total Salaries and Benefits amount for a program budget equals \$600,000, and contractor expects to spend less than \$570,000. The entire \$30,000 in projected unspent funds for this category, which is less than the limit of \$60,000, may be applied to Operating Expenses without requiring prior approval or change to the budget.

- Unexpended Salaries and Benefits that may be applied to Operating Expenses may be from temporary vacancies of budgeted staff.

Contractor shall not purposefully keep positions vacant for the purpose of accruing savings to be used for Operating Expenses. When staffing levels are reduced due to reduced workloads, then it is expected that operating expenses would be similarly underspent. The intent is to fill all budgeted positions and to provide services to clients. Unspent funds due to other reasonable circumstances may be applied to Operating Expenses.

- Unexpended Salaries and Benefits may be applied directly to any temporary replacement staff and do not require prior County approval as long as costs do not exceed amounts budgeted for these positions.

Temporary and/or replacement staff should be listed in the Salaries and Benefits category, and are not subject to prior approval as long as the total of Salaries does not exceed the budgeted amount plus 10% for this category.

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Payment Schedule Budget Guidelines for Cost Reimbursement Contract Only (Contractor Instructions)

- Staffing changes, including addition or deletion of budgeted staff, shall require prior COR approval. Individual salaries may be exceeded up to 5% without prior COR approval.

Adequate and appropriate staffing is normally the most important factor in the successful delivery of contracted services. Any permanent change to the number (FTEs) or classification of staff requires prior written approval. Salaries for each classification may be listed as averages, and individual salaries may be exceeded up to 5% without prior written approval by the COR, as long as the overall 10% rule is heeded. NOTE: Bonuses, incentive pay, and other types of special employee pay require prior written approval by the COR and must comply with Office of Management and Budget (OMB) Guidelines

Total Other Direct Cost

Reimbursable operating costs incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such expenses in Exhibit C. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Operating Expenses category plus any allowable unexpended Salaries and Benefits without the prior written approval of the COR.

The contract does provide some flexibility to transfer funds between Direct Labor Costs and Other Direct Costs. An adjustment to Other Direct costs is allowed if it results in no net change to the total annual contract maximum. Guidance for allowed budget adjustments is listed below.

- Unexpended Operating Expenses (OE), up to 10% of total annual OE budgeted amounts, may be applied to Salaries and Benefits.

All budget adjustments greater than 10% to Operating Expense cost require prior approval from the COR. Example:

Example: If the total Operating Expenses for a program budget equals \$300,000, any unspent amount, up to a maximum of \$30,000 (10% of the total budget for this category), may be applied to Salaries and Benefits without requiring prior COR approval.

- The budgeted amounts for Operating Expenses line items may be exceeded as long as the total of all items does not exceed the total budgeted Operating Expenses (including any allowable unexpended Salaries and Benefits, except for Leasehold Improvements, Consultants/Subcontracts, Interest Expense, Gift Cards and Flex Funds.

Example: If \$1,000 is budgeted for Office Supplies and the total expenses to date equals \$1,500, no prior approval or change to the budget is needed unless the total Operating Expenses amount

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*exceeds the approved amount in the budget. **NOTE:** all expenses must be reasonable and appropriate for the contracted services, and are subject to subsequent review and disallowance.*

- Consulting expenses shall be budgeted on Agreement Budget and shall not be exceeded without prior COR approval, with the exception of temporary staffing. All other consulting services not previously budgeted shall require prior written COR approval.
- Budgeted amounts for Leasehold Improvements, Interest Expense and Gift Cards may not exceed without prior written County approval.
- Budgeted amounts for Client's Flex Funds may exceed up to \$1,000. Costs above \$1,000 require prior written approval by the COR.
- No expense shall be allowed for any line item that does not have an amount currently budgeted.

Expenses without a budget require prior COR approval and detailed justification. Additional expenses due to emergencies and/or unforeseen circumstances for line item(s) that have a \$0 budget will be reviewed on a case-by-case basis. These expenses are not allowed to be claimed in other line items that were not intended for these types of expenses.

Fixed Assets

All fixed asset expenses shall be budgeted and itemized on the Agreement Budget, and no fixed asset budget line item shall be exceeded without prior written COR approval.

The purchase of fixed assets that are not listed on the budget require prior written approval. Fixed assets include all non-expendable property with a value of \$5,000 or more and a normal life expectancy of more than one year.

Purchase of fixed assets that are budgeted on the itemized Supplemental A and any assets not currently budgeted require written notification to the COR.

Total Indirect Cost

Reimbursable indirect costs incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such cost in Exhibit C. The sum of any and all such costs shall not exceed the total amount budgeted for the Indirect Cost category without the written approval of the COR. Reimbursable indirect costs shall be limited such that the ratio of actual total Indirect Cost to actual total Gross Cost shall not exceed the ratio of budgeted Indirect Cost to budgeted Gross Cost.

Organizational Provider Operations Handbook

Payment Schedule Budget Guidelines for Cost Reimbursement Contract Only (Contractor Instructions)

If the total budget is underspent, it is expected that Indirect Costs would decrease proportionately.

Units of Service

Units of Service are the most critical element of the program budget, and the budgeted units of service may not be changed without prior written approval by the COR. Delivery of service below budgeted levels may be considered a performance matter and subject to corrective action.

Start-Up Funds (for Procurement Budget only)

Start-up funds shall be subject to available funding, negotiations and shall be at the sole discretion of the County. This shall be limited to one-time costs of newly awarded contracts and shall be used for the development and implementation of a new or expanded program or service.

- The budget and timelines for expending start-up funds must be approved by the county
- Shall not be available for option years
- Shall not exceed 10% of the annual budget of the first year of contract
- A separate cost center for start-up funds shall be included in the proposed budget for the initial contract period and expenditures shall be tracked separately from ongoing expenditures
- If multiple funding sources are identified within the contract, a plan to allocate the start-up costs amongst various funding sources shall be required and budgeted appropriately to reflect the funding ratios amongst the various funding sources
- Start-up costs will be reimbursed based on actual costs (cost reimbursement). Contractor shall comply with Cost Reimbursement Contract requirements. At a minimum, submit an acceptable Cost Allocation Plan and keep an Inventory List, according to Article 2.4 of the Service Template

Examples of expenditures that may be approved include:

- Costs of staff hiring
- Initial staff training and development related to a new program or operation (ongoing training and development should be included in the annual operating budget)
- Minor equipment
- Supplies and materials
- Licenses and permits
- Tenant Improvements

Start-up funds shall not be used:

- To supplant or supplement ongoing or routine operating expenses
- For ongoing or routine program activities
- To improve an existing program or service

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At the end of the determined start-up period, an evaluation of the start-up expenditures shall be made and remaining start-up funding may be rescinded at that time. Expenditures that do not meet the start-up criteria may be disallowed and subject to reimbursement.

R. QUICK REFERENCE

PHONE DIRECTORY

ACCESS AND CRISIS LINE (ACL)	(888) 724-7240
ACL FAX	(619) 641-6975
COUNTY OF SAN DIEGO MHP ADMINISTRATION	(619) 563-2700
Local Mental Health Director	(619) 563-2700
Medical Director	(619) 563-2700
Quality Management Unit – Program Manager	(619) 641-8802
Serious Incident Reporting Line	(619) 641-8800
QM FAX	(619) 236-1953
QM Email	QIMatters.hhsa@sdcounty.ca.gov
PIT Unit– Program Manager	(619) 584-5015
PIT Email	BHSQIPIT@sdcounty.ca.gov
MIS Unit– Program Manager	(619) 584-3004
MIS Help Desk	(619) 584-5090
MIS Help Desk Email:	
MH_MIS_SystemAdmin.HHSA@sdcounty.ca.gov	
Contract Administration Unit Manager	(619) 563-2733
Claim Submission FAX	(619) 563-2730
MHP Compliance Hotline	(866) 549-0004
MAA Coordinator	(619) 563-2700
Mental Health Billing Unit	(619) 338-2612
FAX	(858) 467-9682
Email	mhbillingunit.hhsa@sdcounty.ca.gov
County Health Information Management Dept. (HIMD)	(619) 692-5700 Option #3 (Medical Record Requests)

OPTUM (ADMINISTRATIVE SERVICES ORGANIZATION)

Provider Line	(800) 798-2254 Option #7
Optum Administrative Services for MHP	(619) 641-6800
Admin FAX	(619) 641-6801
Cerner Assistance - Optum Support Desk	(800) 834-3792
Clinical-Access and Crisis Line	(619) 641-6802
TDD/TTY	(619) 641-6992

CLIENT ADVOCACY ORGANIZATIONS

Consumer Center for Health Education and Advocacy	(877) 734-3258
JFS Patient Advocacy Program	(800) 479-2233

AMERICAN SIGN LANGUAGE (ASL) INTERPRETER SERVICES

Deaf Community Services	(619)398-2441
Videophone	(619) 550-3436
Interpreter's Unlimited	(858) 451-7490

INTERNET RESOURCES

County of San Diego	www.sdcounty.ca.gov
Optum	www.optumsandiego.com
California Board of Behavioral Sciences	www.bbs.ca.gov
California Board of Psychology	www.psychology.ca.gov
California Code of Regulations	www.calregs.com
California Department of Health Care Services	www.dhcs.ca.gov
California Medi-Cal Website	www.medi-cal.ca.gov
County Behavioral Health Directors Association of California	www.cbhda.org
California Welfare & Institutions Code	leginfo.legislature.ca.gov/faces/codes.xhtml
Center for Medicare and Medicaid Services	www.cms.hhs.gov
Community Health Improvement Partners	www.sdchip.org
Disability Benefits 101	www.disabilitybenefits101.org
211 San Diego (Social Services Database)	www.211sandiego.org
Intentional Caregiver Website	www.intentionalcaregiver.com
Psychiatric Rehabilitation Association	www.psychrehabassociation.org
Joint Commission on Accreditation of Healthcare Organizations	www.jointcommission.org
National Institute of Mental Health (NIMH)	www.nimh.nih.gov
Network of Care	www.networkofcare.org
Office of Inspector General Exclusion List	www.oig.hhs.gov
GSA Excluded Parties Listing System (debarment)	www.gsa.gov
Social Security Online	www.socialsecurity.gov or www.ssa.gov
Ticket to Work Program	www.yourtickettowork.com
Voter Registration Services – Secretary of State	www.sos.ca.gov/elections/elections_vr.htm Or (800) 345-VOTE