County of San Diego
Health and Human Services Agency
Mental Health Services

Organizational Provider Operations Handbook(OPOH)

Adult/Older Adult and Children's System of Care

Note:
Program contract, including the Pro Forma and the Statement of Work takes precedence over the Organizational Provider Operations Handbook (OPOH). If providers find any elements of their contract to be in conflict, contact your County COTR.

[Appendix to Mental Health Plan]

Complete Revision January 2013

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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 (HHSA) 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)

CHILDREN'S SYSTEM OF CARE

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

- Youth up to age 18 (EPSDT services 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 Children, Youth and Family Services, including clients seen under MHSA, are 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.

System of Care Principles

San Diego County Children, Youth and Families Mental Health provides services to a broad and diverse population of children, adolescents, transitional youth and families throughout San Diego County. Services are provided in a manner consistent with the Children, Youth and Families System of Care philosophy and principles, are community-based and emphasize the strengths of the client and family. 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/parent participation and influence in the development of the program's policy, program design, and practice evidenced by:

- Individualized services that are responsive to the diverse populations served
- Cultural competence and sensitivity
- Client-focused, family-centered services
- Outcome driven services
- Collaboration of families/youth, public agencies, private organizations and education
- Community-based approach that provides maximum linkage and integration to the local community resources
- Multi-disciplinary and strength-based approach

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 emphasize the strengths of the client and family.

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.

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.

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
- Covered California Health Plan Eligible

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 an integrated care environment, by a Health Plan network provider 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, up to and including those meeting criteria for LPS Conservatorship or other type of involuntary treatment interventions.
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, long term placement, social, vocational and educational goals.

Individuals who may be referred to other providers, including the Health Plans, include:

1. Individuals with moderate psychiatric illness that may be adequately addressed either by a primary care practitioner or an affiliated mental health professional within an integrated 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, a Health Plan network provider or 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. 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 health care providers for clients referred to Health Plans 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 Problems No. 01-06-117, February, 2004, and the HHSA, 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 (HHSA) is committed to maintaining a culture that promotes the prevention, detection and resolution of instances of conduct that do not conform to laws, rules, regulations, or County policies or procedures.

County Compliance Programs

As part of this commitment, all County Mental Health Services employees are expected to be familiar with and adhere to the HHSA Compliance Program that includes all of the required elements of a compliance program as stated below. In addition, County Programs must have processes in place to ensure that they are adhering to all requirements in the HHSA Code of Conduct and Statement of Incompatible Activities, including but not limited to the Compliance Standards listed below.

For more information:

HHSA Code of Conduct and Statement of Incompatible Activities:
http://hhsa_intranet.co.san-diego.ca.us/policy/mpp/m/m1_2.pdf

HHSA Compliance Program:
http://hhsa_intranet.co.san-diego.ca.us/policy/index.html

Provider Compliance Program

Each provider entity is required to have an internal compliance program to ensure that all applicable state and federal laws are followed. At all times during the terms of their contracts, providers shall maintain and operate a compliance program that meets the minimum requirements for program integrity as set forth in 42 CFR 438.608. Failure to establish and maintain a compliance program as required by this section shall be considered a material breach of contract.

Elements of a Compliance Program

1. Code of Conduct and Compliance Standards, as described below.
2. Compliance Officer, who is a senior manager charged with responsibility for overseeing and monitoring implementation of the compliance program.
3. Communications, which create avenues for employees to raise complaints and concerns about compliance issues, including billing fraud, without fear of retribution.
4. Training and Education for employees regarding compliance requirements.
5. Auditing and Monitoring Systems, designed to reasonably detect and prevent potential violations of laws and regulations relating to health care and human services funding and programs.

6. Enforcement and Disciplinary Actions, within labor guidelines, to enforce the program including discipline of individuals for engaging in wrongful conduct or for failing to detect or report noncompliance.
7. Response and Prevention, which consists of mechanisms to respond to and investigate all reasonable concerns regarding compliance and suspected noncompliance and of taking necessary corrective action to prevent recurrence.

Code of Conduct

A Code of Conduct is a statement signed by all employees, contractors, and agents of an organization that promotes a commitment to compliance and is reasonably capable of reducing the prospect of wrongful conduct. Codes of Conduct should be created at the agency level.

Compliance Standards

All programs, both County and contracted, shall have processes in place to ensure at the least the following standards:

- Staff shall have proper credentials, appropriate experience and expertise when providing client treatment and services in the area in which they function.
- Staff shall accurately and completely document all client encounters in appropriate records in accordance with funding source requirements and County guidelines.
- Staff shall participate in activities that promote quality assurance and quality improvement and bring concerns regarding possible deficiencies or errors in the quality of care, treatment or services provided to clients to the attention of those who can properly assess and resolve the concern.
- Staff shall take reasonable precautions to ensure that billing and/or coding of client services are prepared and submitted accurately, timely, and in compliance with all applicable federal, State, local laws, rules and regulations and HHSA's policies and procedures.
- Staff shall provide that no false, inaccurate or fictitious claims for payment or other reimbursement are submitted, by billing only for eligible services actually rendered and fully documented. When coding for services, only service codes that accurately describe the services provided will be used.
- Staff shall act promptly to report and correct problems if errors in claims or billings are discovered.

MHP's Compliance Hotline

The MHP has created a Hotline for its own staff as well as Contractors to report concerns about a variety of ethical, legal, and billing issues. The confidential Hotline is toll-free and available 24 hours per day, 7 days per week. Callers may remain anonymous if they wish. The number of the Compliance Hotline is 866-549-0004.

Documentation Requirements

All organizational providers are recipients of Federal funds and as such 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. The provider is expected to meet all documentation requirements established by the MHP in the preparation of these medical records. This includes all providers of outpatient, day treatment, and case management services. The MHP has the responsibility to prepare and maintain the Documentation and Uniform Clinical Record Manual (DUCRM), which outlines the MHP's requirements and standards in this area. The Quality Improvement Unit distributes copies of the MHP's most recent version of the DUCRM annually throughout the organizational provider system. A copy may also be obtained at anytime by contacting the County QI Unit (619) 584-5026 or County Medical Records (619) 692-5700, extension 3. The Management Information System Anasazi User Manual contains the detailed and specific requirement for the most commonly used services. This information is made available at www.optumhealthsandiego.com or can be found in Management Information Systems Anasazi User manual Organizational Provider Operators Handbook Volume II.

Many of the requirements present in the MHP's DUCRM are derived from the contract to provide specialty mental health services between the California Department of Mental Health and San Diego County Health and Human Services, Exhibit A, Attachment 1, Appendix C "Documentation Standards for Client Records". Other documentation requirements have been established by the MHP's Uniform Medical Record Committee, which is an ad hoc committee chaired by the Quality Improvement Unit.

In order to ensure that organizational providers are knowledgeable of documentation requirements, the Quality Improvement Unit provides the following on an ongoing basis:

- Annual in-service training for all provider program managers that reviews the most current edition of the DUCRM, highlighting modifications or additions to the manual;
- Quarterly in-service documentation trainings for all new clinical staff, or any clinical staff that may need a documentation review;
- In-service trainings that are provided on-site at program's request, tailored to program's specific documentation training needs; and
- In-service trainings provided on-site at a program when QI has identified a specific documentation training need.

Compliance in documentation requirements by all organizational and county providers is monitored on an annual basis via medical record reviews. A Quality Improvement Specialist performs the medical record reviews. The Quality Improvement Unit has the responsibility to track and monitor results of these medical record reviews, and may require a provider to develop a Plan of Correction to address specific documentation requirements that are found to be out of compliance.

For more information about the San Diego County Compliance Office contact:

http://www.sdcounty.ca.gov/hhsa/programs/sd/compliance_office/privacy_and_security_information_notices.html

CONFIDENTIALITY

Providers and their agents will abide by applicable state and federal laws regarding confidentiality. Applicable law could include, but is not be limited to, 45 CFR 164 (HIPAA), CA Civil Code 56 (CMIA), 5 U.S.C. § 552a (the 1974 Privacy Act), U.S.C 38 §7332 (Veterans Benefits), CA W&I Code 10850.1 (Multiple Disciplinary Teams). The maintenance of client confidentiality is of primary importance, not only to meet legal mandates, but also because of the fundamental trust inherent in the services provided through the MHP.

MHP Responsibilities

In order to ensure compliance with confidentiality policies and protocols, the MHP enforces the following procedures:

- Every member of the workforce* is informed about confidentiality policies, as well as applicable state and federal laws regarding client anonymity and the confidentiality of clinical information.
- As a condition of employment, each member of the workforce signs a confidentiality agreement, promising to comply with all confidentiality protocols.
- Any client treatment records gathered during the course of provision of services, provider site and record reviews, or as necessary, are protected through strictly limited access. Internal clinical staff has access to case data and files only as necessary to perform their jobs.

**Workforce is defined as employees, volunteers, trainees, and other persons whose conduct, in the performance of work for the provider, is under direct control of the provider, whether or not the individual is paid by the provider.*

Provider Responsibilities

Each provider will act in accordance with good judgment, clinical and ethical standards and State and Federal law to ensure that all written and verbal communication regarding each client's treatment and clinical history is kept strictly confidential.

Every provider must have policies, procedures and systems in place to protect the confidentiality (or security) of health information and individual rights to privacy. Requirements include

safeguards to prevent intentional or accidental misuse of protected health information and sanctions for employee violations of those requirements.

Each provider must train all members of its workforce on the policies and procedures with respect to protected health information. The provider must document that the training on confidentiality has been provided. At a minimum, documentation of training shall consist of a signed acknowledgement by the member of the workforce specifying which training has been received and the date the training was taken. The provider must retain the documentation of the training for six years. These training records will assist the provider in identifying where supplementary training needs to be conducted, if there are changes in the privacy or security regulations.

Every provider must have in place a Confidentiality Agreement for all workforce members. The Confidentiality Agreement should sufficiently identify the type of information to be protected, the worker's /vendor's responsibility to protect it, and methods that must be used to protect it in order to assure confidentiality and to comply with Health Insurance Portability and Accountability Act (HIPAA) regulations. The Agreement must include a signed statement from the workforce member/vendor saying that he or she has received the information related to the maintenance, disclosure, or destruction of confidential information. This statement must be signed within a reasonable period of time after the person joins the provider's workforce. Additionally providers must be able to also access documentation showing that all vendors and business partner personnel with access to protected information have also signed such agreements with their employers.

Contractor and its agents and employees are subject to and 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).

Providers must provide a written notice of information practices –"Notice of Privacy Practice"—to all clients. Additionally, providers are to distribute the County Mental Health Plan (MHP) Notice of Privacy Practice to all new clients. A notation is made on the Assessment form (MHS-650 and/or MHS-663 and/or MHS 680) when the MHP-Health Plan NPP has been offered.

Providers should disclose to clients the fact that records may be reviewed in the course of supervision, case conferences, and quality management.

For further information regarding legal and ethical reporting mandates, please contact your agency's attorney, the State licensing board or your professional association.

Holder and Release of Records

When there is a request for a client record, it is important for the program to define what specific information is requested. If the party is interested in the record as it relates to the particular provider they are requesting the record from, the provider may release a designated record set. This designated record set includes any information within the record that the program utilized for treatment purposes as per 45 CFR 164.103. Other information within the record that was not used by the program for treatment purposes cannot be released.

If the party is looking for the entire record, and not just information related to the program's specific treatment, the request should be forwarded to the County Health Information Management Services (HIMS) as the County owns the entire client record. Requests can be made by calling (619) 692-5700, Option #3.

As a reminder, programs should always consult with their Legal Entity Administration and Counsel regarding record releases.

Handling/Transporting Medical Record Documents Outside Certified Clinics

To maintain the confidentiality of all client and family members and to maintain security of all medical records, all Mental Health Programs (County and contract) will transport medical records in accordance with a set of guidelines. Medical records must be maintained at a certified clinic site or an approved school site. When a medical document is completed at another service site, the document must be transported to the main program site as soon as possible but no later than 5 working days. The standard protocol for storing confidential materials shall be maintained until transport is possible, i.e. records kept in a locked cabinet.

When transport of the entire medical record is necessary, the following procedures shall be implemented:

- The entire medical record must be returned to the clinic or satellite the same day. No staff can keep the entire medical record overnight at a personal residence;
- The program director shall designate staff members who will be authorized to transport any medical records;
- The staff member shall inform the program director or designee when transport of a medical record is necessary;
- The medical record must be signed out and signed in by staff that will be transporting the record;

- Medical records shall be transported in a secured or locked portable file box or personal briefcase;
- While transporting, the records shall be secured in the vehicle;
- The staff person shall maintain the locked container with the medical records at all times until the transfer is completed;
- Under no circumstances are any records to be left unattended.

The staff person transporting the records is responsible for maintaining security and confidentiality of medical records at all times.

When transporting Identifying Client Data or Medical Record Forms such as progress notes or forms requiring signatures, no identifying information shall be put on these documents until which time said documents are secures in the client's medical record at the primary clinic where the record is being stored. Progress notes or other individual documents transported while in the field shall not contain the full name of the client. Only the initials of the client's name or the client's case number will be put at the bottom of the form. When transferring the document into the medical record at the primary clinic site, the full name and case number of the client will be written on each page within three (3) working days.

A staff member may carry identifying client information only under the following limited circumstances.

1) The staff member is transporting medical records originated at another service site to the main program site where the record is housed (see paragraph 2 of this section).
2) The staff member is doing work outside the clinic site and must carry some client-identifying data from which to contact individuals/families while off site.

The staff member carrying identifying client data will ensure the maintenance of confidentiality by following these guidelines:

1) The confidential information will be with the staff member at all times. It will not be left unattended at any time or place. **This also refers to laptops which may contain client information.** Client information may be kept on an external drive (thumb drive) if appropriately secured.
2) Any client information, including telephone number, address or case number should not be linked to the fact that they are receiving mental health services.
3) The information will not at any time be left overnight in the car or car trunk of the staff member. It will be maintained in a secure container and taken with the staff member at all times.

4) Ideally, the information is kept in a locked compartment, such as a locked briefcase or boxed file. If this is not possible, the information is to be stored in a secure holder such as a three ring binder or accordion file which would not allow the information to be dropped. A manila folder is not adequate. All compartments or containers must be pre-approved for use by the program director.

In the event of a loss of a portion of a medical record or the MR, an incident report should be completed and sent to program monitor. Client, parent, or legally responsible adult shall be notified.

Privacy Breaches of Confidentiality

There are new state laws and regulations that went into effect January 1, 2009 regarding confidentiality breaches. Programs are required to familiar with these new laws. In summary, SB541 adds or changes information on what to do if there are confidentiality breaches, including prompt reporting of privacy to CDPH, notification to patient no later than 5 days after the breach has been detected by the facility, and increased fines and penalties for privacy breaches. SB541 requires reporting of any "unlawful or unauthorized access" to PHI. "Unauthorized" means *"the inappropriate access, review, or viewing of patient medical information without a direct need for medical diagnosis, treatment, or other lawful use as permitted by law".*

In addition, under new federal regulations effective 9/17/09, Health Information Technology for Economic and Clinical Health Act (HITECH) will require notification to patients "without reasonable delay" but no later than 60 days after discovery, unless asked by law enforcement due to ongoing investigation. For larger breaches, see reporting requirements in addition to following all State and Federal laws and regulations, providers shall report to SDCMHS through the Serious Incident reporting process.

Privacy breaches commonly occur in the following ways:

1) Confidential materials being disposed of in non-secured trash receptacle
2) PHI left out on desks and computer screens
3) Laptops stolen when transported back and forth from work to home
4) Chart and other PHI carried outside the facility, then lost or stolen
5) Unlawful or unauthorized access to PHI (peeking issues)
6) Inappropriate verbal disclosures in and out of the workplace.

Claiming and Reimbursement of Mental Health Services

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** in Volume II of this manual.

Coding and Billing Requirements

The Federal Health Insurance Portability and Accountability Act (HIPAA) include requirements regarding transactions and code sets to be used in recording services and claiming revenue. The rule, contained in CFR Chapter 42, took effect in October 2003 and includes a requirement for both standard Procedure Codes and Diagnosis Codes. Uniform Medical Record forms (see Section G, Quality Improvement) of this Manual reflect the required codes, and County QI staff regularly provides training on the use of the Service Record forms. Additional requirements for medical records come from the County's contract with the California Department of Mental Health; 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 Anasazi User Manual, Organization Provider Operations Handbook Volume II.
- Diagnoses must be coded using the International Classification of Diseases (ICD-9 CM, or ICD-10 when adopted). In general, a diagnosis is made using the fuller descriptions of the Diagnostic and Statistical Manual, 4th Edition, Text Revision (DSM-IV TR) and "crosswalked" to the correct service code for the Management Information System software (currently Ansazi) by the clinician. The service code should result in the highest level of specificity in recording the diagnosis.
- Services are recorded on the Service Record, which includes the Anasazi Service Code and the staff number. The Service Record is used to enter services to the MIS and will reflect the range of services actually in the provider's budget.

FALSE CLAIMS ACT

All HHSA employees, contractors and subcontractors are required to report any suspected inappropriate activity. Suspected inappropriate activities include but are not limited to acts, omissions or procedures that may be in violation of health care laws, regulations, or HHSA procedures. The following are examples of health care fraud:

- Billing for services not rendered or goods not provided.
- Falsifying certificates of medical necessity and billing for services not medically necessary.
- Billing separately for services that should be a single service.
- Falsifying treatment plans or medical records to maximize payments.
- Failing to report overpayments or credit balances.
- Duplicate billing.
- Unlawfully giving health care providers, such as physicians, inducements in exchange for referral services.

Any indication that any one of these activities is occurring should be reported immediately to the compliance officer:

Robert Borntrager
HHSA Compliance Officer
619.515.4246
Compliance.HHSA@sdcounty.ca.gov

HHSA employees, contractors and subcontractors may also use the HHSA **Compliance hotline** at **(866) 549-0004** to request information or report suspected in appropriate activities. This line provides direction to the caller on the option to remain anonymous.

The Federal False Claims Act

The Federal False Claims Act ("FCA") helps the federal government combat fraud and recovers losses resulting from fraud in federal programs, purchases, or contracts. 31 U.S.C. §§ 3729-3733.

Actions that violate the FCA include:

- Knowingly submitting (or causing to be submitted) a false claim to the U.S. Government for payment or approval;
- Knowingly making or using (or causing to be made or used) a false record or statement to get a false claim paid or approved by the Government;
- Conspiring to get a false claim allowed or paid by the Government;

- Delivering (or causing to be delivered) less property than the amount of the receipt, where the person with possession or control of the Government money or property intends to deceive the agency or conceal the property;
- Making or delivering a receipt without completely knowing that the receipt is true, where the person authorized to make or deliver the receipt intends to defraud the Government;
- Knowingly buying or receiving (as a pledge of an obligation or debt) public property from an officer or employee of the Government or a member of the Armed Forces who has no legal right to sell or pledge the property; or
- Knowingly making or using a false record to conceal, avoid, or decrease an obligation to pay money or transmit property to the Government.

"Knowing" and "Knowingly" means a person:
- Has actual knowledge of the information;
- Acts in deliberate ignorance of the truth or falsity of the information; or
- Acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

"Claim" includes any request or demand for money or property (including those made under contract) to the Government or to a contractor, grantee, or other recipient, if any portion of the requested money or property is funded by or will be reimbursed by the Government.

A person or organization may be liable for:
- A civil penalty $5,500 to $11,000 for each false claim;
- Three times the amount of damages sustained by the Government due to the violations; and
- The costs of a civil suit for recovery penalties or damages.

If a *qui tam* plaintiff alleges a false claims violation, the complaint and a written disclosure of the evidence and information that the person possesses must be served on the Government. Once the action is filed, no person other than the Government is allowed to intervene or file a lawsuit based on the same facts.

Whistleblower Protection
An employee who has been discharged, demoted, suspended, threatened, harassed, or in any way discriminated against by his or her employer because of involvement in a false claims disclosure is entitled to all relief necessary to make the employee whole, including:
- Reinstatement with the same seniority status that the employee would have had but for the discrimination;
- Two times the amount of back pay plus interest; and
- Compensation for any special damage sustained because of the discrimination (including litigation costs and reasonable attorney's fees).

The protected false claims activities include investigation for, initiation of, testimony for, or assistance in a false claims action that has been or will be filed. An employee is entitled to bring an action in the district court for such relief.

The California False Claims Act

The California False Claims Act ("CFCA") applies to fraud involving state, city, county or other local government funds. 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. Cal. Gov't Code §§ 12650-12655.

Actions that violate the CFCA include:

- Knowingly submitting (or causing to be submitted) a false claim for payment or approval;
- Knowingly making or using (or causing to be made or used) a false record or statement to get a false claim paid or approved;
- Conspiring to get a false claim allowed or paid by the state or by any political subdivision;
- Benefiting from an inadvertent submission of a false claim, subsequently discovering the falsity of the claim, and failing to disclose to the state or political subdivision within a reasonable time after discovery;
- Delivering less property than the amount of the receipt, where the person has possession or control of public property;
- Knowingly making or delivering a false receipt, where the person is authorized to deliver a document;
- Knowingly buying or receiving (as a pledge of an obligation or debt) public property from any person who has no legal right to sell or pledge the property; or
- Knowingly making or using a record to conceal, avoid, or decrease an obligation to pay money or transmit property to the state or local government.

"Knowingly" means the person or organization:

- Has actual knowledge of the information;
- Acts in deliberate ignorance of the truth or falsity of the information; or
- Acts in reckless disregard of the truth or falsity of the information. Proof of specific intent to defraud is not required.

"Claim" includes any request for money, property, or services made to the state or any political subdivision (or to any contractor, grantee, or other recipient), where any portion of the money, property, or services requested was funded by the state or any political subdivision.

The maximum civil penalty is $10,000, per claim. Persons who violate the CFCA may be liable to the state for three times the amount of damages that the state sustains because of the violation. The

court can waive penalties and reduce damages for CFCA violations if the false claims are voluntarily disclosed. The CFCA does not apply to false claims of less than $500. Lawsuits must be filed within three years after the violation was discovered by the state or local official who is responsible for investigating the false claim (but no more than ten years after the violation was committed).

Liability to the State or Political Subdivision

A person or organization will be liable to the state or political subdivision for:

- Three times the amount of damages that the state or local government sustains because of the false claims violations;
- The costs of a civil suit for recovery of damages; and
- A civil penalty of up to $10,000 for each false claim.

Whistleblower Protection

Employers are prohibited from:

- Making or enforcing any type of rule or policy that prevents an employee from disclosing information to a government or law enforcement agency, or from investigating, initiating, testifying, or otherwise assisting in a false claims action; or
- Discharging, demoting, suspending, threatening, harassing, denying promotion to, or in any other manner discriminating against an employee because of his or her involvement in a false claims action.

If you have any questions about the HHSA Compliance Program or the Federal or State False Claims Acts please contact:

- **Bob Borntrager, CHC Compliance Officer at 619.515.4244 or by e-mail at: Compliance.HHSA@sdcounty.ca.gov**

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. A copy of the Request for Services Log – Access Time Report is located in *Appendix C-A.C.1. A copy of the Request for Services Log – Access Time Report Manual is located in Appendix C-A.C.6.*

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 inpatient hospitalization or psychiatric health facility services.

Goal for Services: Face-to-face clinical contact within one (1) hour of initial client contact/ 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.

Goal for Services: Face-to-face clinical contact within seventy-two (72) hours of initial client contact/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.

QM Goal for Services – Adult Mental Health Services: System wide average of eight (8) calendar days from initial contact to mental health assessment. This number is a system wide weighted average for all adult providers. Each year, providers are given a specific benchmark goal for wait times for their individual program based on past performance and QM goal for the current fiscal year. If you do not know your current benchmark, please contact the QM unit.

QM Goal for Services – Children, Youth and Families Services: Face-to-face clinical contact within five (5) calendar days of initial client contact/referral.

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

OptumHealth operates the statewide San Diego County Access and Crisis Line (ACL) on behalf of the San Diego County Mental Health Plan (MHP). The ACL, which is staffed by licensed and master's level counselors, 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 the client or the family's initial access point into the MHP for routine, urgent or emergency situations.

All ACL staff 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 situation, 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.

If the client's condition is serious but does not warrant immediate admission to a facility, ACL staff performs a telephonic risk screening and contacts a provider directly to ensure that the provider is available to assess the client within 72 hours.

The ACL has Spanish-speaking counselors on staff. Other language needs are met 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 (619) 641-6992.

Authorizations for Mental Health Plan Services Provided by the ACL

- Outpatient mental health services delivered to Medi-Cal beneficiaries through the Fee-for-Service (FFS) Provider Network only. This is a network of contracted mental health professionals including psychiatrists, psychologists, licensed clinical social workers, and marriage family therapists.
- Acute Inpatient Mental Health Services
- Child/Adolescent Day Treatment Program Services

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 OptumHealth.

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 should inform clients about the option of directly using the Access and Crisis Line by calling 1-888-724-7240. Clients should be given clear directions on how to use the ACL.

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 of need
- Level of Care guidelines
- Type of treatment or services indicated
- 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.

Available 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 free language assistance. According to Title 9 and AMHS 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. AMHS 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.

Qualified staff members can serve as interpreters at the provider site. Consistent with the Cultural Competency Standards, contractors are encouraged to develop and maintain staff's language competency for threshold languages. If no qualified staff is available, with the approval of the program manager or designee, program staff can contact Interpreters Unlimited (for language interpreting) at (800) 726-9891 or Deaf Community Services (DCS) (for hearing impairment) at (619) 398-2488 to arrange for language assistance. To request interpreter services, Section A of the Service Authorization Form (SAF) is completed and faxed. As soon as the services have been rendered, the provider will fill out Section B of the SAF. The SAF can be found on the Purchasing and Contracting website at http://insite.sdcounty.ca.gov/csg/pc/Pages/pc-bpa.aspx.

The completed form will be faxed to Interpreters Unlimited or Deaf Community Services. The interpreting services will then submit an invoice to the MHP.

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.

In addition, written translation services are available through Accent on Languages at (510) 665-9470. The Written Translation Services Authorization Form can be found on the Purchasing and Contracting website at http://insite.sdcounty.ca.gov/csg/pc/Pages/pc-bpa.aspx.

Client Selection of a Provider

In accordance with 42 CFR and Title 9, providers are reminded that Medi-Cal beneficiaries have the right to obtain a list of BHS providers, including information on their location, hours of service, type of services offered, and areas of cultural and linguistic competence. This right is extended by Mental Health Services of San Diego to all eligible clients. Information about organizational providers is posted on the *Network of Care* website (www.networkofcare.org), and in the BHS Directory which may be obtained through the Behavioral Health Administrative staff by calling (619) 563-2788. Information on fee-for-service providers is available by calling OptumHealth at 1-888-724-7240.When feasible, beneficiaries will be provided with the initial choice about the person who provides specialty mental health services, including the right to use culturally specific providers. Upon client request for a choice of providers, staff must, whenever feasible, supply the requesting party with the names, addresses and phone numbers of at least three appropriate providers. This can also be accomplished by supplying the requester with a current copy of the Provider List that includes a list of Organizational Providers and Fee-For-Service Providers. If requested, staff shall assist the client or responsible adult in reviewing the list of available options and/or obtaining an appointment. Requests for assistance in locating a provider prior to the onset of services shall be entered on the Request For Service Log maintained at the provider site.

Note: Contractors shall report to the QM Unit and COR any changes in location, hours or types of services offered to keep the Organizational Provider Resource Manual current. Providers will be surveyed periodically about cultural and linguistic capabilities.

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 program.
- 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 OptumHealth'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 on the Request For Service Log maintained at the provider site.

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

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 <u>with known capacity</u>, 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 referred from Exodus or Jane Westin must be prioritized for admission at an outpatient clinic within 72 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 HHSA Regions shall accommodate their ongoing, opened clients for urgent services so as 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 wait 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 referred from Exodus or Jane Westin must be prioritized for admission at an outpatient clinic within 72 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.

- See Appendix A.C.2 AMHS for urgent walk-in service schedules and contact information

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 and 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 or 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.

California Code of Regulations, Title 9. Rehabilitative and Developmental Services, Division 1. Department of Mental Health
1810.253. Urgent Condition.

"Urgent Condition" means a situation experienced by a beneficiary that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition.

NOTE: Authority: Section 14680, Welfare and Institutions Code.
Reference: Sections 5777 and 14684, Welfare and Institutions Code.

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, IMD Client/Out of County locked facility referral, Case Management client with a case manager, acute JWWRC/Exodus referral, or COD client whose mental status jeopardizes ADS residential placement.

CLINICAL CASE MANGEMENT CONSERVATORSHIP COORDINATION– ADULT AND OLDER ADULT MENTAL HEALTH SERVICES

For Contractors who provide Clinical Case Management for the Public Conservator, responsibilities include:

- Assume active Clinical Case Management responsibility which includes but is not limited to ensuring that the Conservatee has appropriate food, clothing, shelter and mental health treatment.
- If hospitalized, collaborate with hospital treatment and discharge team.
- Communicate with family members as appropriate.
- Respond to routine e-mails and phone calls within two business days. For more urgent matters, the Program Manager should be contacted if unable to reach the Case Manager.
- Upon request, provide case information to the Public Conservator's Office regarding grave disability including information on clinical presentation, high risk behaviors, activities of daily living, current medications and adherence, placement history as well as strengths and goals.
- Maintain documentation regarding visits for viewing by Public Conservator Office staff.

On an annual basis, complete and submit the Re-establishment Recommendation form (see Appendix C, A.C.5) (HHSA LPS PC RE-EST) to the Public Conservator's Office accurately and in a timely manner recommending reestablishment or termination of LPS Conservatorship.

Maintain Clinical Case Management services while a Conservatorship is in place. Services can be continued on a voluntary basis or closed if the Public Conservator's Office has indicated the Conservatorship has been terminated by the Court or the case has been successfully transferred to another Case Management agency.

Notify the Public Conservator's Office of changes in Conservatee's address, change of case manager or Case Management agency, AWOL or missing person status, hospitalization, death, or Serious Incident Report to the BHS Quality Improvement Unit. It is also recommended that unusual occurrences raising any concerns about risk be reported to the Conservator's Office.

- Notify Public Conservator's Office in writing to recommend a change in rights or that the Conservatee is no longer gravely disabled.

- Initial Face to Face visit with the Conservatee will be conducted according to type of case management program as follows:

  - **ACT**: within 72 hours of the program formally opening the case, consistent with OPOH standard for face to face visit for those recently discharged from acute care

  - **SBCM**: within 30 days of the program formally opening the case unless recently discharged from acute care requiring the OPOH standard of visit within 72 hours

  - **Institutional-In County**: within 30 days of the program formally opening the case to be expedited in response to clinical need on a case by case basis

  - **Institutional-Out of County**: within 90 days of the program formally opening the case to be expedited in response to clinical need on a case by case basis

  - **Hospital Rotation Cases**- The Public Conservator's Office has case management responsibilities during the Temporary LPS Conservatorship period pending establishment of Permanent LPS Conservatorship. During this time, Case Management 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 Case Management Services pending discharge to either long term care or

community placement. If discharge is imminent (planned in less than 10 business days) when case is open to County Case Management, no face to face contact will 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 patient remains in acute care. If discharge is not imminent at the time case is open to County Case Management Services, case manager will plan to meet with the patient in acute care within 10 business days of opening the case to County Case Management Services with the exception of patients in jail settings. For patients in jail settings where discharge is not imminent at the time Permanent Conservatorship is established, face to face contact with conservatee will be made within 30 days of opening case to County Case Management Services to accommodate clearances needed and access to incarcerated individuals."

- 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 time-frames as when the Public Conservator is appointed.

- Frequency of visitation will be conducted according to type of case management program as follows:

  - **ACT and SBCM**: Routine visits to occur at least every 30 days (and often much more frequently for ACT Teams), unless there is a need for more or less frequent visits. Increased or decreased frequency of visits to be based on individualized assessment of each person's clinical need.

  - **Institutional-In County***: routine visits to occur every 30 days.* Frequency to increase based on clinical need on a case by case basis

  - **Institutional-Out of County***: routine 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.

  - When a **Private Conservator** is appointed and requests the assistance of County operated Case Management Services, frequency of contacts will follow the same timeframes as when the Public Conservator is appointed.

- Refer treatment providers to the Public Conservator's Office for matters that require the consent of the Public Conservator such as surgery, routine medical treatment, or end of life decisions.

- Case Manager will contact the Public Conservator's Office if questions arise regarding Conservatee's need to enter into contracts, obtain a driver's license, vote, or participate in a research study.

- A report will be available via the electronic health record (EHR) for the Public Conservator's Office to view monthly showing completed visits (*form to be determined*) updated 4-29-2013.

- Except in cases involving assistance with Social Security and Medi-Cal applications, renewals, redeterminations, appeals, etc., Case Manager should not sign documents on behalf of the Conservatee. Such matters should be referred to the Conservator's Office.

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

OptumHealth, 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 OptumHealth 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 OptumHealth 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 OptumHealth 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 OptumHealth LTC Medical Director or his/her designee may complete an independent on-site evaluation of the referred individual. Once OptumHealth has established that the referred individual meets the admittance requirements for SF/LTC, OptumHealth 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 OptumHealth.

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 OptumHealth.

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. OptumHealth 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 OptumHealth Medical Director and LTC Coordinator prior to authorizing state hospital placement.

2. Upon approval, the LTC Coordinator at OptumHealth sends the current information provided by the hospital and case manager to the Admissions Coordinator at one of the following State Hospitals: Atascadero, Coalinga, Metropolitan, 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 OptumHealth 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 OptumHealth 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, AOD 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 services provided by BHS contractors in conjunction with other treatment services. Referrals are processed through the County.
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 AOD programs which provide non-residential specialized AOD 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 AOD programs which provide 24/7 structured residential alcohol and other drug (AOD) treatment/recovery and ancillary services.
j. Residential detoxification programs which provide 24/7 AOD 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 (AOD) 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 AOD 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 AOD detoxification and pre-treatment and referral services.
k. Non-residential and residential women's programs which provide gender-specific, trauma-informed AOD treatment and recovery services designed for adult women over the age of eighteen (18), including pregnant and 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 (AOD) 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 AOD 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 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 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.

   - 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 AOD 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 AOD programs, the target population is defined as individuals in need of AOD 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 858-694-5191can 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 ideally 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 are 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 doesn't 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. (Sample in Appendix C – A.C.3), including all signatures. The Care Coordinator will include a copy of a Transition Age Youth Referral

Plan (Sample found in Appendix C – A.C.4) 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. OptumHealth acts as the ASO. Reauthorization is required every three months for day intensive services and every six months for day rehabilitative services. Copies of OptumHealth's current Specialty Mental Health Services DPR forms are available at https://www.optumhealthsandiego.com/portal/server.pt *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 assessed 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, should be seen within 72 hours of contact with program.
- Children and adolescents being discharged from acute psychiatric hospital care shall be seen within one week of contact with program unless the referral is deemed Urgent, in which case they should be seen within 72 hours of contact with program.
- Children and adolescents requiring Crisis services different from Urgent services should be assessed within one (1) day
- 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 assessment for Specialty Mental Health Services shall be seen within five (5) calendar days of initial client contact/referral.

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 OptumHealth individual/group provider network, if the child is Medi-Cal eligible.

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.

UNDOCUMENTED CLIENTS

In accord with County and State policy, 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 undocumented immigrants. Without intent to reside in San Diego County, any client, regardless of citizenship, must be billed at full cost. However, persons known to be undocumented immigrants are eligible only for emergency services, such as an acute care hospital or the EPU (AMHS), or Emergency Screening Unit (CYFS).

D. PROVIDING SPECIALTY MENTAL HEALTH SERVICES

ADULT/OLDER ADULT SYSTEM OF CARE

Coordination of Care: Creating a Seamless System of Care

Coordination of care among inpatient and outpatient service providers is essential for a mental health system to work efficiently. As the client may move between different levels of care, it is vital that service providers communicate with each other to provide continuity of care for the client. 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 provide each client with a care coordinator as the "single point of accountability" for his or her rehabilitation and recovery planning, and service and resource coordination. The MHP monitors coordination of care.

For additional related information, review System Redesign Implementation Plan for Adult/Older Adult Mental Health Services, August 1999; and HHSA, MHS Policy and Procedure: Coordination of Care and Services No: 01-06-60. These resources are available by contacting your Program Monitor.

72-Hour Post Discharge Coordination of Care

Any new or current client who meets the criteria for needing "urgent" services shall be seen within 72 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. Any person being discharged from a crisis residential facility, a psychiatric hospital, jail, the EPU or a locked/IMD placement that is screened as needing services urgently shall be seen within 72 hours. In addition any other new or current clients who call for services and are screened as needing services urgently also meets the "urgent" criteria and shall be seen within 72 hours. To assist with tracking of admissions for existing clients, providers are expected to check the Morning Reports that can be generated each day. Providers are expected to track client discharge referrals and follow-up appointments. A sample of a 72-Hour Post Discharge Log is located in *Appendix D (A.D.1).*

Monitoring Coordination of Care

Inpatient medical record reviews include retrospective review of documentation to confirm that clients were referred to an outpatient program, psychiatrist or other licensed mental health care

provider upon discharge. Outpatient reviews include review of chart documentation and the 72-Hour Post Discharge Log to verify outpatient appointments within 72 hours of discharge.

Outpatient 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 fields in Anasazi. Providers must complete the demographic and diagnosis fields and open an Assignment in Anasazi. See the Management Information Systems Anasazi User Manual, Organizational Provider Operations Handbook, Volume II, for a description of how Anasazi 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 Anasazi for each client. The provider's program staff is then responsible for recording all ongoing activity for that client into Anasazi.

Medical Necessity for Outpatient Services

Title 9 (Section 1830.205) Medical Necessity criteria are summarized below. (A complete description of Medical Necessity Criteria has been included in *Appendix D – A.D.2*.)

Note: For a hard copy of Title 9, please call the State Office of Administrative Law at 916-323-6225.

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

1. The client must have a diagnosis included in the Diagnostic and Statistical Manual, Fourth Edition (DSM IV-TR) 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 functioning; and
• The condition would not be responsive to physical health care treatment.

SPECIFIC PROCEDURES AND CRITERIA FOR OUTPATIENT CARE

Clarification of Service Mix for Programs

San Diego County Adult/Older Adult Case Management Services are as follows:

- Strengths-Based Case Management (SBCM) programs are only authorized to provide case management brokerage, individual and group rehabilitation, collateral, and occasional crisis intervention services.
    - 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.
    - ACT programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity, medication support services and some psychotherapy.
- 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.
- Crisis Residential Programs are authorized to provide medication support services, and crisis residential services bundled as a 24-hour service.

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 Anasazi (EHR) and ensure that all relevant clinical information is obtained and documented.

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

Outpatient Providers

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.

Strengths-Based Case Management

Strengths-Based Case Management services are delivered through specific freestanding programs that assist a client to access needed medical, educational, social, prevocational, vocational, and rehabilitative or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring services delivery to ensure beneficiary access to services and the services delivery system, monitoring of the clients progress, and plan development.

Prior to admission to the program, each client must have a face-to-face assessment to establish medical necessity and to determine the presence of serious psychiatric disability and need for case management services. If the clinician determines that medical necessity criteria is not met and the client is not continuing to receive other Medi-Cal specialty mental health services, the client will be issued an NOA-A and their beneficiary rights shall be explained. If medical necessity criteria are met but the person is deemed not in need of case management services, an NOA-A is necessary only if the person is not receiving other Medi-Cal specialty mental health services. Due to limited resources, case management eligibility is prioritized for those persons who have the most severe psychiatric disabilities. Level of case management service intensity will be determined on an individual basis, with usual prioritization of the most intensive case management services established for those persons who have had the highest levels of Medi-Cal hospitalization and/or the most extensive amount of locked long-term care. Within one month of the client's first planned visit, the Client Plan shall be completed.

OUTPATIENT Strengths-Based CASE MANAGEMENT PROGRAMS

Strengths-Based Case Management Service Eligibility

Due to limited resources, Strengths-Based Case Management eligibility is prioritized for those persons who have the most severe psychiatric disabilities. Most clients who receive case management services are Medi-Cal beneficiaries. However, case management services may also be provided to individuals who meet the clinical criteria and are indigent or otherwise unable to access case management services. Level of case management service intensity is determined on an individual basis, with prioritization of the most intensive case management services for those

persons who have had the highest utilization of hospitalization and/or locked long-term care. All case management clients must meet Title 9, Article 2, Section 1830.205 medical necessity requirements for outpatient mental health services and have major impairment in at least one area of life functioning. In addition, the person must demonstrate particular need for the additional services provided by case management services through one or more of the following:

- Has current LPS Conservatorship (may be a designated County Conservator or family member);
- Has been hospitalized or received involuntary psychiatric treatment within the past year;
- 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.

Clients receiving 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 same level of case management.

Levels of Case Management

Three levels of case management services are available: Strengths-Based, Institutional and Assertive Community Treatment.

- ***Strengths-Based Case Management (SBCM)*** services provide a mix of mental health, rehabilitation and case management functions and have a staff-to-client ratio of approximately 1:25. Clients are typically evaluated in person at least monthly and by phone as clinically indicated, and it is expected that the case manager will have contact with significant others at least monthly. Services may be provided on a much more frequent basis, depending on client need.

- ***Institutional Case Management*** services are provided to clients who reside in the 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 1:100. Clients are contacted at least quarterly.

- ***Assertive Community Treatment (ACT)*** services provide a mix of medication, mental health, rehabilitation and case management functions and have a staff-to-client ratio of approximately 1:10-12. Clients are typically evaluated in person at least bi-weekly and

by phone as clinically indicated, and it is expected that the case manager will have contact with significant others at least monthly. Services may be provided on a much more frequent basis, depending on client need.

Referral Process for Case Management

Case management programs may receive referral information from any source. 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.

To align the demand for case management services with the capacity of case management programs and to assure connection with the program most relevant to the client's needs, referrals may be reviewed through the bi-monthly Case Management/ACT/FSP Providers Meeting Referrals among programs recommending transfer of a client (e.g., client has moved, client needs more or less intensive services than the program provides) may also be reviewed at this meeting.

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 DSM-IV-TR Axis I or Axis II 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 in the eligible range on the ASP scoring tool; 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.

Inpatient Services for Medi-Cal Beneficiaries

Pre-Authorization Through OptumHealth

Inpatient service providers must secure pre-authorization for all inpatient services for Adults/Older Adults through the OptumHealth Provider Line, 1-800-798-2254, option #2, 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 a diagnosis included in the Diagnostic and Statistical Manual, Fourth Edition (DSM IV-TR) 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.

Inpatient Services and Mental Health Services for Low Income Health Plan (LIHP)
OptumHealth
Low Income Health Plan (LIHP) was discontinued with the implementation of the Affordable Care Act (ACA) effective 1/1/14

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 OptumHealth. 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 (list of institutions located in *Appendix D – A.D.3*). 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 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 Mental Health 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.

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 states 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" *(located in Appendix D – A.D.4)* 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 (619) 232-3960, 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.

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 "not 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 in *Appendix D (A.D.5 – A.D.14).*

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" *(located in Appendix D – A.D.5)* 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" *(located in Appendix D – A.D.6)* 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

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.

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 reaction, anxiety and depressive symptoms that do not cause significant, functional impairment that could be addressed within the context of a primary care setting or other community resources.

- A score on the **Milestones of Recovery Scale (MORS**) of 1-6

This criteria 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 justification or 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.

IV. Utilization Management process:

In order to continue services, clients shall meet specific criteria and be reviewed through a Utilization management process which will be conducted internally at each program.

1. **All clients will be reviewed for on-going services through the MORS Rating process**
   - A MORS rating will be completed on all client-medication only and medication plus, every six (6) months

2. **Utilization Management is based on MORS rating:**
   - Clients with a MORS rating of 1 to 5 will be qualified to receive ongoing services at the county or contracted outpatient clinic.
     - The MORS rating shall be kept in the client record
     - No other requirements
   - Clients with a MORS rating of 6 to 8 will be referred out of the county or contracted outpatient clinic for ongoing services unless an exception is made (see process noted below)
     - The MORS rating shall be kept in the client record
   - Exceptions for clients with a MORS rating of 6, 7 or 8
     - If a client receives a MORS rating of 6, 7, or 8 but the primary provider believes that the client should continue to receive services at the county or contracted outpatient clinic the primary provider shall complete the **Justification for On-going Services** (JOS) to continue sessions.
   - For subsequent treatment, client must meet both of the following criteria.
     1) Continued Medical Necessity with demonstrated benefit from services
     2) Meet Target Population Criteria

- JOS shall be reviewed by program manager or designee
  - Program Manager or designee shall be licensed
  - Program Manager or designee may agree with primary provider or may recommend a different level of service.
  - Final determination shall be made after agreement by Program Manager or designee and primary provider.

- The JOS shall be kept in the client record.

- For clients with a MORS rating of 6, 7, or 8 the JOS process is to be completed every 6 months to determine continued eligibility for services. [Note that someone with a MORS rating of 8 should probably never be receiving services.]

- **Programs are required to have a Utilization Review Committee in place to review records at least quarterly of a minimum of 5 clients whose MORS scores are not improving.**

  i. For clients whose MORS score is not improving a review of services and treatment plan shall be completed
  ii. Program may chose a minimum of clients to review but must review no less than 5
  iii. Programs are required to use the Utilization Review Committee Form to document the results of the Utilization Review Committee. Attachment D – A.D.08/09.
  iv. QI may request a copy of the Utilization Review Committee Form be sent in to QI for monitoring purposes.

Other notable issues:

A. Clinicians shall clearly explain the process of services to clients upon intake.
B. Transition of existing clients: Effective 7/1/10, all current clients will be eligible for up to 12 brief individual therapy/rehabilitation sessions.
C. Clinicians shall clearly explain the process of services to clients upon intake. MORS shall be completed at admission and discharge and every 6 months.

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 (located in Appendix D- A.D.10)* 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 (located in Appendix D- A.D.11)* 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 (located in Appendix D – A.D.12)* 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.

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

Effective 1-1-13, 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 use of natural community resources, the **Outpatient Level of Care** consists of:

Clinical Presentation	**Appropriate Provider**	**Session Level**	**Notes**
Mild / Non Complex calling for medical intervention or medication	Primary Care Physician (PCP) Medical Home Health Plans	TBD by medical team	
Mild / 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/recommendation
Moderate / Complex needs Medical Necessity met	Organizational Provider	Up to 13 sessions	
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
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.			

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.

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 (HHSA) principles is efficient and effective access to our target populations. Effective 1/1/10, 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 MediCal 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 *Appendix A.D.15*.

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 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 MediCal beneficiary shall be issued an **NOA-A** (*Appendix F.A.F.02)* and **NOA-Back** *(Appendix F – A.F.04*) (which must also be documented in the **NOA Log** tab of the Quarterly Status Report (*Appendix G – A.G.06*) 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 OptumHealth 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 it 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 (*see Appendix A.D.14 – 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 *Appendix A.D.15*.

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 OptumHealth because the day services cycle supersedes outpatient UM. In these cases the outpatient program must also complete UR in accordance with the procedure described in CYF Outpatient Level of Care *(see Appendix A.D.15).*

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 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 Measurement System (CAMS) and Youth Services Survey (YSS). Children's Functional Assessment Rating Scale (CFARS) is to be completed and entered into Data Entry System (DES) annually.

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 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.

DAY REHABILITATION AND DAY INTENSIVE

Definitions for Day Treatment:

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.

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.

Therapeutic Milieu - 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

Authorization of Reimbursement of Services

Prior to admission to the program, each client must:

- have a face-to-face assessment to establish medical necessity.
- The assessment must document a recommendation for day program ,
- document lower levels of care have been tried unsuccessfully or would be unsuccessful if attempted,
- highly structured mental health program is needed to prevent admission to a more intensive level of care.

The Initial Day Program Request (DPR) must be completed/submitted along with a Specialty Mental Health Services DPR if the client receives ancillary services on the same day as day program services. Continued requests that are made must be accompanied with a Specialty

Mental Health Service (Ancillary) DPR if applicable. The Ancillary DPR should be filled out by mental health outpatient providers and coordinated through the Day Program. Utilization review will be completed by OptumHealth according to necessity criteria for the level of day service. (Appendix A – A.D.16 – Initial DPR, Appendix A.D.17 – Specialty DPR and Appendix A. A.D.18 – Continued DPR These service criteria essentially state that the client cannot be served at a lower level of care and that a recommendation for day services has been made. Day services must be reauthorized every 3 months for day intensive and every 6 months for day rehabilitative. If medical or service necessity criteria are not met, the Medi-Cal client will be issued an NOA-A (which must also be documented in the NOA log) and the beneficiary rights shall be explained. In the event that the provider has received a denial of authorization from OptumHealth, a **NOA-B** (*Appendix F – A.F.3*) shall be issued by OptumHealth.

Notes:
*DPRs are to be completed for all day services clients (optional for clients from out-of-county; which require a Service Authorization Request (SAR)) (Appendix D – A.D.19).

****** Note: it is the responsibility of each program to determine insurance coverage (or lack of) in order to decide which process to follow:

*DPRs are faxed to OptumHealth 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)

*DPRs are NOT sent in to OptumHealth 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)

*Initial authorizations may not be submitted prior to the opening of the assignment.

*Authorization cycles are based on months and not days (i.e. for Day Intensive an authorization cycle may look like: Initial DPR 1/1/08-3/31/08 and Continued DPR 4/1/08-6/30/08. For Day Rehabilitation Initial DPR 1/1/08- 6/31/08, Continued DPR 7/1/08 – 12/31/08, etc.).

*OptumHealth will review the DPR and determine authorization within 14 business days. The provider may check directly in the MIS for authorization or contact OptumHealth if there are questions. Authorization letters will no longer be sent out to the program.

*Authorization will include day service and ancillary services for each client. Authorizations for day treatment and ancillary services are entered separately based on the timeline of the receipt of the request by OptumHealth.
*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.

* DPRs 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, OptumHealth will return the DPR for correction and services will not be authorized until the corrections are made and the form is faxed back to OptumHealth for review.

*****When the Specialty Mental Health (Ancillary) DPR is done incorrectly, OptumHealth will send the DPR to the Day program with whom the outpatient program is coordinating.**

If you have any questions regarding the DPR process including following up with authorization questions, please contact: OptumHealth at (800) 798-2254 option #4.

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

Utilization Review

Utilization review of day intensive and day rehabilitation services for Medi-Cal clients is delegated to OptumHealth.

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. Senate Bill (SB) 785 intends to improve the timely access to these services by transferring 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.

Outpatient Programs Procedure(s) for Medi-Cal Eligible Children in a Foster Care, Aid, AAP, and KinGAP:

1. Child Welfare Services (CWS) Social Worker from the county of origin instructs legal guardians to contact San Diego Administrative Services Organization (ASO), at 1-800-479-3339 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 *(see Appendix A.D.20 for (SAR) Out of County Organizational Providers Only (MH5125).*
3. The County of San Diego provider will provide services, if the child meets Medical Necessity Criteria and the county of origin authorizes the provision of services. The service provider is required to inform the child welfare agency of the county of origin of the services being provided, if requested and if the information is available, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.
4. 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.
5. Services shall be entered into the Anasazi 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 Mental Health via the MIS.
7. Service provider shall inform COR of any out of County Clients served.

There are in essence two types of OOC MediCal clients.

1. OOC clients who fall under one of three aid codes (Foster Care, AAP, KinGAP). Those clients require a SAR through the County where the MediCal is from. They are also subject to our local UM process.
   Services shall be entered into MIS.

2. OOC clients who do not fall under one of those codes need to have their MediCal shifted to San Diego in order for us to serve them. Programs need to get authorization from COR to serve those kids prior to MediCal shift and if that authorization is granted prior to the MediCal shift it is with the expectation that program is actively and promptly working with guardian to have MediCal shift to San Diego. No need to complete a SAR; follow local UM process

SARS

1. SAR format is now routinely asking for one year authorization; San Diego provider continues to follow local UM in addition to SAR.
2. SAR is for medically necessary specialty mental health services. However, the Counties are reviewing specifics and it has been determined that at this time a SAR will only be issued for basic outpatient services – not for Day Services, WRAP, TBS, ICC, IHBS or other intensive services.

Day Programs Procedure(s) for Medi-Cal Eligible Children in Foster Care Aid, AAP, and KinGAP:

1. Day Programs will inform their COR when serving out of county Medi-Cal clients.
2. Day Programs first priority is to serve San Diego County clients then out of county Medi-Cal clients with Foster Care Aid, AAP, and KinGAP codes.
3. Day Programs will coordinate with county of origin for SAR authorization. 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. Program submits signed SAR to OptumHealth.
5. Program additionally submits a DPR to OptumHealth. A DPR is not required when the following information is provided with the signed SAR:
   a. Unit and subunit on the SAR
   b. CFARS Rating (new CFARS Rating completed at each UM cycle)
6. Services are entered into the Anasazi (MIS) by the San Diego provider.
7. The County of San Diego will submit the claim for services directly to the State Department of Mental Health via the MIS.
8. All County of San Diego paperwork must be completed as well as any alternate forms/information required by the county of origin.
9. When day services are provided out of county, an alternative Day Program Request Form may be used if it contains all required elements. Approval for its use is to be obtained by either the COR or Program Manager of Quality Improvement.
10. Children/youth with out of county Medi-Cal who do not fall under Foster Care Aid, AAP, and KinGAP Codes shall be evaluated to determine if their Medi-Cal status is in the process to shift to San Diego County prior to providing services. Prior written COR authorization shall be obtained to enroll in services; and a SAR submitted to county of origin. Provider

shall actively work with family to transition MediCal to San Diego County. Services shall be entered in the MIS.

THERAPEUTIC BEHAVIORAL SERVICES

Authorization of Reimbursement of Services

Clients are referred to County TBS as the central point of contact. Referrals are screened to ensure they are Medi-Cal eligible and to confirm the client/family willingness to participate in the services. Clients are then referred to a TBS contract provider within one to three business days of receipt by the County. The referred client will be assessed for eligibility criteria according to California Department of Mental Health guidelines provided in DMH Letter 99-03 and DMH Notice 02-08. The Contractor conducts this assessment and client must meet the class, service, and other TBS criteria prior to services being delivered.

Utilization Review

Authorization management for extended Therapeutic Behavioral Services is retained by the MHP. If a client requires more than four (4) months or 25 hours of coaching per week of TBS, the Contractor shall submit a request for authorization to County TBS. 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 is required through County TBS.

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.

PROVIDING SPECIALTY MENTAL HEALTH SERVICES

The *Organizational Provider Financial Eligibility and Billing Procedures Handbook* (listed as "*Financial and Eligibility User Manual"* at https://www.OptumHealthsandiego.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.

This handbook is not intended to replace the *Management Information System Anasazi User's Manual* (https://www.OptumHealthsandiego.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
- Carbamazapine
- 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 & ISSUE RESOLUTION

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

According to Title 9 and 42 CFR 438.100, the MHP is responsible for ensuring compliance with consumer rights and protections. Providers, as contractors of the MHP, are also required to comply with all applicable regulations regarding consumer rights and protections. These rights and protections from 42 CFR can be summarized as follows:

- *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.

In accordance with 42 CFR and Title 9, the MHP Quality Improvement 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 of English, Spanish, Vietnamese, Arabic and Tagalog.) Additional copies may be obtained from the MHP Quality Improvement Unit at (619) 563-2788.*

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. (See Accessing Services section in this Handbook for details.)

- **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. As the MHP designee, Optum is responsible for informing the treating provider of the second opinion request and for arranging 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/COTR 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. For more complete information about linking clients to free interpreter services, please see the Accessing Services section of this Handbook.

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.

Patient Advocacy 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 be in compliance 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. Copies may be obtained through the MHP QI Unit by calling (619) 563-2788, 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 DMH 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 AND CLIENT PROBLEM RESOLUTION PROCESS

San Diego County Mental Health Services is strongly committed to honoring the rights of every consumer to have access to a fair, impartial, effective process through which the consumer can seek resolution of a problem encountered in accessing or receiving quality mental health

services. All contracted providers are required to participate fully in the Beneficiary and Client Problem Resolution Process (*Appendix F-A.F.1)*. 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. When a provider is notified by the contracted advocacy organization, the Consumer Center for Health Education and Advocacy (CCHEA) or JFS Patient Advocacy Program that a client has filed a grievance or appeal about that provider's program or staff, the provider shall cooperate with the investigation and resolution of the client's concerns in a timely manner as specified in the Process.

Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance/appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to register a grievance/appeal. Additionally, the consumer is not required to present a grievance/appeal in writing and shall be assisted in preparing a written grievance/appeal, if requested.

In accord with 42 CFR and Title 9, the County of San Diego Mental Health Beneficiary and Client Problem Resolution Process has been streamlined, some terms redefined, and strict timelines added. An opportunity for provider appeals has also been added, as well as a clinical review of grievances and appeals concerning clinical issues. The provider continues to play an important part in this process as follows:

Problem Resolution at Provider Sites

In a continuation of past practice to most quickly and efficiently make providers aware of and resolve problems, clients are encouraged to direct their suggestions to program staff or management. This can be done orally or in writing. In attempting to reach resolution consistent with confidentiality requirements, staff or management shall utilize whatever information, resources and/or contacts the consumer agrees to. Provider will log all client reported problems in the Client Suggestions and Provider Transfer Request Log. In order to preserve client confidentiality, this log must be kept in a secure area. 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.

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.

Grievance Process

Timeline: 60 days from receipt of grievance to resolution, with a possible 14-day extension for good cause.

A "grievance" has been defined as an expression of dissatisfaction about any matter other than an action. 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 three (3) days of receiving written permission from the client to represent him/her. Securing this permission can be difficult and time consuming. In order to be in 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.

Appeal Process

Timeline: 45 days from receipt of appeal to resolution, with a possible 14-day extension for good cause.

Appeals are reviews of actions by the MHP regarding provision of services through an authorization process, including:

- Reduction or limitation of services
- Reduction, suspension or termination of a previously authorized service
- Denial of, in whole or part, payment for services
- Failure to provide services in a timely manner.

See the Beneficiary and Client Problem Resolution Process for details. The Advocacy organization will contact the provider within three (3) working days of receiving the written permission to represent the client. Again, the provider's cooperation with the Advocacy organization to find a mutually agreeable solution is necessary to meet the strict mandated timelines in resolving the problem. The advocacy organization shall investigate the appealed matter and make a recommendation to the MHP. The MHP (Local Mental Health Director or

designee) will review the recommendations of the advocacy organization and make a decision on the appealed matter.

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.

Expedited Appeal Process

Timeline: Three (3) working days, with a possible 14-day extension for good cause.

When the standard appeal process could jeopardize a client's life, health or functioning, an expedited appeal may be filed for by the Advocacy organization, necessitating a very rapid turnaround from grievance to resolution. The advocacy organization will notify the provider as soon as possible, but in less than two (2) working days. The Mental Health Director or designee will make a decision on the appeal on the third working day.

State Fair Hearings

Medi-Cal beneficiaries filing an appeal may request a State Fair Hearing, after using the County Beneficiary and Client Problem Resolution Process whether or not they have received a Notice of Action within 90 days after the completion of the Beneficiary and Client Problem Resolution Process. State Fair Hearings are further discussed in the Beneficiary and Client Problem Resolution Process in *Appendix F – A.F.1*.

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.

Monitoring the Beneficiary and Client Problem Resolution Process

The MHP, operating from a shared concern with providers about improving the quality of care and service, will view feedback from the grievance/appeal process as a reflection of potential problems with service effectiveness and/or efficiency and as an opportunity for positive change. Information on problems may be incorporated into the ongoing contract monitoring and/or credentialing process.

CLIENT NOTIFICATION OF ACTION ON SERVICES (NOA PROCESS)

The State has developed the following forms to be used to notify clients about service provision:

Notice of Action-Assessment (NOA-A)

All Mental Health programs (County and contract) shall follow procedures for issuing NOA-A forms for Medi-Cal beneficiaries. In accordance with Title 9, Section 1850.210, an NOA-A shall be issued to a Medi-Cal client when services are requested and medical necessity criteria are not met upon a face to face assessment and therefore no services are appropriate in the mental health system. Issuing of an NOA-A begins the 90-day period that a beneficiary has to file for a State Fair Hearing.

The NOA-A form informs the Medi-Cal beneficiary of the following:

- Reason for denial based on Title 9, California Code of Regulations
- Beneficiary's right to a second opinion
- The grievance/appeal process
- Right to a State Fair Hearing (once local process has been exhausted)
- Criteria for an expedited State Fair Hearing
- Explanation of the circumstances under which a specialty mental health service will be continued if a State Fair Hearing is requested
- Method by which a hearing may be obtained
- Beneficiary may be either self represented or represented by an authorized third party such as legal counsel, relative, friend or any other person.

The following procedures shall be followed by providers when issuing an NOA-A:

1. The Notice of Action-Assessment (NOA-A) form shall be issued to a Medi-Cal beneficiary following a mental health screening and/or assessment (face to face or phone) when it is determined by the provider that the beneficiary does not meet medical necessity criteria, resulting in denial of all specialty mental health services.
    a. If upon screening/assessment, the beneficiary is identified as currently receiving specialty mental health services, an NOA-A shall <u>not</u> be issued.
    b. As part of the screening/assessment process, the beneficiary may be informed of the option to obtain care outside the Mental Health Plan. When a beneficiary

verbalizes interest only in information gathering or in obtaining a referral outside of the Mental Health Plan (thus declining or modifying the original inquiry for specialty mental health services), no NOA-A needs to be issued. Services outside of the Mental Health Plan may not be reimbursable by Medi-Cal.

2. The NOA-A shall outline the action taken by the Mental Health Plan (MHP) or provider, reason for the action, beneficiary's rights, and citation of the specific regulations or MHP payment authorization procedures supporting the action.

3. In accordance with federal regulations, the NOA-A may be hand delivered on the date of the notice or deposited with the United States Postal Service in time for pick-up no later than three (3) working days of the decision by the provider.
4. All above cited programs shall maintain a Notice of Action Assessment Log on the program site.
5. The NOA-A Log shall document all NOA-As provided to Medi-Cal beneficiaries and their response to the NOA-A, if known.
6. The NOA-A Log shall contain the following information:
    a. Date the NOA-A was issued
    b. Beneficiary identification number, if known
    c. Response, including requests and provisions for second opinions, initiation of grievance/appeal procedure, and/or request for State Fair Hearing, if known.
7. The original NOA-A Log will be maintained at the program site, with a copy of each NOA-A issued attached. When no NOA-As are issued in a given month, the Log shall reflect this information with a check in the appropriate box. The Monthly/Quarterly Status Report shall identify the number of NOA-As issued during the report period.
8. When an NOA-A is issued, the Log shall be submitted with the provider's Monthly/Quarterly Status Report.

Notice of Action (NOA-B)

In response to a provider's request for continued treatment authorization, if the MHP or its designee should determine that a Medi-Cal client's treatment be denied or reduced, the provider and the client will receive an NOA-B form. The NOA-Back form describes the Medi-Cal client's right to file a grievance/appeal, and the right to a State Fair Hearing. Please review the NOA-B with the client and request that he/she sign the form, and return the signed NOA-B to the point of authorization. The original NOA-B shall be maintained in a confidential location at the program site for a minimum of three years.

If the Medi-Cal client chooses to exercise the right to file an appeal, or request a State Fair Hearing, the appropriate State office to contact is given on the NOA-Back form.

Note: Copies of the NOA-A, NOA-A Log, NOA-B and the NOA-Back forms in the threshold languages are included in *Appendix F* (A.F.2, - A.F.16) and may be copied.

Additional Types of Notices of Action

In response to 42 CFR, Notices of Action must be sent out for two additional reasons:

1. A Notice of Action form will be sent to a client from an advocacy organization (CCHEA or JFS Patient Advocacy) or the MHP, as appropriate, if a grievance, appeal, or expedited appeal is not completed in accordance with federal timelines. (NOA-D)

2. A Notice of Action form will be sent to a client from Optum if a Treatment Authorization Request (TAR) has been denied as a result of insufficient information submitted by the provider. (NOA-C).

Note: The NOA-C form in the threshold languages is included in *Appendix F* (A.F.20, - A.F.24) and may be copied.

It is expected that issuing these types of NOAs will be infrequent, but may result in clients approaching providers with a few questions. The State has provided the counties with specific forms for these new NOAs.

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 provider programs are required to attend regular Program Manager meetings, quarterly Leadership Plus meetings, QM In-Service, Documentation trainings and other behavioral health meetings as required. 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 (DCHS) Letters and Notices
- the MHP Managed Care contract with the State DHCS, and
- the Annual State DCHS Protocol

The evaluation process is also being reformulated and expanded to meet a number of new Federal regulations and legislative mandates including the following:

- Mental Health Services Act (MHSA)
- MHSA System Transformational Goals for the County of San Diego
- State mandated Performance Improvement Projects (PIP) -- the State has mandated that each county undertake one administrative and one clinical improvement yearly.

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 AND PROVIDER SATISFACTION

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

Adult/Older Adult System of Care: BHS QM administers an annual mandated client survey 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.

> ***Mental Health Survey – Contract Requirement***
> ***Survey Period:*** *Two-week period in spring each year*

BHS selects a two-week time period annually in the spring in which all Outpatient providers, including Case Management, are required to administer the Mental Health survey. This survey consists of two parts, a Mental Health Statistics Improvement Program (MHSIP) section which measures client satisfaction with services and Quality of Life section which measures client satisfaction with other aspects of daily living. This survey should be administered to **all** clients receiving services during the two weeks, **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 time period. The survey returns are scanned in 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 Survey are subject to change as determined by the County. Providers will be notified of changes affecting them.

Children's System of Care: A satisfaction survey is conducted annually within all organizational programs (excluding detention programs, medication only cases, inpatient and

crisis services) as required by the County to assess client satisfaction. The MHP provides education and training to providers regarding the survey, its development, utilization and implementation. See Section N for more information.

Entire System of Care

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

MONITORING THE SERVICE DELIVERY SYSTEM

The MHP mandates internal and external site and clinical monitoring of providers to ensure that all clients receive the highest quality clinical care at the most appropriate level of service. The Quality Management Unit conducts program site and Medical Record reviews of both Medi-Cal and Non Medi-Cal clients. Site visits and Medical Record reviews are scheduled and coordinated with the Program Manager at each provider site. A copy of the site and clinical record review tool is distributed to the provider at that time. Upon receipt of the records list to review, no revisions shall be made to the clinical record or submitted claims.

Using the Uniform Medical Record

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 be in compliance 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 18, plus three (3) 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 Health Public Sector website.

Standard for Timeliness of Documentation

All services provided to a client shall be documented into the client's medical record within a timely manner. Best practice is to document the service on the date the service was provided. If, however, this documentation does not occur on the date of service, the following shall apply:

- To claim a service, the service must be documented within 14 days, including the date of service. For example, if the service was provided on January 2, 2014, January 2nd is the first counted day of the 14 day rule (meaning the progress note must be completed by close of business on January 15, 2014). If a service has not been documented within 14 calendar days including the date of service, the service must still be documented but <u>may not be claimed</u>. The service would be considered a non-billable service and would be entered into Anasazi using the appropriate 800 service code.
- A service is disallowed when the documentation date is over 14 calendar days from the date of service and must be corrected by the program.

Meeting Quality Management & Short-Doyle/Medi-Cal Requirements

Programs will be monitored for quality management and compliance with regulations by the BHS Quality Management Unit. Programs shall be required to submit and implement a QM Plan of Improvement/Correction for issues/problems identified by the QM Unit. The deadline for any quality improvement plan shall set by the QM Unit based on the individual provider's situation.

PLANS OF CORRECTION (POC)

QM Plan of Correction

The QM Unit monitors organizational and county providers on a regular and annual basis to evaluate the provider's performance in various delegated activities. Medical record reviews are conducted to ensure that MHP contract requirements are met pertaining to documentation standards. Site certification and recertification reviews are also conducted to ensure that all

MHP onsite requirements are being adhered to by the provider. If the provider's performance is found to be inadequate, or areas for improvement are identified, a request for QM Plan of Correction will be issued by the MHP to the provider. The provider will have 30 days, or another identified time frame, after receipt of the MHP's written report of findings to complete and submit the specified QM POC to the QM Unit. The QM POC 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 POC. When appropriate, the POC 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 POC, the program is still required to keep this documentation on-file at their program. The POC 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 POC may result in withholding of payment on claims for non-compliance.

Upon receipt of a POC, 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 POC does not adequately address these items, the QM Unit will request that an addendum to the POC be submitted within a specified time frame.

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. These determinations will be made under the direction of the QM Program Manager and may take place within 30 days, 60 days or some other identified time frame 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.

When a program's identified trends and patterns for out of compliance items or areas needing improvement are not responding to the program's written POC, 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 POC actions, and a statement about insufficient improvement having been made. QM may recommend identified interventions or process changes to be implemented. If a Corrective Action Notice 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.

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 within the 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.

Medical Record 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.

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 will conduct a review of the medication service at each program site. This item has been added to the Medical Record Review as QM stopped doing an annual Site Review as of 1/01/2011.

For billing issues identified in the Medical Record review, programs will be required to submit a copy of their Void/Replace forms with the Plan of Correction indicating all billing issues have been resolved.

A billing POC is required for a compliance score of less than 100% in the billing section of the review tool. If there are additional billing concerns, the QM Specialist may conduct another medical record review within 3 months.

Invalid Services – Void or Replace

In order to maintain a complete audit trail, services entered in Anasazi cannot be deleted. Program must file for void or replacement when billing errors occur. Definitions for Void and Replace are:

Replacement: A replacement is an action taken to address a service that was entered incorrectly, for example typographical errors. To replace a claim the billing provider EIN and Subscriber CIN must be the same between the original claim and the replacement claim, and at least two of the following four elements must be the same:

- Procedure Code
- Place of Service
- Date of Service
- Provider ID

Void: A void is an action taken to address a service that is not Medi-Cal billable that is being disallowed because the documentation does not meet the standards of billing for that service.

SDCBH utilizes the standard State criteria to determine which services do not meet the criteria to be billed and must be voided. Services must have been already claimed and paid by the State before a service can be voided.

Deletion: A deletion is a request to remove a non-Medi-Cal service that has been disallowed because of a provider's review, and the service does not qualify as a valid service.
PROCEDURE(S):

1. 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 Medi-Cal billing is substantiated.
2. If the clinical documentation does not meet the 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 Voided Service request form with SDCBHS.
    a. For clients who do not have Medi-Cal and documentation does not meet the documentation standards as set forth in the Uniform Clinical Record Manual, a separate process is being developed at this time. Providers should not include non-Medi-Cal clients on the Void or Replacement form. Non Medi-Cal services should be submitted as a deletion on the old Self Report billing form.
3. To file a Void or Replacement form with SDCBHS providers shall fill out the Void or Replacement Request form and e-mail the form toe Behavioral Health Administration, Financial Management Unit (FMU). The e-mail address is on the form.
4. **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 services for services that are identified as a Medi-Cal billing disallowance and is voided based on the Void Reason in Attachment A. Corrected service information may only be entered once the provider has confirmed that the incorrect service has been voided. NOTE: Replacements can only be processed by the billing unit, and is only used to correct a data entry error, not for billing disallowance.
5. Providers shall ensure that the services listed on the voided 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.

In order to remove billing from EPSDT Review, providers must send the void request form prior to receipt of notification that an EPSDT Review has been scheduled for that provider. Items received fewer than 21 calendar days prior to the receipt of notification that an EPSDT Review has been scheduled may not be fully processed and therefore may not be removed from the EPSDT Review and may still be subject to recoupment by the State.

Medical Record Claims Review and Provider Self Report of Disallowances

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. The designated billing review period will include the month, date, year that the billing review begins and ends. 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.

Medi-Cal Recoupment and Appeals Process

It shall be the policy (Recoupment Based on Medical Record Review; No: 01-01-125) of County of San Diego Mental Health Services to disallow billing by Organizational, County, Individual and Group 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* (*see Appendix G*).
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 in *Appendix G, G.1* 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. Located in *Appendix G, G.2* is the complete description of the step-by-step appeal process with timelines for first and second level appeals.

Site Reviews

The Quality Management Unit is also responsible for monitoring the health and safety of organizational provider sites. Providers must be in compliance 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

QM Site Reviews will not be conducted annually as of 1/01/2011; however QM may conduct a site Review of programs 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.

Medication Monitoring

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 (MM) are set forth in CCR, Title 9, Chapter 11, Section 1810.440; MHP Contract with DCHS, 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 prescribed
- 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.

Within the SDCBHS system, open records of medication services for all County-operated and contracted programs are sampled on a 5% per annual basis.

Contracted providers are required to perform the first-level screening of medication monitoring for their facility, using the Medication Monitoring Screening Tool. If a variance is found in medication practices, a Medication Monitoring Feedback Loop (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:

Medication monitoring reporting has been updated to increase security of client information and streamline reporting. As of September 29, 2011, providers will no longer submit the individual medication monitoring ("Med Mon") tools and McFloop forms. Instead, providers will submit a one page report that replaces the Med Mon Committee Minutes form. This new report does not contain any PHI and does not require any signatures.

- Email/fax the Med Mon report to QM (replaces committee minutes form).
- Do not submit your Med Mon tools and approved McFloop forms. Keep these forms on file at your clinic.

- Use the revised versions of the existing Med Mon forms and discard the old forms.
- 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 med monitoring.

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

Results of medication monitoring activities are reported quarterly by the 15th of each month following the end of each quarter to the QM Unit. *(The QM Medication Monitoring Reports for the Children's and Adult's Mental Health Systems of Care are located in Appendix G.)*

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 Mental 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 trend is noted, the report is forwarded to the Medical Director for recommendations for remediation.

Children's 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.6*)

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) 783-7422 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.7*).

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. This includes on site and secure maintenance of a written Request for Services Log. 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. It is strongly suggested that providers also keep records of the consumer's insurance coverage, and whether the client telephoned or walked in to request services. County and Organizational providers are to retain log for a minimum of 5 years in the office, and 2 years off site (for a minimum total of 7 years).

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. The MHP will be monitoring compliance according to established industry standards and a mandate by the San Diego County Board of Supervisors (see Section C for a review of these standards.)

Adult/Older Adult System of Care: Guidelines for Orientation Groups

Orientation groups were implemented in some outpatient programs in San Diego County in order to educate clients about services and to assist them in completion of required client paperwork prior to a clinical appointment. While orientation groups may aid programs in meeting these objectives, it is critical that program staff understands that the use of Orientation Groups may not create a barrier to accessing services and may not be counted as a first appointment for Wait Times purposes.

New clients who are being discharged from a hospital or crisis residential facility shall not be required to attend an orientation group prior to receiving a mental health and/or psychiatric assessment. Clients who choose not to or are unable to attend an Orientation Group must be given alternative ways to receive the information shared in this meeting and cannot be denied a mental health assessment based on attendance or non-attendance.

It is the responsibility of each Program Manager to train appropriate staff on the limitations regarding the use of Orientation Groups, and the inability to count a group as a first appointment for Wait Times purposes.

Wait Times

Another measure of system efficiency is the amount of time that clients need to wait to receive services. County-operated and designated contracted providers of outpatient assessments and medication evaluations shall report Wait Times information each month. This information shall be reported to the Program Monitor/COR, the Contract Administration Unit, and other designated staff. Data shall include the previous month's information on client access (waiting time) for routine initial mental health and psychiatric assessments. For questions on the Wait Times Program, contact QIMatters.hhsa@sdcounty.ca.gov

The Wait Time (for both Mental Health and Psychiatric Assessments) is defined as the time between the initial contact from a new client requesting services until the first available assessment appointment, which may be for a face-to-face screening or complete Mental Health

Assessment. If a client is unwilling to wait as long as necessary in a given program, the program must refer to another provider (including emergency rooms, if needed) who can offer a more timely appointment. Requests for services must be logged on the Request for Services Log. (*Appendix C. C.1.)*

Wait Times are monitored by Performance Outcomes Group of QM, and any program that consistently exceeds its Wait Time benchmark will be required to submit a quality improvement plan.

Wait Times for Emergency and Urgent Services:

- Any client who needs emergency service shall have his/her needs addressed within one hour.
- Any client who meets the criteria for needing "urgent" services shall be seen within 72 hours. A need for urgent services is defined 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. Any client being discharged from a psychiatric hospital facility, or who calls for services and is screened as needing services urgently meets the "urgent" criteria and shall be seen with 72 hours. (*For adult programs, this includes persons being discharged from a crisis residential facility, the EPU or a locked/IMD placement).*

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 that client outcomes tracking may not be feasible due to the special nature of your program, please contact 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. Until the Anasazi electronic assessment is operational at each provider's site, providers are to fax completed client and clinician tools to HSRC.

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 client outcomes indicators 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.

Section N details the system-wide outcome measure. Additional performance requirements are described in that section. The outcomes measures manual is available on the Optum website at:

https://www.optumhealthsandiego.com. Go to "Organizational Providers" "County Staff & Providers" then the "Manuals" tab.

Every three years starting in September/October, 2009, Program Managers or Administration will be asked to complete a short Recovery Self-Assessment tool designed to measure progress toward the recovery-orientation of each program as a whole. The data from this tool will be used to help agency personnel and stakeholders review their relative standing in comparison to other programs in the same level of care, their strengths, and areas of improvement.

Children's System of Care:

In April of 2004, the Mental Health Board adopted new outcome measures for Children's Mental Health programs. These measures include the Child and Adolescent Measurement System (CAMS) and the Family Centered Behavior Scale (FCBS). The outcome tools measure the effectiveness and appropriateness of County funded Children's Mental Health programs. In March of 2005 a Client Functioning Quadrant measure rating 8 domains was implemented, and in August of 2007 it was replaced by the Colorado Functional Assessment Rating Scale (CFARS) which consists of a 16 index rating. Section N details the system-wide outcome measures. Additional performance requirements are described in that section.
The outcomes measures manual is available on the OptumHealth website:

https://www.optumhealthsandiego.com

Go to "Organizational Providers" "County Staff & Providers" then the "Manuals" tab.

Some data is obtained via the Anasazi system. Other data is manually collected by providers and submitted monthly. 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 and Federal mandates to show program effectiveness and client progress, the MHP is extending the Client Outcomes tracking to all programs. 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 MSR. 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 Child and Adolescent 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 study which 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". Progress on each PIP is evaluated annually by the External Quality Review Organization (EQRO), an independent State contracted organization.

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 must include at least one of the following:

- The event has the potential for significant adverse media involvement, i.e. appears on local news station, in the newspaper, internet website, reported in the public domain.
- The event is associated with a significant adverse deviation from the usual process for providing behavioral health care.
- The event has results in a death or serious physical injury on the program's premises.

For Level One, upon knowledge of the incident, the provider shall immediately verbally report the incident to the QM SIR Line at 619-563-2781. The provider shall complete a Serious Incident Report (see *Appendix A.G.9*) and fax it to the QM Unit within 24 hours of knowledge of incident.

For Level Two, upon knowledge of the incident, the provider shall verbally report the incident to the QM SIR at 619-563-2781. The provider shall complete a Serious Incident Report (see *Appendix A.G.9*) and fax it 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 QM Unit will monitor serious incidents and report data to the QRC and Executive Quality Improvement Team (EQIT).

Serious incidents are categorized as follows:

- Incident reported in the media/public domain (e.g. on television, newspaper, internet)
- 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
- Suicide attempt by client that requires medical attention or attempt is potentially fatal and/or significantly injurious.
- Alleged homicide committed by a client (client is perpetrator)
- Alleged homicide attempt by a client (client is perpetrator)
- Alleged homicide attempt on a client (client is victim)
- Injurious assault on a client (client is victim) occurring on the program's premises resulting in 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 program's premises 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.

- 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.

- 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 resulting in a client experiencing severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.

- 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.

- Major confidentiality breach (lost or stolen laptop, client files/records accessed, PHI breach, etc.)

- Use of physical restraints (prone or supine) <u>only</u> during program operating hours (applies <u>only</u> to CYF mental health clients during program operating hours and excludes ADS 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 verbally report the incident and all known details to the SIR Line at 619-563-2781.
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 verbally report 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 verbally 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 client's medical record/s will immediately be located and safeguarded by the program manager or designee. Program manager should review chart as soon as possible and until that review is complete the client medical record will be secured in a location that is not accessible by any staff member other than the program manager or designee.
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 and the Report of Findings form shall be completed and faxed to QM within 30 days of knowledge of incident.
8. An SIR is not part of the client medical record and should never be filed in the medical record. A Serious Incident Report should be kept in a separate, confidential file.
9. A serious incident that results in a completed suicide 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.
10. A serious incident that results in a major confidentiality breach shall require the completion of an RCA within 30 days of knowledge of the incident.
11. The Action Items as a result of the RCA shall be summarized and faxed to the QM unit with 30 days of knowledge of the incident. Do not submit the RCA worksheet, only a summary of action items.

Please Note:

The Serious Incident RCA Worksheet found in Appendix G (A.G.11) is required for San Diego County operated programs per current HHSA/MHS General Administration Policies and Procedure. 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 strongly 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/sentinelevents/forms/ for more info on RCA). Technical assistance is available through the BHS QM Unit by calling 619-563-2747. RCA training is offered on a regular 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.

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 as usual.
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 – Adult Providers 2) CYF SOC Assistant Deputy Director – Child Providers 3) Director, BHS (third back up).

UNUSUAL OCCURRENCE REPORTING

An unusual occurrence is reported directly to your COR/Program Monitor. 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 Unusual Occurrences occur 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 which 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. These 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, please contact the QM unit at (619) 563-2778.

NATIONAL VOTER REGISTRATION ACT (NVRA)

Per the National Voter Registration Act of 1993, providers are required to offer voter registration materials at intake (except in a crisis situation), renewal and anytime a change of address are reported. 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. Failure to implement the NVRA may subject the agency to legal liability. Voter Registration forms in the threshold languages can be found in Appendix A.G.18-A.G.22. For more information, refer to Medi-Cal Eligibility Division Information Letter I 12-02 (http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/cI12-02.pdf).

ADDITIONAL RESOURCES

An informational sheet has been created to orient new program managers to key personnel and resources in Quality Improvement. Links for manuals, documents, training information and other valuable information is available for your convenience in Appendix G – A.G.17.

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 2010 the San Diego County Mental Health Cultural Competence Plan noted an increase in the number of Medi-Cal mental health clients from various minority populations. While progress has been made in addressing disparities in service among ethnic and racial populations, the Plan notes that minority populations are still under-represented among total mental health clients, especially among adult populations. For example, as of 2007, 10% of the County population was Asian/Pacific Islander, but only 6% of the adult mental health clients and 2.6% of child clients were from these ethnic groups in FY 09-10. 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 child population is the most rapidly increasing portion of the population. The number of older adults living in San Diego is also growing, with 20% being 55 plus years of age.

Cultural Competence Plan

To address these issues in the 2010 Cultural Competence 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 of 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.

***Culturally Competent Clinical Practice Standards**:*

The Culturally Competent Clinical Practice Standards currently utilized by SDCMHS have the following goals: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels.

The standards are as follows:

1) Providers engage in a culturally competent community needs assessment.
2) Providers engage in community outreach to diverse communities based on the needs assessment.
3) Providers create an environment that is welcoming to diverse communities.
4) Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served.
5) There is linguistic capacity & proficiency to communicate effectively with the population served.
6) Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed.
7) Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.

8) Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.

9) Cultural factors are integrated into the clinical interview and assessment.

10) Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.

11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.

12) Psychiatrists will consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services.

13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.

14) Staffs actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

Culturally Competent Practice Standards are operationalized for mental health providers as follows:

- To support the cultural competence standards, providers are required to maintain policies and procedures that support culturally competent services and provide training to staff.
- Staff should reflect the specific cultural patterns of the region to the maximum extent possible.
- Providers are to recruit staff who can meet the language needs of their clients to the maximum extent possible.
- Include in job applications, questions regarding experience in working with ethnic/minority clients, and/or culture communities for direct service or interpreting positions.
- Establish a method or process for ensuring that staff who indicate they are bi/multi-lingual have the language capability to appropriately communicate ideas, concerns, and rationales.
- Contractor shall ensure that program staff are knowledgeable of the culturally diverse backgrounds of the clients being served by the program.
- Contractors shall establish a method or process for ensuring that staff who indicate they are bi/multi- cultural have knowledge of culturally appropriate evaluation, diagnosis, treatment, referral resources, and familiarity with culturally variant beliefs regarding mental illness.
- Train direct services staff on MHP Cultural Competence Clinical Practice Standards and establish a process for monitoring adherence to the standards.

Cultural Competence Training Opportunities through the MHP

- Cultural Competence Trainings are available through the County Knowledge Center for County operated program staff at no cost and for a small number of providers on a fee basis.
- Cultural Competence Trainings available through some of SDCMHS's larger contractors. Community Research Foundation, New Alternatives, and Mental Health Systems, Inc offer their own such trainings to their own program staff but other providers may send staff on a fee basis.
- SDCMHS Contracted Trainings 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.
- SDCMHS Cultural Competence Academy Intensive Training—a 32-40 hour course will be offered starting in fall, 2011 to two groups of up to 60 staff per year to implement a Cadre model for cultural competence training.
- MHSA Workforce Education and Training Plan Educational Opportunities—includes a Nursing Partnership for Public Mental Health Professions; a Community Psychiatry Fellowship; Child Psychiatry Fellowship; LCSW/MFT Residency /Intern; and Targeted Financial Incentives to Recruit and Retain Licensable and Culturally, Linguistically and/or Ethnically Diverse Public Mental Health Staff. Details on these programs can be obtained from *Workforce Education and Training Coordinator Laura Colligan at Laura.Colligan@sdcounty.ca.gov*.

Cultural Competence Monitoring and Evaluation:

The MHP QI Unit and the COTR 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 QI Unit and the COTR 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 are now cultural competence requirements:

Program Level Requirements:

1. Cultural Competence Plan (CCP). By April 1, 2012, contractors are required to provide a Cultural Competence Plan that includes how the contractor will tailor services to reflect the unique ethnic, racial, cultural and linguistic profile of their service area, as well as plans for addressing and reducing any service disparities affecting the program
    - New contractors need to submit a CCP, 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 CCP. If your organization does not have a Plan, the County will be providing a format that may be used.

- Plans can be sent via email to Allison Williams at Allison.Williams@sdcounty.ca.gov or mailed to:

  Allison Williams
  Cultural Competence Plan
  3255 Camino Del Rio South
  San Diego, CA 92108

2. Culturally Competent Program Annual Self-Evaluation (CC-PAS)—Every two to three years, programs will be required to complete a cultural competence assessment of each program, using the tool which will be provided by SDCBHS to each program. This survey was first delivered electronically in a Survey Monkey format to the programs in April 2012 with required completion within 30 days. The CC-PAS is a 22 item survey that can be completed in approximately 1 hour or less; there is also a slightly modified survey for non-clinical programs. For your information, a copy of the CC-PAS has been included in the Organization Provider Handbook, Appendix H-A.H.1.

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

4. California Brief Multicultural Competence Scale (CBMCS). Contractors are required to assess, at least every other year, the cultural competence of all staff members who provide direct services to clients through the use of the California Brief Multicultural Competence Scale (CBMCS) tool. The CBMCS was first delivered electronically in a Survey Monkey format by SDCBHS to programs in the October, 2011 and completed by program staff within one month of distribution. The CBMCS is a 21-item assessment that can be completed in less than 30 minutes. For your information, a copy of the CBMCS has been included in the Organization Provider Handbook, Appendix H-A.H.2.

5. 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 Monthly 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.

- 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. Topics that may be covered in the survey or focus group include:
  - Regarding Language:
    - Offers of providers who speak the client's language, or interpreter services
    - Linguistic proficiency of staff providing services or interpreters who provide services.
    - Staff's ability to clearly communicate ideas, concerns, and rationales in client's preferred language
    - Availability of written materials, including alternate formats in client's preferred language
  - Regarding Culture/Ethnicity:
    - Direct services staff's knowledge of culturally appropriate evaluation, diagnosis, and treatment
    - Direct services staff's knowledge of culturally appropriate referral

resources

- Direct services staff's familiarity with variant beliefs regarding mental illness
- Appropriateness of clinic environment

• The County has provided technical assistance with developing survey/focus group questions in the Cultural Competence Handbook published in Fall 2011.

• Explore whether there are barriers to service being created by cultural competence issues.

• Document the results of the focus group(s) including findings and plans for interventions, as needed.

I. MANAGEMENT INFORMATION SYSTEM

Anasazi

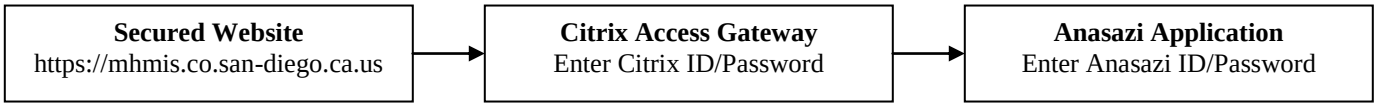
San Diego County Mental Health Services contracted in 2006 with Anasazi Software to create a new Mental Health Management Information System (MH MIS). Previously there was one system for client tracking/billing and one for managed care authorizations. The new MH MIS replaces the two systems with one integrated system. All client information, including clinical documentation, is entered into this integrated system, thus allowing each staff responsible for a client's care to access that client's pertinent information.

For the complete **Management Information System: Anasazi User Manual**, go to the Optum Health Public Sector Website at https://www.optumhealthsandiego.com/portal/server.pt (Note that the "S" in "publicSector" is capitalized. If you do not enter the capital "S", you will not access the website.)

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.

MH MIS uses Anasazi Software which is a web based application that is housed on the County of San Diego Network. Network access to County data systems, including MHMIS, is the responsibility the County Technology Office (CTO). Security and maintenance of the County network is outsourced to the County's Information Technology Outsourcing Contractor (ITOC). Under the direction and oversight of the CTO, the ITOC is responsible for the security of the county network, the Citrix Access Gateway and maintenance of the County's servers which host the Anasazi application. In addition, the ITOC is responsible for the set up and maintenance of Citrix user network accounts. The following diagram demonstrates the access to Anasazi through the County network secured internet website using the Citrix Access Gateway.



System Administration responsibility for MH MIS 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 Anasazi 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 CTO, ITOC 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 Anasazi environments, producing reports for legal entities, electronic submission of state reporting, coordination with Anasazi Software, and providing the User Support Help Desk.

Technical Requirements to Access Anasazi

Prior to accessing the Anasazi 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.

In order to access and operate Anasazi the following are required:

- Operating System on computer:
  - Windows 2000 (Citrix 10.0 does not supports Windows 95/98)
  - Windows XP Pro
  - Windows XP Home
  - Windows 7
- Internet Explorer version 5.0 or later with a minimum of 24 kbps per concurrent user (high speed internet access)
- A Citrix compatible printer (most newer printers today are Citrix compatible)
- Download Citrix Presentation Server Client file on the user's computer

Staff Set Up and User Account Access

All individuals who provide services or perform some other activity to be recorded in MH MIS as well as those who are authorized to access MH MIS must have a staff account. A "staff" in Anasazi 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 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 Anasazi Request Form. For additional information regarding staff or program access contact the SDCMHS MIS System Administration.

Staff authorized to access MH MIS will be given login access and a password and are considered "users".

User Access requires the following steps:

1. Program manager completes the "Anasazi Request Form" (ARF) (Appendix I – A.I.1).

2. Contractor employee and employee's supervisor must read and sign the "Staff Electronic Signature Agreement" (Appendix I – A.I.3).

3. Contractor employee and employee's supervisor must also read and sign the County's "Summary of Policies" (SOP) form (Appendix I – A.I.2).

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**

5. MHMIS Unit completes the County's "Computer Services Registration Form" (CSRF).

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. Complete and process the CSRF for set up of a Citrix User Account with ID/password

2. Set up Anasazi User Account with ID/password

3. User will be provided his/her Citrix/Anasazi ID/passwords at the Anasazi training.

Program managers and other supervisors are responsible to:

1. Register new staff who will be users to attend the "New User Anasazi Training"

2. Contact the QM Unit to confirm Anasazi training date/time/location

3. Confirm that employee has successfully completed Anasazi training

Note: No user will be granted access to Anasazi without successfully completing the Anasazi Training.

All forms with instructions are available electronically on the ASO's (Optum Health) Public Sector website at https://www.optumhealthsandiego.com/portal/server.pt

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 Anasazi 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. Due to security and privacy issues, each program will be limited to two staff that will have this higher level of access. 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. Requests for exceptions to the two staff rule must be made in writing directly to and approved by the MH MIS Unit.

Staff Access to Live Production and Training Environment in Anasazi

For most users, after logging on to Anasazi through the Citrix Access Gateway, two visible Anasazi 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 set up 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 Anasazi 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 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 in San Diego County's "Summary of Policy". The program manager shall immediately notify the MH MIS Unit whenever there is a change in staff information such as staff demographics, email, job title, credential/licensure, and Unit/Subunit assignment. This includes the initial staff setup, modifying or terminating existing staff accounts**. Under no circumstances shall a staff person**

NOTE !
For system security, providers must notify Optum Health when staff with access to Anasazi move, change jobs, or are terminated.

who has terminated employment have access to the EHR through Anasazi. 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 Anasazi 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 Anasazi and Citrix staff accounts.

Application Training

Prior to staff obtaining access to Anasazi, he/she shall successfully complete the Anasazi training. Program managers are responsible for registering new and returning Anasazi users for training on the Anasazi application. The Quality Management (QM) Unit provides training on a regularly scheduled basis. Previous Anasazi 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.optumhealthsandiego.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 polices 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 OptumHealth Support Desk. The OptumHealth 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 OptumHealth 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 OptumHealth Support Desk may be contacted as follows:

Phone: 1-800-834-3792
Fax: (619) 641-6975
Emails: sdhelpdesk@optumhealth.com

- OptumHealth Support Desk hours: Monday through Friday, from 6:00 am to 6:00 pm except on holidays.

The OptumHealth Support Desk will provide after-hour cell phone emergency support for urgent Citrix and Anasazi issues. Urgent issues affecting multiple users include:

- When logging into Anasazi, the system does not respond or appears to be frozen, and/or no data can be entered or viewed
- 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 OptumHealth Support Desk involvement.

NOTE: Printing issues, password resets technical and Anasazi 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. OptumHealth Support Desk Phone: 1800-834-3792
6. OptumHealth Support Desk 24 Hour Pager: 619-893-4839
7. OptumHealth Support Desk email: sdhelpdesk@optumhealth.com
8. Web address to access Anasazi: https://mhmis.co.sandiego.ca.us
9. OptumHealth Public Sector Website: www.optumhealthsandiego.com

J. PROVIDER CONTRACTING

Note: References to contracting do not apply to County-operated programs.

All Medi-Cal providers shall adhere to the Managed Care Contract executed between San Diego County and the California State Department of Mental Health. As outlined in that contract, Medi-Cal contractors are prohibited from subcontracting with a "legal entity" as defined in the California State Medicaid Plan for Short-Doyle/Medi-Cal services. The California State Medicaid plan defines legal entity as each county mental health department or agency and each of the corporations, partnerships, agencies, or individual practitioners providing public mental health services under contract with the county mental health department or agency. The prohibition on subcontracting does not apply to providers and their relationships with vendors such as nursing registries, equipment, part-time labor, physicians, etc. Such providers do not meet the legal entity definition cited above. The legal entity concept prohibits a county from contracting with a legal entity to provide Short-Doyle/ Medi-Cal services that in turn contracts with another legal entity to provide Short-Doyle/Medi-Cal services.

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;
- Budget schedules; and
- Statutes and/or regulations particular to the Medi-Cal managed mental health care programs as well as programs supported by other funds.

All contracted providers will be expected to adhere to these requirements. Please contact Behavioral Health Services Contract Support (BHSCS) at 619-563-2718 if you have any questions regarding your contract.

Program Monitoring

Each provider will have assigned to their program a Program Monitor (also known as Contracting Officer Technical Representative – COTR), 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/COTR's 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/COTR.

Contractor Orientation
All new contracts require a contractor orientation meeting within 45 days of contract execution. Agency Contract Support shall, in conjunction with the BHS Contract Support Team, 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) COTR and QI in writing if any of the following changes occur:

- 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 MHS Program Monitor/COTR/Designee, MHS CAU, MHS Quality Improvement (QI) Unit, and the Health and Human Services Agency (HHSA) 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 and certification documentation;
- Fiscal and accounting policies and procedures;
- Compliance with standard terms and conditions.

Information from the QI site visit will be included in the contract monitoring process. For Medi-Cal–providers, the annual site review will include a medical record review and review of pharmaceutical services. When a Medi-Cal re-certification is due, an in-depth site review will be completed and the QI medical record review will be scheduled separately during that same fiscal year. 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/COTR or Designee within 2 work 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.

Quarterly Status Reports
Contracted providers are required to submit a completed Quarterly Status Report (QSR) within 15 calendar days after the end of the report month. The QSR includes the NOA Log and Suggestion / Provider Transfer Request Log. It is important to become familiar with using these logs and document pertinent information as required. The QSR template 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. Typically twice a year y, in July and December, the County submits a Cultural Competency Report to the State by extracting information provided on the QSR from the Staffing and Personnel as well as Training section of the QSR.

Contract Issue Resolution
Issues, problems or questions about your contract should be addressed to your COTR at their respective addresses.

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.
- 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 COTR 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 COTR 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 MHS CAU 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, dated July 1989.
- Quarterly Cost Reports are due by October 31, January 31, April 30.
- Year-end Cost report is due by August 31.

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: (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
Beginning April 1, 2003, all claims for reimbursement submitted must contain a certification about staff freedom from federal disbarment or exclusion from services. The details of this new procedure are laid out in the February 21, 2003, Letter from Health and Human Services Agency (HHSA) Contract Support and Compliance directed to all HHSA contractors.

In order to be in compliance with these federal regulations, all organizational providers must verify monthly the status of employee professional licenses with both the Office of the Inspector General (OIG) and Government Services Agency (GSA).

To verify through the Internet if someone is on the OIG Exclusion list or the GSA debarment list, go to:
http://oig.hhs.gov/fraud/exclusions/listofexcluded.html

To view the list of what will get someone placed on the OIG list, go to:
http://oig.hhs.gov/fraud/exclusions/exclusionauthorities.html

Please remember the following:

- Providers must retain the records verifying that these required monthly checks have been performed and the names of the employees checked.
- Any employees who appear on either the OIG or GSA lists are prohibited from working in any County funded program
- Providers are encouraged to consult with their compliance office or legal counsel should any of their employees appear on either of the exclusion lists.

License Verifications
As of July 1, 2003 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. This is in accordance with the Pro Forma requirements. In order to ensure the license is valid and current, the appropriate website must be checked and documented.

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, Statewide Maximum Allowances (SMA), negotiated rates or actual costs if the provider does not contract on a negotiated rate basis."

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.

Statewide Maximum Allowances (SMA) is upper limit rates established for each type of service, for a unit of service. SMA is an annual rate for reimbursement of a SD/MC unit of service.

Negotiated Rate is a fixed prospective rate subject to the limitations of rate setting requirements.

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 Mental Health Billing Unit/Fiscal(MHBU/F) 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 97 days to fix denied services. Once the program has fixed the error, in order to rebill for the service, the program must complete the current Rebilling Service Request form located in OptumHealth Public Sector Web-site at https://www.optumhealthsandiego.com/portal/server.pt and email the form to the email addresses stated on the form. Once the form has been received, the program will be given a tracking number. If the reason for the denial is for Other Health Coverage, the explanation of benefits (EOB) must be faxed to the billing unit with the tracking number notated on the EOB – fax to MHBU/F 858 467-9682.

County of San Diego HHSA – Mills Bldg.
Mental Health Billing Unit Fiscal Services (MHBU/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*

Per the current California State DMH Reasons for Recoupment of FFP dollars, BHS is obligated to disallow the Medi-Cal claim under the following categories:

- Medical Necessity
- Client Plan
- Progress Notes.

Located in *Appendix J (A.J.2)* is the complete listing of recoupment criteria based on the above categories. 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.

In FY 04-05, 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 Mental 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 Deletion forms if the service was billed and paid in Short Doyle Phase I prior to March, 1, 2010 or a Void Service Request form if the service was billed and paid under Short Doyle Phase II March 1, 2010 and later. E-mail the applicable form to MH Admin email addresses as directed on the form who will forward the form to MHBU. If the service was paid before March 1, 2010 they must use the current Anasazi form located in OptumHealth Public Sector Web-site at https://www.optumhealthsandiego.com/portal/server.pt. After March 1, 2010 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 Anasazi. 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 Anasazi Void -Replace Service Forms document located in OptumHealth Public Sector Web-site at https://www.optumhealthsandiego.com/portal/server.pt. Services that are submitted for corrections because of clerical errors may be replaced, programs will need to complete the replacement service request form and submit to MH Admin who forwards to the MHBU.
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 Contract Support (BHSCS) 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, BHSCS 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 (BHSCS) 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 (BHSCS) 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)
P O Box 85524
San Diego, CA 92186-5524
Attn: Lead Fiscal Analyst

Questions can also be addressed by calling the Lead Fiscal Analyst 619-563-2729.

County Operated Mental Health Services

County programs are required to follow county policy.

Contractors Inventory Guides For A Cost Reimbursement Contract

1. **Inventory Acquisition**:

When a contract budget with capital assets and minor equipment funding is approved, a Contractor may acquire property with funds from this contract. If contract payments are on a cost

reimbursement basis, including property acquired by lease purchase agreement, the County retains ownership to all property.

2. Definitions:

2.1. **Capital Assets** (previously referred to as fixed assets): Includes property such as furniture, machines, tools and vehicles. Items costing $5,000 or more shall be budgeted in the appropriate capital asset account.

2.2. **Minor Equipment**: Individual items that cost less than $5,000 and are useful for one (1) year or longer are categorized as Minor Equipment.

- **Non-consumable** supplies (of a relatively permanent nature with useful live of one year or longer) costing less than $5,000 should be listed on the inventory list as minor equipment.

- **Consumable** supplies valued under $500 are not considered minor equipment.

NOTE: Beginning with FY July 2010- June 2011 do not list consumable supplies valued under $500. For previous fiscal years, do not remove the items previous listed (valued from $100 to $499) unless they were returned to the County.

3. BHS Property Inventory Form - The Process for Cost Reimbursement Contracts and Record Keeping:

3.1. All purchases or leases reimbursed by a County funded contract shall be listed on the Behavioral Health Services (BHS) Inventory Form *(Appendix J, A.J.1)*, or the contractor's form with the required information, with the exception of property having the value of zero. Capital assets and minor equipment should be accounted for at cost or, if the cost is unknown, estimated cost at time of acquisition. Inventory records on property shall be retained, and shall be made available to the County upon request, for at least three (3) years following date of disposal.

3.2. Contractors will maintain equipment records that include a description of the property, a serial number or other identification number; the acquisition date; the acquisition costs; location of the property; condition of the property; program funding for the property; and any ultimate disposition data including the date of disposal.

3.3. Contractor may not expend funds under this agreement for the acquisition of property having a unit cost of $5,000 or more and a normal life expectancy of more than one (1) year without the prior written approval of the Contracting Officer's Technical Representative (COTR). After approval from the COTR, as contractors acquire capital assets, notify the COTR by including the expenditure on the monthly invoice/cost report.

3.4. As the contractor acquires equipment, they will notify the COTR within 30 days by including the expenditure on their monthly invoice/cost report. The COTR will forward the tags that identify the object as "County of San Diego PROPERTY". The contractor is responsible for immediately attaching the labels to the property.

4. Inventory Disposition:

4.1. Contact the COTR before disposing of property purchased with County funds.

Non-expendable property that has value at the end of a contract (e.g. has not been fully depreciated with a value of zero), and which the County may retain title under this paragraph, shall be disposed of at the end of the Contract Agreement as follows:

4.2. At County's option, it may:

4.2.1. Have contractor deliver to another County contractor or have another County contractor pick up the non-expendable property;

4.2.2. 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;

4.2.3. Direct the Contractor to return to the County the non-expendable property.

5. BHS Property Inventory Form: *Appendix J (A.J.1)***:**

5.1. As the contractor disposes of equipment the following columns on the BHS Inventory form must be completed and a copy provided to the COTR :

5.1.1. "Date of Disposition of Capital/Fixed Assets or Minor Equipment": This is the actual date the item was delivered and accepted by County Salvage.

5.1.2. "Date form AUD253 completed": This is the date the COTR signs and returns AUD253 form to the contractor.

6. **AUD253 Property Loan or Transfer Request Form:**

NOTE: Procedure for Property transfer to the County of San Diego – Property Disposal or transfer to another contractor. Form AUD253 will be provided to the Contractor by BHS and shall be signed by the Contractor's program manager. 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.

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.

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:
Client Data: Any identifying information relating to any individual receiving services from any program.

Portable Devices: Tools such as laptops, external hard drive, PDAs, Blackberries, Tablet PCs, other USB memory devices and cameras (digital, non-digital, and video).

Portable Media: Any tool used to transport information any distance such as floppy disks, CDs, DVDs, USB memory sticks, flash drives or smart cards.

Minimum Guidelines:
All Contractors' executives shall be responsible for maintaining a current inventory of all portable devices and portable media in their program.

1. All Contractors' electronic devices shall be password protected.
2. All client data transported on any portable device or media shall be encrypted and/or password protected.
3. Portable devices or portable media shall not be used for routine storage of client data.
4. For major confidentiality breach (lost or stolen laptop, client files/records accessed, etc.) refer to *Serious Incident Reporting to Quality Improvement Unit* procedures.

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. 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 interpretations of best practices, the guidelines may change as new information and/or technology becomes available. 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. Providers shall comply with standards as 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.
- Substance use or abuse, including involving a caretaker should be coded under the Axis IV (Psychosocial and Environmental Problems) classification.
- 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 Mental Health Services (AMHS) and the Children, Youth and Family Services (CYFS) 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 HHSA 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 know 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), Clozapine (Clozaril), Olanzapine (Zyprexa), Paliperidone, Quetiapine (Seroquel), Risperidone (Risperdal), and Ziprasidone (Geodon).

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.
- 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 TEVA Clozaril Registry 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).

For recommended monitoring parameters please check Attachment A.L.1.

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 in the Road Map to Recovery (R2R) Handbook. The R2R Handbook is available by contacting MH Administration at (619) 563-2771.

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 ASW/IMF 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.

BOTH SYSTEMS OF CARE

PROFESSIONAL LICENSING WAIVER REQUIREMENTS

Professional Licensing Waiver Guidelines -Welfare and Institutions Code (W&IC) Section 5751.2.

The purpose of this letter is to provide counties with updated information regarding professional licensing waiver requirements and instructions on how to request these waivers pursuant to *Welfare and Institutions Code* (W&IC) Section 5751.2.

The entire 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 in bulleted form.

Section 5751.2 (a): Except as provided in this section, persons employed or under contract to provide mental health services pursuant to this part shall be subject to all applicable requirements of law regarding professional licensure, and no person shall be employed in local mental health programs pursuant to this part to provide services for which such a license is required, unless the person possesses a valid license.

- This applies to all psychologists, clinical social workers, or marriage and family therapists employed by, or under contract to, local mental health programs.

- This applies to both county employees and contract providers.

- This applies regardless of payer source.
- 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. There are probably only a few, if any, persons statewide still in this category.

Section 5751.2. (c): *While registered with the licensing board of jurisdiction 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 or marriage, family, and child counselors shall be exempt from subdivision (a). Registration shall be subject to regulations adopted by the appropriate licensing board.*

- Licensed Clinical Social Worker (LCSW) and Licensed Marriage and Family Therapist (LMFT) candidates do not need a waiver, nor can one be obtained. (See the exception to this statement under Section 5751.2 (e) below for license-ready persons recruited from outside California.)
- Each LCSW and LMFT 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 qualifying hours.

Section 5751.2. (d): *The requirements of subdivision (a) shall be waived by the department 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 department for persons who have been recruited for employment from outside this state as psychologists, clinical social workers, or marriage, family, and child 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 three professions who are recruited from outside this State.

- To be eligible, the psychologist, LCSW, 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.

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) 563-2795 or email documents to Ian Rosengarten (ian.rosengarten@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.

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., R.N., Ph.D., LCSW, or MFT do not require a co-signature on any documentation in the medical record. In addition, the same holds true for staff that are registered associates or interns (ASW or IMF) with the Board of Behavioral Sciences (CA) or waivered 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.

In the Uniform Clinical Record Manual, there are specific forms for Mental Health Assessments,

Client Plan, and Discharge Summary that require the signature of a licensed/registered/waivered staff member. If the staff completing the form is not licensed/registered/waivered, then a co-signature by a licensed/registered/waivered staff is required. These forms have specific time requirements which affect compliance with regulations and recoupment of FFP dollars. In order to be in compliance and not risk recoupment of FFP dollars, all required co-signatures must be signed within the required time frame. Following is a brief summary chart, which indicates in general, documentation and co-signature requirements. For additional questions, please contact your QM Specialist.

CO-SIGNATURE REQUIREMENTS

(From Documentation and Uniform Clinical Record Manual)

YES - co-signature required
NO - co-signature not required
N/A - credential cannot provide service

STAFF DISCIPLINE	Behavioral Health Assessment	Client Plan	Discharge Summary
M.D.	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) Professional Counselor Intern (PCI)	NO	NO	NO
RN	NO	NO	NO
Licensed Vocational Nurse (LVN)	YES	YES	YES
Licensed Psychiatric Technician (LPT)	YES	YES	YES
Mental Health Rehab Specialist (MHRS) *ADULT programs*	YES	YES	YES
Mental Health Rehab Specialist (MHRS) *CHILDREN programs*	N/A	YES	N/A
Staff not meeting minimum qualifications for MHRS (Trainee, etc)	N/A	N/A	N/A

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 waivered/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, waivered, and trainees) and up to 12 total staff, to include clinical staff.
- Programs must provide adequate training, supervision, and co-signatures by a licensed/registered/waivered 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 CYFS 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 CYFS 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 waivered 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 waivered. 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 interns and trainees shall be no more than 1:3 FTE, i.e., there must be at least one FTE licensed clinician per 3 FTE interns and trainees. Interns and trainees 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 Interns/Trainees

- 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.
- Interns/trainees 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 bachelors 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
- Registered Nurse
- Licensed Vocational Nurse
- 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)

Source of Information: Short Doyle/Medi-Cal Manual for the Rehabilitation Option and Targeted Case Management, Revised 7/1/95.

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.

CHILDRENS' 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, waivered, or trainee (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 Anasazi 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 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 year 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 waivered 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 waivered staff member.
- 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 waivered 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 Anasazi User's Manual. Service entry shall be kept up to date and the data shall be entered into the SDMHS MIS (Anasazi) 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 Health Public Sector website (www.optumhealthsandiego.com/portal/server.pt) 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 Anasazi 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 Mental Health.

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.

Included in *Appendix N (A.N.1)* 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. See *Appendix N (A.N.2)* for the MAA Community Outreach Service Record referenced in Appendix A.N.1.

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 the DES, an Access database supplied by CASRC, or as otherwise directed by the County. This database permits client results to be compiled for individual cases and by program. Data recorded in the database is supplied to CASRC via direct drop off or traceable mailing to ensure HIPAA regulations are followed.

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 HOMS. The HOMS 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 HOMS database or the Data Centers will set up for extracts from contractor's database into the HOMS. 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 HOMS. The HOMS 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 HOMS database or the Data Centers will set up for extracts from contractor's database into the HOMS. 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 HOMS 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 HOMS database or the Data Centers will set up for extracts from contractor's database into the HOMS. 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 only

Substance Abuse Treatment Scale—Revised (SATS-R)
SATS-R is a single item assessment of clients' substance abuse stage of treatment/recovery (not for determining a diagnosis). A SATS-R is completed when the client has an active substance related treatment plan goal in his/her client plan. The SATS-R shall be completed at initial development of the substance use goal and every 6 months thereafter, as long as the client continues to have a substance related goal in his/her client plan. SATS-R is completed by clinicians

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 12 months following intake, and 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 dis-charge,

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.optumhealthsandiego.com** Go to "Organizational Providers" "County Staff & Providers" then the "Manuals" tab.

Outcome Measures - Children's System of Care only

Data Collection and Retention
All treatment programs shall maintain an outcome data entry system (DES) for all clients. DES entry shall be completed promptly upon collection of data at designated intervals, including intake, UM/UR authorization cycle and discharge.

Outcome Tools and Requirements
Measuring outcomes is an integral aspect of System of Care principles. Standard outcomes have been established for all CYFS treatment providers. Specialized program may have individual

program outcomes either in addition to or in lieu of standard outcomes measured by all programs.

- Child/Adolescent Measurement System – Youth (CAMS-Y) – 11years of age or older
- Child/Adolescent Measurement System - Parent/Caregiver (CAMS-P) – all ages
- Child/Adolescent Measurement System -Clinician (CAMS-C) – when acting as caregiver
- Children Functional Assessment Rating Scale (CFARS)– all ages
- 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
- Eyberg Child Behavior Inventory (ECBI) – children 0 through 5 in 0-5 specific programs
- CRAFFT- all ages (as assessment tool only).
- Personal Experience Screening Questionnaire (PESQ) – Youth enrolled in Clinic Alcohol and Drug FSP Sub Unit.
- Satisfaction Questionnaire – for youth enrolled in Clinic Alcohol and Drug FSP Sub Unit.

Discharge Outcomes Objective:

- A minimum 80% completion rate of standardized measures.
- For 80% of discharged clients whose episode lasted 2 months or longer, the CAMS-P total score shall show improvement between intake and the last CAMS collected.
- For 80% of discharged clients whose episode lasted 2 months or longer, the CAMS-Y total score shall show improvement between intake and the last CAMS collected.
- For 80% of discharged clients whose episode lasted 3 weeks or longer, the CFARS score shall be at least one level improved at discharge than at admission in at least one of the four index areas.
- For 80% of those clients, the discharge summary shall reflect no increased impairment resulting from substance use, as measured by the CFARS domain rating for substance use.
- For 80% of discharged clients, the Eyberg scores shall be below the clinical cut point on either the ECBI intensity score (132 or below) or the ECBI problem score (15 or below).

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 in the two most favorable categories (e.g., 25% Agree plus 55% Strongly Agree) for at least 75% of the individual survey items.
- Effective 1-1-13 Clinics with Drug and Alcohol Counselors shall administer four item satisfaction questionnaires at discharge from AD program component to youth enrolled in the FSP Alcohol and Drug Sub Unit. Data shall be entered into the DES (when DES is updated to record information). Clients enrolled in AD FSP Sub Unit shall demonstrate a minimum of 80% satisfaction with the AD Program Component.

1. Symptoms/Functioning:

Child and Adolescent Measurement System (CAMS)

a) Youth aged 11 and over shall be administered the CAMS modules at intake into the program, UM/UR cycle (session based for outpatient clients and 3 or 6 month UR/Authorization cycle for Day Programs), and at discharge from program.
b) Most current CAMS scores should be considered during UM/UR Authorization supporting medical necessity and clinical effectiveness.
c) Parents/Caregivers of all youth (except those completing the ECBI effective 7-1-10) shall be administered the parent modules of the CAMS on the same cycle. When no guardian is available, staff may be in the role of caregiver (often in a residential program) and complete measure, notating it was completed by clinician/staff.
d) All responses shall be recorded by program staff in the DES, an Access database supplied by CASRC, 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) Data recorded in the database shall be supplied to CASRC via direct drop off or traceable mailing to ensure HIPAA regulations are followed.
f) Effective June 1, 2010, CAMS data is no longer entered into Anasazi.
g) Medication only cases are excluded from the CAMS measure.
h) Programs exempt from completing the CAMS (such as TBS or DEC) shall maintain written exception documentation from COR on file.

Children's Functional Assessment Rating Scale (CFARS)

a) All CYFS clients shall be assessed at intake into the program in accordance with the CFARS as part of Behavioral Health Assessment, UM/UR cycle, or the Initial/Annual Client Functioning Form (for TBS & medication only cases). The CFARS shall also be completed annually and at discharge, as part of UM/Authorization forms, the Annual Client Functioning Form (for TBS & medication only cases), Day Program Requests and the Discharge Summary. CFARS scores should be used to support medical necessity and clinical effectiveness.
b) All responses shall be recorded by program staff in the DES, an Access database supplied by CASRC, 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) CFARS data is entered into Anasazi and embedded in the Day Program Requests and Specialty Mental Health DPRs.
e) Medication only cases are excluded from the CFARS measure.

CRAFFT

a) All CYFS 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 Anasazi.
b) Intake CRAFFT responses shall be recorded by program staff in the DES, an Access database supplied by CASRC, or as otherwise directed by the County. Note that although the CRAFFT must be completed at intake and annually, only the intake responses must be entered into the database. 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) Medication only cases are excluded from the CRAFFT measure.

Eyberg Child Behavior Inventory (ECBI)

a) Effective 7-1-10 caregivers of children aged 0 through 5 served by early childhood identified programs shall be administered the Eyberg at intake into the program, UM/UR cycle, and at discharge from Contractor's program.
b) The most current Eyberg score shall be considered during UM/Authorization supporting medical necessity and clinical effectiveness.
c) All responses shall be recorded by program staff in the DES, an Access database supplied by CASRC, or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
d) Data recorded in the database shall be supplied to CASRC via direct drop off or traceable mailing to ensure HIPAA regulations are followed.
e) Caregivers of children administered the Eyberg shall not be administered the CAMS, but these children require the CFARS, CRAFFT and YSS.
f) Medication only cases are excluded from the Eyberg 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 from the AD subunit.
b) All responses shall be recorded by program staff in the DES, an Access database supplied by CASRC when it becomes available.
c) Data shall be utilized to evaluate individual treatment and program effectiveness.
d) Data recorded in the database shall be supplied to CASRC via direct drop off or traceable mailing to ensure HIPAA regulations are followed.

2. **Client Satisfaction**: Currently administered twice annually to all clients and families who receive services during a selected two-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 May and August of each year. The survey returns

are scanned in to facilitate tabulation, therefore original printed forms provided by the MHP must be used.

Youth Services Survey (YSS)

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) Surveys shall be delivered by hand or through traceable mail adhering to HIPAA regulations to CASRC within 7 days after the completion of each survey interval.
e) Medication only cases are excluded from the YSS measure.

Family Centered Behavior Scale (FCBS) - optional

a) Parent / Guardians of clients may be administered the Family Centered Behavior Scale (FCBS) at each UR / Authorization cycle, and additionally at discharge, along with the other assessment tools.
b) For participating programs, when no measure is obtained (caregiver refuses / not available), enter that information into DES.

Alcohol and Drug Counselor Satisfaction Survey

a) Only for youth enrolled in Clinic Alcohol and Drug Counselor 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) Measure information shall be entered into the DES when Database is updated to receive information.

Meds Only Clients

Outcome measures identify the effects of mental health treatment. Clients transitioning from “Meds Plus” to “Meds Only” will need to be recorded as separate treatment episodes in the DES database.

- Administer and record CAMS/ECBI and CFARS as a discharge assessment upon transition to meds only and close client to DES- this is the discharge measure.
- Administer and record CAMS/ECBI and CFARS as an intake assessment if client is returning to treatment services (Meds Plus) from meds only as a new DES episode.

If program has a medication only client who is still open in the DES- do not go back and close clients in the DES but rather insure that the procedure outlined above is followed moving forward for medication only clients.

Outcome Measures Manual
For more information about outcomes measures, the Outcome Measures Manual is available on the Optum website **https://www.optumhealthsandiego.com** Go to "organizational providers" "county staff & providers" then the "manuals" tab.

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 the Family and Youth Roundtable (http://www.fyrt.org/)

The Quality Improvement Unit

The Quality Improvement 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
- Anasazi User Trainings
- QM Specialized Trainings
- Regular QM Communications
- Organizational Provider Operations Handbook

- Regular Provider Meetings
- TKC—The Knowledge Center
- BHETA

For information on upcoming trainings or in-services, or if you require technical assistance, please contact the:
www.QIMatters.hhsa@sdcounty.ca.gov

Electronic Health Record Trainings

Various trainings are available for the electronic health record, Anasazi.

All clerical staffs are required to attend Anasazi Admin Data Entry training in order to have access to the system for entering data and pulling reports.

Any staffs entering billing for services are required to attend Anasazi Service Entry Training.

Specialized staffs are required to attend Anasazi 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 Anasazi 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 Anasazi, 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 Anasazi system.

Information about Anasazi trainings may be found on the OptumHealth Public Sector website.

P. MENTAL HEALTH SERVICES ACT - MHSA

After California voters passed Proposition 63 in November 2004 the Mental Health Services Act (MHSA) became effective January 1, 2005. The purpose of the act was to expand mental health services to create a comprehensive, innovative and culturally and linguistically competent community based mental health system for persons of all ages with serious and persistent mental health problems, including prevention and early intervention services and medical and supportive care. The Mental Health Plan has completed its initial extensive community program planning process and has approved plans for all 5 components of the MHSA: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovations, Capital Facilities and Technological Needs (CFTN), and Workforce Education and Training (WET). These components have been implemented, or are in some phase of implementation, according to current plans.

MHSA System Transformation

Under the MHSA, community based services and treatment options in San Diego County are to be 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 MHSA 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.

MENTAL HEALTH SERVICES ACT - MHSA

These providers are required to participate in a State data collection program 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.

For current information on MHSA visit:
www.sandiego.networkofcare.org/mh/countycontent/san-diego/MHSAI.cfm

For current State level and general MHSA information visit:
www.dmh.ca.gov/Prop_63/MHSA/default.asp

Payment Schedule
Budget Guidelines for Cost Reimbursement Contract Only
(Contractor Instructions)

Q. Payment Schedule Budget Guidelines for Cost Reimbursement

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 budgets for each fiscal year serve as objectives and guidelines for contract performance and allowable expenditures. The budget guidelines allow for flexibility within specified 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.
The clauses expanded upon below are only those that have been subject to inquiry or that have been recently modified or updated.

Budget Guidelines

Contractor must obtain written approval from the County prior to exceeding any fiscal year's budgeted amounts. Unexpended budgeted amounts may not be applied to subsequent fiscal years expenditures unless authorized by an Agreement Amendment. An Agreement Amendment is required prior to exceeding any fiscal year's budgeted maximum Agreement amount.
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 approval. Any expenditures requiring written approval must be requested in advance via an Administrative Adjustment or Contract Amendment. Approval is not effective, and contractor should not incur any requested expense, until notified that the Administrative Adjustment or Contract Amendment has been executed.

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, as evidenced by Schedule I – Agreement Budget, that is attached hereto and by reference made a term and condition hereof. 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 (as defined in Clause) without the prior written approval of the Local Mental Health Director or his/her designated representative.
In addition to the stated limitations on the total Salaries and Benefits amount, additional guidelines for changes that require prior written approval are listed below.

- Unexpended Salaries and Benefits, up to 10% of total budgeted amounts, may be applied to Operating Expenses.

  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 savings for this category, up to $50,000 (10% of the $500,000 Total 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 savings 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 only be from temporary vacancies of budgeted staff.
  Contractor may not purposefully keep positions vacant for the purpose of accruing savings to be applied to Operating Expense. When staffing levels are reduced due to reduced workloads, then it would be expected that operating expenses would be similarly under-expended. The intent is to fill all budgeted positions. Savings due to other reasonable variables can be applied to Operating Expense.
  - Unexpended Salaries and Benefits may be applied directly to any temporary replacement staff and do not require prior 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 total of Salaries does not exceed the budgeted amount plus 10% for this category.
  - All staffing changes, including addition or deletion of budgeted staff, and unbudgeted salary increases require prior approval from the County.
    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 fluctuate within the range as budgeted, as long as the overall 10% rule is heeded.

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, as evidenced by Schedule I – Agreement Budget, that is attached hereto and by reference made a term and condition hereof. 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 (as defined in

Clause 0) without the prior written approval of the Local Mental Health Director or his/her designated representative.

- Unexpended Operating Expenses, up to 10% of total budgeted amounts, may be applied to Salaries and Benefits.
  Example: If the total Operating Expenses for a program budget equals $300,000, any unexpended amount for the year, 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 approval or change to the budget.
  - 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 as defined in Clause 0), except for Leasehold Improvements, Consultants, Interest Expense, and Depreciation.
    Example: If $1,000 is budgeted for Office Supplies and the expenses to date equals $1,500, no prior approval or change to the budget is needed unless the total Operating Expenses amount is exceeded beyond allowable limits; however, all expenses must be reasonable and appropriate for the contracted services and are subject to subsequent review and approval.
  - Consulting expenses are budgeted on Schedule II of the Agreement Budget and may not be exceeded without prior approval, with the exception of temporary staffing as per Clause . All other consulting services not previously budgeted require prior written County approval.
  - Budgeted amounts for Leasehold Improvements, Interest Expense, and Depreciation may not be exceeded without prior written County approval.
  - No expense will be allowed for any line item that does not have an amount currently budgeted.
    Any expense within a line item that has no currently budgeted amount requires prior approval. It is assumed that the approved budget includes most expected expenditures, and unbudgeted items were deliberately omitted; therefore, prior approval is required if an unbudgeted expense is subsequently considered necessary.

Fixed Assets.
All fixed asset expenses must be budgeted and itemized on Schedule II, and no line item budget may be exceeded without prior written County approval. Purchase of fixed assets not currently budgeted and itemized requires prior written County 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 Schedule ll and any assets not currently budgeted require written notification to the COTR.

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, as evidenced by Schedule III – Indirect Cost Statement, attached hereto and by reference made a term and condition hereof. 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 Local Mental Health Director or his/her designated representative. 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.
If the total budget is under-expended, it is expected that Indirect Costs would decrease proportionately.

- Budgeted Units of Service may not be changed without prior written County approval.

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. Delivery of service below budgeted levels may be a performance issue and subject to notice of required corrective action.

R. QUICK REFERENCE

PHONE DIRECTORY

ACCESS AND CRISIS LINE	**1-888-724-7240**
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
Director, Quality Improvement	(619) 563-2754
Children, Youth and Family Services	(619) 563-2750
Chief, Children, Youth and Families Services (Frances Edwards)	(619) 584-3015
Chief, Children, Youth and Families Services (Lauretta Monise)	(619) 563-2787
Chief, Children, Youth and Families Services (Wendy Maramba)	(619) 548-5076
Chief, Children, Youth and Families Services (Yael Koenig)	(619) 563-2773
Chief, Adult Mental Health Services (Virginia West)	(619) 563-2744
Chief, Adult Mental Health Services (Ana Palid)	(619) 584-5009
Chief, Adult Mental Health Services (Debbie Malcarne)	(619) 564-2764
Program Manager, Quality Management Unit	(619) 563-2747
Serious Incident FAX	(619) 236-1953
Adult Service Intake/Triage Log FAX	(619) 563-2799
QIMatters.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) (Medical Record Requests)	(619) 692-5700 Option #3
OPTUM HEALTH (ADMINISTRATIVE SERVICES ORGANIZATION) Provider Line 1-800-798-2254	
Optum Administrative Services for MHP	(619) 641-6800
Admin Fax	(619) 641-6801
Director, Regulatory and Provider Services	1-877-309-4862
Regulatory & Provider Services FAX	1-877-309-4862
Anasazi Assistance - Optum Help Desk	(800) 834-3792
Clinical-Access and Crisis Line	(619) 641-6802
TDD/TTY 1-888-881-4816	(619)641-6992LIHP FAX

QUICK REFERENCE

CLIENT ADVOCACY ORGANIZATIONS

Consumer Center for Health Education and Advocacy	1-877-734-3258
JFS Patient Advocacy Program	1-800-479-2233

AMERICAN SIGN LANGUAGE (ASL) INTERPRETER SERVICES

Deaf Community Services	1-800-290-6098
Interpreters Unlimited	1-858-451-7490

WORLD WIDE WEB RESOURCES

County of San Diego	www.sdcounty.ca.gov
Optum Health	www.optumhealthsandiego.com
California Board of Behavioral Sciences	www.bbs.ca.gov
California Board of Psychology	www.psychboard.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
California Mental Health Directors Association	www.cmhda.org
California Welfare & Institutions Code	www.leginfo.ca.gov/calaw.html
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 Care Website	www.intentionalcare.org
International Association of Psychosocial Rehabilitation Services (IAPSRS)	www.iapsrs.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