COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

CHILDREN, YOUTH AND FAMILIES (CYF) BEHAVIORAL HEALTH SYSTEM OF CARE COUNCIL

MEETING AGENDA

July 10, 2017 – 9:00-10:30 A.M.

Health Services Complex-Coronado Room-3851 Rosecrans Street, San Diego, CA 92110

I. **Welcome and Introductions** (Delrena Swaggerty) **5 minutes**

II. **Approval of Minutes** (Renee Cookson) **3 minutes**
- June 12, 2017 minutes
- Review action items from June 12, 2017 meeting-See meeting minutes

III. **Business Items** (Delrena Swaggerty) **15 minutes**
- Advancing the Children's System of Care Principles Awards
- FY 17-18 Strategic Planning Meeting Monday-Rescheduled to September 11, 2017 from **9:00 to 11:00 A.M.** Meeting location pending
- CYF Council meeting **Dark** in August 2017
- CYF Council Orientation: August 14, 2017 from **9:00 to 10:30 A.M.** at the Coronado Room of Health Services Complex-3851 Rosecrans Street, San Diego, CA 92110
- Hepatitis A Status update and information

IV. **Mental Health Services Act (MHSA)- Update** (Martin Dare) **10 minutes**
- MHSA Three Year Plan Update
- MHSA Innovation Plan Update
- BHS Annual Forums

V. **Sectors "Hot Topics"** **35 minutes**
Public Input/Discussion (Renee Cookson and Delrena Swaggerty)
- CYF families facing immigration challenges "Part 3"
- Dialogue between sectors

VI. **Sub-Committee Update Reports-Handouts** **10 minutes**
- Family/Youth Liaison-Handout
- Quality Improvement-Quality Management-Handouts
- May 2017 Child Welfare Services/Probation Homes Summaries- Handouts

VII. **Announcements** **2 minutes**
- MHSA Three Year Plan Ad Hoc Sub-Committee meetings (Open to all) Meeting dates and times will be announced once the plan is released
- Family Support Partners and Peer Support Specialists (Family/Youth Support Partners) Survey
- 8th Annual Early Childhood Mental Health Conference - We Can't Wait! September 14-16, 2017 at the Crowne Plaza Hotel in Mission Valley, San Diego Registration available at: https://www.regonline.com/registration/Checkin.aspx?EventID=1995522

VIII. **Director's Report** (Alfredo Aguirre) **10 minutes**

Next Executive Committee Conference Call:
Date: TBD
Time: TBD

Next Meeting: Strategic Planning
Date: Monday, September 11, 2017
Time: 9:00-11:00 A.M.
Location: TBD

Sub-Committees/Sectors/Workgroups Meetings Information:

CCRT: Meets the 1st Friday of the month-3851 Rosecrans St.-Coronado Room, San Diego, CA 92110 from 10:00 to 11:30 A.M.
CSOC Academy: Meets the 1st Wednesday of the month-6505 Alvarado Road, Suite 107, San Diego, CA 92120 from 9:00 to 10:00 A.M.
CYF CADRE: Meets quarterly-2nd Thursday of the month-Del Mar Room from 1:30 to 3:00 P.M.
Early Childhood: Meets the 2nd Monday of the month- 3160 Camino Del Rio South Suite 101, San Diego, CA 92108-at 11:00 A.M.
Education Advisory Ad Hoc: Meets as needed.
Family and Youth As Partners: Meets the 3rd Thursday of the month- Del Mar Room from 2:00 to 3:30 P.M.
Family/Youth Sector: Meets quarterly on 4th Thursday of the month at 8964 N Magnolia St, Santee, CA 92071 from 6:30 to 8:00 P.M.
Outcomes: Meets the 1st Tuesday of the month-La Vista Room from 11:30 A.M. to 1:00 P.M.
Private Sector: Meets the 3rd Wednesday of the month- 7535 Metropolitan Dr, San Diego, CA 92108 at 1:00 P.M.
TAY Workgroup: Meets the 4th Wednesday of the month-6160 Mission Gorge Rd. Suite. 100. San Diego, CA 92120 from 3:00 to 4:30 P.M.

CHILDREN'S SYSTEM OF CARE PRINCIPLES

CSOC Council Vision: *San Diego youth are healthy, safe, successful in school, and in their transition to adulthood, while being law abiding, while living in a home and community that supports strong family connections.*

Mission: *The purpose of the System of Care Council is to ensure that all agencies serving San Diego county youth from age 0 through age 21 have coordinated services resulting in improved youth and family, and system outcomes consistent with System of Care Values and Principles.*

1. **Collaboration of four sectors:** The cornerstone of the CSOC is a strong four sectors partnership between youth/families, public agencies, private organizations and education that ensure accountability to achieve System of Care (SOC) goals and quality outcomes consistent with SOC philosophy.

2. **Integrated:** Among the four sector partners services are comprehensive, accessible coordinate behavioral and physical health care, provide seamless transition of care and utilize natural community supports,

3. **Youth guided, family driven:** Youth and families actively participate in service delivery, planning, and program and policy development.

4. **Individualized:** Services are flexible and designed to meet and build upon the unique needs, strengths and potential of each youth, and family.

5. **Strength-based:** Individualized plans and services identify and utilize youth/family strengths to facilitate health and wellness.

6. **Community-based:** Sector partners offer an array of services in each region and strengthen family and youth connections to neighborhood and local community resources.

7. **Outcome driven:** Service delivery systems continuously improve services by measuring and evaluating outcomes and use results to modify practices.

8. **Culturally Competent:** Service providers honor the diversity of cultures; address the complexities within and between cultures, and provide accessible and relevant services.

9. **Trauma Informed:** Sector partners recognize that trauma and chronic stress influence coping strategies and behavior, respond with compassion, and commit to the prevention of re-traumatization and the promotion of self-care and resilience.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

CHILDREN, YOUTH AND FAMILIES (CYF) BEHAVIORAL HEALTH SYSTEM OF CARE COUNCIL

MEETING MINUTES

June 12, 2017 – 9:00-10:30 A.M.

Scottish Rite Masonic Center- 1895 Camino Del Rio South- Shell Room

+=Member in Attendance O=Absent E=Excused

		MEMBER	STATUS	ALTERNATE	STATUS
PUBLIC SECTOR					
1	Behavioral Health Advisory Board (BHAB)	Rebecca Hernandez	O	*VACANT*	
2	Behavioral Health Services (BHS)	Dr. Laura Vleugels	+	Dr. Jeffrey Rowe	+
3	Public Safety Group/ Probation	Ken Mosey	+	Margie Deleon	O
4	Child Welfare Services (CWS)	Cathi Palatella	O	Barry Fox	+
5	HHSA Regions	Dori Gilbert	+	Jennifer Sovay	O
6	Public Health	Dr. Dean Sidelinger	O	Rhonda Freeman	O
7	Juvenile Court	H. Judge Carolyn Caietti	O	Michelle Johnson	O
8	First 5 Commission	Kim Gallo	O	Jennifer Wheeler	O
EDUCATION SECTOR					
9	Special Education Local Plan Area (SELPA)	Angela McNeece	+	Carolyn Nunes	O
10	Regular Education Pupil Personnel Services	Mara Madrigal-Weiss	O	Heather Nemour	+
11	School Board	Barbara Ryan	O	Carol Skiljan	O
12	Special Education	Aidee Angulo	O	Yuka Sakamoto	+
PRIVATE SECTOR					
13	San Diego Regional Center (SDRC) for Developmentally Disabled	Carlos Flores	O	Therese Davis on behalf of Peggy Webb	+
14	Alcohol and Drug Service Provider Association (ADSPA)	Angela Rowe	+	Marisa Varond	+
15	Mental Health Contractors Association	Steve Jella	O	Barent Mynderse	+
16	Mental Health Contractors Association	Angela Chen	+	Delrena Swaggerty	O
17	San Diego Nonprofit Association (SDNA)	Margaret Iwanaga Penrose	O	Rosa Ana Lozada	+
18	Fee- For-Service Network	Dr. Sherry Casper	O	*VACANT*	
19	Managed Care Health Plan	George Scolari	+	Rogelio Lopez	O
20	Healthcare/ Pediatrician	Dr. Pradeep Gidwani	+		
FAMILY AND YOUTH SECTOR					
21	Family and Youth Liaison	Renee Cookson	+	Suzette Southfox	O

22	Caregiver of child/youth served by the Public Health System	Debbie Stolz	+	Pam Toohey	O
23	Youth served by the Public Health System (up to age 26)	Emma Rodriguez	+	*VACANT*	
24	Youth served by the public health system (up to age 26)	Travis Webster	+	*VACANT*	
SUB-COMMITTEES (Non-voting members unless a member of the Council)					
-	Outcomes Committee	Angela Chen Chair	+		
-	Executive Committee	Delrena Swaggerty Chair	O		
-	Early Childhood Committee	Stacey Annand Chair	+		
-	Education Committee	Mara Madrigal-Weiss Chair	O		
-	CYF CADRE	Julie McPherson/Marisa Varond	O/+		
-	Family and Youth as Partners	Renee Cookson	+		

CYF Council Staff: Yael Koenig, Edith Mohler, Darwin Espejo

I. **Welcome and Introductions** (Renee Cookson)

II. **Approval of Minutes** (Angela Chen)
- May 8, 2017 Council meeting minutes approved.
- Review of Action items from May 8, 2017 (Yael Koenig). See May 8, 2017 meeting minutes for details.

III. **Business Items** (Yael Koenig)
- MHSA Three Year Plan Ad Hoc Sub-Committee-Signing Sheet-Tentative 30 day review: June 30 through July 31, 2017. John Laidlaw is the sub-committee chair.
- Fiscal Year 17-18 CYF Council Strategic Planning meeting is scheduled for July 10, 2017.
- CYF Council meeting Dark in August 2017.
- CYF Council Orientation: August 14, 2017 from 9:00 to 10:30 A.M. at the Coronado room of the Health Services Complex-3851 Rosecrans Street, San Diego, CA 92110. Meeting orientation is open to everyone.

IV. **Director's Report (Yael Koenig for Alfredo Aguirre)**
- BHS submitted the Drug Medi-Cal Organized Delivery System Implementation Plan to the Department of Health Care Services (DHCS) at the end of May 2017 to join the State's Drug Medi-Cal Waiver program. This is the first of a two-step process now being reviewed by the State for consideration. The second part of the process will involve reviewing our fiscal rates/plans that would convert existing Substance Use Disorders (SUD) programs into an organized delivery system.

V. **Mental Health Services Act (MHSA) – Update** (Martin Dare)
- MHSA Three Year Plan Program and Expenditure Plan for Fiscal Year 2017-18 through Fiscal Year 2019-20
  - ✓ The plan is tentatively scheduled to be released for a 30-day public review from June 30 through August 1, 2017.
  - ✓ Tentatively scheduled to be presented to the BHAB on August 3, 2017 for a public hearing scheduled for September 7, 2017.
  - ✓ Tentatively scheduled to be presented to the Board of Supervisors on September 20, 2017.

- MHSA Innovation Plan Updates
  On May 25, 2017, three Innovation plans were approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC). Implementation is expected in Fiscal Year 2019-20:
  - ✓ Medication Clinic (Dr. Jeffrey Rowe and Yael Koenig)
  - ✓ Roaming Outpatient Access Mobile (ROAM)
  - ✓ The Recuperative Services Treatment (ReST)

  There are seven more Innovation projects (new or to be extended) that are pending approval.
- BHS Forums
  BHS will host two public forums, tentatively, between July and August, 2017, one in North County and the other one in Central San Diego. Several focus groups and an online "Tele- Town Hall" will be also take place in order to obtain feedback. Harbridge Consulting will assist with these activities.

VI. "Hot Topic" CYF families facing immigration challenges "Part 2"

- Refugee Resettlement Agencies presentations
  - ✓ Etleva Bejko (Jewish Family Service)
    - Immigrants and refugees are legally different from each other. However both populations are exposed to trauma. There have been approximately 80,000 refugees admitted into the United States since the 1970's.
    - San Diego has four Refugee Resettlement agencies; Jewish Family Service (JFS), International Rescue Committee (IRC), Alliance for African Assistance and Catholic Charities of San Diego. All Refugee Resettlement agencies are federally funded and are tasked to connect refugees/immigrants to community services such as welfare benefits, housing, education and employment.
    - JFS, in partnership with HHSA offers a healthcare management program to refugees that have severe medical issues.
    - The backgrounds and medical clearance process for incoming refugees is lengthy.
    - Refugees share similar fears and uncertainty as the undocumented immigrant population.
  - ✓ Nadine Toppozada and Brad Mills (Catholic Charities of San Diego)
    - Catholic Charities is contracted by the State to perform mandated health screenings on all incoming refugees in San Diego County. They also have a dedicated mental health portion in their health screening questionnaire. The majority of refugees screened decline follow up referrals to treat mental health issues.
    - Catholic Charities is the only resettlement agency that has a Cuban and Haitian refugee entry program. In 2016, more than 4000 Haitian refugees were admitted into the United States as asylees. Many of them suffered rape, sexual exploitation and other traumatic experiences during their journey to the United States. Nevertheless, only few of them would follow up to referrals for mental health treatment.
    - Catholic Charities recently incorporated an Associate Clinical Social Worker into their health screening process for those willing to discuss their mental health issues. Their acculturation programs conduct separate sessions that specifically cover the topic of mental health.
    - Catholic Charities also conducts one-on-one sessions with indivduals at their office and initiate mental health discussions during acculturation presentations in schools.
  - ✓ Chris Williams (IRC)
    - IRC offers an extensive 30 hours/week vocational English as a second language program (ESL) to refugees. The program fulfills Welfare to Work requirements and is geared more towards employment and gaining computer and financial literacy.
    - IRC coordinates the City Heights Farmers' Market and the downtown El Cajon Farmers' market and organize community gardens located within the same communities. IRC also conducts an intensive wellness program that explores various issues refugees face, while indirectly discussing mental health and offering peer support.
    - All resettlement agencies are mandated to provide immigrants and refugees supportive services for 90 days. However, services could be extended to three to five years, depending on specific situations.

- Discussion Summary
  - ✓ Dialogue between peer refugees with lived experience within a group setting may contribute to facilitate referrals for mental health treatment.

- ✓ Several local agencies have limited knowledge about services and resources for the refugee population, including County funded services.
- ✓ Dr. Gidwani mentioned the success of the First Steps home visit program utilizing representatives from the same culture as a model. He also suggested outreach to an individual's own faith-based community to facilitate treatment.
- ✓ Heather Nemour recommended the peer support model and incorporating the topic of mental health into ESL classes as a catalyst to seek treatment.
- ✓ Michelle Ly recommended the use of child-based mental health assessment tool when screening at resettlement agencies.
- ✓ CWS is working on providing a more supportive role in communities. For example, they provide outreach support services using Arabic-speaking social workers in the East county They also exploring other opportunities to support this population.
- ✓ Rosa Ana Lozada proposed to take this opportunity to find ways to provide cultural competent mental health treatment to the refugee population in a coordinated manner.
- ✓ Currently, due to insufficient resources, a pre-existing mental health diagnosis like schizophrenia will prevent resettlement.
- ✓ JFS has connected with the San Diego Unified School District, Family and Community Engagement Department (FACE) to promote psycho-education within the refugee/immigrant communities they serve.
- ✓ Yael Koenig proposed to continue with this topic and have discussions on how the System of Care supports immigrant, refugee and undocumented Children. George Scolari suggested to begin the dialogue with refugees first and then to undocumented population. Yael urged all sector representatives to think about the topic within their own perspective and also re-invited all subject matter experts to the next Council meeting.

VII. Action Items

Action Items	Action By	Action Due
Ensuring that System of Care Principles and Wraparound Principles are infused.	• Delrena Swaggerty/or designee	Update to be provided to the Council on July 10, 2017.
Warm Handoff Training Update.	• Shannon Jackson • SDRC • ADSPA	Completed. PowerPoint included in meeting packet. Electronic version will be sent to the Council after the July 10, 2017 meeting.
Ad Hoc subcommittee letter for the BHS Director with recommendations regarding Proposition 64-Marijuana Legalization.	• Steven Jellá	Input was due by May 15, 2017 to Mr. Jellá. Ad Hoc subcommittee to update Council on July10, 2017.
Ad Hoc subcommittee to review the MHSA Three Year Program and Expenditure Plan for Fiscal Year 2017-18 through Fiscal Year 2019-20.	• All	Mid/End of July 2017.
Provide resettlement agencies with the CYF Provider's manual and Health Plan contact cards. Copy George Scolari.	• Yael Koenig	Completed by Edith Mohler. E-mail sent 6/13/17.
Continue the immigrant/refugee conversation among sectors on the system of care impact and opportunities to exchange effective learning from each other. Focus will be on refugee population first and then undocumented population.	• All	July 10, 2017 at the Council meeting.

Sub-Committees/Sectors/Workgroups Meetings Information:

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Early Childhood: Meets the 2nd Monday of the month- 3160 Camino Del Rio South, San Diego, CA 92108- Suite 101 at 11:00 A.M.
Education Advisory Ad Hoc: Meets as needed.
TAY Workgroup: Meets the 4th Wednesday of the month-6160 Mission Gorge Rd. San Diego, CA 92120 from 3:00 to 4:30 P.M.
CYF CADRE: Meets quarterly-2nd Thursday of the month-Del Mar Room from 1:30 to 3:00 P.M.
CCRT: Meets the 1st Friday of the month-La Jolla Room from 10:00 to 11:30 A.M.
Family and Youth Sector: Meets the 4th Thursday of the month at 8964 N Magnolia Street, Santee, CA 92071 from 6:30 to 8:00 P.M.
Family and Youth as Partners: Meets the 3rd Thursday of the month- Del Mar Room from 2:00 to 3:30 P.M.
Private Sector: Meets the 3rd Wednesday of the month- 7535 Metropolitan Dr, San Diego, CA 92108 at 1:00 P.M.

The Warm Handoff

"Helping to the door and walking through together"

LIVE WELL SAN DIEGO

The warm handoff process...

- At the request of the Children, Youth, and Family System of Care Council (CYFSOC), the Private Sector Work Group analyzed how service participants transfer and/or overlap between providers, with the goals of providing an integrated and coordinated experience (specific with Medical Care as a provider).
- Four sectors, including Health Plans, collaborated in developing a model that could be broadly implemented.
- The **"Warm Handoff"** is a model identified by the group as a potential point of focus and improvement to increase the effectiveness, efficiency, and continuity of service participants' transfer and/or overlap between providers in the System of Care.
- The ideal model is in-line with the CYFSOC principles, the Trauma Informed Care philosophy, and the Pathways to Well-Being service model.

What is a warm handoff?

A warm handoff is the carefully coordinated transfer or linkage of a client to another provider, entity, agency, or organization who will continue, add, or enhance services.

Who do we "warm handoff" to?

- Primary Care Provider
- Community Clinic for on-going Medication Management post discharge
- Other treatment providers within our BHS System of Care when stepping up/down or linking to services (Ex – Crisis Action Connection, client transitioning from Residential treatment to Outpatient)
- Other Community Based Providers (Ex- San Diego Regional Center)

Purpose:

A successful warm handoff from another agency is a collaborative process between all parties.

This is beneficial for clients because it allows the entire team to come together, discuss specific tasks, and figure out who will be responsible for completing the tasks moving forward.

Warm handoffs are needed when:

- There will be a delay between the end of services and the beginning of the new provider's services
- The client or family needs continuous services
- Anytime a referral is provided to another entity outside or in the servicing agency, regardless if it is a step up or step down in service intensity

Warm handoffs are not appropriate when:

- The client explicitly requests not to have that level of involvement
- If the client was not opened and had minimal contact (less than a triage contact) with the servicing entity
- If the client is uninvolved and unavailable in attempts to be contacted
- When a client is served by the BHS system with high level needs; BHS completes the treatment episode. BHS treatment clients generally do not transition to the Health Plans for treatment.

The warm handoff includes:

1. Clear communication
2. A joint session/meeting with the past and current provider
3. A final session/meeting with the past provider
4. Information being shared between the past provider and the current provider about what works well or doesn't work well when working with the client

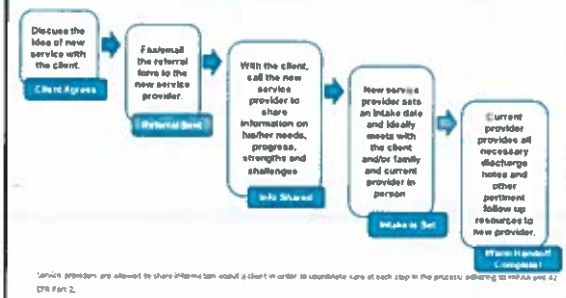
When joint sessions are not available:

1. Clear communication is still vital
2. Phone conference with the past and current provider
3. Information being shared between the past provider and the current provider about what works well or doesn't work well when working with the client
4. Supporting the client to ensure that the need for transition of services is clearly understood

The warm handoff will:

- Occur prior to the case closing at the current program (case closure dependent on program protocol)
- Sometimes occur with concurrent services
- Be conducted by the provider who has worked with the client
- Ensure client is clear on reason for transfer of care
- Include the family, client or youth in the process whenever possible
- Include a direct conversation between providers to ensure passing of critical information in a timely manner
- Include all pertinent documents (including signed release of information when necessary & other relevant clinical information) to ensure transfer in a timely manner

Warm Handoff Process



Service providers are allowed to share information about a client in order to coordinate care at each step in the process, adhering to HIPAA and 42 CFR Part 2.

Are Warm Handoff Services Claimable? (MH only)

- Services to client may be claimable for reimbursement
- Documentation of Medical Necessity is required
- Choose the correct Service Code – may be an individual or family session, collateral service, or a case management service depending on the service you delivered
- Document to Medi-Cal Title IX documentation standards
- Documentation is key to demonstrate no duplication of service
- Questions? Contact QIMatters.hhsa@sdcounty.ca.gov

In short...

Lessons learned to facilitate a warm handoff for Mental Health programs include:

- Clinicians may provide Case Management, Medication, Collateral, Rehab and ICC services as needed after the client's last (13th or 18th) session.
- The Client Plan is good for one year and needs to be reviewed before providing additional *therapy* (UM for individual/family sessions), but may be used for other specialty mental health services with a valid client plan.
- If necessary, psychiatrist can provide oversight until clinicians provide the warm handoff and the new provider opens.

In short...

Lessons learned to facilitate a warm handoff for SUD programs include:

- Warm handoffs also include coordination with collateral providers that provide the client with services the SUD program does not offer
  - Ex. Coordination with clinic providing medication management
  - Collaboration with case management or Housing support programs
- Assessing clients level of need, based on assessments such as ASAM criteria

Coordination with Primary Care

- Coordination of care between behavioral health care providers and health care providers is necessary to optimize the overall health of a client.
- Behavioral Health Services (BHS) values and expects coordination of care with health care providers. linkage of clients to medical homes, acquisition of primary care provider (PCP) information and the entry of all information into the client's behavioral health record.
- BHS providers shall strengthen integration efforts by improving care coordination with primary care providers. Requesting client/guardian authorization to exchange information with primary care providers is mandatory, and upon authorization, communicating with primary care providers is required.

County providers shall utilize the *Coordination and/or Referral of Physical & Behavioral Health Form & Update Form*, while contracted providers may obtain legal counsel to determine the format to exchange the required information.

Coordination and/or Referral of Physical & Behavioral Health Form

HHSA

Coordination and/or Referral of Physical & Behavioral Health Form

☐ Referral for physical healthcare – (Program Name) will continue to provide specialty behavioral health services
☐ Mental Health ☐ Alcohol and Drug

☐ Referral for physical healthcare & Medication Management – (Program Name) will continue to provide limited specialty behavioral health services
☐ Mental Health ☐ Alcohol and Drug

☐ Referral for SUD healthcare – Program Name (is no longer providing specialty behavioral health services Available for psychiatric consult

☐ Coordination of care notification only

IN ADDITION TO THE FORM
INCLUDE OTHER RELEVENT CLINICAL INFORMATION TO ACHIEVE A SUCCESSFUL WARM HANDOFF

Some Examples

- CRF's Crossroads: They came up with a warm handoff sheet (see next slide) that they fax
  - Along with this, they fax ROI, BHA, psych assessment and last progress note (med management)
- Rady Children's Hospital: They are part of the Blue Shield Transition grant.
  - Their case manager contacts, and one of the case managers goes to one of their appointments (therapy or meds) at least 1 month before they close the case
  - Rady's faxes ROI, discharge sheet, BHA, psych assessment and last progress note (med management)
- The youth/family can request a tour of La Maestra BEFORE deciding to receive services there
  - Also, case not closed at Rady's UNTIL AFTER their intake with La Maestra. They can return to previous services at Rady's if they are not satisfied with new services

Providers can make their own form...

Remember...

A warm handoff requires 2 warm hands and communication

The handoff is complete after there is confirmation that the client has engaged and met with the new provider

Next steps...

- Share information and expectation with your team
- Review the current practices at the program
- Update the practices as indicated
- Communicate with your key partners
  - Be mindful of the unique policies and procedures for all involved
- Consider creating a warm handoff tool specific to your program
- Continue to discuss warm handoff practices at staff meetings
  - What is working
  - What is not
- Keep your COR updated on your programs experience so we can improve the system!

Thank you for your participation!

HEPATITIS A VIRUS INFECTION

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Why Should You Care About Hepatitis A?

If a person has an infection with the Hepatitis A virus, it can easily spread from person-to-person and cause liver disease lasting a few weeks to a serious illness lasting many months. In some cases, people can die because of Hepatitis A.

How Does Hepatitis A Spread?

- Touching objects or eating food that someone with Hepatitis A infection handled
- Having sex with someone who has a Hepatitis A infection

What Are the Symptoms of Hepatitis A?

Fever

Fatigue

Nausea

Loss of appetite

Jaundice (yellowing of the skin or eyes)

Stomach pain

Vomiting

Dark urine, pale stools, and diarrhea

If you think you have Hepatitis A because of these symptoms, see your doctor or visit the closest Emergency Room. Always wash your hands with soap and water after going to the bathroom and before preparing food.

How Can You Prevent Hepatitis A?

- Get two shots of the Hepatitis A vaccine
- Don't have sex with someone who has Hepatitis A infection
- Use your own towels, toothbrushes, and eating utensils
- Don't share food, drinks, or smokes with other people

For More Information

- Contact the Nurse's Line at 866-358-2966 option 5
- Dial 2-1-1 on your phone to learn where you can get the Hepatitis A vaccine

Hepatitis A Summary and Frequently Asked Questions

Updated 5/24/2017

Summary of San Diego Hepatitis A Outbreak, 2017

Since early 2017, the Public Health Services Division, in the County of San Diego Health and Human Services Agency, has been investigating a local Hepatitis A outbreak. The outbreak investigation is currently ongoing. Control of the outbreak has been challenging because of the long time that it takes for the disease to develop (15 to 50 days) after a person is exposed to the infection (i.e., incubation period) and the difficulty of contacting many individuals sickened with the illness who are homeless and/or illicit drug users. To date, no common source of food, beverage, or other cause has been identified, as a result, the source of the outbreak remains undetermined.

Vaccination efforts are being implemented in targeted locations by County staff and in collaboration with health care partners. For weekly updates on total cases, deaths, hospitalizations, additional educational resources, and the latest public communications (e.g., press releases and health alerts), please go to the County's Hepatitis A webpage or https://tinyurl.com/n8z6mf3.

What is Hepatitis A?

Hepatitis A is a highly contagious liver infection caused by the Hepatitis A virus (HAV). It can cause liver disease, which may last a few weeks and sometimes progress to a serious illness lasting months. In some cases, people can die, but in most cases the infection is self-limiting

How Is It Spread?

The Hepatitis A virus is spread primarily by the fecal-oral route. This is when an uninfected person ingests food or water that has been contaminated with even a tiny or microscopic amount of the feces from an infected person infected person. This can occur when:

- Touching objects or eating food that someone with HAV infection handled, or
- Having sex with someone who has a HAV infection (not limited to anal-oral contact).

What Are the Symptoms?

HAV does not always cause symptoms. Adults are more likely to have symptoms than children and can develop symptoms 15 to 50 days after being infected.

Symptoms include fever, fatigue, nausea, loss of appetite, yellowing of the eyes (jaundice), stomach pain, vomiting, dark urine, pale stools, and diarrhea. HAV can cause liver failure and even death – this is rare and is more likely to occur in persons 50 or older and individuals with other forms of liver disease (Hepatitis B or C).

HAV can be spread up to two weeks before and one week after noticing symptoms. It can also be spread by individuals who are infected, but do not have symptoms.

How Can HAV Be Prevented?

- **The best way to prevent Hepatitis A is with the safe and effective Hepatitis A vaccine.** Get two shots of the HAV vaccine, six months apart.
    - Also, the vaccine may be given as a twin vaccine against both Hepatitis A and B, which is given as three shots over six months.
- Don't have sex with someone who has HAV infection.
- Use your own towels, toothbrushes, and eating utensils.
- Don't share food, drinks, or smokes with other people.
- Wash hands after using the bathroom, changing diapers, and before preparing food.

Where Can I Get Vaccinated?

- Call your medical provider or 2-1-1 to find a community clinic or public health center near you to request the HAV vaccine.

Is the Hepatitis A Vaccine Safe and Effective?

- Yes, the vaccine is safe and highly effective in preventing Hepatitis A virus infection. You will be protected approximately 2 to 4 weeks after the first injection and longer-term defense is gained with the second injection. If you do not remember whether you were vaccinated, repeating the vaccination series is not harmful.

  According to the Centers for Disease Control and Prevention (CDC), before the Hepatitis A vaccine became available in 1995, more than 25,000 people developed Hepatitis A each year in the U.S. In 2014, there were about 2,500 cases reported.

Who Is At Increased Risk for Getting HAV Infection?

- Travelers to countries with high or medium rates of HAV.
- Men who have sex with men.
- Users of injection and non-injection illegal drugs.
- Persons with clotting factor disorders.
- During this outbreak, individuals with ongoing, close contact with homeless and illicit drug using individuals in San Diego County may also be at increased risk.

I routinely work with homeless and/or illicit drug using individuals and am NOT a health care worker. What precautions should I take?

- Most employees have a low risk of contracting Hepatitis A, if they comply with hand-washing and other hygiene requirements associated with their jobs.
- The best way to protect yourself is to continue to always use standard precautions AND get vaccinated.
- Under usual (non-outbreak) circumstances, occupational exposure does not warrant a routine recommendation to provide HAV vaccination. However, given the current outbreak, the County Public Health Officer recommends HAV vaccination for individuals with ongoing, close contact with homeless and illicit drug using individuals in San Diego County. This includes persons working in public safety,

homeless shelters, and homeless and behavioral service provider agencies (not including health care personnel).

I routinely work with homeless and/or illicit drug using individuals and am a health care worker. What precautions should I take?

- Staff in healthcare environments would be expected to be protected by utilizing standard precautions; however staff should also consider HAV vaccination for long-term protection.
- CDC recommends that everyone 12 months of age and older should be vaccinated for Hepatitis A.
- Please discuss with your primary care provider and/or occupational health if you are unsure.

What can local businesses do to prevent the further spread of Hepatitis A?

- Remind employees of the importance of hand-washing with soap and warm water after using the bathroom, and before preparing, serving, or eating food.
- Maintain routine and consistent cleaning of bathrooms using a chlorine-based disinfectant (bleach) with a ratio of ¾ cup of bleach to one gallon of water. Include bathrooms that are for employees only and those that are open to the public.
- For employees in physical contact with others, especially those at risk for Hepatitis A, wear disposable gloves and wash hands after each encounter.
- Coordinate with your occupational health provider to determine if Hepatitis A vaccine should be offered to employees.

Our Organization Would Like a Presentation About Hepatitis A. Who Should We Contact?

- To request a County staff to come to your organization to give a Hepatitis A presentation, please contact the Epidemiology Program at 619-692-8499.

What If I Need Additional Assistance?

If additional assistance is needed, please contact your healthcare provider, occupational health provider, or call the following:

- California AIDS, STD and Hepatitis Hotline—800-367-AIDS (2437) (24 hours/day, 7 days/week)
- Centers for Disease Control and Prevention (CDC) Information Hotline—800-CDC-INFO (232-4636) (24 hours/day, 7 days/week)

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

County of San Diego Public Health Centers

Immunization Clinic Schedules

The clinic hours below are subject to change.
A limited number of people will be seen each day.

Online appointments available at some locations. Visit: https://onlineappts.hhsa-sdcounty.org/.

SAN DIEGO CITY			
City Heights (619) 229-5400	Central Region Public Health Center 5202 University Ave.,92105	Mon. Thurs	8:30-11:30 a.m. & 1-4 p.m. 8:30-11:30 a.m. & 1-4 p.m.
Southeast City (619) 595-4452	VIP Trailer 3177A Oceanview Blvd., 92113	Mon.-Fri.	8:30-11 a.m. & 1-3 p.m.
NORTHERN SAN DIEGO CITY			
Kearny Mesa (858) 573-7300	North Central Public Health Center 5055 Ruffin Rd., 92123 Located at the North Central Regional Center	Mon.-Fri. 2nd Thurs.	8:30-11 a.m. & 1-4 p.m. 1-4 p.m.
SOUTH COUNTY			
Chula Vista (619) 409-3110	South Region Public Health Center 690 Oxford St., 91911 Behind WalMart	Mon., Tues., Wed. & Fri Thurs.	8 a.m.-4 p.m. 8 a.m.-12 p.m.
EAST COUNTY			
El Cajon (619) 441-6500	East Region Public Health Center 367 N. Magnolia Ave., Ste. 101, 92020	Mon., Tues., Wed. & Fri Thurs.	8:00-11 a.m. & 1-4 p.m. 1-4 p.m
NORTH COUNTY			
Escondido (760) 740-3000	North Inland Public Health Center 649 W. Mission Ave., Suite 2, 92025	Mon. & Fri.	8-11 a.m. & 1-4 p.m.
Fallbrook (760) 967-4401	Fallbrook Public Health Office 202 W. College Ave., 92028	2nd Mon. of the month & (3rd & 4th Tues. of the month by appt. only; call 760-967-4401)	10 a.m.-4 p.m.
Oceanside (760) 967-4401	North Coastal Public Health Center 3609 Ocean Ranch Bl., Ste. 104, 92056	Mon., Tues., Thurs. & Fri. Wed.	8:30 a.m.-4:30 p.m. 8:30-11 a.m.
Ramona (760) 740-3000	Ramona Public Health Office 1521 Main St., 92065	2nd Wed. of the month	1-3 p.m.
Rancho Penasquitos (760) 740-3000	New Hope Church 10330 Carmel Mountain Rd.,92129	3rd Wed. of the month	8:30-11 a.m.
Solana Beach (760) 967-4401	Solana Beach Presbyterian Church 120 Stevens Ave., 92075	2nd Tues. of the month	1-5 p.m.

For information regarding TB skin testing, please call **(619) 692-5565**

For immunization information, please visit our website at www.sdiz.org or call 211.

HHSA IZ9ES(2-21-17)–County of San Diego Health and Human Services Agency–Mail Stop P573–P.O. Box 85222–San Diego, CA 92186-5222 (Español al dorso)

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Agencia de Servicios Humanos y de Salud

Clínicas de Vacunación

Las horas de las clinicas pueden cambiar sin previo aviso.

Un número limitado de personas se verán por día.

Línea disponible para citas en algunos lugares. Visita: https://onlineappts.hhsa-sdcounty.org/.

EN LA CIUDAD DE SAN DIEGO			
City Heights (619) 229-5400	Central Region Public Health Center 5202 University Ave.,92105	lunes jueve	8:30-11:30 a.m. y 1-4 p.m. 8:30-11:30 a.m. y 1-4 p.m.
Del Sur Este (619) 595-4452	VIP "La Trailita" 3177A Oceanview Blvd., 92113	lunes a viernes	8:30-11 a.m. y 1-3 p.m.
DEL NORTE			
Kearny Mesa (858) 573-7300	Centro de Salud Pública–Zona Norte Central 5055 Ruffin Rd., 92123 Ubicado dentro del Centro de la Región Norte Central	lunes a viernes 2do jueves	8:30-11 a.m. y 1-4 p.m. 1-4 p.m.
SOUTH COUNTY			
Chula Vista (619) 409-3110	Centro de Salud Pública–Zona Sur 690 Oxford St., 91911 Atrás de WalMart	lunes, martes, miércoles y viernes jueves	8 a.m.-4 p.m. 8 a.m.-12 p.m.
CONDADO ESTE			
El Cajon (619) 441-6500	Centro de Salud Pública–Zona Este 367 N. Magnolia Ave., Ste. 101, 92020	lunes, martes, miércoles y viernes jueves	8:00-11 a.m. y 1-4 p.m. 1-4 p.m
NORTH COUNTY			
Escondido (760) 740-3000	Centro de Salud Pública–Zona Norte Interior 649 W. Mission Ave., Suite 2, 92025	lunes y viernes	8-11 a.m. y 1-4 p.m.
Fallbrook (760) 967-4401	Oficina de Salud Pública del Fallbrook 202 W. College Ave., 92028	2do lunes de cada mes y (3er y 4to martes de cada mescon cita solamente; llame 760-967-4401)	10 a.m.-4 p.m.
Oceanside (760) 967-4401	Centro de Salud Pública–Zona Costera 3609 Ocean Ranch Blvd., Ste. 104, 92056	lunes, martes, jueves y viernes miércoles	8:30 a.m.-4:30 p.m. 8:30-11 a.m.
Ramona (760) 740-3000	Oficina de Salud Pública del Ramona 1521 Main St., 92065	2do miércoles de cada mes	1-3 p.m.
Rancho Penasquitos (760) 740-3000	New Hope Church 10330 Carmel Mountain Rd.,92129	3er miércoles de cada mes	8:30-11 a.m.
Solana Beach (760) 967-4401	Solana Beach Presbyterian Church 120 Stevens Ave., 92075	2do martes de cada mes	1-5 p.m.

Para información acerca de la prueba de tuberculosis, favor de llamar al (619) 692-5565

Para más información sobre Vacunación visite www.sdiz.org o llame211.

FY1718 Dates for CYFL **Family Voice Town Hall Meetings**, *where the voice of families matter*. Town Hall meetings are facilitated gatherings for youth and parents receiving services in the *Children's System of Care* to learn about CYFBHS offerings and elicit the authentic voice of families for feedback on the challenges, successes and trends in order to inform policies, practices and programs. Location TBD.

FY1718 First Quarter | Family Voice Town Hall Meeting

Date	*Time*	*Region*
Monday, July 10, 2017	8:30 AM - 11:30 AM	North County
Thursday, July 27, 2017	10:00 AM - 11:30 AM	South Bay
Thursday, August 10, 2017	10:00 AM - 11:30 AM	East County
Thursday, August 24, 2017	6:00 PM - 7:30 PM	Central

FY1718 Second Quarter | Family Voice Town Hall Meeting

Date	*Time*	*Region*
Thursday, October 12, 2017	6:00 PM - 7:30 PM	North County
Thursday, October 26, 2017	10:00 AM - 11:30 AM	South Bay
Thursday, November 9, 2017	10:00 AM - 11:30 AM	East County
Thursday, November 30, 2017	6:00 PM - 7:30 PM	Central

FY1718 Third Quarter | Family Voice Town Hall Meeting

Date	*Time*	*Region*
Thursday, January 11, 2018	6:00 PM - 7:30 PM	North County
Thursday, January 25, 2018	10:00 AM - 11:30 AM	South Bay
Thursday, February 8, 2018	10:00 AM - 11:30 AM	East County
Thursday, February 22, 2018	6:00 PM - 7:30 PM	Central

FY1718 Fourth Quarter | Family Voice Town Hall Meeting

Date	*Time*	*Region*
Thursday, April 12, 2018	6:00 PM - 7:30 PM	North County
Thursday, April 26, 2018	10:00 AM - 11:30 AM	South Bay
Thursday, May 10, 2018	10:00 AM - 11:30 AM	East County
Thursday, May 24, 2018	6:00 PM - 7:30 PM	Central

NAMI San Diego

HHSA | LIVE WELL SAN DIEGO

NAMI San Diego | Children, Youth & Family Liaison **CYFBHSOCC Update | July, 2017**

1. CYFL producing a short, family friendly **Animated Video Introduction to the CSOC**
2. Continuing 4th Friday **Family Youth Partner Coaching Meetings** (support/development)
3. Continuing 3rd Wednesday **"Families for Families" Parent & Caregiver Support**
4. Building **'CYFL Presenters Pool' of Family Youth Partners** (paid hourly part-time)
5. Increasing **Family Voice Town Hall Meetings** for CSOC feedback from 4 to 16, annually
6. Now offering of **NAMI Basics**, 6 week class for parents of children < 18 w/BH concerns
7. Taking interest list for **NAMI Basics, *Provider Version!***
8. New CYF App by NAMI San Diego available for free download: **oscER Jr.** (Organized Support Companion in an Emergency Situation for Children, Youth & Families)
9. New CYF App by NAMI San Diego available for free download: **alfrEDU** (Accessing & Leveraging Families Rights to Education)
10. Added two staff; CYFL Community Developer & CYFL Technology Engineer

FY1718 Dates for CYFL **Online Family Youth Focus Groups – *Facebook Live!*** On-line focus groups are facilitated live, virtual gathering to help parents, caregivers, youth, and TAY engaged in the Children's System of Care learn in real time about CYFBHS offerings while sharing their authentic voice on emerging practices, programs and policies. Time TBD.

FY1718 Q1 & Q2 On-Line Family Youth Focus Groups – *Facebook Live!*

FY1718 | Quarter 1	Tuesday, August 1	On-Line, time TBD
FY1718 | Quarter 1	Tuesday, September 5	On-Line, time TBD
FY1718 | Quarter 2	Tuesday, November 7	On-Line, time TBD
FY1718 | Quarter 2	Tuesday, December 5	On-Line, time TBD

Q3 & Q4 dates TBD.

QI Provider Updates

July 2017

QUALITY MANAGEMENT TEAM UPDATES

Services Provided Prior to Completion of Client Plan (Memo 06/21/17)
The Department of Health Care Services (DHCS) has clarified the types of services that may be provided prior to completion of the Client Plan and services subject to disallowance without a valid Client Plan. This is effective 7/1/2017.

Client Plan Redesign (Memo 6/20/17)
The current Client Plan has undergone a redesign to make the document more user and client friendly. Changes include the following redesign: new Client Plan family folders, formatting changes, and a new confirmation page. Client Plan family folders will be available in CCBH effective July 3. This memo contains several documents. In addition there are the following documents: Client Plan Clinical Standards, Tip Sheet, and two Quick Click Guides. This is effective 7/3/2017.

Utilization of BHA ADULT WALK IN for Outpatient Programs with Walk In Services (Memo 6/21/17)
For the Adult/Older Adult Outpatient Programs a change has been implemented for the assessment process to improve efficiency and client access to outpatient walk in services. This is effective 7/1/2017.

New Evidence Based Practice (EBP) Indicators for Performance Improvement Project (PIP) and the Child Family Team Meeting-CYF System of Care (Memo 6/23/17)
BHS is collecting data regarding the assignment and completion of therapeutic homework. CYF Programs are expected to enter EBP indicators for therapeutic homework assignment/completion when entering services in CCBH. This is effective 7/3/2017.

Progress Note Rewrite
New progress note promotion is targeted for October 2, 2017. Stay tuned!

OPOH Updates
None.

Quality Improvement Partners Meeting will take place on Tuesday, July 25, from 2:30-4:30 pm. Location: 3851 Rosecrans, San Diego Room, San Diego, 92110. Look for an email reminder that includes a call-in number for a teleconferencing option.

CCBH Users Group Meeting is the 3rd Tuesday of every other month from 1 to 3 PM. The next meeting is July 18 held at 3851 Rosecrans in the Coronado Room.

Annual QI Knowledge Forum Meeting
The BHS Quality Improvement Teams (QM, MIS, PIT) will provide knowledge sharing and important updates for the Mental Health System of Care. The meeting is Tuesday, July 11, 2017 from 9 am to 1 pm. Location: Scottish Rite Center, 1895 Camino del Rio South, 92108.

Substance Use Disorders (SUDS) Updates

1. DHCS DMC-Certification Quarterly Technical Assistance Calls. The next call is scheduled for July 10, 2017 from 10:30 – 11:30 a.m. To participate, call (800) 475-0533 and use participant access code 96553.

QI Provider Updates

July 2017

2. Reminder: Opportunities to Learn About Medication Assisted Treatment (MAT)
   - For non-clinical and specific to agency leaders you can request a training session by way of email. Contact Betty Milton at Bertha.Milton@sdcounty.ca.gov and include general guidance as to objectives and questions to be answered, so the session will be tailored to your agency's needs.
   - For direct line staff a one-hour recorded webinar session is offered through BHETA.
     - To access the BHETA webinar, create an account (if you don't have one) or sign in to their Learning management System (LMS) via this website: https://theacademy.sdsu.edu/online-training/.
     - Once logged in, go to the "search icon" (the "magnifying glass") and type "MAT" You'll see a series of results. Go to the one under "Activity" – it's the only MAT activity listed.
     - There is a down arrow on the right side of the "Select" button – click that and select the "Register" option.
     - For additional assistance contact the BHETA Help Desk at BHETA@mail.sdsu.edu.

3. ASAM Learning Opportunities
   - There are two, one-hour recorded ASAM Overview webinars available via BHETA. For details on registration, refer to above item on MAT.
   - ASAM C – Using ASAM to Re-Assesse Clients: Friday, July 7th 9 a.m. – 3:30 p.m. Use this link to register: https://www.eventbrite.com/e/07-07-2017-asam-criteria-c-training-san-diego-registration-34863918920

4. BHS Received Response from DHCS regarding DMC-ODS Implementation Plan
   - On May 26, 2017, BHS submitted the Drug Medi-Cal Organized Delivery System Implementation Plan to DHCS.
   - DHCS responded that it has been received and initially reviewed. There were a few questions for clarification.
   - DHCS will be submitting the Implementation Plan to the Centers for Medicare & Medicaid Services (CMS) for review and input.
   - CMS will return the plan to DHCS to forward back to the County. At that time, the County will update the plan to address all issues/questions posed by both DHCS and CMS.
   - We will continue to keep programs posted on the progress of the DMC-ODS Implementation Plan.

5. Upcoming SUDPOH updates
   - The SUD QM team will be working on updating the SUDPOH during the month of July. Information from our current contract with DHCS that will be added includes:
     i. Unannounced DHCS visits to programs may occur
     ii. Programs must keep sufficient financial records and statistical data to support year-end documents filed with DHCS
     iii. Programs must include in any contract with an audit firm a clause to permit DHCS access to the working papers of the external independent auditor

- Will also add information DHCS shared with the county during our recent Annual Site Review with DHCS SUD Compliance:
    i. Any SUD Program complaint must be reported to the county (i.e. your COR). County will investigate and notify DHCS of the findings.
    ii. If a program is using an EHR with electronic signatures, this must be reported to the county to ensure compliance with ADP Bulletin 10-01 requirements
    iii. An electronic signature agreement form must be signed by each staff with an electronic signature in the program's EHR
    iv. All SUD staff must sign confidentiality forms annually

PERFORMANCE IMPROVEMENT TEAM (PIT) UPDATES:
Outpatient clinics are being asked to document any change in housing status (Living Arrangement) upon each client interaction, especially those that are homeless or transitioned from homelessness. This can be documented in either the Behavioral Health Assessment or the Demographic Form. It is important to consistently inquire and update the living arrangement to ensure accurate data collection on housing status. If you have a client that has prepopulated fields of H, X, Y, Z (an inactive living arrangement) when starting a new Demographic Form or BHA, please update with XX, YY, or ZZ as appropriate.

MANAGEMENT INFORMATION SYSTEM (MIS) UPDATES:
No Updates.

QUALITY MANAGEMENT MEMO

To: Mental Health System of Care **Date:** 06/21/17

From: Steve Jones, LCSW, QM Program Manager

Re: Services Provided Prior to Completion of Client Plan

Effective: July 1, 2017

Dear Providers,

This memo is to inform providers about clarification from the Department of Health Care Services about the types of services that may be provided prior to the completion of the Client Plan. The information below is provided by DHCS regarding services prior to having a completed client plan and services subject to disallowances without a valid client plan. This is effective July 1, 2017.

A. PROVISION OF SERVICES PRIOR TO A CLIENT PLAN BEING IN PLACE

1. **Medi-Cal will reimburse a MHP for some services provided to a beneficiary before his or her client plan is approved. What are those services?**

Prior to the client plan being approved (required staff signature(s) on the client plan) the following services are reimbursable:

a. Assessment
b. Plan Development
c. Crisis Intervention
d. Crisis Stabilization
e. Medication Support Services (*if there is an emergency or immediate need which must be documented*)
f. *Some* Targeted Case Management Services ***(See 1-3 below)***

Pursuant to the State Plan "Targeted Case Management" includes the following services:

1. *Comprehensive assessment to determine whether a beneficiary needs targeted case management services to access medical, educational, social or other services.*
2. *Development of a client plan.*
3. *Referral and Related Activities to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services.*
4. Monitoring and follow up activities to ensure the beneficiary's client plan is being implemented and that it adequately addresses the beneficiary's needs.

Please see State Plan, Section 3, Supplement 1 to Attachment 3.1-A, (SPA 12-025) pages 9-11 for a complete list of services that can be provided as part of Targeted Case Management. See State Plan, Section 3, Attachment 3.1-B, page 7.

The State Plan Amendment can be found on the OPTUM website, under Organizational Provider Documents, under the References Tab.

2. **Medi-Cal will disallow payment for certain services if at the time the services were provided the beneficiary being treated did not have an approved client plan. What are those services?**

The following specialty mental health services cannot be billed to Medi-Cal unless the beneficiary receiving the services has an approved client plan:

a. Mental health services (except assessment, client plan development)
b. Day treatment intensive
c. Day rehabilitation
d. Adult residential treatment services
e. Crisis residential treatment services, except crisis intervention services, assessment and client plan development
f. Psychiatric health facility services
g. Psychiatric Inpatient Hospital services
h. Psychiatrist services
i. Psychologist services
j. EPSDT supplemental specialty mental health services
k. Psychiatric nursing facility services

3. **Can a provider (or MHP) prepare a temporary client plan for a beneficiary in order to begin providing services to that beneficiary prior to completion of a comprehensive Client Plan?**

MHPs and providers may elect to prepare an "initial client plan" for a beneficiary within a short period of time of the beneficiary coming into the system in order to quickly begin providing services to the beneficiary that cannot be provided without an approved client plan. For example, if a beneficiary is initially assessed to need medication support services the MHP or provider could prepare (and obtain the necessary signatures for) an initial client plan that includes medication support services only. Once the MHP or provider has completed a comprehensive assessment of the beneficiary, the initial client plan would be updated to be comprehensive. Note, the beneficiary's comprehensive client plan must be completed within the MHPs time line for completion of an initial client plan and all other client plan requirements must be met.

Please direct any questions and/or comments to the QI Matters mailbox: ***QIMatters.HHSA@sdcounty.ca.gov***

QUALITY MANAGEMENT MEMO

To: Mental Health System of Care Providers **Date:** 6/22/17

From: Steve Jones, LCSW, QM Program Manager

Re: CCBH Client Plan Redesign

The current Client Plan has undergone a redesign in hopes to create a more user and client friendly document. There are several changes with this redesign including; Client Plan family folders, formatting changes, and a new Confirmation page. Also included in this memo will be a transition plan into the new Client Plan family folders.

Client Plan Family Folders

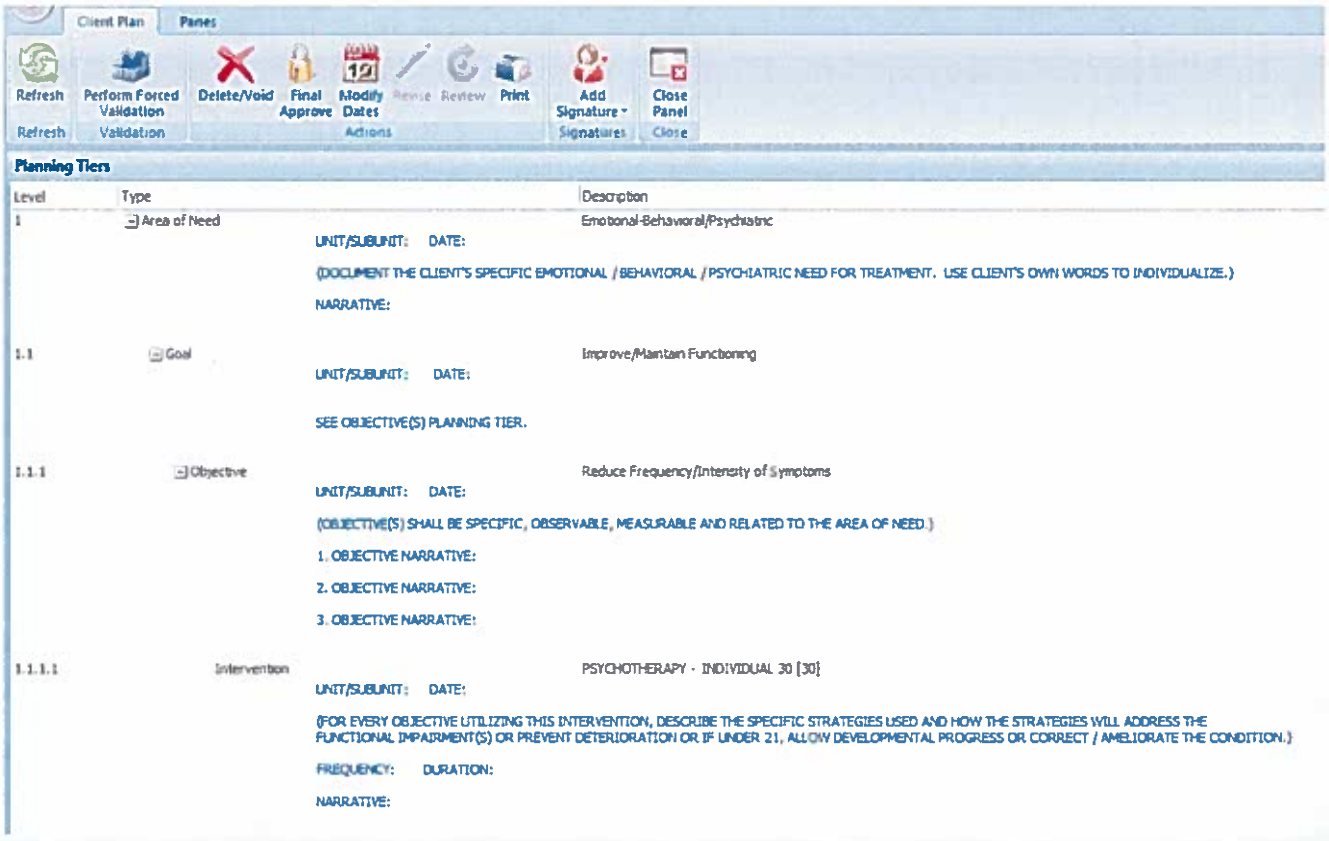
There are now Client Plan family folders which are separated out by service types. The new families will allow for programs to develop a Plan that is specific to the type of service being provided and will decrease the instances in which Plans are shared. While there will be fewer instances in which a Client Plan will be shared, it is still necessary to view any other open Plans and determine if duplicative services are being offered. The table below includes the Client Plan family folders that will be available in CCBH **EFFECTIVE JULY 3**.

[Description]
ACT Client Plan
ACT Interim Folder
CAC Client Plan
CAC Interim Folder
Case Management Client Plan
Case Management Interim Folder
Day School Service Client Plan
Day School Svcs Interim Folder
Day Treatment Med Folder
Limited Service Log
Outpatient / FSP Client Plan
Outpatient/ FSP Interim Folder
TBS Client Plan
TBS Interim Folder
WRAP Client Plan
WRAP Interim Folder

Formatting Changes in the Client Plan

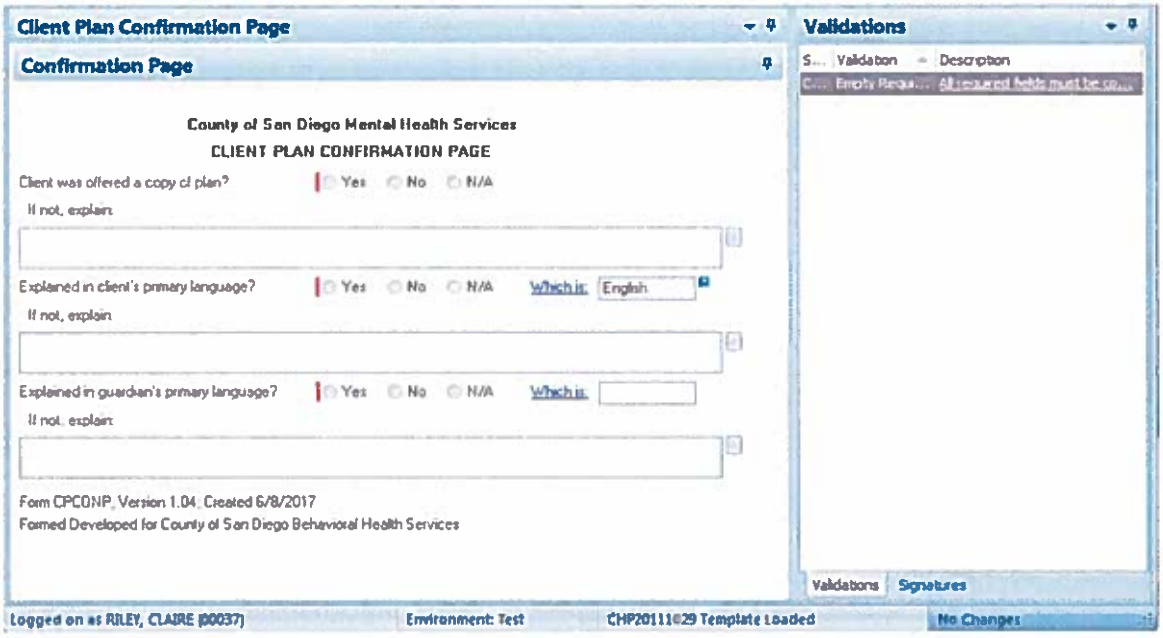
Several changes have been made to the Client Plan format. There is a Quick Click Guide that will be distributed with the redesign changes along with a Clinical Standards for Client Plans to help with explaining the changes.

The Goal tier remains as part of the plan however narration will not be entered as this tier will now defer to the Objective tier. The Applied Strength tier has been removed and there will only be the Strength tier to individualize with strength and applied strength information. There will now be standard text in all narratives to help guide providers towards appropriately individualizing each tier along with prompts for unit/subunit, date, frequency, and duration. The standard text will be in CCBH on June 30, 2017. In the Clinical Standards for Client Plans there is guidance around choosing one broad Objective from the drop down menu with the possibility of including several Objectives under that one heading, by listing them in numerical form.



Confirmation Page

A new page has been added to the Client Plan to capture the information currently documented on the paper signature page. The Confirmation Page includes offering the client/guardian a copy of the plan and in which language.



It is possible to mark N/A when making administrative updates but keep in mind, it is required to offer the client or guardian a copy of their Plan in their preferred language within 30 days of intake, at UM cycle, when clinically significant changes have been made to the Plan, and annually.

Transition Plan

As of July 3, 2017, the new format will be available in CCBH and the current Client Plan folder will be made inactive to accepting new information. Plans in this folder however will remain valid. Programs are advised to Final Approve any Plans prior to July 3, after this date, any Plans that are to be Reviewed or Revised are to be ended and a new Plan is to be entered into the appropriate Client Plan family folder. If a Plan is SHARED, contact the other provider and communicate the plan for transitioning.

**** See Attached Tip Sheets, Quick Click Guide and Clinical Standards for Client Plans**

Please direct any questions and/or comments to the QI Matters mailbox:
QIMatters.HHSA@sdcounty.ca.gov

QUICK CLICK GUIDE
CCBH CLIENT PLAN

Basic Steps to create a CCBH Client Plan

Click on ***"New Client Plan"*** button

Click on ***"Planning Tiers"*** pane

Add the following Tiers in order:

Strength *Right click in white **space***

These are the client's general strength(s) and how they can use these strength(s) to help them self and to help achieve their objective(s)

INSTRUCTIONS for ALL TIER SCREENS
(same steps for every Tier)

Click on *"Planning Tier"* hyperlink ~ select from pull down list
Start with Unit/Subunit, then Date, follow standard text and narrate Tier
(standard text may be highlighted and deleted)
Click "Save and Close" button

Area of Need *Right click in white **space***

This is an area or areas for the client where a level of impairment has been identified

Goal *Right click on **Area of Need***

Enter Unit/Subunit and Date only. No narration required for this Planning Tier

Objective *Right click on **Goal***

These are the actions/activities/steps of the client or others to help reduce the impairment(s)
For multiple objectives list numerically under one Objective heading
For only one objective delete extra Objective Narrative standard text

Make Objective(s) narration - observable & measurable

Intervention *Right click on **Objective***

Interventions are the MH services provided to the client

Specify frequency, duration, detailed description(s) of and individualized purpose for all services

When to **Review** or **Revise** Client Plan

Annual Updates

Adult Programs	**REVIEW** - 365 days from current plan Final Approval date
CYF Programs	If UM does not occur prior to Annual date then **REVIEW** - 365 days from current plan Final Approval date

UM/UR

CYF Outpatient Programs	**REVIEW** at every UM cycle (13/26, 18/36 sessions)
CYF Programs having special COR Approval	**REVIEW** every 6 month
CYF STRTP/Day School Services	**REVIEW** at every 3 month UM cycle

Client Plan Changes or Additions

Adult & CYF Programs	**REVISE** whenever changing or adding information to the plan but not changing the begin or end date of the plan

CCBH Folders and Progress Notes TIP SHEET

Progress Note Folder Types

Service Type Family Interim Folder (IF) is available to be opened and used for up to 30 days, when providing pre-client plan billable services to a new client until a client plan is written. Electronically sign and Final Approve the Family **IF** for the type of service you provide before entering progress notes. The **IF** must be ended before a client plan folder can be opened. **IF** and a client plan folder dates cannot overlap. There is no need for an **IF** once a client plan folder is opened. If a client plan is written at client's admission, then an **IF** would not be opened or used, as a client plan folder is used instead. ***~ See Interim Folder section of CP Training Manual***

Service Type Family Client Plan Folder (CP) is required to be written, signed, Final Approved within 30 days of client's admit date. **CP**s are active for up to one year for Adult programs and for CYF programs until all sessions are completed and a UM request is submitted or up to one year, whichever comes first. Complete the **CP** Tiers and narrations before signing the **CP**. Clinician must have client agreement documented within the first 30 days or have client/guardian signature of approval, be electronically signed and be Final Approved within timeline requirements for **CP** to be valid. ***~ See Client Plan section of CP Training Manual***

Modify Dates option is for modifying or changing the begin and/or end date of an open **IF** or **CP**. This occurs when ending an **IF** and beginning a **CP** or modifying a **CP** end date for UM or for starting a completely new **CP** when a current plan exists. ***~ See Client Plan: Modifying Dates section of CP Training Manual***

Revise option is for making changes to a current **CP**. **Revise option is NOT used for CYF UM.** When you **Revise** the system will not change the **CP** begin or end dates. Clinician must have client/guardian signature of approval, complete electronic signatures in the EHR and Final Approve **CP**. ***~ See Client Plan: Revising section of CP Training Manual***

Review option is used when the current **CP** is expiring, or when CYF programs UM for additional sessions requiring an updated **CP**. The system will add new timelines (begin and end dates). Clinician must have client/guardian signature of approval, complete electronic signatures in the EHR and Final Approve within required timelines for **CP** to be valid. ***~ See Client Plan: Reviewing section of CP Training Manual***

Progress Notes Types

Informational Progress Note is used for entering information into a client chart that is Never Billable information. Begin with Unit/Subunit in narration. Template is not used. All staff with access to sign can Final Approve. Co-signature is not required. ***~ See Informational Progress Note section of PN Training Manual***

Individual Progress Note is used to document and bill for individual MH services. Templates can be used, particularly for Rehabilitation or Psychotherapy services and Med. notes. Enter the narrative first, signatures second. Enter the service billing information after the signature lines are properly completed, including Co-signature if needed, within timelines, and then Final Approved. ***~ See Individual Progress Note section of PN Training Manual***

Group Progress Note is used when providing services to multiple individuals in a group setting. All clients must have open folders in the system to Final Approve the progress notes. Enter Documentation Time after progress notes are Final Approved. In general, each step must be saved before moving to the next step, including each client narration. The note must be Final Approved within timelines. ***~ See Group Progress Note section of PN Training Manual***

DISCLAIMER

This tip sheet is only a brief description and not a replacement for the Client Plans and Progress Notes Resource Packet!

Clinical Standards for Client Plans

The process for developing an effective Client Plan is collaboration between the provider and client/family. The Client Plan is a road map to a successful treatment outcome. While there are administrative elements to the Client Plan (for example, billing disallowance when not completed within timelines), creating the Client Plan is more than an administrative task.

The Client Plan should be written in realistic and attainable language, using the client's words as much as possible. After a thorough assessment, staff should help the client/family prioritize needs and focus attention on regularly offered services to meet those needs within a specified timeframe. As such, Client Plans should be written concisely, simply, and be easily understood by the client/family.

The following guidelines are provided for direction in navigating CCBH Client Plan functionality and to delineate the documentation standards for the Client Plan process.

CLIENT PLAN FAMILY FOLDERS

There are now Client Plan family folders which are separated out by service types. The new families will allow for programs to develop a Plan that is specific to the type of service being provided and will decrease the instances in which Plans are shared. While there will be fewer instances in which a Client Plan will be shared, it is still necessary to view any other open Plans and determine if duplicative services are being offered. Check with your Program Manager to determine the appropriate Client Plan family folder to choose.

CLIENT PLAN FUNCTIONALITY IN CCBH

Initial Client Plans must be written and final approved with all required signatures within 30 days of assignment to the program; assignment date counts as day one. In CCBH, a Client Plan is valid for up to one year from the date it is created. Each program is responsible for tracking the Client Plan timelines to guarantee there are no lapses.

In addition to creating a new Client Plan, there are two other functions in CCBH – **Revise** and **Review.**

Revise

When a client has an active Client Plan in place and a change needs to be made (adding, editing, or updating), use the **Revise** function. The start date and end date of the Client Plan will remain the same and the current information will prepopulate.

Review

The Client Plan must be Reviewed at least annually. CYF programs are required to Review the plan at the UM cycle. When using the Review function in CCBH, it establishes a new start and end date from the previous Client Plan and prepopulates the information for updating.

FUNCTIONALITY OF PLANNING TIERS

- **Strength**
  a) Select the **Strength** the client/family has indicated to be utilized to meet the **Objective**(s).
  b) Detail in the narrative how the client will apply and utilize the **Strength** to reach the **Objective**(s).

- **Area of Need**
  a) **Area of Need** shall describe the client's symptoms, behaviors, and functional impairments from the behavioral health assessment (BHA) and diagnosis form.

b) Use the client and/or family member(s) own words to individualize.
c) Do not copy/paste the clinical formulation or other large portions of narrative from the BHA into the narrative.
d) It is recommended to choose one general **Area of Need** and include numerically detailed needs in the narrative section.

- **Goal**
  a) Select the **Goal** that attaches to the selected **Area of Need.**
  b) The narrative will prepopulate with the phrase, **"See Objective(s) Planning Tier".**
  c) You will only be required to add your unit/subunit and date to this planning tier.

- **Objective**
  a) Select the **Objective** that will help the client achieve his or her desired outcome.
  b) Detail in the narrative how the **Objective** is specific, measureable, and observable.
  c) It is recommended to choose one general **Objective** and detail each **Area of Need** in the **Objective** narrative as a numerical list. Listed **Objectives** shall be specific, measurable, and observable and address all **Area(s) of Need.**
  d) The standard text will offer three (3) **Objective** narratives; you may delete or add additional narrative **Objectives.**

- **Intervention**
  a) Select the regular ongoing planned service codes.
     i) Examples of regularly ongoing service/**Intervention** codes include (but are not limited to) service codes 20, 25, 26, 27, 30, 31, 32, 33, 34, 35, 36, 50, 82, 83.
  b) The **Intervention** narrative must be individualized to address the specific needs of the client.
  c) **Interventions** must be tied to specific **Objective(s)** and include a description of specific strategies to be used and how the **Intervention** will diminish impairment or prevent deterioration (or, if under 21, allow developmental progress).
  d) Frequency and duration are templated as standard text. For example, frequency is written: 1x/week or twice/month, etc. and duration is written: for the next 3 months or for the next 6 months, etc. General terms (i.e. "as needed" or "prn") are not permitted.
  e) There are numerous services/**Interventions** that are <u>not</u> typically provided as ongoing services and can be documented as "unplanned services" for the progress note.
     i) Examples of service codes that are not regularly provided include (but are not limited to) service codes 9, 10, 11, 13, 14, 15, 28, 37, and 70
  f) If you find during the course of treatment that an **Intervention** is being used more regularly, the Client Plan shall be REVISED to add that intervention.

REVISING/REVIEWING CLIENT PLANS (Not shared):

- The tiers must be assessed and there should be changes made or a clear reason why no changes are being made to the tier. Upon a review/revise update narratives with the current status.
- Always ***BEGIN*** narrative with unit/subunit and date with the most current information on top. Remember to change the "Status Date" to the date you reviewed this information with the client.
- If information is still relevant, meets the documentation standard as described previously, and the Status is "Active," leave the information. If the information is still relevant but does not meet the documentation standard, re-write the narrative to meet the current standards.

- **Objective:** Document progress towards meeting this **Objective**. If the information is still relevant but does not meet the documentation standards, re-write the narrative to meet the current standards.
    - If the **Objective** has been met and only one **Objective** is written in the **Objective** tier, change the Status to "Resolved." ***(KNOW THAT WHEN RESOLVING AN OBJECTIVE, ALL INTERVENTIONS LISTED UNDER THAT OBJECTIVE WILL BE RESOLVED.)***
    - If there are several **Objectives** numerically listed in the narrative and one **Objective** has been met, DO NOT change the Status to "Resolved" as this will inactivate all **Interventions** listed under the **Objective** tier. Beginning with the unit/subunit and date document in the narrative related to that specific **Objective** that the **Objective** has been met and why. The narrative of the met **Objective** may be removed at the next update.
- **Intervention:** Read the Intervention planning tier narrative(s) with the client/family.
    - If information is still relevant, meets the documentation standard as described previously, and the Status is "Active," leave the information.
    - If the information is still relevant but does not meet the documentation standard (not individualized, does not indicate every **Objective** utilizing the **Intervention**, does not provide strategies used, does not include frequency/duration), re-write the narrative to meet the current standard. Remember, to change the "Status Date" to the date you reviewed this information with the client.
    - If information is not relevant and the Status is "Active", change the Status to "Inactive" and indicate reasoning in narrative.

SHARED CLIENT PLANS

Client Plan functionality in CCBH also allows for shared Plans when two or more programs are providing services to a client/family at the same time. This occurrence should happen infrequently as there are specific service related Client Plan Families that separate service types. It is the expectation that programs will ***CHECK IN THE CLIENT ASSIGNMENTS TO SEE IF THE CLIENT IS CURRENTLY OPEN TO ANY OTHER PROGRAM*** and if so, work together to best meet the client/family needs and to support one another with the shared Client Plans in CCBH. When a Client Plan is shared between programs, each program must:

- Document in a way that demonstrates there is no duplication of services by documenting their own narrative on each ***PLANNING TIER*** that they will be utilizing. Most recent narrative goes on the top, beginning with unit/subunit and date.

- **Consult with one another** prior to ending a Client Plan or making other substantial changes (such as changing any Status on a planning tier) as it may create administrative burdens for the other program. For example, inactivating a planning tier will inactivate everything that is connected to that planning tier. Ending a Client Plan may leave another program without a valid Client Plan in place, and risk disallowance of services.

- **Revising SHARED Plan with a SHARED Objective:** Retain previous **Objective** narration to show client's progress. If **Areas of Need** or **Objectives** have been resolved, DO NOT INACTIVATE PLANNING TIER; indicate this in the narrative section.

- **Reviewing SHARED Plan:** ONLY AFTER CONSULTATION WITH OTHER PROGRAM(S). Remove **Area(s) of Need** and **Objective(s)** that has been resolved.

PLANNING TIER AND STATUS DATES

To monitor progress and keep the Client Plan current, it is important to utilize the "Status" and "Status Date" functions in CCBH Client Plans. The Status selections primarily used are "Active," "Inactive," and "Resolved."

- "Inactive" tiers allow for their deletion upon next use of the Revise or Review function; this is generally used when the information currently documented is not relevant.
- "Resolved" tiers provide positive feedback to a client/family on their successful completion of part of their journey to recovery. Remember to always consult with other programs if this is a shared Client Plan and a planning tier will be made "Inactive" or "Resolved" ***AS THESE ACTIONS MAY IMPACT THE OTHER PROGRAMS.***
- Remove the "Inactive" and "Resolved" tiers and narrative at the next update.

OBTAINING CLIENT SIGNATURES

As the Client Plan is to be seen as a living document, it is likely within the first 30 days of admission to the program the Plan will be revised on several occasions to capture the necessary information. The Initial Plan can be discussed with the client and agreed upon verbally, then created in CCBH and final approved with the Document Client Non-Signature option chosen, documenting in the Progress Note that the client/guardian agrees with services offered and was a part of creating the Plan. The requirement is that the final Plan be completed, Final Approved and signed by client or guardian within the first 30 days.

When writing a new Client Plan or using the Review function in CCBH, it is required to obtain the client or guardian signature. The signature date on the hard copy signature page should be entered as the signature date in CCBH. If the client is unwilling to sign the Plan, choosing the Document Client Non-Signature option is acceptable with documentation in the Plan and in a Progress Note. Ongoing effort should be made to obtain the client's signature if at first unwilling to sign.

When using the Revise function for administrative updates, a client signature may be obtained but is not required. If no signature is obtained, choose the Document Client Non-Signature option and document in the Plan and in a Progress Note the client's participation in and agreement with any changes.

Please note, if at admission to your program you will be sharing a Client Plan and using the Revise function to create your portion of the Plan, you are required to obtain all appropriate signatures within the 30 day requirement (as if you were following the New Plan guidelines).

CLIENT PLAN Q&A

Q: Do signature dates need to match for Client/Parent and Service Staff? And does this date need to match the date in CCBH?

A: The date the client (and parent/guardian, if applicable) signs the hard copy signature page is what should be entered for his/her signature dates in CCBH.

The staff is required to sign the Client Plan in CCBH and the date is then automatically entered at Final Approval; the staff does not need to sign the hard copy page. As long as all signatures are dated within the acceptable timeframes, the Plan is valid.

Q: I have a client who is reaching the end of her UM Cycle and I have some additional information to add, but I see that the annual Plan is due in the next few weeks for Review, what should I do?

A: In a case like this, it would be advised to **Review** the Plan instead of Revising. This way, the begin date of the Plan changes and you will avoid having to do the plan again in such a short time, also avoiding the possibility of oversight and having the Plan expire which could lead to an absence of a valid Client Plan.

Q: I met with a client today for his annual update and client refused to sign. Would this be an example of a time when I can check the "Document Client Non-Signature" and provide explanation? Also, although he refused to sign, can I still go in and update the Client Plan to reflect his needs for this year?

A: To sign off the EHR client signature, you would choose the Document Client Non-Signature option and document the reason that the client did not sign. This information must be documented in your Progress Note along with client or guardian's agreement with services. You can go ahead and provide needed services to the client without his or her signature provided there is documentation with explanation. The expectation, however, is that there will be continual attempts, when clinically appropriate, to discuss the signing of the Plan with the client, with these instances and client responses documented. If the client never agrees to sign but demonstrates openness and continual participation in services, your documented attempts to have them sign and their participation is enough to provide ongoing services until discharge.

Q: A new client comes to my program for services and I see that they have an open assignment at another program and that they also have an active Client Plan in CCBH. What do I do?

A: You must collaborate and coordinate care. With new Client Plan family folders being available for specific services, there is the possibility that you will not need to share a Plan. Check which Client Plan family folder the current provider is using; if it is a different Client Plan family folder than your assigned folder, you will view the current Plan and you are then to open a new Plan in your specified Client Plan Family Folder. If you have determined that you will be sharing a Client Plan family folder with another provider, you are to contact the other provider to assess if your services are duplicative. If they are, then you must decide who will close the client as duplicative services may not be provided to the same client. If they are not duplicative services, you must view the active Client Plan and work with the client to determine the appropriate planning tiers. **Revise** the Plan to add your specific items and individualize to demonstrate how services are not duplicative. Remember to include your unit/subunit and date when adding to current narratives. Final Approve the Plan with all necessary signatures within the appropriate timelines. If client is new to your program, the program is still required to have signatures within 30 days.

To: Mental Health System of Care Providers **Date:** 6/23/17

From: Steve Jones, LCSW, QM Program Manager

Re: New Evidence Based Practice (EBP) Indicators for Performance Improvement Project (PIP) and the Child Family Team Meeting

Effective: July 3, 2017

I. EBPs for PERFORMANCE IMPROVEMENT PROJECT (PIP) – CYF SYSTEM OF CARE

Under federal regulations, and by the direction of the External Quality Review Organization, Mental Health Plans (MHPs) are required to have a Clinical Performance Improvement Project (PIP).

The CYF System of Care is currently conducting a PIP on the efficacy of therapeutic homework assignment/completion and its relation to improved treatment outcomes. To that end, BHS is collecting data regarding the assignment and completion of therapeutic homework. CYF Programs are expected to enter therapeutic homework assignment/completion EBP indicators when entering services in CCBH.

Recent Activities

Considering the potential positive impact of homework on client outcomes, BHS administered a systemwide baseline survey of homework utilization in 2016, and piloted a series of interventions with staff from a selected program to enhance the use of therapeutic homework as part of a two-year PIP.

What It Means for Staff

While a question about homework utilization has already been added to the Medical Record Review, the addition of the homework utilization tracking mechanism in CCBH is the next step to enhance the quality of therapy services in the system. The goal is to offer trainings on the use of homework systemwide and to continue to use the data fields to monitor the intervention.

For more information, please see the informational handout on Enhancing Services through Effective Utilization of Therapeutic Homework that is available on the Technical Resource Library at http://www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html (Section 3).

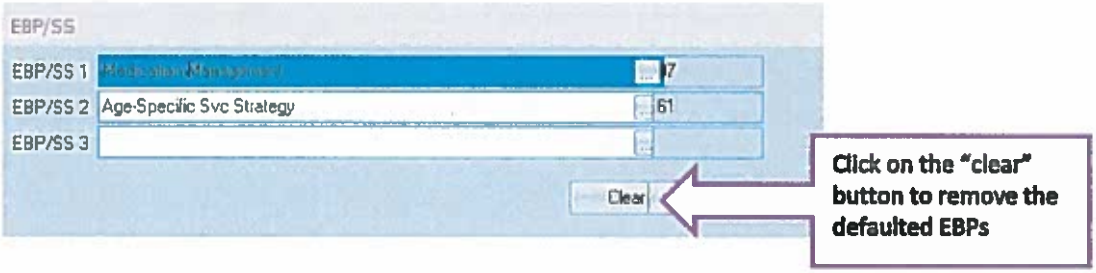
Two New EBP Indicators for Therapeutic Homework PIP

1. ID 90 = Homework Assignment Given
2. ID 91 = Homework Assignment Completed

Recording the Therapeutic Homework

When therapeutic homework is assigned and/or completed in the course of a mental health service, the clinician shall record the designated EBP when entering the service detail in the service Entry Screen. The therapeutic homework field shall only be used by Masters-level or higher clinicians (including but not limited to Masters-level Trainees and Interns).

When entering the EBP, staff will see that there are defaulted values in those fields. Staff will **"clear"** all the defaulted values, and then enter the appropriate EBP indicator for homework. When entering, it is important to remove the defaulted indicators first, and then enter the EBP for homework.



II. CHILD FAMILY TEAM MEETING – CYF SYSTEM OF CARE

Recording the Child Family Team Meeting for Pathways to Well-Being

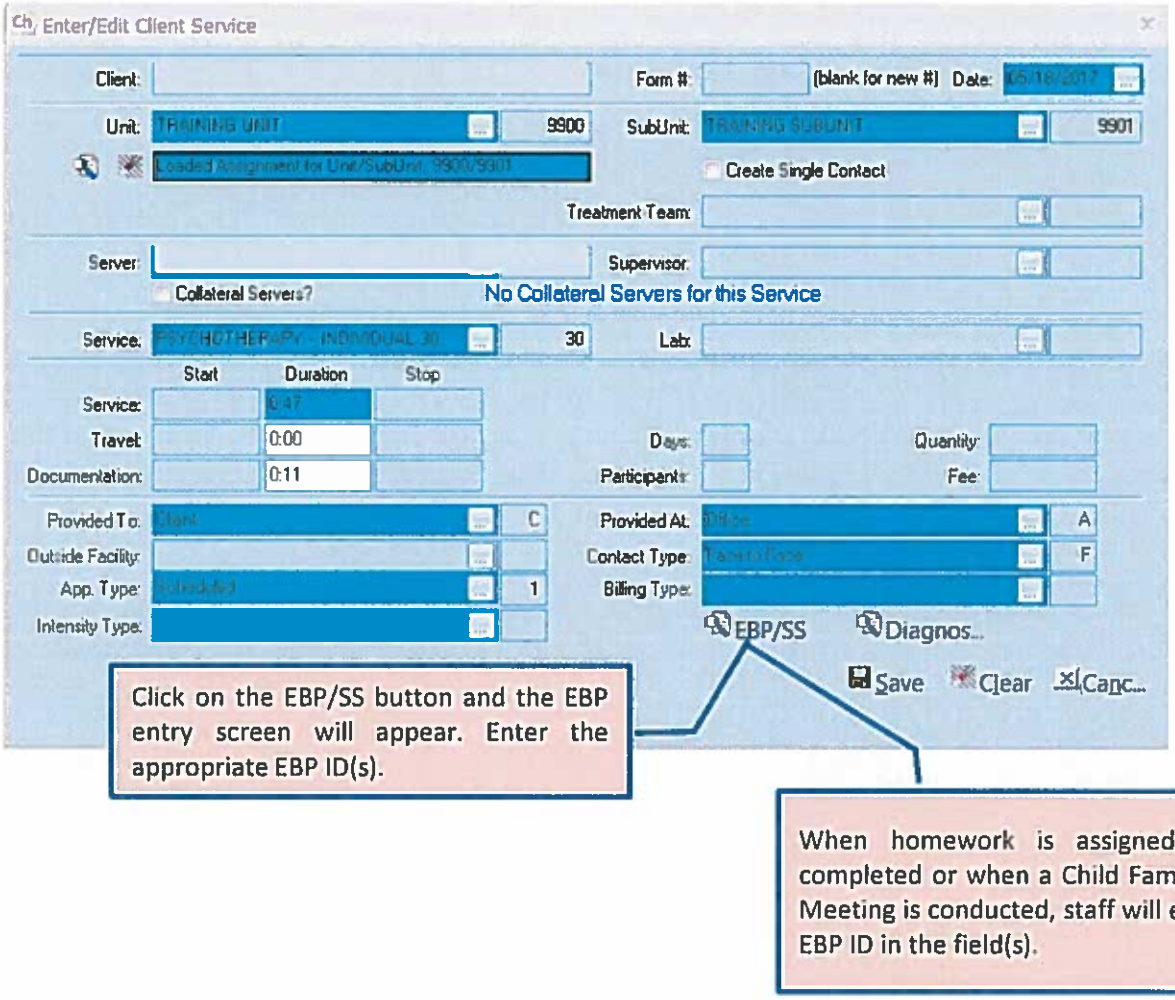
BHS is collecting data on when the required Child Family Team meeting is conducted (minimum every 90 days) for Pathways to Well-Being clients. CYF Providers shall enter the **Child Family Team Meeting** in the EBP service encounter section when it is conducted as part of a mental health service.

One New Indicator for Child Family Team Meeting

1. ID 92 = Child Family Team Meeting (for Pathways to Well Being)

When entering the EBP, staff will see that there are defaulted values in those fields. Staff will **"clear"** all the defaulted values, and then enter the appropriate EBP indicator for Child Family Team Meeting. See above.

EXAMPLE OF SERVICE ENTRY SCREEN



NOTES FOR NEW DATA INDICATORS ENTERED INTO THE EBP TABLE

1. All EBPs are identified for each program and entered in the Sub-Unit Table. Therefore, when you click on the EBP/SS button in the service entry screen, the fields will already contain the EBP that was set up in the Sub-Unit table.
2. When entering the Homework EBPs, staff may enter the EBP ID in any of the three EBP/SS fields. Staff shall "clear" all defaulted EBP(s) and enter any of the three new EBPs in those fields. The EBPs can be entered in any order.
3. There must be at least one EBP listed for the service.

4. If there was no Child Family Team Meeting, no homework assigned, or no homework assignment completed as part of the mental health service, staff will skip the EBP fields. No entry is needed.
5. When assigning and/or following up on completion of homework, please document the details in the progress note.
6. When entering services for the "Provided To" field, the current indicator of **T – Child Family Team** will be removed/inactivated as the CFT Meeting will now be entered as an EBP in the Service Entry Screen.
7. Individual and Group Services may be entered through the Clinicians Home Page and through the Individual and Group Service Maintenance views.

Please direct any questions and/or comments to the QI Matters mailbox: QIMatters.HHSA@sdcounty.ca.gov

CWS Foster Family Agency Homes			
Agency Name	License No	Placement Count	Children Count
ALLIANCE HUMAN SERVICES, INC.	197806287	1	1
ANGELS FOSTER FAMILY AGENCY	374603866	63	62
ASPIRANET - BAKERSFIELD	157806052	6	3
CASEY FAMILY PROGRAM, THE	370603103	4	3
ENVIRONMENTAL ALTERNATIVES LAKEPORT	175002501	1	1
KAMALI'I FOSTER FAMILY AGENCY	336407693	18	18
KOINONIA FOSTER HOMES, INC	374603502	31	30
KOINONIA FOSTER HOMES, INC.	336426848	1	1
LEGACY BEHAVIORAL SERVICES, INC.	157806078	1	1
NEW ALTERNATIVES INC FOSTER FAMILY AGENCY	374603503	23	22
OLIVE CREST	336425183	2	2
OLIVE CREST FOSTER FAMILY AGENCY-SUB-OFFIC	374600985	10	10
SAN DIEGO YOUTH SERVICES	370602725	28	27
SPECIAL FAMILIES: A PROGRAM OF SDCC	370600001	19	18
TOWARD MAXIMUM INDEPENDENCE INC.	370603102	10	10
UNITY CARE GROUP, INC.	435202676	1	1
WALDEN FAMILY SERVICES	374603904	7	7
Grand Total		226	217

THP+FC Agency Name	License No	Placement Count	Children Count
CASA DE AMPARO	374603568	15	14
SAN DIEGO YOUTH SERVICES - MID-CITY YOUTH C	374603662	23	21
SBCS -TROLLEY TRESTLE TRANSITIONAL LIVING PR	374603854	19	18
WALDEN FAMILY SERVICES	374603903	24	24
YMCA YOUTH & FAMILY SERVICES	374603488	22	21
NEW ALTERNATIVES, INC.	374603479	40	40
CREATIVE ALTERNATIVES, INC.	507206800	1	1
Total		144	139

CWS Group Home Summary			
Facility Name	License No	Placement Count	Children Count
ALPHA CONNECTION GROUP HOME FOR CHILDREN	366412000	1	1
ALPHA CONNECTION-SHOSHONEE PLACE, THE	366402331	1	1
ASSOCIATED RESIDENTIAL SVCS INC I	374602285	9	9
CAMERON YOUTH HOME	157806044	1	1
CASA DE AMPARO	374603234	8	8
CASA PACIFICA	565800021	2	2
CENTER FOR POSITIVE CHANGES 3	374603292	3	3
CINNAMON HILLS YOUTH CRISIS CENTER	602300079	1	1
CIRCLE OF FRIENDS	374602611	6	6
CIRCLE OF FRIENDS II	374602603	6	6
CLARINDA ACADEMY	602300055	3	3
CRITTENTON SVCS FOR CHILDREN AND FAMILIES	300612972	1	1
DEVEREUX-VICTORIA	602300087	1	1
FIRST STEP TREATMENT HOME	374602535	2	2
FRED FINCH YOUTH CENTER-SAN DIEGO	374602631	1	0
GROUP HOME SPECIALISTS	336427935	2	2
JACK & CAROL CLARK ADOLESCENT TREATMENT PROGRAM	374602245	3	3
KIDSPEACE: ORCHARD HILLS CAMPUS	602300048	2	2
LAUGHERY HOUSE	374603441	1	1
MARY'S SHELTER - HOUSE 1	306000793	1	1
MILESTONE GROUP HOME	372008440	3	3
NEW ALTERNATIVES INC. #18	374600056	16	16
NEW ALTERNATIVES, INC. #16	374600197	22	21
NEW ALTERNATIVES, INC. NO 1	370801541	8	7
PROMESA, MADERA HOUSE	200405478	1	1
RITE OF PASSAGE: MT. ROSE	602300070	1	1
ROP/ATCS: SIERRA RIDGE	57001447	1	1
S.A.M.'S	374601272	3	3
S.D.C.F.C.-SAN DIEGO CENTER FOR CHILDREN	370808583	17	16
SAN DIEGO CENTER FOR CHILDREN	374600859	11	11
STAR VIEW COMMUNITY TREATMENT FACILITY	197803340	2	2
TRINITY HOUSE 2	565801787	1	1
VARSITY TEAM INC.#3	134603562	1	1
VARSITY TEAM, INC. #2	374603865	3	3
VARSITY TEAM, INCORPORATED #1	374603652	7	5
WOODWARD ACADEMY	602300054	1	1
YOUTH FOR TOMORROW	602300081	1	1
Grand Total		154	148

Probation Group Home Summary			
Facility Name	License No	Placement Count	Children Count
ALPHA CONNECTION-SHOSHONEE PLACE, THE	366402331	1	1
ASSOCIATED RESIDENTIAL SVCS INC I	374602285	3	2
CASA DE AMPARO	374603234	2	2
CENTER FOR POSITIVE CHANGES	374601510	5	5
CENTER FOR POSITIVE CHANGES 3	374603292	1	1
CENTER FOR POSITIVE CHANGES 5	374602641	1	0
CENTER FOR POSITIVE CHANGES II	374601477	8	7
CFLC-SUNSET HOUSE	330908391	1	1
CHILDREN'S HOME OF STOCKTON-REDWOOD	390300131	1	1
CLARINDA ACADEMY	602300055	1	0
DAVID AND MARGARET YOUTH AND FAMILY SERVICES	191500192	1	1
DEVEREUX VIERA	602300049	1	1
FIRST STEP TREATMENT HOME	374602535	3	3
NEW ALTERNATIVES INC. #18	374600056	4	4
NEW ALTERNATIVES, INC. #16	374600197	5	5
NEW ALTERNATIVES, INC. NO 1	370801541	2	2
NEW HAVEN-CONNIE GAYLE	374600210	2	2
OAK GROVE INSTITUTE	330911240	4	4
PROMESA, MILLBROOK HOUSE	107201149	1	1
PROMESA, SPRUCE HOUSE	100406294	1	1
RITE OF PASSAGE: SIERRA SAGE ACADEMY	602300001	1	1
ROP QUALIFYING HOUSE TALLAC	90314963	1	1
ROP/ATCS: SIERRA RIDGE	57001447	1	1
RTC	107200940	4	4
S.A.M.'S	374601272	3	3
SAN DIEGO CENTER FOR CHILDREN	374600859	1	1
STAR VIEW COMMUNITY TREATMENT FACILITY	197803340	1	1
STARSHINE TREATMENT CENTER, INC.	366402532	2	2
STARSHINE-GARDEN DRIVE	360910261	1	0
TRINITY - EL MONTE	191591941	1	1
TRINITY - YUCAIPA	360900416	4	4
VARSITY TEAM INC. #4	134603561	1	1
VARSITY TEAM, INC. #2	374603865	1	1
WOODWARD ACADEMY	602300054	2	1
YOUTH FOR TOMORROW	602300081	1	1
Grand Total		73	67

Family Support Partners (FSPs) and Peer Support Specialists (PSSs)

Feedback Wanted!

County of San Diego Behavioral Health Services (SDCBHS) will be sending out a survey mid-July for all individuals employed as FSPs and PSSs within SDCBHS.

Your assistance is greatly appreciated to help distribute the survey to any staff currently serving as FSPs and PSSs.

Please forward the survey and help us better understand their experiences!