L. PRACTICE GUIDELINES

Practice guidelines refer to methods and standards for providing clinical services to clients. The MHP applies guidelines that comply with 42 C.F.R. 438.236(b) and Cal. Code Regs., Title 9 1810.326. They are based on clinical consensus and research findings as to the most effective best practices and evidence-based practices available. Because they reflect current best practices, the guidelines may change as new information and/or technology becomes available. As these changes occur, the MHP is responsible for disseminating the guidelines to Providers, as well as ensuring that changes being made are done so with consideration to the needs of the consumers. Special efforts must be given in respect to the unique values, culture, spiritual beliefs, lifestyles and personal experience in the provision of mental health services to individual consumers. The MHP and providers have created the Clinical Standards Committee as a means for collaboration within the MHP and Contracted Providers. Providers shall comply with standards that may be adopted by the Mental Health Clinical Standards Committee. This Committee sets standards of care for Mental Health within the county, develops system-wide guidelines, and includes representatives from County and Contract programs.

Treatment of Co-Occurring Substance Abuse and Mental Health Disorders Comprehensive, Continuous, Integrated System of Care (CCISC) Model

Clients with co-occurring mental health and substance use issues are common in the public mental health system and present with complex needs. Consequently, the presence of substance use should be explored with all clients and caretakers as part of routine screening at the point of initial evaluation, as well as during the course of ongoing treatment. San Diego County has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) Model, which is an integrated treatment approach for individuals with co-occurring psychiatric and substance disorders. The presence of substance use should be explored with all clients and caretakers as part of routine screening at the point of initial evaluation, as well as during the course of ongoing treatment.

For adult clients with serious mental illness who meet eligibility criteria, integrated treatment of a co-occurring substance use disorder and the mental health diagnosis is nationally recognized as evidenced based practice.

For children/youth clients know that they may be impacted by substance use or abuse on the part of their caretakers. Be aware that some children in San Diego have been identified as beginning to use substances as early as age 6 and this must be assessed, particularly in high risk family situations.

When serving adults, children, adolescents, or their families that meet the criteria for co-occurring disorders these guidelines are to be implemented:

- Document on the Admission Checklist that the client and/or family was given a copy of your program's Welcoming Statement, if any.
- Include substance use and abuse issues in your initial screening, assessment and assessment updates, included on the Behavioral Health Assessment. In addition, use any screening tools that may be adopted or required.
- If both types of disorders are indicated for the client at diagnostic levels, list the mental health diagnosis as the primary disorder and the substance use diagnosis as the secondary disorder. This indicates that the mental health diagnosis will be the primary focus of treatment, not necessarily that the mental health disorder is the more important disorder or the cause of the substance use.
    - **For adult clients** who do not meet the specialty mental health medical necessity criteria, but do have an identified substance use issue, the provider will make appropriate services referrals and document actions taken.
- Treatment services and documentation shall focus on the primary mental health diagnosis and the identified functional impairment(s). Treatment planning should deal with the substance use issue, either by referral or direct treatment. The co-occurring substance use issue may be integrated into treatment interventions in terms of how it impacts the functional impairment related to the mental health diagnosis. Even if the client or family is referred for substance abuse treatment, the client plan should document how that treatment will be coordinated or integrated into mental health treatment.
- Documentation of treatment services and interventions must meet the federal and CCR Title 9 requirements if mental health services are to be claimed to Medi-Cal. Progress notes should be carefully stated to remain within Medi-Cal guidelines. If the substance use is in a collateral person, the progress note must focus on the impact of the substance use on the identified client. In most instances, it is preferable to approach the substance use in the context of the mental health disorder and create an integrated note and treatment regime.
    - **For child/youth clients** though notes may focus solely on substance use in an EPSDT client, this is permissible only if treatment for the substance use disorder is not otherwise available.
- It is not appropriate to exclude a client from services solely because of the presence of a substance use disorder or a current state of intoxication. This decision should be made based on the client's accessibility for treatment, as well as client and provider safety concerns.

For more information, please reference HHSA's MHS Policy and Procedure: Specialty Mental Health Services for Clients with Co-occurring Substance Use Problems No: 01-02-205 This resource is available by contacting your Program Monitor.

Dual Diagnosis Capable Programs

Certain programs within the HHSA/BHS system are certified as Dual Diagnosis Capable or Dual Diagnosis Enhanced. These certifications refer to program and staff competence with clients with co-occurring disorders. In general, Dual Diagnosis Capable programs will welcome clients

with both types of diagnosis, make an assessment that accounts for both disorders, and may provide treatment for the substance use within the context of the mental health treatment. Enhanced programs will be able to provide comprehensive, integrated treatment for both disorders. Following are the characteristics of Dual Diagnosis Capable Mental Health Programs when fully developed:

- Welcomes people with active substance use
- Policies and procedures address dual assessment, treatment and discharge planning
- Assessment includes integrated mental health/substance abuse history, substance diagnosis, and phase-specific needs
- Treatment plan: 2 primary problems/goals
- Discharge plan identifies substance specific skills
- Staff competencies: assessment, motivational enhancement, treatment planning, continuity of engagement
- Continuous integrated case management/phase-specific groups provided: standard staffing levels

For participating programs, the following describes criteria for these characteristics in both the Adult/Older Adult (A/OA) and Children, Youth and Family (CYF) programs. These criteria will become more demanding as the system develops its capability.

- The program's Administrator has signed the CCISC Charter
- The program has self-surveyed by annual use of the COMPASS survey
- The program has developed an action plan after completing the COMPASS, which incorporates:
    - ✓ Screening
    - ✓ Assessment
    - ✓ Treatment Plan
    - ✓ Progress Notes
    - ✓ Discharge summary
    - ✓ Medication planning when appropriate
    - ✓ Referrals
- The program has identified leads responsible for implementation of Dual Diagnosis Capability
- The program's CADRE staff are available for trainings
- Each clinician has completed the CODECAT
- The program has developed Mission and/or Welcoming Statements that reflect dual diagnosis capability
- The program has a Policy and Procedure to support Mission and Welcoming statements, including visible materials such as posters and referral brochures

Education on MAT as Alternative to Pain Management Training

Effective January 1, 2019 a 12-hour continuing education course on MAT (Medication Assisted Treatment) and treating opiate-dependent patients may be taken as a condition of licensure by the Medical Board of California (MBC) as an alternative to the mandated 12-hour course on treating terminally ill and dying patients.

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), asenapine (Saphris), clozapine (Clozaril), iloperidone (Fanapt), lurasidone (Latuda), olanzapine (Zyprexa), paliperidone (Invega), quetiapine (Seroquel), risperidone (Risperdal), ziprasidone (Geodon) and any derivatives of these medications (i.e. long acting injectable formulations, extended release formulation, etc.)

Clinical Advisory on Monitoring Antipsychotic Medications**:**

- Ordering labs and monitoring should be tailored to each patient. Patients may require more or less monitoring than these recommendations.
- All antipsychotic medications carry a Black box warning for increased risk of mortality for older adult patients with dementia-related psychosis.
- Geriatric patients may require more frequent monitoring due to changes in metabolism and renal function.
- Obtain baseline assessment for Tardive Dyskinesia and Abnormal Involuntary Movement Scale prior to initiate of antipsychotic and every 6 months.
- Atypical antipsychotics are associated with abnormal blood work such as elevated serum glucose and lipid levels, and increased prolactin levels. They are also associated with weight gain, increased risk of type 2 diabetes, diabetic ketoacidosis, and cardiovascular side effects.
- Avoid using ziprasidone (Geodon), haloperidol (Haldol), thioridazine (Mellaril), and chlorpromazine (Thorazine) in patients with known history of QT_c prolongation, recent Acute Myocardial Infarction, uncompensated heart failure, taking other medications with prolong QT, and alcoholic patients on diuretics or having diarrhea which may alter electrolytes.
- All patients should be assessed for cardiovascular disease before initiating antipsychotic therapy.
- Refer to Clozapine REMS Program for monitoring Clozaril.
- An initial comprehensive baseline assessment should include a thorough personal and family medical history, including risk factors for diabetes, vital signs, weight, body mass index, waist circumference, metabolic laboratory analysis such as fasting glucose, and lipid profile.
- Fasting blood glucose is preferred, but HbA_{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).

Naloxone for Risk of Overdose

Effective January 1, 2019, prescribers are required to offer a prescription for naloxone hydrochloride or similar drug to patients and/or family when the patient is at risk for overdose (because patient is taking 90 mme/day or more; patient risk is increased due to prior high dose with no tolerance now or prior overdose; or patient is concurrently prescribed an opioid and a benzodiazepine).

As of September 5, 2019, the risk factor related to opioids and benzodiazepine only applies when prescribing an opioid within a year from the date a prescription for benzodiazepine has been dispensed to the patient. AB 714 also added patient history of opioid use disorder (OUD) to the list of risk factors for overdose.

Children Youth and Families

There are continued active legislative changes around the use/monitoring of psychotropic medication in youth. The County of San Diego has and will continue to disseminate information about legislative changes to the Children's System of Care.

In April 2015, Department of Health Care Services published "California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care" (CA Guidelines). These guidelines target youth involved in county child welfare and probation agencies and is specific to those children and youth who are placed in foster care. Foster Care is defined as 24-hour substitute care for children placed away from their parents or guardians and for whom the State and/or county agency has placement care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, childcare institutions, and pre-adoptive homes. County of San Diego prescribers should be familiar with the CA Guidelines as they shall serve as the guideline for provision of care locally to all youth.

https://www.chhs.ca.gov/wp-content/uploads/2017/06/Committees/California-Child-Welfare-Council/Council-Meeting-Information/after-march-2-2016/CA-Guidelines-for-Use-of-Psychotropic-Medication-with-Children-and-Youth-in-Foster-Care.pdf

Appendix A of this document "Prescribing Standards with Children and Youth in Foster Care" provides guidelines regarding the number of allowable medication for youth in specific age groups. County of San Diego prescribers should be familiar with Appendix A as this shall serve as the guideline for provision of care locally.

This document includes as Appendix B the Los Angeles "Department of Mental Health Parameters 3.8 For Use of Psychotropic Medication in Children and Adolescents." DHCS has recognized this living document as the guideline for provision of psychotropic medication. County of San Diego prescribers should be familiar with Appendix B as this shall serve as the guideline for provision of care locally. The document is available for download from the Optum website in the OPOH tab, Appendix A.L.2

https://www.optumsandiego.com/content/sandiego/en/county-staff---providers/orgpublicdocs.html

The Department of Social Services (CDSS), in collaboration with stakeholders, developed measures to track youth in foster care who received a paid claim for psychotropic medication from the California Department of Health Care Services. These measures will be publicly posted with a goal of improving the health and well-being of youth in care. Those measures include select Healthcare Effectiveness Data and Information Set (HEDIS) measures and Child Welfare Psychotropic Medication Measures. County of San Diego providers shall be familiar with these measures as they shall serve as the guideline for provision of care locally to all youth. For recommended monitoring parameters please check Attachment A.L.1.

Monitoring Controlled Substance Prescriptions

For the past number of years, abuse of prescription drugs has become increasingly prevalent. In September 2016, Senate Bill 482 pertaining to controlled substances and the CURES database was enacted. This law requires a health care practitioner to consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, III or IV controlled substance for the first time to that patient and at least once every four months thereafter, if the prescribed controlled substance remains part of the patient's treatment, with specified exemptions. The County of San Diego expects prescribers to document monitoring efforts consistent with this law.

Client/Family Education Program

Client and family education and involvement with treatment are essential to achieving successful outcomes. A Road Map to Recovery client/family education/program exists for this purpose. A list of group sites at which this peer education and empowerment program is provided can be found on the RHIS website at: https://theacademy.sdsu.edu/programs/rihs/roadmap-to-recovery/group-sites/.