Organizational Provider Operations Handbook OPOH

Adult/Older Adult (A/OA)

Children, Youth & Families (CYF)

System of Care (SOC)

Note:

- The Pro Forma and Statement of Work for each Program take precedence over the OPOH. If providers find any elements of their contract to be inconsistent with the OPOH, contact your COR.

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

- For the next five years the County of San Diego will be identified as a managed care delivery system under the Federal Regulation waiver authority Section 1915b.

- All Forms and Manuals referenced in the OPOH can be found on the Optum Website https://www.Optumsandiego.com

- Documents are located under the County Staff & Providers tab. Then click on Organizational Provider Documents link.

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Please visit: optumsandiego.com > References > San Diego County BHS Abbreviations for most updated version

CUSTOMER SERVICE

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

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

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

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

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

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

1. Establish Customer Service Standards which may include elements such as:
    - Answering phones and email in a friendly and timely manner
    - Informing clients when appointments will be cancelled

- Having a positive attitude to clients and families.
- Going the extra mile for clients, such as fitting in one more client when you are about to close, taking more time to explain a bill to a confused client, initiating a friendly conversation, dealing with questions instead of deflecting them to others.
- Having a clean, neat, organized and cheerful workplace can never be undervalued. A welcoming waiting room invites visitors to feel at home and creates an expectation that services will be equally caring and accepting.

2. Ensure that all staff members are aware of the standards and are clear that adhering to Customer Service Standards is an expectation of your organization and your facility.

3. Encourage your customers to give you input that will allow you to make changes to improve the service that you are delivering.

4. Ensure clients and families that if they give input to you or your program about improvements that are needed that they will not face any kind of retaliation.

5. Enhance your program based on the input you receive from customers to demonstrate that you are listening.

6. Make Customer Service training available to all staff.

7. Recognize great customer service

A. SYSTEMS OF CARE (SOC)

Mission of Health and Human Services Agency (HHSA) Behavioral Health Services (BHS)

The mission of the Health and Human Services Agency is: "Through partnerships, and emphasizing prevention, assure a healthier community and access to needed services, while promoting self-reliance and personal responsibility." Behavioral Health Services adds to that mission: "By being committed to making people's lives healthier, safer and self-sufficient by delivering essential services in San Diego County." The broad vision of BHS is to achieve a transformational shift from a model of behavioral health care driven by crises, to one driven by chronic or continuous care and prevention through the regional distribution and coordination of resources to keep people connected, stable, and healthy. Under Substance Use Disorders the mission is further enhanced: "Lead the County of San Diego in reducing substance use disorders through community engagement."

Medi-Cal Transformation

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called Medi-Cal Transformation. Medi-Cal Transformation advances several key priorities by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

The goal of the new Medi-Cal Transformation is to ensure that beneficiaries have access to the right care in the right place at the right time. As part of the Medi-Cal Transformation initiative, the Department of Health Care Services (DHCS) aims to reform behavioral health documentation requirements to improve the beneficiary experience; effectively document treatment goals and outcomes; promote efficiency to focus on delivering person-centered care; promote safe, appropriate, and effective beneficiary care; address equity and disparities; and ensure quality and program integrity.

Medi-Cal Transformation includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including updates to the criteria to access specialty mental health services (SMHS), implementation of standardized statewide screening and transition tools, payment reform, and other changes summarized in the Medi-Cal Transformation proposal and behavioral health information notices.

The vision of the Medi-Cal Transformation is that people should have longer, healthier, and happier lives by utilizing a whole system, person centered approach to health and social care, in which services are only one element of supporting people to have a better health and wellbeing.

This initiative will be an integrated wellness system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

Medi-Cal Transformation has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health,
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

For more information on the Medi-Cal Transformation please visit:
https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx

CLIENT POPULATION SERVED BY THE MENTAL HEALTH PLAN (MHP)

Child, Youth & Families (CYF) System of Care (SOC)

In accordance with Welfare and Institutions (W&I) Code sections 14059.5 and 14184.402, for individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.). The federal EPSDT mandate requires states to furnish all appropriate and medically necessary services that are Medicaid coverable (as described in 42 U.S.C. Section 1396d(a)) as needed to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state's Medicaid State Plan. Consistent with federal guidance from the Centers for Medicare & Medicaid Services, behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition, are thus medically necessary, and are thus covered as EPSDT services. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria below. If a beneficiary under age 21 meets the criteria as described in (1), the beneficiary meets criteria to access SMHS. It is not necessary to establish that they also meet criteria in (2).:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following:
    - Scoring in the high-risk range under a trauma screening tool approved by the department,
    - Involvement in the child welfare system (open child welfare or prevention services case),

- Juvenile justice involvement (has ever been detained or committed to a juvenile justice facility or is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency),
- Experiencing homelessness (Literally homeless, imminent risk of homelessness, unaccompanied youth under 25 who qualify as homeless under other Federal statues, fleeing/attempting to flee domestic violence)

OR

(2) The beneficiary meets both of the following requirements in a) and b) below:

a) The beneficiary has at least one of the following:

- A Significant impairment
- A reasonable probability of significant deterioration in an important area of life functioning
- A reasonable probability a child will not progress developmentally as appropriate
- A need for specialty mental health services, regardless of impairment, that are not included in the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

b) The beneficiary's condition as described in subparagraph (2) above is due to one of the following:

- A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the Internal Statistical Classification of Diseases and Related Health Problems
- A suspected mental disorder that has not yet been diagnosed
- Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional

Seriously Emotionally Disturbed (SED) Clients:

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

Seriously emotionally disturbed children or adolescents means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental

disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

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

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

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

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

CYF SOC Principles

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

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

CYF SOC Values:

- **Collaboration of four sectors:** Coordination and shared responsibility between child/youth/family, public agencies, private organizations, and education.

- **Integrated:** Services and supports are coordinated, comprehensive, accessible, and efficient.

- **Child, youth, and family guided:** Child, youth, and family voice, choice, and lived experience are sought, valued, and prioritized in service delivery, program design and policy development**.**

- **Individualized:** Services and supports are customized to fit the unique strengths and needs of children, youth, and families.

- **Strength-based:** Services and supports identify and utilize knowledge, skills, and assets of children, youth, families, and their community.

- **Community-based**: Services are accessible to children, youth and families and strengthen their connections to natural supports and local resources.

- **Outcome driven**: Outcomes are measured and evaluated to monitor progress and to improve services and satisfaction.

- **Culturally Competent:** Services and supports respect diverse beliefs, identities, cultures, preference, and represent linguistic diversity of those served.

- **Trauma Informed:** Service and supports recognize the impact of trauma and chronic stress, respond with compassion, and commit to the prevention of re-traumatization and the promotion of self-care, resiliency, and safety.

- **Persistence:** Goals are achieved through action, coordination, and perseverance regardless of challenges and barriers.

All providers are encouraged to utilize the 2019 young adult developed Trauma-Informed Care Code of Conduct. This document, created by young adults with lived experience, is intended to guide programs in developing policies and procedures related to trauma informed care, to inform trainings for staff, and to be offered to clients to outline the commitment of the program to follow trauma informed principles.

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

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

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

CYF Goals

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

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

Outcome Objectives

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

FAMILY & YOUTH PARTNERSHIPS

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

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

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

Types of Youth or Family Partners:

Youth or Family Partner: An overarching term for an individual with experience as a child or youth or a parent/caregiver of a child/youth who is or has received services from a public agency serving children and families. Youth & Family Partner roles may include, but are not limited to Administrative, Advocacy/Community Engagement, Training and Supervision, Support Partners (direct service), Peer to Peer, and Outcome and Evaluation activities.

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

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

Y/FSP AS DIRECT SERVICE PROVIDERS

Through system reform the value and benefits of Youth and Family Support Partners was identified. Support Partners do not require a professional license but have firsthand experience in navigating a *public agency serving children* as well as specific training in the supportive role. Welfare and Institutions Code Section 14184.402(a) governs the provision of services to Medi-Cal eligible clients and its provisions determine San Diego County Behavioral Health Services (BHS) policy regarding service provisions to all clients, however funded.

Y/FSP: SELECTION, TRAINING AND SUPERVISION

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

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

2. Training: Minimum Curriculum should include the role and function of the Y/FSP, the role of supervision, basic knowledge of Principles of Family Youth Professional/System Partnership, Pathways to Well Being / Katie A, Children's System of Care (CSOC), community and system resources to which youth/family may be referred. This also includes the safety, cultural competency, boundaries and dual relationships, Systems' Mandate, or introduction to peripheral systems on the child/youth's continuum of care Mandated Reporting

confidentiality, documentation requirements, conflict resolution and effective listening. Other training as specified by employer or BHS-CYF.

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

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

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

Duties and Responsibilities of the Y/FSPs

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

PROVISION OF SERVICES AND CLAIMING

Services and claiming for Y/FSPs shall be classified as Rehabilitation Services (MHS-R), Case Management/Brokerage (CMBR), Intensive Care Coordination (ICC), or Intensive Home-Based Services (IHBS) and limited by the individual employee's experience. Y/FSPs with additional qualifications may be eligible to provide additional services within their scope of practice.

Claiming to Other Funding Sources

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

YOUTH & FAMILY PARTNER ROLES OTHER THAN DIRECT SERVICES

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

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

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

Youth/Family Partnership, both as direct service providers and partners for policy, program, and practice development shall be monitored. All documentation by Y/FSPs in the medical records shall be subject to annual Medical Record Reviews through the County Quality Management (QM) unit. Programs are tasked with implementing regular internal monitoring to ensure that proper documentation and claiming standards are in compliance. In addition, for items not reflected in

charting, such as inclusion of Youth/Family Partners in advisory boards, planning groups, and the like, the monitoring shall be completed via review of sign- in sheets, meeting minutes and group deliverables.

ADULT &OLDER ADULT SYSTEM OF CARE (SOC)

Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

For Beneficiaries 21 years of age or older must meet both of the following criteria:

(1) The beneficiary has one or both of the following:
   - Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities
   - A reasonable probability of significant deterioration in an important area of life functioning.

AND

(2) The beneficiary's condition as described in paragraph (1) is due to either of the following:
   - A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the Internal Statistical Classification of Diseases and Related Health Problems.
   - A suspected mental disorder that has not yet been diagnosed

AOA Populations Served

Clients who are:

- Adults ages of 18-59
- Older adults aged 60 and over
- Transitional Age Youth 18-25 and transitioning from the children's behavioral health system into the adult behavioral health system
- Clients with co-occurring mental health and substance use
- Medi-Cal eligible
- Indigent

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

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

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

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

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

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

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

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

Psychosocial Rehabilitation and Recovery

Adult & Older Adult Mental Health Services (A/OAMHS) utilizes the principles and practices of biopsychosocial rehabilitation and recovery in the System of Care.

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

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

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

San Diego County Adult & Older Adult Behavioral Health, Children, Youth and Families Services and Substance Use Disorders, recognize that clients with a dual diagnosis, a combination of mental illness and substance use, may appear in all parts of the system. These conditions are associated with poor outcomes and higher costs for care. Integrated treatment of co-occurring substance use and mental health diagnosis is recognized evidence-based practice.

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

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

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

For additional information on the Dual Diagnosis initiative, please refer to the County of San Diego Health and Human Services Agency, Co-Occurring Mental Health and Substance Use Disorders, Consensus Document, March 2017; and the County of San Diego, Mental Health Services Policy and Procedures Specialty Mental Health Services for Clients with Co-occurring Substance Use No. BHS 01-02-205 and the HHSA, Dual Diagnosis Strategic Plan, 2005.

Adult & Older Adult Staff Productivity Standard:

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

Older Adult Services

Older adults living with mental illness comprise a segment of the population whose co-occurring health and social problems present ongoing challenges and opportunities for providers of adult mental health services. Recognizing the compounding effects of untreated mental illness on older adults (increased risk for institutionalization, hospitalization and medical services, increased mortality and social isolation, untreated medical illnesses, as well as the barriers that prevent older adults from accessing mental health services). The Adult & Older Adult System of Care's mission and vision are: to make people's lives healthier, safer, and more self-sufficient by delivering essential services and to provide recovery and wellness services to adults and older adults in the behavioral health system to be healthier and more independent.

Providers will participate in ongoing training regarding meeting the unique needs of older adult clients. In addition, providers will participate in networking efforts with providers of collateral services for older adults, to continue to develop the system-wide capacity and expertise.
For additional information, please refer to the California Department of Health Care Services (DHCS), California's Master Plan for Aging, 2019 and AIS Aging Roadmap, 2020.

Peer Support Specialist Recovery and Rehabilitation Services

As with the fields of physical disability and substance use disorder service, there is a long history of peer support within behavioral health services. The County of San Diego BHS recognizes the value of individuals in the process of recovery from mental health or substance use conditions, either as a consumer of these services or as the parent/family member of a consumer. BHS supports the provision of Peer Support Specialist services throughout the system of care, including, but not limited to, outpatient clinics, case management programs and clubhouses. This position has distinct services as part of a multidisciplinary team creating recovery opportunities for individuals receiving services. Peer Support Certification is required, with training to align with County designated certification process.

Providers shall utilize the talents of individuals with lived experience in competitive employment positions which align with the education and experiences of the individual.

Services for Persons Experiencing Homelessness

Homeless Outreach Services

Homeless Outreach Services are provided to individuals who are homeless to determine if there is a suspected serious mental illness and/or substance use problem. Homeless Outreach Services consist of the following services:

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

Flexible Funds

Flexible Funds are used for client-related needs including food, clothing, transportation, and other incidentals necessary for accessing ongoing benefits.

Short Term & Bridge Housing

Homeless Outreach Workers are the gatekeepers and case managers of the utilization of Short Term & Bridge Housing. Participants utilizing these beds engage with the Homeless Outreach Workers and Peer Support Specialists (through separately contracted provider) to work towards identified goals, including permanent housing.

Additional References:

Regional Homeless snapshot: Data source Service Point, prepared by the Regional Task Force on Homelessness.

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

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

B. COMPLIANCE AND CONFIDENTIALITY

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

COMPLIANCE

County Programs

As part of this commitment, all County Mental Health Services workforce members[1] shall be familiar with and adhere to Agency Compliance Office (ACO) policies and procedures. In addition, County Mental Health Programs shall have processes that ensure adherence to the HHSA Code of Conduct. All ACO policies and procedures, including the Code of Conduct, may be found on the ACO website, www.cosdcompliance.org.

Contracted Programs

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

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

Compliance Standards

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

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

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

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

MHP's Compliance Hotline

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

Mandated Reporting

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

Documentation Requirements

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

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

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

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

Claiming and Reimbursement of Mental Health Services

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

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

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

Coding and Billing Requirements

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

- Services must be coded in compliance with the Management Information System User Manual, Organization Provider Operations Handbook (OPOH) and the Financial Eligibility and Billing Manual.
- Diagnoses must be coded using the International Classification of Diseases (ICD-10). In general, a diagnosis is made using the fuller descriptions of the Diagnostic and Statistical Manual, and "cross-walked" to the correct service code for SmartCare by the clinician. The service code should result in the highest level of specificity in recording the diagnosis.
- Services are recorded in SmartCare through progress note entry or if done on paper on the corresponding downtime form. If completed on paper, the document is then scanned into the HER and viewed on the "Documents (Client)" page. The program should follow the Administrative Service Entry instructions..
- Documentation standards associated with coding and billing requirements can be found in the OPOH, Section G, UCRM, Financial Eligibility and Billing Manual, and the CPT Crosswalk located on the Optum website, www.optumsandiego.com.

False Claims Act

The Federal False Claims Act[3] (FCA) helps the government combat fraud in federal programs, purchases, and contracts. The California False Claims Act[4] (CFCA) applies to fraud involving state, city, county or other local government funds. All workforce members shall report any suspected inappropriate activity related to these Acts, which include acts, omissions or procedures that may violate the law or HHSA procedures. Some examples include:

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

County and County Contracted Programs are required to promptly report circumstances that may affect the beneficiary's eligibility such as the death of a beneficiary to the California Department of Health Care Services (DHCS). in addition to notifying the DHCS, the County or County Contracted Programs shall conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed.

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

[3] 31 U.S.C. §§ 3729-3733.
[4] CA Gov't Code §§ 12650-12655.

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

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

In addition, any potential fraud, waste, or abuse shall be reported directly to DHCS' State Medicaid Fraud Control Unit. Reporting can be done by phone, online form, email or by mail.

- 1-800-822-6222
- fraud@dhcs.ca.gov
- Medi-Cal Fraud Complaint – Intake Unit Audits and Investigations
  P.O. Box 997413
  MS 2500 Sacramento, CA 95899-7413

All reporting shall include contacting your program COR immediately, as well as the BHS QA team at QIMatters.HHSA@sdcounty.ca.gov to report any of these same concerns, or suspected incidents of fraud, waste, and/or abuse.

Program Integrity- Service Verification

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

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

CONFIDENTIALITY

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

MHP Responsibilities

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

COMPLIANCE AND CONFIDENTIALITY

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

- Be trained on privacy and security of client data and shall sign a certification indicating the workforce member's name and date on which the training was completed. The certifications shall be kept at least six years. Training must be provided within a reasonable period of time upon hire and at least annually thereafter. If any County or Contracted program needs assistance with privacy and security training, reach out to the ACO at 619-338-2808 or privacyofficer.hhsa@sdcounty.ca.gov.
- Sign a confidentiality statement prior to provision of client information. The statement must adhere to State Agreement requirements, currently including, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies sections and retention for six years.
- Only access client records as necessary to perform their jobs.
- Will otherwise act in accordance with good judgment, clinical and ethical standards and applicable privacy laws to ensure that all written and verbal communication regarding each client's treatment and clinical history is kept confidential.

Notice of Privacy Practices

County and Contracted Programs must provide a HIPAA-compliant Notice of Privacy Practices (NPP) to all clients, as well as those with authority[6] to make treatment decisions on behalf of the client. A notation is made on the Behavioral Health Assessment form when the NPP has been offered. Providers should ensure clients (and those with authority) understand the NPP and address any client questions about client privacy rights and the Program's privacy requirements.

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

Uses and Disclosures of Records

The County of San Diego BHS manages an electronic health record (EHR) for the MHP County and Contracted providers. The EHR holds client's protected health information (PHI) which is

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

accessible by County and Contracted providers in order to improve coordination of care across the MHP System of Care. PHI documented within the EHR is also used for internal County operation purposes.

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

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

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

Client Requests for Records

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

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

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

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

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

Client Requests for Amendment and Client Requests for Accounting of Disclosure

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

When a program receives a request to amend records within their internal electronic health records, the program should work with their Compliance Officer and follow internal policies and procedures in alignment with related regulations.

Handling/Transporting Medical Record Documents

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

- Client records must be maintained at a site that complies with Article 14 requirements, including the current State Agreement. This means no client information may be left at a site unless that site has a contract with the County that includes Article 14. If a program is unsure, they should check with their Contracting Officer's Representative (COR).
- County workforce members may, as needed, transport client records and/or keep client records overnight at a personal residence if they have completed the ACO approved data safeguarding form (HHSA 23-26) and follow the applicable ACO Policy and Procedures (HHSA L-26). Contracted workforce members should develop their own policies and procedures that comply with Article 14 and State Agreement requirements. Programs should

only remove client information from program offices for approved business purposes, with prior management approval, and information shall be stored in an appropriate manner.

- Programs shall sign in and out records, as needed.
- When saving client contact information on an encrypted device, such as a phone or laptop, include the minimum client identifying information necessary. Remember that even identifying an individual as receiving mental health services is protected information. Client information should not be stored on a non-encrypted device (such as a flip phone).
- No workforce member may ever leave client information unattended in a car, even if the records are in a locked box, and/or inside a locked trunk, and/or it's only for a few minutes.
- When transporting client information out of the Program office or clinic, include only the minimum client identifying information needed.

Privacy Incidents

A privacy incident[7] is an incident that involves the following:

- Unsecured protected information in any form (including paper and electronic); or
- Any suspected incident, intrusion, or unauthorized access, use, or disclosures of protected information; or
- Any potential loss or theft of protected information.

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

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

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

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

Privacy Incident Reporting (PIR) for Staff and Management

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

San Diego County contracted providers should work directly with their agency's legal counsel to determine external reporting and regulatory notification requirements. Additional compliance and privacy resources are available at:
https://www.sandiegocounty.gov/hhsa/programs/sd/compliance_office/

C. ACCESSING SERVICES

Consistent with the Health and Human Services Agency's "No Wrong Door" policy (BHIN 22-011) , clients may access mental health services through multiple points of entry. Clients may call the Access and Crisis Line (ACL), call or walk into an organizational provider's program directly, or walk into a County-operated program.

Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services, and the Medi-Cal Provider Manual: Non-Specialty Mental Health Services: Psychiatric and Psychological Services, MCPs are required to provide or arrange for the provision of the following non-specialty mental health services (NSMHS):

- Mental health evaluation and treatment, including individual, group and family psychotherapy.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring drug therapy.
- Psychiatric consultation.
- Outpatient laboratory, drugs, supplies, and supplements.

The county MHP shall provide or arrange for clinically appropriate, covered SMHS to include prevention, screening, assessment, treatment services. These services are covered and reimbursable even when:

1. Services were provided prior to determining a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met.
2. The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.
3. The beneficiary has a co-occurring mental health condition and substance use disorder; or
4. NSMHS and SMHS services are provided concurrently if those services are coordinated and not duplicated.

SMHS Provided During the Assessment Period Prior to Determination of a Diagnosis or Prior to Determination of Whether SMHS Access Criteria Are Met

- Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the beneficiary meets access criteria for SMHS. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the beneficiary does not meet criteria for access to SMHS. MHPs must not deny or disallow reimbursement for SMHS provided during the assessment process described above if the assessment determines that the beneficiary does **not** meet criteria for access to SMHS or meets the criteria for NSMHS.

- MHPs, DMC and DMC-ODS programs and providers may use the following options during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established:
    - ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).
    - ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.
    - In cases where services are provided due for a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMPH in the CMS-approved ICD-10 diagnosis code list11, which may include Z codes. LPHA and LMHP may use any clinically appropriate ICD-10 code12. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

Co-occurring Substance Use Disorder

- Clinically appropriate and covered SMHS delivered by MHP providers are covered Medi-Cal services whether or not the beneficiary has a co-occurring SUD. MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary who meets SMHS criteria based on the beneficiary having a co-occurring SUD, when all other Medi-Cal and service requirements are met. Similarly, clinically appropriate, and covered Drug Medi-Cal (DMC) services delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) services delivered by DMC-ODS providers are covered by DMC counties and DMC-ODS counties, respectively, whether or not the beneficiary has a co-occurring mental health condition. Likewise, clinically appropriate and covered NSMHS are covered Medi-Cal services via the FFS and MCP delivery systems whether or not the beneficiary has a co-occurring SUD. Similarly, clinically appropriate, and covered SUD services delivered by MCP providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment; MAT) are covered by MCPs whether or not the member has a co-occurring mental health condition.

Concurrent NSMHS and SMHS

- Beneficiaries may concurrently receive NSMHS via FFS or MCP provider and SMHS via a MHP provider when the services are clinically appropriate, coordinated and not duplicative. When a beneficiary meets criteria for access to both NSMHS and SMHS, the beneficiary should receive services based on individual clinical need and established therapeutic relationships. MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary based on the beneficiary also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Likewise, MCPs must not deny or disallow reimbursement for NSMHS provided to a beneficiary based on the beneficiary also

meeting SMHS criteria and/or receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between MCPs and MHPs to ensure beneficiary choice. MHPs must coordinate with MCPs to facilitate care transitions and guide referrals for beneficiaries receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the beneficiary. Such decisions should be made via a patient-centered shared decision-making process.

- Beneficiaries with established therapeutic relationships with a FFS or MCP provider may continue receiving NSMHS from the FFS or MCP provider (billed to FFS or the MCP), even if they simultaneously receive SMHS from an MHP provider (billed to the MHP), as long as the services are coordinated between these delivery systems and are non-duplicative (e.g., a beneficiary may only receive psychiatry services in one network, not both networks; a beneficiary may only access individual therapy in one network, not both networks).
- Beneficiaries with established therapeutic relationships with a MHP provider may continue receiving SMHS from the MHP provider (billed to the MHP), even if they simultaneously receive NSMHS from an FFS provider or MCP provider (billed to FFS or the MCP), as long as the services are coordinated between these delivery systems and are non-duplicative.

Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services

The Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (i.e. "Medi-Cal Transformation") initiative for "Screening and Transition of Care Tools for Medi-Cal Mental Health Services" aims to ensure all Medi-Cal beneficiaries receive coordinated services across Medi-Cal mental health delivery systems and improve health outcomes. The goal is to ensure beneficiary access to the right care, in the right place, at the right time.

The Screening and Transition of Care Tools for Medi-Cal Mental Health Services guide referrals to the Medi-Cal mental health delivery system (i.e., Medi-Cal Managed Care Health Plan (MCP) or MHP) that is expected to best support each beneficiary. DHCS is requiring MCPs and MHPs to use the Screening and Transition of Care Tools – for beneficiaries under age 21 (youth) and for beneficiaries age 21 and over (adults). (BHIN 22-065) The Screening and Transition of Care Tools for Medi-Cal Mental Health Services consist of:

- The Adult Screening Tool for Medi-Cal Mental Health Services.
- The Youth Screening Tool for Medi-Cal Mental Health Services.
- The Transition of Care Tool for Medi-Cal Mental Health Services.

Adult and Youth Screening Tool

The Adult and Youth Screening Tools determine the appropriate delivery system referral for beneficiaries who are not currently receiving mental health services when they contact the MCP or MHP seeking mental health services. The Screening Tools are not required or intended for use with beneficiaries who are currently receiving mental health services. The Screening Tools are also not required for use with beneficiaries who contact mental health providers directly to seek mental health services. Mental health providers who are contacted directly by beneficiaries seeking mental health services are able to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy described in BHIN 22-011 or subsequent updates.

The Screening Tool will be completed by either the MCP or Optum ACL and if deemed appropriate, a referral will be made to the appropriate individual FFS or organizational provider. Upon receiving the referral, the provider/program will ensure that Timeliness Standard requirements are followed.

The Adult and Youth Screening Tools do **not** replace:

a. MHP policies and procedures (P&P) that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals.
b. MHP protocols that address clinically appropriate, timely, and equitable access to care.
c. MHP clinical assessments, level of care determinations, and service recommendations.
d. MHP requirements to provide EPSDT services.

Completion of the Adult or Youth Screening Tool is not considered an assessment. Once a beneficiary is referred to the MCP or MHP, they shall receive an assessment from a provider in that system to determine medically necessary mental health services.

Description of the Adult and Youth Screening Tools

The Adult and Youth Screening Tools are designed to capture information necessary for identification of initial indicators of a beneficiary's mental health needs for the purpose of determining whether the MHP must refer the beneficiary to their MCP or to an MHP provider (county-operated or contracted) to receive an assessment. The Adult and Youth Screening Tools include both screening questions and an associated scoring methodology. The screening questions and associated scoring methodology of the Adult and Youth Screening Tools are distinct and described below.

Adult Screening Tool

The Adult Screening Tool includes screening questions that are intended to elicit information about the following:

a. Safety: information about whether the beneficiary needs immediate attention and the reason(s) a beneficiary is seeking services.
b. Clinical Experiences: information about whether the beneficiary is currently receiving treatment, if they have sought treatment in the past, and their current or past use of prescription mental health medications.
c. Life Circumstances: information about challenges the beneficiary may be experiencing related to school, work, relationships, housing, or other circumstances.
d. Risk: information about suicidality, self-harm, emergency treatment, and hospitalizations*

*If the beneficiary responds affirmatively to the question related to suicidality, the MHP must immediately coordinate referral to an MHP provider (county-operated or contracted) for further clinical evaluation of suicidality after the screening is complete. Referral coordination should include sharing the completed Adult Screening Tool and follow up to ensure an evaluation was rendered. The referral and subsequent evaluation may or may not impact the mental health system referral generated by the screening score.

The Adult Screening Tool also includes questions related to substance use disorder (SUD). If a beneficiary responds affirmatively to these SUD questions, they shall be offered a referral to the county behavioral health plan for SUD assessment. The beneficiary may decline this referral without impact to their mental health delivery system referral.

Youth Screening Tool

The Youth Screening Tool includes screening questions designed to address a broad range of indicators for beneficiaries under the age of 21. A distinct set of questions are provided for when a beneficiary under the age of 21 is contacting the MHP on their own. A second set of questions with slightly modified language is provided for use when a person is contacting the MHP on behalf of a beneficiary under the age of 21.

The Youth Screening Tool screening questions are intended to elicit information about the following:

1. Safety: information about whether the beneficiary needs immediate attention and the reason(s) a beneficiary is seeking services.
2. System Involvement: information about whether the beneficiary is currently receiving treatment and if they have been involved in foster care, child welfare services, or the juvenile justice system.
3. Life Circumstances: information about challenges the beneficiary may be experiencing related to family support, school, work, relationships, housing, or other life circumstances.
4. Risk: information about suicidality, self-harm, harm to others, and hospitalizations.

*If the beneficiary responds affirmatively to the question related to suicidality, the MHP must immediately coordinate referral to an MHP provider (county-operated or contracted) for further clinical evaluation of suicidality after the screening is complete. Referral coordination should include sharing the completed Adult Screening Tool and follow up to ensure an evaluation was rendered. The referral and subsequent evaluation may or may not impact the mental health system referral generated by the screening score.

The Youth Screening Tool includes questions related to SMHS access and referral of other services. Specifically:

- Questions related to SMHS access criteria, including those related to involvement in foster care or child welfare services, involvement in the juvenile justice system, and experience with homelessness. If a beneficiary under the age of 21, or the person on their behalf, responds affirmatively to the questions related to SMHS access criteria, they shall be referred to the MHP for an assessment and medically necessary services. Please reference BHIN 23-041 for additional detail on SMHS criteria and definitions of key terminology.
- A question related to substance use. If a beneficiary under the age of 21, or the person on their behalf, responds affirmatively to the question related to substance use, they shall be offered a referral to the county behavioral health plan for SUD assessment. The beneficiary may decline this referral without impact to their mental health delivery system referral.

Administering the Adult and Youth Screening Tools

The Adult and Youth Screening Tools can be administered by clinicians or non-clinicians in alignment with MHP protocols and may be administered in a variety of ways, including in person, by telephone, or by video conference. Adult and Youth Screening Tool questions shall be asked in full using the specific wording provided in the tools and in the specific order the questions appear in the tools, to the extent that the beneficiary is able to respond. Additional questions shall not be added to the tools. The scoring methodologies within the Adult and Youth Screening Tools shall be used to determine an overall score for each screened beneficiary. The Adult and Youth Screening Tool score determines whether a beneficiary is referred to their MCP or the MHP for assessment and medically necessary services. Please refer to the Adult and Youth Screening Tools for further instructions on how to administer each tool.

The Adult and Youth Screening Tools are provided as portable document formats (PDFs) and are available on the Optum Website; however, MHPs are not required to use the PDF format to administer the tools. MHPs may build the Adult and Youth Screening Tools into existing software systems, such as electronic health records (EHRs). The contents of the Adult and Youth Screening Tools, including the specific wording, the order of questions, and the scoring methodology shall remain intact.

Following Administration of the Adult and Youth Screening Tools

After administration of the Adult or Youth Screening Tool, a beneficiary's score is generated. Based on their screening score, the beneficiary shall be referred to the appropriate Medi-Cal mental health delivery system (i.e., either the MCP or the MHP) for a clinical assessment. If a beneficiary is referred to an MHP based on the score generated by MCP administration of the Adult or Youth Screening Tool, the MHP must offer and provide a timely clinical assessment to the beneficiary without requiring an additional

screening and in alignment with existing standards as well as medically necessary mental health services.

If a beneficiary shall be referred by the MHP to the MCP based on the score generated by the MHP's administration of the Adult or Youth Screening Tool, MHPs shall coordinate beneficiary referrals with MCPs or directly to MCP providers delivering NSMHS. Referral coordination shall include sharing the completed Adult or Youth Screening Tool and following up to ensure a timely clinical assessment has been made available to the beneficiary. Beneficiaries shall be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice.

The Adult and Youth Screening Tools shall not replace MHPs' protocols for emergencies or urgent and emergent crisis referrals. For instance, if a beneficiary is in crisis or experiencing a psychiatric emergency, the MHP's emergency and crisis protocols shall be followed.

For complete instructions on how to complete the Adult and Youth Screening Tools, please refer to the Explanation Sheet that can be found on the Optum website (www.optumsandiego.com).

Transition of Care Tool

The Transition of Care Tool for Medi-Cal Mental Health Services is intended to ensure that beneficiaries who are receiving mental health services from one delivery system receive timely and coordinated care when either: (1) their existing services need to be transitioned to the other delivery system; or (2) services need to be added to their existing mental health treatment from the other delivery system consistent with the No Wrong Door policies regarding concurrent treatment set forth in W&I section 14184.402(f) and described in BHIN 22-011 and APL 22-005 and continuity of care requirements described in MHSUDS IN 18-059 and APL18-008, or subsequent updates. The Transition of Care Tool documents beneficiary needs for a transition of care referral or a service referral to the MCP or MHP.

The Transition of Care Tool does not replace:

a. MHP P&Ps that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals.
b. MHP protocols that address clinically appropriate, timely, and equitable access to care.
c. MHP clinical assessments, level of care determinations, and service recommendations.
d. MHP requirements to provide EPSDT services.

Completion of the Transition of Care Tool is not considered an assessment.

Description of Transition of Care Tool

The Transition of Care Tool is designed to leverage existing clinical information to document a beneficiary's mental health needs and facilitate a referral for a transition of care to, or addition of services from the beneficiary's MCP or MHP, as needed. The Transition of Care Tool documents the beneficiary's information and referring provider information. Beneficiaries may be transitioned to their MCP or MHP for all, or a subset of, their mental health services based on their needs. The Transition of Care Tool is designed to be used for both adults and youth alike. The Transition of Care Tool provides information from the entity making the referral to the receiving delivery system to begin the transition of the beneficiary's care.

The Transition of Care Tool includes specific fields to document the following elements:

- Referring plan contact information and care team.
- Beneficiary demographics and contact information.
- Beneficiary behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications.
- Services requested and receiving plan contact information.

Referring entities may provide additional documentation, such as medical history reviews, care plans, and medication lists, as attachments to the Transition of Care Tool.

Administering the Transition of Care Tool

MHPs are required to use the Transition of Care Tool to facilitate transitions of care to MCPs for all beneficiaries, including adults aged 21 and older and youth under age 21, when their service needs change. The determination to transition services to and/or add services from the MCP delivery system must be made by a clinician via a patient-centered shared decision-making process in alignment with MHP protocols. Once a clinician has made the determination to transition care or refer for additional services, the Transition of Care Tool may be filled out by a clinician or a non-clinician. Beneficiaries shall be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice. The Transition of Care Tool may be completed in a variety of ways, including in person, by telephone, or by video conference.

The Transition of Care Tool is provided as a PDF document, but MHPs are not required to use the PDF format to complete the tool. MHPs may build the Transition of Care Tool into existing systems, such as EHRs. However, the contents of the Transition of Care Tool, including the specific wording and order of fields, shall remain intact. The information shall be collected and documented in the order it appears on the Transition of Care Tool, and additional information shall not be added to the forms but may be included as attachments. Additional information enclosed with the Transition of Care Tool may include documentation such as medical history reviews, care plans, and medication lists.

Following Administration of the Transition of Care Tool

After the Transition of Care Tool is completed, the beneficiary shall be referred to their MCP, or directly to an MCP provider delivering NSMHS if appropriate processes have been established in coordination with MCPs. Consistent with BHIN 22-011 and APL 22-005, or subsequent updates, MHPs shall coordinate beneficiary care services with MCPs to facilitate care transitions or addition of services, including ensuring that the referral process has been completed, the beneficiary has been connected with a provider in the new system, and the new provider accepts the care of the beneficiary, and medically necessary services have been made available to the beneficiary. All appropriate consents shall be obtained in accordance with accepted standards of clinical practice.

Health Plan	Transition Tool Referrals & Contact
Blue Shield CA Promise Health Plan	BSCPromiseCMC@beaconhealthoptions.com
Community Health Group	Salvador Tapia 1-800-404-3332 Stapia@chgsd.com
Kaiser Permanente	Transition Tools Fax: 858-451-5199 Questions: Michelé Buland Michele.k.buland@kp.org
Molina Healthcare	Adults: (833) 234-1258 – Care Mngmnt Email: CMescalationCA@MolinaHealthCare.Com and cc: MHC_BH_Solutions@MolinaHealthcare.com Youth: (562) 506-1249 – Care Mngmnt Email: MHCHealthcareservicesCCS/RCCasemanagement@MolinaHealthcare.com and cc: MHC_BH_Solutions@MolinaHealthcare.com

For complete instructions on how to complete the Transition Tool, please refer to the Explanation Sheet that can be found on the Optum website (www.optumsandiego.com).

Timely Access Data Tool (TDAT)

In accordance with California Health & Safety Code § 1367.03 requirements, organizational providers and County-operated clinics must maintain logs of all persons requesting Specialty Mental Health Services. Required information includes the date of inquiry, client's name, nature, and degree of urgency of the request, and disposition of request. The Timely Access Data Tool (TDAT) is available and completed through the electronic health record (EHR). Should access to the EHR be unavailable, the form can also be located on the Optum Website **(www.optumsandiego.com).** The FAQ & Tip Sheet for how and when to complete, the Access to Services Journal is located on the Optum website **(www.optumsandiego.com)** under the Communications Tab.

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

Urgent Psychiatric Condition

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

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

Routine Condition

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

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

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

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

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

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

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

MHP Services Authorization Requirement Provided by Optum

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

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

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

Referrals to the ACL

It is appropriate to refer individuals to the ACL for:

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

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

Provider Interface with the ACL

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

of the client. (Please obtain a signed Release of Information from the client). To facilitate the most effective ACL response to the high-risk client's needs when he or she calls, please provide the ACL with all relevant clinical and demographic information.

Receiving Referrals from the ACL

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

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

Hours of Service Availability

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

Language Assistance

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

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

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

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

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

Provider Selection, Terminations, Incentives

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

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

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

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

The MHP does not currently offer any physician incentive plans.

Requests for Continuity of Care

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

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

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

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

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

<u>Validating Pre-existing Provider Relationships</u>
An existing relationship with a provider may be established if the beneficiary has seen the out-of-network provider at least once during the 12-months prior to the following:

- The beneficiary establishing residence in the county.
- Upon referral by another MHP or MCP; and/or,
- The MHP determining the beneficiary meets criteria for access to SMHS.

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

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

Timeline Requirements

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

- Thirty calendar days from the date the MHP received the request.
- Fifteen calendar days if the beneficiary's condition requires more immediate attention, such as upcoming appointments or other pressing care needs: or,
- Three calendar days if there is a risk of harm to the beneficiary.

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

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

A continuity of care request is considered complete when:

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

Requirements Following Completion of Continuity of Care Request

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

beneficiary's authorized representative, in writing, of the following:

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

The written notification to the beneficiary must comply with Title 42 of the Code of Federal Regulations, part 438.10(d) and include the following:

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

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

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

Repeated Requests for Continuity of Care

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

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

Beneficiary and Provider Outreach and Education

MHPs must inform beneficiaries of their continuity of care protections and must include

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

Reporting Requirements

MHPs are required to report to DHCS all requests, and approvals, for continuity of care. The MHP must submit a continuity of care report, with the MHPs quarterly network adequacy submissions, that includes the following information:

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

Continuity of Care Requests Processed by ASO

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

Clients Who Must Transfer to a New Provider

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

- The client and caregiver should be informed of the impending change as soon as it is clinically indicated and possible, but at least 14 days prior to the final visit with the first provider.
- The client and caregiver should be informed of the client's right to request a new provider.
- The client and caregiver should be encouraged to voice their needs regarding provider clinical and language capabilities, time of appointment, location of the new clinic or program, transportation, etc.

- Report transfers on the Suggestion and Provider Transfer Log, which is found on the required Quarterly Status Report.
- The client should be assisted in making a first appointment with the new program.
- The old and new program must communicate as completely as possible, via case consultations, phone conversations, and release of discharge summaries and other chart materials.
- A thorough discharge summary (or a transfer note if the client will continue in the same program) should be written and incorporated into the chart.
- Final outcome tools should be administered if the client will go to another provider program.
- A written plan for emergency services should be developed with the client and caregiver, to include the ACL, the new program, and informal supports.

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

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

MOBILE CRISIS SERVICES

Mobile crisis services provide rapid response, individual assessment and community-based stabilization to client who are experiencing a behavioral health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care and psychiatric inpatient hospitalizations.

Psychiatric Emergency Response Team (PERT)

PERT contributes to the well-being of individuals experiencing a mental health crisis that have come in contact with law enforcement. PERT has been designed to improve collaboration between the behavioral health and law enforcement systems with the goal of a more humane and effective handling of incidents involving law enforcement officers and individuals with mental illness, developmental disabilities and/or substance use disorders.

Service Delivery and Training

- Contractor shall provide direct client interventions in conjunction with law enforcement officers to individuals experiencing a mental health crisis.
- Contractor shall reduce inappropriate hospitalization and/or incarceration for clients and to refer the client to the most appropriate, least restrictive mental health program.
- Contractor shall refer and link individuals to needed services.
- Contractor shall provide client follow up services as appropriate.
- Contractor shall provide required trainings and community outreach as outlined within the contractual requirements.

Mobile Crisis Response Teams (MCRT)

No sooner than January 1, 2023, and upon receiving approval from DHCS, county MHPs, DMC counties, and DMC-ODS counties (collectively, "Medi-Cal behavioral health delivery systems") shall provide, or arrange for the provision of, qualifying mobile crisis services in accordance with the requirements set forth in the BHIN 23-025.

The County of San Diego has contracted with current system of care providers to provide these services and align with the requirements outlines in the BHIN. All mobile crisis teams, regardless of delivery system, shall meet the same requirements. The County of San Diego has implemented a fully integrated approach across both the mental health and SUD delivery systems.

Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the beneficiary is experiencing the behavioral health crisis. Locations may include, but are not limited to, the beneficiary's home, school, or workplace, on the street, or where a beneficiary socializes. Mobile crisis services shall be available to beneficiaries experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year. Mobile crisis teams shall meet the standards outlined in BHIN 23-025.

Mobile crisis response teams shall arrive at the community-based location where a crisis occurs in a timely manner (2 42 U.S.C. § 1396w–6(b)(2)(C); CMS, SHO #21-008, (Dec. 28, 2021) p. 7). Specifically, mobile crisis teams shall arrive:

- Within 60 minutes of the beneficiary being determined to require mobile crisis services in urban and within 120 minutes in rural areas.

Each service encounter shall cover the following service components:

- Initial face-to-face crisis assessment;
- Mobile crisis response;
- Crisis planning, as appropriate, or documentation in the beneficiary's progress note of the rationale for not engaging the beneficiary in crisis planning;
- Facilitation of a warm handoff, if needed;
- Referrals to ongoing services, if needed; and

- Follow-up check-ins, or documentation in the beneficiary's progress note that the beneficiary could not be contacted for follow-up despite reasonably diligent efforts by the mobile crisis team. *Note: follow-ups to the beneficiary shall occur within 72 hours of the initial crisis response.

Mobile crisis services include warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services; coordination with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care. Mobile crisis services are directed toward the beneficiary in crisis but may include contact with a family member(s) or other significant support person(s) if the purpose of the support person's participation is to assist the beneficiary in addressing their behavioral health crisis and restoring the beneficiary to the highest possible functional level. For children and youth, in particular, mobile crisis teams shall work extensively with parents, caretakers and guardians, as appropriate and in a manner that is consistent with all federal and state laws related to minor consent, privacy and confidentiality.

All mobile crisis teams shall meet DHCS' core and enhanced training requirements before delivering qualifying mobile crisis services, as outlined in BHIN 23-025. The core training curriculum will include crisis intervention and de-escalation strategies, harm reduction strategies, delivering trauma-informed care, conducting a crisis assessment, and crisis safety plan development. The enhanced training curriculum will include~~,~~ but is not limited to, training in provider safety, delivering culturally responsive crisis care, and crisis response strategies for special populations (e.g., children, youth and families, tribal communities, and beneficiaries with I/DD).

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

Urgent Psychiatric Condition

Title 9 defines an "Urgent Psychiatric Condition" as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition. The County further refers to Urgent as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention.
Access Standard: Face-to-face clinical contact for urgent services shall be within (48) hours of initial client referral.

Exodus and Jane Westin – Full Time Access

- Individuals who walk in and who are not currently receiving services will be triaged/screened. If they are not deemed in need of urgent services, they may be referred to a primary care provider with known capacity, the closest outpatient mental health

provider, or a fee for service provider, via the Access and Crisis Line phone number (client should mention that your program referred them to ACL). The client's choice prevails as per DHCS regulations.

- Clients who are already receiving mental health services and walk in and request medication will be triaged/screened. If they are not deemed in need of urgent services, they may be referred back to their own mental health provider, fee for service provider, or primary care provider. Alternatively, the client may be advised/assisted to call their pharmacist to contact their prescribing physician for a refill.

- Clients who walk in after missing an appointment with their provider will be triaged/screened. If they are not deemed in need of urgent services, they may be referred to their own mental health provider, fee for service provider, or primary care provider. If they are requesting medication, the client may be advised/assisted to call their pharmacist to contact their prescribing physician for a refill.

- Clients with urgent mental health needs and/or urgent medication needs shall be triaged/screened and offered appropriate services, regardless of where the client may be receiving mental health services. If a walk-in clinic staff treats a client open to another program due to urgent service needs, the assigned program should be notified within 24 hours, or the next business day, for follow-up services.

- New clients assessed as needing urgent services that are referred from Exodus or Jane Westin must be prioritized for admission at an outpatient clinic within 48 hours.

- All referrals received that indicate urgency or high risk and that do not show up to the walk-in clinic will prompt a response from the walk-in clinic to the referring party for follow up. If the referring party is a Hospital or CRISIS RESIDENTIAL program, the walk-in clinic will follow up with the client directly.

Outpatient Clinics with Walk-In Urgent Components

- All outpatient clinics in all HHSA Regions shall accommodate their ongoing, opened clients for urgent services to prevent clients from needing to access services at Exodus and Jane Westin.

- All clients who are triaged/screened and are deemed appropriate for routine admission must be admitted in accordance with acceptable access times already established for routine services, or according to the 72-hour policy for clients leaving 24-hour settings or known case management clients.

- Institutions and Case Managers can call a clinic to arrange for a triage day during walk-in times, within 72 hours, and individuals will be given the highest priority to be triaged/screened that day.

- New clients assessed as needing urgent services that are referred from Exodus or Jane Westin must be prioritized for admission at an outpatient clinic within 48 hours.

- Programs must have processes in place to follow up with clients who come in for walk-in services, are triaged/screened and not deemed urgent, but need specialty mental health services at the clinic and are asked to return the following day but who do not show up.

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

Access to Electronic Health Record (EHR):

- In the EHR, the Initial Screening form can be used for the triage/screening contact.

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

All programs:

- The initial site providing service shall ensure that clients do not have to go to multiple facilities for an evaluation.

- MD's/Nurse Practitioners (NP's) must be prepared to provide care to a client who is in urgent need of medications even though the client may be open at another clinic.

- MD's/NP's should be prepared to provide outpatient detox medications to COD clients entering County-contracted detox programs, if in the MD's/NP's opinion it is deemed safe. This will be evaluated on a case-by-case basis.

- All programs shall post signage to inform clients what to do after hours. E.g., "In case of an emergency after business hours please go to the nearest emergency room, call the Access and Crisis Line at-1-888-724-7240, or call 911."

- HIPAA Privacy Rule Sec. 164.506 states that a covered entity may use or disclose protected health information for treatment. This would apply in the case of a clinical

referral source (another clinic, case management, hospital, IMD, etc.) inquiring whether a referred client appeared for their intake process.

Priority List

Prioritization is always based on clinical judgment regarding highest acuity and risk; however the following will generally be highest priority: A client appearing agitated in the waiting room, any Psych hospital/crisis residential discharge, Police/PERT, jail, IMD Client/Out of County locked facility referral, Case Management client with a case manager, acute JWWRC/Exodus referral, homeless or at risk of homelessness with SMI or COD client whose mental status jeopardizes SUD residential placement.

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

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

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

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

ASSISTED OUTPATIENT TREATMENT/LAURA'S LAW

Laura's Law/Assisted Outpatient Treatment authorizes court-ordered outpatient treatment pursuant to Welfare and Institutions Code (WIC) Sections 5345-5349.5 for individuals who have a history of untreated mental illness and meet all seven of the following criteria stipulated in the Code:
https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=5.&title=&part=1.&chapter=2.&article=9.

1. The person is at least 18 years of age.
2. The person is mentally ill as defined in WIC 5600.3
3. There has been a clinical determination based on the person's treatment history and current behavior that at least one of the following is true:
    a. The person is clinically determined to be unlikely to survive safely in the community without supervision.

   b. The person is in need of assisted outpatient treatment in order to prevent relapse or deterioration that would result in grave disability or serious harm to the person or others.
4. The person has a history of treatment non-compliance as evidenced by one of the following:
   - Two occurrences of hospitalizations, or mental health treatment in prison or jail within the last 36 months **OR**
   - One occurrence of serious and violent behavior (including threats) within the last 48 months.
5. The person has been offered treatment (including services described in WIC Section 5348) and continues to fail to engage in treatment.
6. Assisted Outpatient Treatment must be the least restrictive placement to ensure the person's recovery and stability.
7. The person is expected to benefit from AOT.

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

- Anyone at least 18 years of age living with the person.
- Any parent, spouse, sibling at least 18 years of age.
- A director of a public or private agency, treatment facility, charitable organization, or licensed residential care facility providing MH services to the person.
- A director of the hospital where the person is being hospitalized.
- The licensed MH treatment provider supervising treatment of or treating the individual.
- A peace officer, parole officer, or probation officer assigned to supervise the individual.

1) In the event that the referred individual is not engaged in IHOT services, a clinical determination will be made to refer the individual for an assisted outpatient examination. Following the assisted outpatient examination, the individual will be provided with the opportunity to voluntarily enter the assisted outpatient treatment program. If the individual refuses to enter the assisted outpatient treatment program voluntarily, and the individual continues to meet all nine (9) criteria as stated in Laura's Law, a request for an assisted outpatient treatment examination is made through the BHS Director or his designee. Upon receiving the request, the BHS Director or his designee must conduct an investigation into the appropriateness of the filing of the petition.
2) The petition with an affidavit from the designated IHOT licensed mental health clinician (LMHC) shall state that s/he has personally evaluated the person within 10 days prior to the submission of the petition; the person meets all 9 criteria; the LMHC recommends AOT and is willing and able to testify at the hearing on the petition,
   OR

The licensed mental health clinician has made within 10 days of filing the petition appropriate attempts to elicit the cooperation of the person but has not been successful in persuading the person to submit for the AOT examination and is willing and able to testify at the hearing on the petition.

3) If the individual refuses to be examined by a licensed mental health clinician from IHOT, the court may request the individual's consent to the examination by a licensed MH treatment clinician appointed by the court. In the County of San Diego, the Public Conservator's Office is the designated program to conduct the AOT court order examination for individuals who refused the initial examination by IHOT.

4) If the individual does not consent and the court finds reasonable cause, the court may conduct the hearing in the person's absence OR order an individual to be transported to San Diego County Psychiatric Hospital for examination by a licensed mental health professional under WIC 5150. Hold may not exceed 72 hours.

5) In the event that the AOT examination is upheld, the County's designee, San Diego County Counsel, will file the petition with the AOT Judge and upon receipt of the petition, the court must schedule a hearing within five business days. Individuals will be personally served with the petition and notice of hearing date.

6) If after hearing all evidence the court finds the individual does not meet criteria for AOT, the court may dismiss the petition.

7) If the court finds that all nine criteria are met, the court may order the person to AOT for an initial period not to exceed six months. The individual may voluntarily enter into a settlement agreement for services after a petition for an order of AOT is filed, but before the conclusion of the hearing. Settlement agreements may not exceed 180 days and has the same force as an order for AOT.

8) If the person is court ordered for AOT services and is not participating in the AOT program, and if unsuccessful attempts are made to engage the person in AOT, the person may be transported to San Diego Psychiatric Hospital for up to 72 hours to be examined to determine if the person is in need of treatment pursuant to Section 5150.

COMMUNITY ASSISTANCE, RECOVERY AND EMPOWERMENT (CARE) ACT

The Community Assistance, Recovery and Empowerment (CARE) Act program was implemented on October 1, 2023. In collaboration with County and community partners, the CARE Act program creates a new pathway to deliver mental health and substance use services to individuals who are diagnosed with schizophrenia or other psychotic disorders and are not engaged in treatment.

Families, clinicians, first responders, and others may begin the process by filing a petition with the civil court to connect people (ages 18+) to court-ordered, voluntary treatment if they meet criteria and may benefit from the program.

CARE Eligibility Criteria:

An individual shall qualify for the CARE process only if ***all*** of the following are true:

1. The person is 18 years of age or older.
2. The person is currently experiencing a severe mental illness, as defined in paragraph (2) of subdivision(b) of Section 5600.3 and has a diagnosis identified in the disorder class: schizophrenia spectrum and other psychotic disorders, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.
    a. This section does not establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in nature, including, but not limited to, physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions.
    b. A person who has a current diagnosis of substance use disorder as defined in paragraph (2) of subdivision (a) of Section 1374.72 of the Health and Safety Code, but who does not meet the required criteria in this section shall not qualify for CARE process.
    c. A person with a diagnosis identified in the class of mood disorders, including mood disorders with psychotic features, does not meet the required eligibility criteria for CARE process.
3. The person is not clinically stabilized in on-going voluntary treatment.
4. Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure the person's recovery and stability.
5. It is likely that the person will benefit from participation in a CARE plan or CARE agreement.
6. At least one of the following is true:
    a. the person's condition is substantially deteriorating.
    b. The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others, as defined in Section 5150.

If the individual meets criteria above, a CARE petition may be initiated.

CARE Process:

1. **Referral:** A referral can be initiated by family members, behavioral health providers, first responders, or other approved petitioners, by filing a petition with the Superior Court. Petitions must include required State documentation to establish clinical history. Detailed instructions on filing a CARE petition and forms can be found here: CARE Act | Superior Court of California - County of San Diego
2. **Initial Determination:** The Superior Court makes an initial determination as to whether the petition appears to meet criteria for the CARE Act program. If the petition appears to

meet initial criteria, the Superior Court will order County Behavioral Health Services (BHS) to conduct an investigation.

3. **Investigation and Engagement:** County BHS will investigate and report back to the Superior Court within 14 days with a recommendation regarding the establishment of a CARE Act case. During the investigative process, BHS will conduct outreach and attempt to engage petitioned individuals with treatment and may avoid the need for a CARE Act case.
4. **Establishing a CARE Agreement/ Plan:** If the Superior Court determines that a case should be established, a CARE Agreement/Plan will be developed with County BHS, in partnership with the petitioned individual and their counsel. The CARE Agreement/Plan will be submitted to the Superior Court for review.
5. **Connection to Services:** Once a CARE Agreement/Plan is accepted by the Superior Court, BHS and its network of community-based providers such as the Telecare CARE ACT team, will actively engage the individual for whom a CARE Agreement/Plan has been established to connect to services, including behavioral health treatment, stabilization medication, a housing plan, and other supports as needed.

   * Program participation is 12 months but may be extended for an additional 12 months depending upon individual circumstances.

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

Locked/secure facilities service those residents of San Diego County who experience serious psychiatric disabilities and require a secure, safe, and structured environment; these residents are not entitled to services through other systems, either public or private. SF/LTC Facilities funded by the County of San Diego include Institution for Mental Disease Mental Health Rehabilitation Centers (MHRC), Skilled Nursing Facilities/Special Treatment Program (SNF-STP), additional funds for a County SNF Patch, and State Hospitals.

Referral Process

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

1. Referral form for a San Diego County-funded SF/LTC

2. Court Investigative Report for San Diego County LPS Conservatorship

3. Complete Psychiatric Assessment including psychiatric history, substance abuse history and history of self-destructive or assaultive behavior, if applicable

4. Current Physical and Medical History

5. Current medications

6. One week of progress notes (including nursing, group notes, and psychiatrist notes)

7. Hospital face sheet

8. Proof of current Medi-Cal coverage (an Automated Eligibility Verification System [AEVS] strip from the hospital business office) or proof that client is Medi-Cal eligible, and that Medi-Cal has been applied for.

9. Current completed Mini-Cog Exam

10. Current lab reports and toxicology screen from day of admission

11. Result of purified protein derivative (PPD) (tuberculosis [TB] test) or clean chest x-ray done within the past 30 days

12. Recommendation and information from the case manager if client has case management services.

13. Signed payee form

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

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

Target Population

The persons served should have the potential to benefit functionally from psychiatric rehabilitation services and have the capacity to progress to a less restrictive level of care. The client must have a Title 9, ICD 10 psychiatric diagnosis (as the primary diagnosis) and meet the Medi-Cal criteria

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

Eligibility Criteria for Admittance to SF/LTC

To County-Funded Secure Facilities/Long-Term Care

Individuals must meet all the following criteria:

1. Have met Title 9 medical necessity criteria for psychiatric inpatient services at time of referral.

2. Be unable to be maintained at a less restrictive level of care.

3. Have an adequately documented Title 9, ICD 10 diagnosis of a serious, persistent, major**,** non-substance-abuse-related mental disorder as stated in Title 9. This diagnosis must not be primarily a manifestation of developmental delay or other developmental disorder. Clients may also have a secondary, co-occurring substance abuse diagnosis not covered under Title 9. If the sole diagnosis is not covered under Title 9, that diagnosis alone is not sufficient to meet criteria.

4. Have the potential to benefit from psychiatric rehabilitation services and potential to progress to a less restrictive level of care.

5. Be gravely disabled as determined by a court's having established a temporary or permanent public or private San Diego County Lanterman-Petris-Short (LPS) Conservatorship. Grave disability is defined in the Welfare and Institutions Code 5008, Section (h) (1) (A)… "A condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic needs for food, clothing, or shelter."
6. A current resident in the State of California with Medi-Cal eligibility for the County of San Diego.

7. Not be entitled to comparable services through other systems (i.e., Veterans Administration Regional Center, private disability insurance, Forensic system, etc.).

8. Be 18 to 64 years old, although persons 65 and older may be admitted to Skilled Nursing Facilities (SNFs).
9. Have absence of a severe medical condition requiring acute or complex medical care in accordance with applicable Skilled Nursing Facility/Special Treatment Program (SNF/STP) or Mental Health Rehabilitation Center (MHRC) regulations.

10. Have current tuberculosis (TB) clearance.

11. Be on a stable, clinically appropriate medication regimen.

12. Have absence of chronic or recurrent dangerousness to self or others. This includes absence of chronic or recurrent episodes of assaultive behavior.

To San Diego County Funded SNF Patch Facilities

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

To Vista Knoll

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

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

To a State Psychiatric Hospital

Individuals must meet all the following criteria:

1. Individual must be a current or recurrent danger to self or others, which includes chronic or recurrent episodes of assaultive or suicidal behavior**.** Documentation must show that assaultive behavior is a result of psychosis that has been resistant to treatment rather than antisocial behavior, Dementia or Traumatic Brain Injuries (TBI).

2. Individual cannot be admitted or maintained at an Institution for Mental Disease/Mental Health Rehabilitation Center (IMD/MHRC).

3. Admissions to state hospitals shall be approved by the County LTC Coordinator.
4. Individual shall be on LPS Permanent Conservatorship. The Lanterman-Petris-Short (LPS) Conservator must authorize A/OAMHS to provide case management services to monitor the individual's placement and progress.

Reviews of Determination Decisions

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

1. New detailed specific information as to why the individual meets the criteria for admittance.

2. Supportive documentation, as relevant.

The Healthcare Oversight Unit shall review the information and a case conference will be held that includes the Behavioral Health Services Chief Medical Officer. After review of the documentation, San Diego County shall render the final determination regarding admittance.

Placement

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

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

1. Individual meets all criteria for in-County placement;

2. Individual has been refused placement by all in-County facilities, or there are compelling clinical reasons (e.g., deaf program) established that the individual would benefit from out-of-County placement;

3. Public Conservator's Office has approved the placement

4. San Diego County Programs and Services Long Term Care Manager verified that funding is available for placement.

MHP and MCP Responsibility to Provide Services for Eating Disorders

BHIN 22-009 states that the MHPs and MCPs share a joint responsibility to provide medically necessary services to Medi-Cal beneficiaries with eating disorders. Some treatment for eating disorders (both inpatient and outpatient SMHS) are covered by MHPs. Some treatment for eating disorders is also covered by MCPs. Since eating disorders are complex conditions involving both physical and psychological symptoms and complications, the treatment typically involves blended

physical health and mental health interventions, which MCPs and MHPs are jointly responsible to provide.

1. MCPs are responsible for the physical health components of eating disorder treatment and NSMHS, and MHPs are responsible for the SMHS components of eating disorder treatment.

2. MHPs must provide or arrange and pay for, medically necessary psychiatric inpatient hospitalization and outpatient SMHS.

3. MCPs must provide inpatient hospitalization for beneficiaries with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization.

4. MCPs must cover and pay for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations.

5. For partial hospitalization and residential eating disorder programs, MHPs are responsible for the medically necessary SMHS components, and MCPs are responsible for the medically necessary physical health components.

6. DHCS does not require a specific funding split for MHPs and MCPs to share the cost of services provided in partial hospitalization and residential eating disorder programs. DHCS recommends that both parties mutually agree upon an arrangement to cover the cost of these medically necessary services.

Placement in a State Hospital

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

2. Upon approval, the LTC Coordinator at Optum sends the current information provided by the hospital and case manager to the Admissions Coordinator at one of the following State Hospitals: Atascadero, Coalinga, Napa, Patton, Salinas Valley, and Metropolitan State Hospital.

3. Once the state hospital has accepted the client, the county case manager/conservatorship designee shall ensure that all legal documents and paperwork are in order enabling transportation and admission to state hospital.

   a) Certification must be obtained from the County LTC Optum that funds are available to support the placement, by his or her signature on the “Short/Doyle” form.

b) Current Letters and Orders of Conservatorship must be obtained from the Conservator.

c) Authorization must be obtained for the county to provide case management services if conservator is a private conservator.

d) The case manager shall notify the facility and the Optum LTC Coordinator of the discharge and transportation date and time.

e) The referring facility is responsible for arranging for transportation to the state hospital and shall have the client and the client's belongings ready to go.

TRANSITIONAL AGE YOUTH (TAY) REFERRAL PROCESS

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

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

1. The Children, Youth and Families Behavioral Health System of Care service array includes:

    a. The critical care/emergency screening unit, which provides emergency psychiatric evaluation, crisis stabilization, and screening for inpatient care for families during mental health crisis.
    b. Outpatient services which include crisis intervention, mental health assessments, medication management, family therapy, group therapy, Substance Use Disorder (SUD) issues and case management. Services are clinic based, school based, institutionally based, and community based and offered through contracted and Fee for Service providers. These include a number of specialized programs that focus on specific populations.
    c. Full-Service Partnerships are outpatient programs which provide intensive services that comprehensively address client and family needs and "do whatever it takes" to meet those needs.
    d. Case Management/wraparound services are for children, youth and families with complex needs and require intensive supports in addition to treatment service.
    e. Therapeutic Behavioral Services are one on one behavioral service provided by BHS contractors in conjunction with other treatment services.
    f. Day treatment services are several hours per day and all-inclusive in terms of the mental health services provided.

- School based day rehabilitation services are provided through the San Diego Unified, Cajon Valley, and Grossmont Union School Districts. Services are accessed through referral by the district.
- Day Treatment is offered for Dependents of the Court residing in residential treatment and long-term placement at San Pasqual Academy.

g. Inpatient services which are for mental health emergencies that require a hospital setting.
h. Non-residential SUD programs, which provide non-residential specialized SUD services that build a more integrated and coordinated strategy to meet the unique substance abuse treatment and recovery needs of youth. Programs also provide appropriate referrals for youth and their family, if needed.
i. Residential SUD programs, which provide 24/7 structured residential alcohol and other drug (SUD) treatment/recovery and ancillary services.
j. Residential detoxification programs which provide 24/7 SUD detoxification and pre-treatment/referral services.
k. Case Management Juvenile Justice Programs support clients referred by the Probation Department and Juvenile Drug Court to assist in the intervention, treatment and recovery from substance abuse issues. Juvenile justice programs offer services at designated County Probation service centers and the Juvenile Drug Court.

2. The Adult/Older Adult system serves individuals living with serious psychiatric disabilities who may have alcohol and other drug induced problems and the service array includes:

a. Clubhouses which are informal centers with employment and education supports and socialization opportunities with a focus on well-being.
b. Outpatient clinics which provide individual and group therapy and medication support services.
c. Case Management services which provide assistance with linkage to services and community supports as well as psychosocial intervention and resource management to assist individuals to obtain optimum independence.
d. Full-Service Partnership programs which provide intensive services that comprehensively address client and family needs and "do whatever it takes" to meet those needs.
e. Residential programs, which are 24/7, structured treatment programs that may provide individual, group, family therapy and other treatment modalities as appropriate.
f. Crisis Residential programs which are an alternative to acute hospitalization for persons in crisis of such magnitude so as not to be manageable on an outpatient basis.
g. Inpatient services which are for mental health emergencies that require a hospital setting.
h. Non-residential alcohol and other drug (SUD) treatment and recovery programs which provide process, educational and curriculum groups to assist individuals in recovering from substance abuse disorders on an outpatient basis. Programs may also provide specialized services for special populations including criminal justice populations (on a referral basis).
i. Residential SUD programs which provide 24/7 structured treatment and recovery services for individuals requiring a higher level of care.

j. Residential detoxification programs which provide 24/7 SUD detoxification and pre-treatment and referral services.
k. Non-residential and residential women's programs, which provide gender-specific, trauma-informed SUD treatment and recovery services, designed for adult women over the age of eighteen (18), including pregnant, parenting women, and their dependent minor children from birth through and including age seventeen (17).
l. Drug Court programs, which provide non-residential alcohol and other drug (SUD) treatment and testing program services to serve non-violent adult male and female offenders who have been referred to Adult Drug Court.
m. Driving under the Influence (DUI) programs which provide state licensed and mandated education and counseling programs for offenders arrested and convicted of Wet Reckless or first or multiple offense DUI. Programs are funded entirely by participant fees; SUD is responsible for local administration and monitoring.
n. Special population programs which provide SUD
o. Treatment and recovery services to traditionally harder to reach populations, such as Gay, Lesbian, Bi-sexual, and Transgender (GLBT), serial inebriates and HIV positive adults.

Identify the System Target Population

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

   Behavioral Health Information notice (BHIN) No: 21-073 which supersedes BHIN 20-043, in part, provides the criteria for beneficiary access to Specialty Mental Health Services that are medically necessary. For individuals under 21 years of age, a service is meets criteria for access to SMHS and the services are medically necessary if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain,

support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services. Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

Covered specialty mental health services shall be provided to enrolled beneficiaries who meet **either of the following criteria** below. If a beneficiary under age 21 meets the criteria as described in (1), the beneficiary meets criteria to access SMHS. It is not necessary to establish that they also meet criteria in (2).

1. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma by scoring high-risk under a trauma screening tool approved of by the department; involvement in the child welfare system; juvenile justice involvement; experiencing homelessness, imminent risk of homelessness, unaccompanied youth under 25 who qualify as homeless under Federal statues, fleeing/attempting to flee domestic violence.

OR

2. The beneficiary meets **both of the following** requirements:
   a) The beneficiary has **at least one** of the following:
      i. a significant impairment
      ii. a reasonable probability of significant deterioration in an important area of life functioning
      iii. a reasonable probability a child will not progress developmentally as appropriate
      iv. a need for specialty mental health services, regardless of impairment that are not included in the mental health plan benefits that a Medi-Cal managed care plan is required to provide.

AND

   b) The beneficiary's condition is due to **one of the following**:
      i. a diagnosed mental health disorder
      ii. a suspected mental health disorder that has not yet been diagnosed
      iii. significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

- A short-term model of treatment is utilized in CYFBHS.

  - All mental health programs will be on a time-based Utilization Management (UM) cycle and reviews will occur within the program level Utilization Management Committee at each program's identified time-based interval.
  - Outpatient: 6-month UM cycle
  - STRTP: 3-month UM cycle aligned with DHCS 90-day Clinical Review

In the SUD Adolescent programs, the target population is defined as adolescents aged twelve (12) through seventeen (17) years of age with substance use problems. Adolescents learn how

to socialize, grow, and recover in a safe and supportive, youth-focused, alcohol and drug free environment.

2. In the A/OABHS, the target population is defined as individuals with a serious psychiatric illness that threatens personal or community safety or that places the individual at significant risk of grave disability due to functional impairment. In addition, the system of care serves people with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and / or who require unusually complex medication regimens. Required psychosocial services may include illness management, or skill development to sustain housing, social, vocational, and educational goals. In the Adult SUD programs, the target population is defined as individuals in need of SUD treatment and recovery services. The goal of alcohol and other drug treatment and recovery services is to assist individuals to become and remain free of alcohol and other drug problems, which lead to improved individual and family capability, overall functioning, decrease the incidence of crime, and support the person's ability to become self-sufficient through employment. Additionally, Regional Recovery Centers and select residential programs serve a target population of PROs (Post Release Offenders) and Probationers who are referred for services and are assigned to high-risk caseloads and supervision by the Probation Department.

3. When youth are between ages 18-21 and the most appropriate level of care is being determined, the following shall be considered:

   - System of care target population defined above, with individual needs being considered
   - Youth's goals and preference
   - Youth's functional level
   - Youth's need for shorter term or longer-term services
   - Youth's relationship with current provider and impact of consistency based on youth's history

Coordinate Care Between Sectors:

1. Child Welfare Services: In an effort to coordinate care with CWS, a call to 858-694-5191can be made to access the name and phone number of a San Diego County foster youth's social worker. To access the name of a youth's Independent Living Skills (ILS) worker, the ILS INFO Line can be called at 866-ILS INFO (866-457-4636). The ILS INFO Line can also be used as the starting point for an eligible former foster youth to re-enter foster care after age 18. Additional information about ILS and transitional housing opportunities can be found at www.fosteringchange.org.

2. Probation: If a youth has probation involvement, communication with the Probation Officer would be an important aspect of services.

3. Education: If a youth has been in Special Education and did not receive a diploma, they are eligible for educational services through their school district until age 22. Their last school of attendance would be able to assist with school records and educational placement. If there is any difficulty at the school site getting information, it is advised to contact either the Special Education Department Chair at that school site or the Vice Principal of Special Education.

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

Coordinate Care When Making Referrals:

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

2. Involvement of the family in transition planning is integral when family is available. It is critical that the youth and family understand the differences within the CYFBHS and the A/OABHS in terms of consent to treat and expectations of support systems.

3. If a referral to the Adult/Older Adult System of Care is determined, it is recommended that a call to the selected program be made to discuss the referral process and to allow for some transition time when the youth can be introduced to the new program on a timeline that is comfortable to all parties.

4. It is also recommended that visits with the youth, their supports, the existing provider, and the prospective provider occur, as this can be a helpful step in supporting a transition.

Procedures to follow if unsuccessful routine referral is below:

1. Youth who need transition planning due to their unique needs but for whom routine referrals have been unsuccessful will be identified by the CYF System of Care staff, either their Case Manager or Care Coordinator, who shall submit a referral packet containing the following information:

   - Referral Form/Cover Letter
   - Children’s Mental Health Assessment and most recent update
   - The Mental Health Diagnosis
   - Youth Transition Evaluation
   - Mental Status conducted by psychiatrist within the last 45 days
   - Physical Health Information
   - Medication Sheet

- Service Plan and other plans, e.g., Flexible Service Plan, Therapeutic Behavioral Services (TBS) Plan
- Psychological Testing done within past year (if available)
- Individual Education Plan and Individual Transition Plan
- Assessment of financial needs (may need referral to apply for Supplemental Security Income (SSI) six months prior to 18th birthday if applicable)
- Any self-evaluations recently given to youth.

2. This packet shall be submitted with releases to the Mental Health Program Coordinator (MHPC) of Adult Mental Health Services in the region where the youth resides. The MHPC offices are located at 3255 Camino del Rio South, San Diego, CA 92108.

3. The MHPC will review the packet to determine if access criteria are met for SMHS and the Service Eligibility Policy for the Adult/Older Adult System of Care.

4. If the client does not meet criteria to access SMHS, then the client shall be referred back to the referral source for services in the community. If the youth is 18 or over, an assessment will be requested from an adult provider agreeable to the client and family. If the assessment indicated a Medi-Cal beneficiary does not meet criteria to access SMHS, a Notice of Adverse Benefit Determination (NOABD) will be issued, advising him/her of his/her rights to appeal the decision.

5. If a transition plan is agreed upon, the client's CYFBHS Case Manager or Care Coordinator will attempt to link the client with the appropriate service.

6. If the linkage is not successful, the MHPC shall coordinate an initial meeting with a multidisciplinary support team within two weeks of the initial referral that will include relevant persons that may include, but are not limited to, the following:

   - Youth
   - Support System as defined by the youth/family (parent, social worker, family members)
   - CYFBHS Case Manager and /or Therapist
   - Current Psychiatrist
   - CYFBHS Contracting Officer's Representative (CORS), or designee
   - Adult/Older Adult BHS COR if applicable, or designee
   - Probation Officer (if applicable)
   - CWS Social Worker (if applicable)
   - Education/Vocational Specialist

7. Team will review youth defined needs and options and create a transition plan, complete a Transition Age Youth Referral form, including all signatures. The Care Coordinator will include a copy of a Transition Age Youth Referral Plan in the medical record. The plan shall

identify the individual that will follow up with the transition plan. Should the youth decide this plan is not acceptable, an alternative shall be identified, and same procedure followed.

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

Organizational Provider Outpatient Services or County Operated Services

If a client first accesses services by calling or walking into an organizational provider site or a county-operated program, the client can be seen and assessed, and the organizational provider authorizes services based on meeting criteria for access to SMHS as outlined in Welfare and Institutions Code section 14184.402.

Day Intensive and Day Rehabilitative Services (CYFS)

Day services are offered in school/community settings and as enhanced treatment services in residential facilities for the most severely emotionally disturbed children and youth who meet criteria for access to SMHS and the services must be medically necessary. Referral and admission to all day services may come from Juvenile Probation, Child Welfare Services, or schools. All programs are Medi-Cal certified and comply with Medi-Cal standards regardless of funding source.

Prior authorization is required for all day services. Clients referred to day services shall begin treatment services within contract guidelines. Prior to admission of the client, day programs shall comply with authorization procedures for day services as set forth in the DHCS Informational Notice No.: 19-026. An Administrative Services Organization (ASO) provides authorization for all day services. Optum acts as the ASO. Reauthorization is required every three months for day intensive services and every six months for day rehabilitative services. Copies of Optum's current Prior Authorization Day Services Request (DSR) for both Initial and Continued requests are located in the Uniform Clinical Records Manual (UCRM) with the Ancillary Specialty Mental Health Services Request when needed. Both are available at https://www.optumsandiego.com.

If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

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

Service Priority for Outpatient Assessment Services – CYFS

High

- Children and adolescents requiring emergency services should be seen within one hour of contact with program. They may be seen at the program or referred to Emergency Screening Unit.

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

Routine

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

Ongoing Services

- Children and adolescents with moderate mental health needs who meet criteria for access to SMHS and the services must be medically necessary shall be provided with appropriate services based on the client needs as well as the program's Utilization Management process. For children and adolescents with mild, non-complex mental health needs clinicians at all programs shall assist the parent/caregiver in accessing services within the region through the Optum individual/group provider network, if the child is Medi-Cal eligible.

THERAPEUTIC BEHAVIORAL SERVICES (TBS)

Prior authorization through Optum is required preceding the provision of Therapeutic Behavioral Services (TBS). Clients are referred to New Alternatives, Inc. (NA), who is the point of contact for TBS. The referring party may include COSD SOC, CWS and Probation Department. The referring party will complete and return an authorization request form to the Administrative Services Organization (ASO) who provides authorization for TBS. Optum acts as the ASO. Authorization requests are then screened and assessed by Optum UM licensed clinicians for eligibility criteria according to California Department of Mental Health guidelines provided in DMH Letter 99-03 and DMH Notice 08-38. Optum UM licensed clinicians will then send authorization response to the referring party within 5 business days of receipt of request. The provider assigned to the client/family will conduct assessment to ensure client meet the class, service, and other TBS criteria prior to services being delivered.

If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to

approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Utilization Review

Authorization management for extended Therapeutic Behavioral Services is retained by the MHP. If a client requires more than 25 hours of coaching per week of TBS, the Contractor shall contact COR for approval. However, if client requires more than 4 months of services, provider will use internal/tracking request system that does not require COR approval.

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

DUAL DIAGNOSIS CAPABLE PROGRAMS

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

MENTAL HEALTH SERVICES FOR INDIAN ENROLLEES

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

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

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

RESIDENCY

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

D. PROVIDING SPECIALTY MENTAL HEALTH SERVICES COUNTY OF SAN DIEGO DOCUMENTATION STANDARDS

For additional guidance please refer to the CalMHSA Documentation Manual
https://www.calmhsa.org/documentation-guides/

Assessment Standards

To ensure that members receive the right service, at the right time, and in the right place, providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice. Assessments shall be updated **as clinically appropriate,** such as when the member's condition changes.

Care Plan Standards

DHCS no longer requires prospectively completed, standalone client plans for Medi-Cal Specialty Mental Health Services. The intent of this change is to affirm that care planning is an ongoing interactive component of service delivery rather than a one-time event. Required care plan elements may be notated within the assessment record, problem list, or progress notes, or the provider may use a dedicated care plan template within the Electronic Health Record. The provider shall be able to produce and communicate content of the care plan to other providers the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable state and federal privacy laws if requested.

Federal or state laws continue to require the following services to have care plans and/or specific care planning activities in place. All required elements of the Care Plan must be addressed as indicated in Enclosure 1a of BHIN 23-068: TCM, ICC, Peer Support Services, TBS, STRTPs, Crisis houses FSPs and Medicare recipients.

For more detailed information on specific requirements please refer to the Care Plan Explanation Sheet, located on Optum Website under MHP Provider Documents/ UCRM Tab via this link: (https://www.optumsandiego.com/content/sandiego/en.html).

Problem List Standards

All clients receiving services after July 1, 2022 are required to have a Problem List documented within the EHR. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. Updates to the Problem List are to be completed on an on-going basis

within the EHR on the "Client Clinical Problem Details" page as well as service notes to reflect the current presentation of the client, with problems being added or removed when there is a relevant change to the client's condition. (https://www.optumsandiego.com/content/sandiego/en.html).

Service Note Standards

Providers shall create service notes for the provision of all services. Each service note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description. = Notes are to be completed and signed within 3 business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

*Please be advised certain service lines have requirements which remain in effect due to applicable federal regulations or guidance, regulations which supersede these indicated timelines above. In these cases, regulations must be followed as indicated by DHCS.

PEER SUPPORT ROLE

Interventions Rendered by Certified Peer Support Specialists

Beginning July 1, 2022, per Behavioral Health Information Notice (BHIN 22-019), peer support services provided by a Certified Peer Support Specialists must be based on an approved plan of care. The plan of care shall be documented within the progress notes in the Client's clinical record and approved by any treating provider who can render reimbursable Medi-cal services.

Peer Led Interventions provide an additional tool to assist clients in developing self-awareness and self-mastery skills. Those providing this service can be peer specialist, individuals with "lived experience" or family members of consumers. Examples of peer led interventions include but are not limited to Wellness Recovery Action Plan® and Whole Health Action Plan (WHAM). These services are designed to assist clients in managing day to day activities in at home and in the community. Designated staff with an understanding of the peer experience may also facilitate the structured interventions.

ADULT/OLDER ADULT SYSTEM OF CARE

Coordination of Care: Creating a Seamless System of Care

Coordination of care between service providers is essential for a client's continuity of care and a

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

To this end, the MHP defines a long-term client as any individual that receives behavioral health services beyond 60 days of his/her/their admission to a behavioral health program. Long-term clients would be expected to have a completed behavioral health assessment, problem list and client plan (as applicable).

Clients diagnosed with a primary or co-occurring opioid and/or alcohol use disorder should be offered a referral for an assessment for Medication Assisted Treatment (MAT). Although it is outside the scope of practice for a non-prescribing staff to make specific medication recommendations, staff can recommend a referral for MAT at the intake appointment and at other points in the treatment process, as clinically indicated. Staff are encouraged to use motivational interviewing to help clients who would benefit from medication treatment to consider this option. Clients with an opioid and/or stimulant use disorder should be referred or linked to naloxone treatment to prevent overdose risk.

Program Policy and Procedures should address clinical training and supervision on providing appropriate MAT referrals as clinically indicated at any time during treatment or following an overdose. This training and supervision should also address access to Naloxone, especially for clients who refuse a MAT referral and have an opioid use disorder.

Post Discharge Coordination of Care

New or current clients discharged from a 24-hour facility (acute psychiatric hospital or crisis house) shall be assessed by program within 72 hours. If the referral is deemed urgent, client shall be seen within 48 hours of contact with program. A need for urgent services is defined in Title 9 as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition. The County further refers to Urgent as a condition for which treatment

should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention. Compliance to this standard is monitored through the Medical Record Review process.

Outpatient, Case Management and Assertive Community Treatment Services

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

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

When the provider conducts an assessment of a client who has called or walked into the program, providers will follow the "Smartcare Walk-in Workflow" under the "Smartcare" tab on the Optum website.

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

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

As specified in Welfare and Institutions Code section 14184.402, the revised definitions and criteria below are effective January 1, 2022. AB 133 gives DHCS authority to implement the criteria for access to SMHS and medical necessity through Behavioral Health Information Notice (BHIN 20-073) and supersedes California Code of Regulations (CCR), title 9, sections 1830.205 and 1830.210 and other guidance published prior to January 1, 2022 regarding medical necessity criteria for MHP reimbursement of SMHS (other than psychiatric inpatient hospital and psychiatric health facility services) until DHCS implements new regulations by July 1, 2024.

For beneficiaries **21 years of age or older**, a county mental health plan shall provide covered specialty mental health services for beneficiaries who meet both of the following criteria, (1) and (2) below:

1. The beneficiary has one or both of the following:
    a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

b. A reasonable probability of significant deterioration in an important area of life functioning.

AND

2. The beneficiary's condition as described in paragraph (1) is due to either of the following:
   a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
   b. A suspected mental disorder that has not yet been diagnosed.

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

Brief Description of Services Available

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

- Transitional Case Management provides short-term case management services (up to 90 days) for unconnected clients who suffer from severe mental illness (SMI) and are discharged from Acute Care (ex: Behavioral Health unit (BHU). The goal is to connect clients to outpatient case management and/or Assertive Community Services as clinically indicated.

- Institutional Case Management services are provided to clients who reside in a State Hospital or in out-of-county or in-county Institutes of Mental Disease (IMD) or Skilled Nursing Facilities (SNF). Services consist primarily of linking, coordinating, and monitoring functions and have a staff-to-client ratio of up to 1:60. Clients are contacted face to face at a minimum of once a quarter.

- Strengths-Based Case Management (SBCM) programs are only authorized to provide case management brokerage, individual and group rehabilitation, coordination of care, and occasional crisis intervention services. SBCM services provide a mix of mental health, rehabilitation and case management functions and have a staff-to-client ration of approximately 1:25. Clients are typically evaluated in person at a minimum of once a month. Services may be provided on a much more frequent basis, depending on client clinical need. It is also expected that the case manager will have contact with significant others as clinically appropriate.

- Note that the evaluation completed when a client enters a case management program is designed to determine case management and rehabilitation needs and should be coded as a Rehab Evaluation only if it is done by an SBCM program run by the County of San Diego.

Case Management evaluations done by contractors should be coded as an Assessment.

- Assertive Community Treatment (ACT) programs are authorized to provide primarily case management brokerage and individual and group rehabilitation, coordination of care, and occasional crisis intervention services. The services provided are a mix of medication, mental health, rehabilitation and case management functions and have a staff-to-client ration of approximately 1:10. Clients are typically evaluated in person at a minimum of four (4) times per week in order to meet the client's clinical needs and meet a high ACT fidelity rating. ACT programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity, medication support services and some psychotherapy.

Clinical Assessment for Medical Necessity

At the time a client is admitted to a program, clinicians shall perform a face-to-face assessment to ensure that each new client meets criteria for access to specialty mental health services and the services must be medically necessary. According to service mix outlined above, the clinician shall complete the appropriate assessment form in the Electronic Health Record (EHR) and ensure that all relevant clinical information is obtained and documented. Within 60 days after program assignment, an Assessment, Problem List and Client Plan (as applicable) shall be completed for clients in community setting.

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

Strength-Based Case Management

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

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

- A face-to-face meeting is necessary to determine the presence of a severe psychiatric disability and need for Strength Based Case Management (SBCM) services per LOCUS (Level 3 – High Intensity Community Based Services)
- Has current LPS Conservatorship (may be a designated County Conservator or family member (Private Conservator)
- Client is not homeless but may be at-risk of homelessness
- Minimum one hospitalization in the past year, OR multiple ER utilizations, PERT interventions, jail mental health service and/or long-term care hospitalization.
- Have major impairments in life functioning
- Person is not connected to outpatient treatment
- Person is experiencing an acute psychiatric episode that might require SBCM level services
- Is at high risk of admission to an inpatient mental health facility
- Has a substantial need for supportive services (including care coordination and outreach mental health services) to maintain current level of functioning in the community, as evidenced by missed appointments, medication non-adherence, or inability to coordinate services from multiple agencies
- Does not have a case manager from another program who is able to address mental health needs.

Services provided include, but are not limited to:

- Medication management which is coordinated outside the SBCM program in the FFS sector
- Strength Based Case Management
- Rehabilitation and recovery services
- Care Coordination to needed services
- Co-occurring services linkages
- Access and linkage to Supportive Housing
- Access to Supportive employment/vocational and educational services

Discharge Criteria:

- The goal of SBCM is to help improve the clients' mental health and quality of life to support clients to live in the least restrictive environment. A LOCUS is completed every 6 months to assist in determining if client is ready for lower level of care. Clients receiving Strength-Based Case Management services are reviewed by the program's Utilization Review Committee (URC) to determine continuation of case management services and/or changes in the level of case management.

Assertive Community Treatment (ACT) Services

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

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

Eligibility Criteria:

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

Services provided include, but are not limited to:

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

Discharge Criteria:

- Same as SBCM

<u>Overview</u>

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

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

- Medical care and treatment
- Psychiatric care and treatment
- Personal care
- Food/Nutrition
- Clothing
- Shelter
- Education and employment
- Recreation and socialization

2. Ensure a clear photograph of the conservatee is taken at the initial face-to-face visit and annually thereafter. The photo must be preserved in the case file for the purpose of identifying the conservatee if he or she becomes missing (per Probate Code 2360)

3. Collaborate/Coordinate with medical and psychiatric professionals and hospital treatment teams on behalf of the conservatee.

4. Notify all appropriate parties, including family members and other significant parties, of the assigned Case Manager or Case Management team within 14 calendar days (see item #10 below for notification requirements for the Public Conservator's Office)

5. Respond to routine e-mails and phone calls within 2 business days; for more urgent matters, a Supervisor/Program Manager should be available if parties are unable to reach the Case Manager.

6. Upon request, provide case information to the Public Conservator's Office regarding grave disability, including information on the following:
   a. Clinical presentation (psychiatric/medical, functional ability, etc.)
   b. High-risk behaviors
   c. Activities of daily living
   d. Current medications and adherence
   e. Placement history
   f. Strengths and goals

7. Maintain documentation regarding visits for viewing by Public Conservator Office staff.

8. Ensure conservatee has both a psychiatrist and a primary care physician who will prepare (by a psychiatrist/psychologist) and concur with (by a primary care physician) the annually required Medical Recommendation and Declaration to Reestablish Conservatorship (see Optum Website OPOH Tab: Reestablishment Recommendation Form) (HHSA LPS PC RE-EST). This form must be prepared/signed by both of the conservatee's physicians and submitted to the Public Conservator's Office at least 45 days prior to the end date of the current conservatorship period, which communicates their recommendation as to either the reestablishment or termination of LPS conservatorship. The case management agency must ensure the conservatee is able to see both the psychiatrist and a primary care physician 2 to 4 months prior to the end date of the current conservatorship period. The names and telephone numbers of these physicians must be provided to the Public Conservator's Office and should be kept current in Cerner.

9. Maintain involuntary clinical Strength Based Case Management and/or Assertive Community Treatment Services at all times while a conservatorship is in place. If the conservatee is being transferred to another Case Management Agency, services of the sending agency must be maintained until verification is received that the conservatee has been contacted and is prepared to receive involuntary case management services from the receiving agency. The receiving agency must notify the Public Conservator's Office of the successful transfer and start of services with the receiving agency. Services may only be provided on a voluntary basis (or closed) if the Public Conservator's Office has indicated the conservatorship has been terminated by the court.

10. Notify the Public Conservator's Office within 24 hours when any of the following situations occur for a conservatee:

    - Address changes
    - A new case manager is assigned
    - A new case management agency has been assigned
    - AWOL or in a missing person status
    - Hospitalization (medical and/or psychiatric)
    - In custody
    - Death
    - A Serious Incident Report is submitted to the BHS Quality Improvement Unit
    - Any unusual occurrences that raise risk/safety concerns

11. Notify Public Conservator's Office in writing when it is believed a change in rights or when it is believed the Conservatee is no longer gravely disabled.

12. Refer treatment providers to the Public Conservator's Office for matters requiring the consent of the Court via the Public Conservator's Office, such as surgery, non-routine medical treatment, or end of life decisions.

13. Contact the Public Conservator's Office when questions arise regarding the Conservatee's desire/need to enter into contracts of any kind, obtain a driver's license, vote or participate in a research study.

14. Contact the Public Conservator's Office when there is a need to have documents signed on behalf of the Conservatee, except in cases involving assistance with Social Security and Medi-Cal applications, renewals, redeterminations, appeals, etc.

15. Ensure a report is available via the electronic health record (EHR) for the Public Conservator's Office to view monthly, including completed visits.

Initial Face-to-Face Visits

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

1. **ACT**: within 48 hours of the program formally opening the case, consistent with the OPOH standard for face-to-face visits for those deemed urgent and recently discharged from acute care

2. **SBCM**: 10 business days of the program formally opening the case, unless deemed urgent and recently discharged from acute care which would then require the urgent visit within 48 hours

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

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

5. **Hospital Rotation Cases**: The Public Conservator's Office has case management responsibilities during the Temporary LPS Conservatorship. During this time Strength-Based Case Management and/or Assertive Community Treatment programs will not be responsible for face-to-face visits or discharge planning, as this will remain the responsibility of the Public Conservator. Once Permanent Conservatorship is established, as long as patient remains in acute care, the case will be opened to County Institutional

Case Management services pending discharge to either long-term care or community placement.

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

6. When a **Private Conservator** is appointed and requests the assistance of County operated Case Management Services, initial face-to-face contacts will follow the same periods as when the Public Conservator is appointed.

On-Going Face-to-Face Visits

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

1. **SBCM**: Clients are typically seen in person at a minimum of once a month. Services may be provided on a much more frequent basis, depending on client clinical need. It is also expected that the case manager will have contact with significant others as clinically appropriate.
    - Clients who are **conservatees** are required to be seen, at minimum, within **30 calendar days** from the date of the previous visit.
2. **ACT**: Clients are typically evaluated in person at a minimum of four (4) times per week in order to meet the client's clinical needs and meet a high ACT fidelity rating. It is also expected that the case manager will have contact with significant others as clinically appropriate.
3. **Institutional-In County**: routine visits to occur every 90 days. Frequency to increase based on clinical need on a case-by-case basis.
4. **Institutional-Out of County**: visits to occur every 90 days. Telehealth contacts to occur monthly in between face-to-face visits. Frequency of visits may be adjusted based on

clinical need on a case-by-case basis, as approved by Public Conservator's Office COR or designee.

Dual Track Programs

Dual Track programs are designed to treat both mental health and substance use conditions under the same program, however enrollment in both programs simultaneously is not a requirement. Mental Health treatment will align with Bio-Psychosocial Rehabilitation (BPSR) or Assertive Community Treatment (ACT) Models and Substance Use treatment will align with the American Society of Addiction Medicine (ASAM). Admission and Discharge criteria will align with similar outpatient services. Coordination of service delivery between Dual Track programs and other levels of care to be reviewed by Contracting Officers Representative (COR).

Augmented Services Program

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

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

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

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

Telehealth Services

Each telehealth provider is required to be licensed in California and enrolled as a Medi-Cal provider. If the provider is not located in California, they must be affiliated with an enrolled Medi-Cal provider group (or border community) as indicated in the Medi-Cal Provider Manual. Each telehealth provider must meet the requirements of Behavioral Health Information Notice (BHIN 23-018), BPC Section 2290.5(a)(6), or equivalent requirements under California law in which the provider is licensed.

Existing Medi-Cal covered services may be provided via telehealth modality if all the following criteria are met:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment, and that the member has a right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit,
- The member has provided verbal or written consent, at least once prior to initiating applicable health care services via telehealth, and it has been documented in the client record,
- An explanation that the use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time by the Medi-cal beneficiary without it affecting their ability to access covered Medi-cal services in the future,
- The member has been provided with an explanation of the availability of Medi-cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted,
- The presence of a health care provider is not required at the originating site unless determined medically necessary by the provider at the distant site,
- An explanation of the potential limitations and risks related to receiving services through telehealth as compared to an in-person visit to the extent that any limitations or risks are identified by the provider,
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Medi-Cal providers have the flexibility to determine if a service is clinically appropriate for telehealth via audio-visual two-way real time communication. No limitations are placed on origination or distant sites. Providers must use the applicable billing indicators for services delivered via telehealth.

Videoconferencing Guidelines for Telehealth

Telehealth services are designed to assure timely access of routine and urgent mental health and psychiatric services to reduce emergency and acute clients' hospital inpatient services Specialty Mental Health Provider; hereafter referred to as "telehealth provider" will perform various specialty mental health services via tele-video linkage when an on-site mental health provider is unavailable; primarily due to illness or other scheduled absences or vacancies; or other special needs as arranged. The site where the telehealth provider is located who will provide the mental health service will be termed "distant" site and the site where the mental health services are being received by the client will be termed the "originating" site. This practice also extends mental health services to clients in remote areas of the county.

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

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

- Use a secure, trusted platform for videoconferencing.

- Verify your devices and software use the latest security patches and updates. Install the latest antivirus, anti-malware, and firewall software to your devices. The underlying network must provide security.

- Verify your device uses security features such as passphrases and two-factor authentication. Your device preferably will not store any patient data locally, but if it must, it should be encrypted.

- Verify your audio and video transmission is encrypted. The Federal Information Processing Standard (FIPS) 140-2 is used by the United States government to accredit encryption standards. Encryption strengths and types can change. When partnering with 3rd party telehealth vendors, verify if their encryption meets the FIPS 140-2 certified 256 bit standard; that any peer-to-peer videoconferencing (streamed endpoint-to-endpoint) is not stored or intercepted by the company in any way; and that any recorded videoconferences or—if available—text-based chat sessions near the chat window are stored locally, on your own HIPAA-compliant device or electronic record keeping system, in order to safeguard any electronic protected health information or PHI.

- Choose a software solution that is HIPAA-compliant, as many popular, free products are

not. Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996) is essential. HIPAA sets a minimum federal standard for the security of health information. States may also set privacy laws that can be even more strict, so be sure to check any relevant statute for the state in which you practice. Just because software says its HIPAA-compliant is not enough. HIPAA compliance may also be dependent on the interface of your videoconferencing software with other aspects of your practice, such as EHRs, so it is best to think about HIPAA and telehealth from a global, "all technologies" perspective.

- It is recommended to use a broadband internet connection that, at minimum, has a transmission speed of at least 5 MB upload/download to avoid pixilation, frequent buffering, and other video and audio difficulties associated with slow and insufficient transmission. Higher speeds might be required for newer technologies that use HD capabilities.

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

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

Crisis Stabilization Services

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

Crisis Stabilization is a package program, and no other specialty mental health services are reimbursable during the same time period this service is reimbursed, except for Targeted Case Management. Crisis Stabilization shall be provided on site at a licensed 24 hour health care facility or hospital-based outpatient program or a provider site certified by the Department or a Mental Health Plan (MHP) to perform crisis stabilization. CCR, Title 9 1840.338

Admission Criteria:

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

Services provided include, but are not limited to:

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

Discharge Criteria:

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

Staffing Requirements for a Crisis Stabilization Unit:

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

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

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

If crisis stabilization services are co-located with other specialty mental health services, persons providing crisis stabilization must be separate and distinct from persons providing other services. Persons included in required crisis stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services. CCR, Title 9 1840.348

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

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

Staffing Requirements for a Crisis Stabilization Unit that is a 5150 LPS Designated Facility:

A Crisis Stabilization Unit that is 5150 LPS designated and approved is required to meet California Code of Regulations (CCR) Title 9, Division 1, Article 10, Section 663 inpatient staffing requirements.

Inpatient services shall be under an administrative director who qualifies under Section 620 (d), 623, 624, 625 or 627. In addition to the director of the service, the minimum professional staff shall include psychiatrists if the administrative director of the services is not a psychiatrist, who shall assume medical responsibility as defined in Section 522; a psychologist, social worker, registered nurse, and other nursing personnel under supervision of a registered nurse.
Nursing personnel shall be present at all times. Physicians, psychiatrists, registered nurses and other mental health personnel shall be present or available at all times. Psychologists and social workers may be present on a limited-time basis. Rehabilitation therapy, such as occupational therapy, should be available to the patients.

The minimum ratio of the full-time professional personnel to resident patients shall be as follows.

Personnel	Ratio Per 100 patients
Physician	5
Psychologists	2
Social Workers	2
Registered Nurse	20
Other Mental Health Personnel	25

Inpatient Services for Medi-Cal Beneficiaries
Pre-Authorization Through Optum

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

- Emergencies/Urgent Services
- Clients directed by the San Diego County Psychiatric Hospital Emergency Psychiatric Unit (EPU) to the FFS Hospitals

- Intoxicated clients who will be assessed within 24 hours to determine the etiology of their symptomatology
- Medicare clients who convert to Medi-Cal on the Medi-Cal eligible date.

If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Criteria for Access to Inpatient Services for Adult/Older Adults

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

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

AND

Both of the following:

- The condition cannot be safely treated at a lower level of care,
- Psychiatric inpatient hospital services are required as a result of a mental disorder and the associated impairments listed in 1 or 2 below:

1. The symptoms or behaviors:
   a. Represent a current danger to self or others, or significant property destruction,
   b. Prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter,
   c. Present a severe risk to the beneficiary's physical health,
   d. Represent a recent, significant deterioration in ability to function.

OR

2. The symptoms or behaviors require one of the following:
   a. Further psychiatric evaluation; or
   b. Medication treatment; or
   c. Other treatment that can be reasonably be provided only if the patient is hospitalized.

- Hospitals cannot require as a condition of admission or acceptance of a transfer that a patient voluntarily seeking mental health care first be placed on a 5150 hold.

- Continued stay services in a hospital shall be reimbursed when a beneficiary experiences

one of the following:

1. Continued presence of indications that meet the medical necessity criteria
2. Serious adverse reaction to medications, procedures or therapist requiring continued hospitalization
3. Presence of new indications that meet medical necessity criteria; and,
4. Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in the hospital

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

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

Crisis Residential Services

The MHP, through its contracted provider, operates Crisis Residential Services, which are considered a "step down" or diversion from inpatient services. Crisis residential services are provided to both Medi-Cal and non-Medi-Cal clients who meet medical necessity and admission criteria. Referrals for services can be made directly to the Crisis Residential intake staff but do require initial authorization from Optum. Optum will then reauthorize medically necessary services, as appropriate, concurrently with the client's stay based on the continued need for services. More information about the locations and services provided by the Crisis Residential Programs may be obtained from the contractor's website, Community Research Foundation (www.comresearch.org). The Optum Provider Line for authorization is 1-800-798-2254.
If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Mental Health Services to Parolees

On a regular basis, individuals are discharged on parole from California State penal institutions; the list of institutions can be located on the Optum Website. In many instances, these persons are in need of mental health services. State law requires the California Department of Corrections to establish and maintain outpatient clinics that are designed to provide a broad range of mental

health services for parolees. Sometimes, parolees are not aware of the availability of these services and present themselves to the County of San Diego Mental Health Services (MHS) outpatient clinics for their mental health needs. It shall be the responsibility of staff to ensure that all parolees from California State penal institutions who present for mental health services at a San Diego County program are appropriately served, or referred for service, in accordance with federal, State and County regulations as set out in the following guidelines:

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

1. Parolees who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.

2. Parolees with Medi-Cal coverage can receive inpatient services at any County-contracted acute care hospital. Indigent parolees can receive inpatient services at the San Diego

3. Psychiatric Hospital.

4. Parolees who are Medi-Cal beneficiaries and who meet specialty mental health medical necessity requirements, as specified in Welfare and Institutions Code section 14184.402 and Behavioral Health Information Notice (BHIN 20-073) will be provided appropriate Medi-Cal covered mental health services.

5. Parolees, whether or not they are Medi-Cal beneficiaries, who do not meet specialty mental health medical necessity requirements will be referred for services at the local Department of Corrections-established outpatient mental health clinic, which is designed to meet the unique treatment needs of parolees, or to another health care provider.

6. Parolees who are not Medi-Cal beneficiaries and who do meet specialty mental health medical necessity requirements will be informed of the availability of services at the local Department of Corrections-established outpatient mental health clinic and may choose to receive services from either County Mental Health or from the local Department of Corrections outpatient mental health clinic.

7. Due to the passage of SB 389, MHSA funds may be used to provide services to persons who meet existing eligibility criteria for MHSA-funded programs and who are participating in a pre-sentencing or post-sentencing diversion program, to provide services to persons who are on parole, probation, PRCS, or mandatory supervision. When included in county

plans, and in accordance with all the requirements outlined in W&I § 5349, funds may be used for the provision of mental health services in an Assisted Outpatient Treatment program in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1). Additionally, MHSA may be used for programs and/or services provided in juvenile halls and/or county jails when the purpose of the service is facilitating discharge (CCR, Title 9, § 3610).

8. MHSA funded services are **not** available for individuals incarcerated in state or federal prisons (W&I § 5813.5(f); CCR, tit. 9, § 3610, subd. (f)).

Correctional Program Checklist (CPC)

As directed by COR, contractor will fully participate in the Corrections Program Checklist (CPC) to improve treatment quality for clients who are assessed to be moderate to high risk for recidivism. Additional information regarding the CPC is located on the Optum Website: https://www.optumsandiego.com/content/sandiego/en/county-staff---providers/orgpublicdocs.html

Mental Health Services to Veterans

Federal law has established the Department of Veterans Affairs (USDVA) to provide benefits to veterans of armed services. In 1996, the U.S. Congress passed the Veterans' Health Care Eligibility Reform Act, which created the Medical Benefits Package, a standardized, enhanced health benefits plan (including mental health services) available to all enrolled veterans. A prior military service record, however, does not automatically render a person eligible for these benefits. Only veterans who have established eligibility through the USDVA and have enrolled may receive them. In recognition of the fact that there are veterans in need of mental health services who are not eligible for care by the USDVA or other federal health care providers, the legislature of the State of California in September 2005 passed AB599, which amended section 5600.3 of the California Welfare and Institutions Code (WIC). Specifically, veterans who are ineligible for federal services are now specifically listed as part of the target population to receive services under the mental health account of the local mental health trust fund ("realignment"). California veterans in need of mental health services who are not eligible for care by the USDVA or other federal health care provider and who meet the existing eligibility requirements of section 5600.3 of the WIC shall be provided services to the extent resources are available. It shall be the responsibility of staff to ensure that all veterans who present for mental health services at a San Diego County program are appropriately assessed and assisted with accessing their eligible benefits provided through the USDVA or other federal health care program or are referred and provided services through a San Diego County program.

Referral Process for Providing Mental Health Services to Veterans

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

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

Utilization Management

The MHP delegated responsibility to County-operated and contracted organizational providers to perform utilization management for, outpatient, crisis residential and case management services. Decisions are based on the medical necessity criteria delineated in Welfare and Institutions Code

section 14184.402. The MHP monitors the utilization management activities of County-operated and contracted organizational providers to ensure compliance with all applicable State and federal regulations.

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

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

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

Utilization Review for Crisis Residential Programs

Each crisis residential program meets the utilization management requirement through the service authorization process conducted by the County's Administrative Services Organization (ASO), Optum. Referrals to crisis residential level of care can be made directly to the intake staff but do require initial authorization from Optum. Crisis residential intake staff shall submit the initial authorization request, documenting medical necessity for crisis residential level of care, to Optum for review. Optum will review the initial authorization request form to identify if medical necessity is justified and respond to the provider with a final determination. For continued stay services, the crisis residential program shall submit requests for concurrent authorization review based on client's need. Optum will then reauthorize, as appropriate, concurrently with the client's stay based on the continued need for services.

Crisis residential programs invite clients to attend their treatment team meeting when continuation of care is being discussed. Should clients not want to attend the treatment meeting, staff will have input from the client prior to the meeting and will meet with the client again following the meeting in order to review the request for concurrent authorization determination. The treatment team

meeting will be documented and submitted to Optum along with the request for concurrent authorization. The authorization determination shall be maintained in the client's hybrid chart. If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Utilization Review for Outpatient Programs

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

Outpatient Guidelines:

I. Brief Solution-Focused Outpatient Services

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

- Clinical triage
- Assessment
- Group therapy
- Case Management
- Medication support as indicated
- Outpatient Biopsychosocial Rehabilitation Programs (OP/BPSR) are authorized to provide primarily individual and group rehabilitation, coordination of care, medication support, case management brokerage and occasional crisis intervention services.
    - OP/BPSR programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity and some psychotherapy.

The initial Behavioral Health Assessment, Problem List and Client Plan (as applicable) shall be completed and final approved within sixty (60) days of program assignment. If, after completing the assessment, the clinician determines that medical necessity criteria for specialty mental health services are not met, the client will be issued an NOABD (see more complete description of the process in the Beneficiary Rights and Issue Resolution chapter of this Handbook) and his/her/their beneficiary rights shall be explained.

Clients will receive appropriate support and services to ensure that transition to other services are successful.

Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the client does not meet criteria for services.

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

II. Initial Eligibility for Services

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

- W&I Code 14148.402 Medical Necessity Criteria. The AOAMHS Target Population- Individuals we will serve:
  1. Individuals with a serious psychiatric illness that threatens personal or community safety, or that places the individual at significant risk of grave disability due to functional impairment.
  2. People with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and/or who require unusually complex medication regimens. Required psychosocial services may include illness management; or skill development to sustain housing social, vocational, and educational goals.

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

III. Eligibility for Ongoing County or Contracted Program Outpatient Services

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

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

diagnosis:

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

IV. Utilization Management process for Outpatient Programs:

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

- **Provision of services shall be reviewed for clients based on follow criteria:**

1. MORS rating of 6 or higher must go through Utilization Management
   a. Clients with a MORS rating of 6 to 8 will be referred out of the County or County contracted outpatient clinic for ongoing services unless an exception is made (see exception noted below).
   b. If a client receives a MORS rating of 6 to 8 but the primary provider believes that the client should continue to receive services at the county or contracted outpatient clinic the primary provider may request Utilization Review Committee (URC) to review client's case and justify ongoing services if applicable. [Note that someone with a MORS rating of 8 would probably be better supported at a lower level of care.]

- **While not required, the provision of services may be reviewed for clients based on one or more of the follow criteria:**

1. Clients with unchanged MORS rating
2. Clients who have been enrolled in program services for 2 years or longer
3. Treatment Team recommendation.
   a. URC may review client's that meet the above criterion in order to determine appropriateness for ongoing services or transition to a lower level of care.

- **For continued authorization of ongoing services, the following criteria must also be met:**

  1. Continued Medical Necessity with demonstrated benefit from services.
  2. Meet Target Population Criteria.

Utilization Review Committee (URC)

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

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

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

V. Outcome Measures

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

1. Recovery Markers Questionnaire (RMQ)
2. Illness Management and Recovery (IMR)

3. Milestones of Recovery Scale (MORS)
   a. Clients with a MORS rating of 1 to 5 will be qualified to receive ongoing services at the County or Contracted outpatient clinic.
   b. The MORS rating shall be kept in the client record.

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

Utilization Review for ACT/FSP/Case Management Programs

Each ACT, FSP, and case management program shall convene a URC to review the provision of services on a concurrent basis. The URC shall decide issues of medical necessity, continuation of treatment and level of case management services. These decisions will be based on Welfare and Institutions Code section 14184.402 for diagnosis, impairment and interventions and Case Management Service Level Criteria. Decisions shall be supported by chart documentation of the client's individual functioning level, symptoms, and needs.

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

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

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

A *URC Record* shall be created for each client reviewed and filed in the front of the progress notes

of the client's chart. This URC record will provide a summary of clinical information that supports the authorization decision. The *URC Minutes* shall summarize the outcomes of the cases reviewed. These minutes will be maintained in a designated file. The file shall be available for review as needed by the QA unit.

AOA and CYF Missed Appointment and Follow Up Standard

County of San Diego MHP has adopted a SOC average "No Show" rate for both licensed/registered/waivered clinicians and psychiatrists. The SOC average "No Show" rate is 15% for licensed/registered/waivered clinicians and 20% for psychiatrists. As data is collected, the County will continue to evaluate the SOC average "No Show" rates and consider adjustments to standards as necessary. Missed Appointment policies and procedures shall cover both new referrals and existing clients, and at minimum, include the following standards:

- **For new referrals**: When a new client (and/or caregiver, if applicable) is scheduled for their first appointment and does not show up or call to reschedule (defined as a "No Show"). The client shall be contacted within 1 business day by clinical staff. If the client has been identified as being at an elevated risk[1], the client (or caregiver, if applicable) will be contacted by clinical staff on the same day as the missed appointment. Additionally, the referral source, if available, should be informed.

- **For current clients**: When a client (and/or caregiver, if applicable) is scheduled for an appointment and does not show up or call to reschedule (defined as a "No Show"). The client shall be contacted within 1 business day by clinical staff. If the client has been identified as being at an elevated risk[1], the client (or caregiver, if applicable) will be contacted by clinical staff the same day as the missed appointment. For clients who are at an elevated risk[1] and are unable to be reached on the same day, the program needs to document next steps, which may include consultation with a supervisor, contacting the client's emergency contact, or initiating a welfare check. Additionally, the policy shall outline how the program will continue to follow up with the client (or caregiver, if applicable) to re-engage them in services, and should include specific timeframes and specific types of contact (e.g., phone calls, letters). Staff should continue to monitor the client's whereabouts and admittance to different levels of care throughout the County(e.g., hospital, PERT or jail admissions).

All providers shall have policies and procedures in place regarding the monitoring of missed appointments for clients (and/or caregivers, if applicable).

All attempts to contact a new referral and/or a current client (or caregiver, if applicable) in response to a missed appointment must be documented by the program. **Elevated risk** is to be defined by the program and/or referral source.

CHILDREN'S SYSTEM OF CARE

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

Department of Health Care Services (DHCS) Information Notice No.: 22-016 dated 04.15.22 outlines authorization requirements for Specialty Mental health Services (SMHS). It emphasizes that all medically necessary covered SMHS must be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished (42 CFR). The information notice specifies that for outpatient services prior authorization is required for Intensive Home-Based Services, Day Treatment Intensive, Day Rehabilitation, Therapeutic Behavioral Services, and Therapeutic Foster Care. Prior authorization may not be required for Crisis Intervention, Crisis Stabilization, Metal Health Services, Targeted Case Management, Intensive Care Coordination, and Medication Support Services.

SCREENING

All referrals shall be **screened** by a clinician for appropriate level of care. Screening will facilitate timely and appropriate services which are family centered and support maximizing capacity at the Organizational Provider level. Direct referrals from the Access and Crisis Line (ACL) do not require program screening as screening was completed by the ACL, and therefore an assessment appointment shall be offered. To determine level of care, clinician brief screening (non-billable activity) will consider:

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

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

- Primary Care Physician through Medical Home and Health Plans
- Fee For Service (FFS) Network via Access and Crisis Line (ACL)
- Organizational Provider
- Children/Youth who present with safety risk factors may require a 911 contact and/or an evaluation at the Emergency Screening Unit (ESU) to determine need for crisis stabilization or inpatient psychiatric care.

CRITERIA FOR ACCESS TO SMHS

Provider must demonstrate that each client receiving Specialty Mental Health Services meets criteria for access to SMHS and the services must be medically necessary. Authorization is performed through the MHP Utilization Management Process, using Welfare and Institutions Code section 14184.402Medical Necessity criteria as summarized below. Services provided to clients are reimbursable when the following criteria are met:

Outpatient and Day Services Clients:

Welfare and Institutions Code section 14184.402(i), outlines Medical Necessity Criteria for Specialty Mental Health Services.

For enrolled beneficiaries under 21 years of age, a county mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r)(5) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2) below:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness (Note: Children/Youth meeting medical necessity due to significant trauma shall be based on the assessment of a licensed mental health professional.).

OR

(2) The beneficiary meets **both of the following** requirements in a) and b), below:

a) The beneficiary has **at least one** of the following:

i. A significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning

iii. A reasonable probability of not progressing developmentally as appropriate.

iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

b) The beneficiary's condition as described in subparagraph (2) above is due to **one of the following:**
   i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders6 and the International Statistical Classification of Diseases and Related Health Problems.
   ii. A suspected mental health disorder that has not yet been diagnosed.
   iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

SERIOUSLY EMOTIONALLY DISTURBED CLIENTS:

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

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

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

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

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

OUTPATIENT SERVICES

Outpatient Time Based Utilization Management

One of the overarching Health and Human Services Agency (HHSA) principles is efficient and effective access to our target populations. CYFS clients receive treatment services that focus on the primary areas of need identified/confirmed by the client/family and conclude when those are stabilized. The focused model shall be communicated at the onset of treatment so the client/family can maximize use of sessions and be prepared for conclusion of treatment.

Clients who meet the criteria for medical necessity shall be eligible for up to 6 months of treatment sessions. This will apply to Medi-Cal and MHSA (indigent) clients. Additional treatment time may be authorized as clinically indicated. Utilization Management shall be completed at the program level by a licensed clinician.

Authorization for Reimbursement of Services

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

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

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

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

Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the client does not meet criteria for services.

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

Utilization Management

The MHP has delegated responsibility to outpatient County operated and contracted organizational providers to perform utilization management for specialty mental health services, outpatient services, medication services, and case management services. Authorization decisions are based on the medical necessity criteria delineated in Welfare and Institutions Code section 14184.402. Each delegated entity shall be accountable to the Behavioral Health Services Division Director and shall follow the Utilization Management processes established for children's mental health programs. The UM process is in addition to Department of Health Care Services (DHCS) Information Notice No.: 22-016 dated 04.15.22, which outlines that for outpatient services prior authorization is required for Intensive Home-Based Services, Day Treatment Intensive, Day Rehabilitation, Therapeutic Behavioral Services, and Therapeutic Foster Care.
At the time a client is admitted to a program, clinicians shall perform a face-to-face (including tele-video as appropriate) assessment to ensure that each new client meets criteria for access to SMHS and the services must be medically necessary. The clinician shall complete the County's applicable Behavioral Health Assessment Form and ensure that all required domains are completed.

Clients who approach six months of treatment and appear to require additional services shall be evaluated for continuation of care. The Utilization Management Committee operates at the

program level and must include at least one licensed clinician and may not include the requesting clinician. The Utilization Management Committee bases its decisions on whether medical necessity is still present and works with the treating clinician to ensure that the proposed services are likely to promote meeting the client's treatment goals or resolving areas noted on the Problem List. To assist in its determination, the Utilization Management Committee receives a UM Request form and a new Care Plan/Problem List to cover the interval for which authorization is requested. Secondary UM review at 6 months of treatment is reserved for clients who demonstrate ongoing need and require additional services. Secondary and subsequent UM review is also conducted by the program level Utilization Management Committee. Medication only clients are not included in the Utilization Management process as they are subject to medication monitoring. Specific information regarding medication only clients is found in Section D, Medication Only Services. For detailed information and requirements regarding Utilization Management for outpatient programs see the Optum Website for the UM Request form and Explanation Sheet.

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

For information specific to STRTP Utilization Management, see Section D: Authorization Process for Intensive Services.

Medication Only Services

The MHP has delegated the responsibility to outpatient County operated programs and contracted providers to assure proper enrollment, services and monitoring of children and youth who are receiving only medication support and have no therapist or case manager involved.
Children and adolescents, as a result of their rapid development, should receive a thorough assessment as a part of any clinical service, and for most, services should include a full spectrum of treatment services, including psychotherapy, designed to reduce or ameliorate symptoms and functional impairment. However, a small number of youths may have chronic conditions for which periodic breaks in treatment are appropriate. For those that require ongoing medication treatment even during such a hiatus, outpatient providers shall leave the assignment open with the psychiatrist designated as the primary server. Such cases are not subject to utilization management but are subject to medication monitoring and additional peer review if the situation is unusually prolonged. Children and adolescents who have completed an assignment of psychotherapy and been retained as a medication only client must have rapid access to a resumption of therapy if a need should arise.

Procedure for Medication Only Clients:

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

2. When the child or adolescent has a therapist in a different organizational provider program, that program shall be contacted as to why the needed medications are not being provided by the assigned therapist's program.

3. If the child's therapist is a fee-for-service provider, the child's legal representative shall be provided the number to the Access and Crisis Line for assignment to a fee-for-service psychiatrist.

4. In the event that service goals have been met, that a Utilization Management (UM) Committee has denied further treatment, or if in the opinion of the therapist, client, and caregiver, a break in psychotherapy treatment is appropriate, the client shall be assessed for the need for ongoing medication support by provider's staff psychiatrist or referred to the Center for Child and Youth Psychiatry program. Criteria for requiring such support shall include:

    a) The client has been stabilized on a medication regime for a minimum of three (3) months under the care of the provider's staff psychiatrist,
    b) In the opinion of the prescribing psychiatrist, the child or adolescent would experience an exacerbation of symptoms or impairment if removed from the medication,
    c) The child's primary care physician is unable or unwilling to continue the medication, even with consultation from the program psychiatrist,
    d) The continuation of medication support is desired by the client and caregiver; and
    e) For School Based clients, clinician shall have the outpatient services removed from the student's Individual Education Program (IEP).

5. When the decision is to continue the case as medication-only, within the same Unit/SubUnit, the case shall remain open, but the previous therapist shall complete a discharge summary stating that continuing medication support is necessary. In the MIS, the name of the server shall be updated to reflect the name of the physician. Crisis Intervention visits may be offered by the previous therapist or other staff during a medication-only interval without utilization management requirements.

6. Documentation for a medication only case shall include: a complete and up to date Behavioral Health Assessment, Psychiatric Assessment (completed on initial medication evaluation and for each follow up medication management session), and an active Problem List. Medication only cases are exempt from completion of Child and Adolescent Needs and Strengths (CANS), Pediatric Symptom Checklist (PSC) and Youth Services Survey (YSS).

7. Medication-only cases shall be billed using only the range of Medication Support service codes, except in the case of Crisis Intervention. In the event that case management or formal assessment is required in addition to Medication Support, the case no longer meets the criteria of medication-only and routine charting and authorization procedures shall be followed.

8. Medication-only cases are not subject to UM, but cases open in this status for 12 months or more shall be reviewed annually by the Medication Monitoring Committee. When reviewed by the Medication Monitoring Committee, the reviewer shall consider:

   a) Whether the child's age, health status, and emotional functioning continue to support the need for ongoing medication treatment.
   b) Whether a return to active psychotherapy is indicated.

9. If a client who has been receiving medication-only services should experience an increase in symptoms or impairment, or if the course of the client's development suggests that an interval of active psychotherapy is likely to be helpful, the case shall be reviewed to determine if a current UM authorization is in place.

   a) When authorization is in place, therapy may resume, however a new Problem List is indicated.
   b) When authorization has expired, the UM Committee must first authorize services for billing of therapy to resume.
   c) In the MIS (EHR) the name of the server shall be updated to reflect the name of the current clinician.

SCHOOL INTERFACE

Effective 7-1-12 CYFS is no longer contracted through County Office of Education to provide Educational Related Mental Health Services (ERMHS) which is in line with repeal of AB2726/3632 in October of 2010. Aligned with AB114, students with mental health needs are assessed through the school system and when appropriate are offered related services through the school district so they can benefit from their education. Students receiving services through the school may also access CYFS services through the County system when they meet medical

necessity criteria for specialty mental health services. CYFS standard of practice is to offer a full range of services which may include medication services as well as services which are educationally related and therefore coordination of care with the school continues to be critical. Through contracts with Community Based Organizations, School ink services are offered on identified school campuses. Information about School ink can be accessed through the HHSA-BHS webpage at:
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mental_health_services_children/Schools.html

INTENSIVE SERVICES

Day Rehabilitation - a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries and is available at least four hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation, and coordination of care. See a more detailed list of required services below. Program design promotes a therapeutic milieu which is a therapeutic program with specified service components and specific activities performed by identified staff. The program must operate for more than four continuous hours for a full-day program and a minimum of three continuous hours for a half-day program. The therapeutic milieu must be made available for at least a weekly average of three hours per day for full-day programs and an average of two hours per day for half-day programs. The milieu includes staff and activities that teach, model, and reinforce constructive interactions, includes peer and staff feedback to clients on strategies for symptom reduction, increased adaptive behavior, and stress reduction, and includes client involvement and behavior management interventions.

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

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

Short-Term Residential Therapeutic Programs (STRTP) –include a full range of short-term Outpatient Specialty Mental Health Services (SMHS) including assessment, evaluation, plan development, case management, individual/group/family therapy, rehabilitation, Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), crisis intervention, and case management services provided in a residential facility. Some STRTPs include Day services in addition to Outpatient SMHS. Services are intensive and flexible to meet the needs of the client and assist in transitioning to a less restrictive, community based or family care setting through an aftercare program component.

Intensive Outpatient Program (IOP) - IOP offers outpatient specialty mental health services to children and youth up to age 21 who would benefit from time limited programming in an intensive outpatient setting. Average length of stay for services is typically 6-8 weeks with a cohort of similar age youth and presenting problems. Program services are typically offered three to five times a week after school hours where youth attend Day Intensive Half (DIH) programming consisting of an evidenced based approach to addresses specific treatment issues. Additionally, the local model offers weekly caregiver groups and multi-family group once a month. The design calls for a full range of ancillary Outpatient Specialty Mental Health Services (SMHS) inclusive of medication monitoring which is offered outside of the Day Treatment program hours. Referrals to IOP typically come through an outpatient service provider and/or emergency screening/crisis stabilization unit when it is determined that intensive services are needed or as a step-down service from an acute setting. A prior authorization is required for Medi-Cal beneficiaries receiving DIH.

Partial Hospitalization Program (PHP) - PHP offers outpatient specialty mental health services to children and youth up to age 21 who would benefit from time limited intensive programming. Average length of stay is typically 2-4 weeks with a cohort of similar age youth and presenting problems. Program services are typically offered Monday through Friday. Throughout the day, youth attend an all-inclusive Day Intensive Full (DIF) program with individual, group, and family treatment sessions utilizing an evidenced based approach, as well as educational instruction. Medication Services are available as ancillary. Referrals to PHP typically come from the emergency screening/crisis stabilization unit to prevent an escaladed need for inpatient psychiatric care, from intensive hospital teams as a step down from an acute setting and/or from an Intensive Outpatient Program who determine a higher level of care is needed. A prior authorization is

required for Medi-Cal beneficiaries receiving DIF.

Prior Authorization Process for Day Services

(Day Treatment Intensive and Day Rehabilitation Services)

Prior to obtaining authorization to receive services within the program, each client must have

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

The initial STRTP Prior Authorization Day Services Request (DSR) is to be completed and submitted to Optum prior to the provision of services and re-authorized every 90 calendar days for STRTP services. Initial STRTP DSRs shall be submitted to Optum at least 5 business days prior to the initial provision of STRTP Day Services, and continuing authorization requests shall be submitted to Optum at least 5 business days prior to the expiration of the STRTP Day Services authorization. The STRTP Day Service Request (DSR) form is located on the Optum Website under UCRM tab.

The initial IOP or PHP Prior Authorization Day Services Request (DSR) is to be completed and submitted to Optum prior to the provision of services and re-authorized every 4 weeks for PHP and every 12 weeks for IOP if indicated. Initial IOP & PHP DSRs shall be submitted to Optum at least 5 business days prior to the initial provision of Day Services, and continuing authorization requests shall be submitted to Optum at least 5 business days prior to the expiration of the IOP or PHP Day Services authorization. The IOP & PHP Day Service Request (DSR) form is located on the Optum Website under UCRM tab.

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

An Ancillary Service request must be submitted if a client is going to receive Outpatient services in addition to the Day Intensive services.

If Day Service and Outpatient Services are provided by the same program, the Ancillary Services Request section in the DSR form will be completed as part of the prior authorization.

If Outpatient services are provided by another program, an Ancillary Services Request form must be completed by the OP provider and sent to IOP for submission to Optum.

Prior Authorization Day Services Request (DSR) Information for STRTP, IOP, and PHP

- Prior authorization must be submitted prior to the opening of the assignment or the provision of services. The Optum Provider Line for authorization requests is 1-800-798-2254. The required authorization request forms are located on the Optum Website under BHS Provider Resources Tab via this link: MHP Provider Documents
- All clients receiving Day Services (Rehab or Intensive) will require Prior Authorization Day Services Requests (DSR) and must be submitted to Optum and approved before Day Services are initiated.
- Authorization cycles are based on days (every 90 calendar days for STRTP and every 12 weeks for IOP & every 4 weeks for PHP and can be submitted up to 10 business days prior to the expiration.
- Optum will review the DSR and determine authorization within 5 business days. The provider may contact Optum if there are questions. The signature page of the DSR will be faxed back to the program upon authorization.
- Authorization will include intensive services and, when applicable, ancillary services for each client. Authorizations for intensive and ancillary services are entered separately based on the timeline of the receipt of the request by Optum.
- DSRs are faxed to Optum for all Day Service Authorization Requests regardless of client's insurance coverage or lack thereof.
- Programs are responsible to check on a monthly basis all Medi-Cal and UMDAP clients for eligibility and update the MIS as appropriate.
- DSRs should be filed in the medical record in the Plans section or be accessible upon request.
- If any of the above is not done correctly, Optum will return the DSR for correction and services will not be authorized until the corrections are made and the form is faxed back to Optum for review.
- When the DSR Ancillary information is done incorrectly, Optum will send the DSR to the Day program with whom the outpatient program is coordinating.
- Questions regarding the DSR process may be directed to: Optum at (800) 798-2254 option #4.
- Optum sends completed DSRs (STRTP only) to the BHS Continuum of Care Reform (CCR) Team on a monthly basis for review of the Clinical Review Report section. The

BHS CCR Team will follow up with the STRTP regarding the Clinical Review Report when indicated.

If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Utilization Review

Utilization review of day treatment intensive and day rehabilitation services for Medi-Cal clients is delegated to Optum and managed on a 90-day cycle for STRTPs and 12 weeks for IOP & and 4 weeks for PHP.

Program Monitoring – The Quality Management Unit will monitor Day Treatment Programs in accordance with state standards. For more information, see links: DAY TREATMENT INTENSIVE AND DAY REHABILITATION SERVICE COMPONENTS- ATTACHMENT A and DMH INFORMATION NOTICE NO.: 02-06

Monitoring includes but it not limited to:

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

Short-Term Residential Therapeutic Programs (Outpatient only)

Short-Term Residential Therapeutic Programs (STRTP) providing Outpatient Services only shall document Utilization Management Requests on the STRTP UM Request form for all youth within 90 calendar days of arrival, and within each 90 calendar days thereafter while a youth is residing in the STRTP.

STRTP UM Request Form Information

- The STRTP UM Request form is completed by a STRTP Mental Health Program clinical staff and reviewed by the STRTP Program Manager and designated STRTP UM Committee
- STRTP UM Request form includes Clinical Review Report section, which is monitored by QM annually in accordance with current DHCS Interim STRTP regulations.
- STRTP UM Requests shall be completed and reviewed by the program level UM Committee within 90 calendar days of arrival into the STRTP and within every 90 calendar days thereafter.

OUT OF COUNTY MEDI-CAL CLIENTS

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

AB 1299 for Foster Youth: Establishes the presumptive transfer of responsibility and payment for providing or arranging mental health services to foster children from the county of original jurisdiction (placing county) to the foster child's county of residence.
MHSUDS Information Notice No. 17-032 (Dated 7/14/17)

SB 785 for AAP and KinGAP: Transfers the responsibility for the provision of specialty mental health services to the county of residence of foster, AAP and KinGAP children.
DMH Information Notice No. 08-24 and 09-06 (Dated 8/13/08 and 5/4/09). Although the statutory sections included in the originally enacted version of SB785 have been amended over time, none of these amendments changed any of the original provisions of SB785. Furthermore, the original provisions of SB 785 did not change as a result of AB1299. However, the provisions of SB785, including Service Authorization Request (SAR) provisions, are no longer necessary or required for foster children or youth under the conditions of presumptive transfer, or under a waiver of presumptive transfer. However, for children and youth who receive assistance under Kin-GAP and AAP, the county of original jurisdiction continues to retain responsibility for authorizing and reauthorizing SMHS.

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

1. Placing agency from the county of original jurisdiction may instruct legal guardians to contact San Diego Administrative Services Organization (ASO), at 1-888-724-7240 for services referrals. The ASO makes a referral to a Fee-For-Service (FFS) or an organizational provider.
2. The placing agency informs Optum of the presumptive transfer.
3. If requested by the placing agency of the county of original jurisdiction, the program will inform them of the services being provided, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.
4. Services shall be entered into the EHR by the MIS.
5. The County of San Diego will submit the claim for services directly to the State Department of Health Care Services via the MIS.
6. STRTPs who provide day services shall submit DSR to Optum.

7. STRTPs shall complete an AB1299 STRTP Admission Report submitted to the COR, BHS CCR team, and Optum San Diego with a copy of the Notice of Presumptive Transfer form by the 15th day of the month following admission to the STRTP.

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

1. Placing agency from the county of origin may instruct legal guardians to contact San Diego Administrative Services Organization (ASO), at 1-888-724-7240 for services referrals. The ASO makes a referral to a Fee-For-Service (FFS) or an organizational provider.
2. The program providing the services will submit the Service Authorization Request (SAR*)* to the county of origin for authorization and signature.
3. For outpatient services, if county of origin SAR authorization is delayed, services may be provided when the reason for delay is administrative in nature and not a clinical denial.
4. If requested by the placing agency of the county of origin, the program will inform them of the services being provided, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.
5. Services shall be entered into the EHR by the MIS.
6. The County of San Diego will submit the claim for services directly to the State Department of Health Care Services via the MIS.
7. SPA shall submit the notification SAR and the DSR to Optum.
8. STRTPs shall contact the COR for written prior authorization for admission to mental health treatment services and confirm that out-of-county youth has a San Diego connection/caregiver to whom they will be discharging to.
9. STRTPs shall submit the completed SAR to the county of jurisdiction and forward a copy of the SAR and DSR to Optum with a written COR approval to serve youth under County contract due to discharge to San Diego residence.
10. STRTPs shall complete an AB1299 STRTP Admission Report submitted to the COR and BHS CCR team by the 15th day of the following month and clearly indicate that the AB1299 STRTP Admission Report is being utilized to provide information about an out of county KinGAP or AAP youth under a COR written authorization.

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

1. OOC clients who fall under the aid codes AAP or KinGAP. For those clients the program shall submit a SAR to the Mental Health Plan (MHP) from the County of Jurisdiction. The clients are subject to our local UM process and the services are entered into our EHR.
2. OOC clients who do not fall under one of those codes need to have their Medi-Cal shifted to San Diego in order for programs to serve them. Programs need to get written authorization from COR to serve those kids prior to Medi-Cal shifting to San Diego. When

authorization is granted prior to the Medi-Cal shift it is with the expectation that the program is actively and promptly collaborating with the guardian to have Medi-Cal shift to San Diego. No need to complete a SAR; follow local UM process.

3. All BHS CYF contracted programs are to ensure that the "County of Responsibility" code is accurate and up to date for each youth admitted to the program to also track all youth's Medi-Cal County of origin.. Please refer to the 3rd Party Billing Tip Sheet, located on the Optum San Diego Website (https://www.optumsandiego.com/), for detailed instructions on entering the Medi-Cal County of origin for youth upon admission.

Therapeutic Behavioral Services (TBS)

Prior authorization through Optum is required preceding the provision of Therapeutic Behavioral Services (TBS). Clients are referred to New Alternatives, Inc. (NA), who is the point of contact for TBS. The referring party may include COSD SOC, CWS and Probation Department. The referring party will complete and return an authorization request form and to the Administrative Services Organization (ASO) who provides authorization for TBS. Optum acts as the ASO. Prior authorization must be submitted prior to the opening of the assignment or the provision of services. All prior authorizations are sent via FAX to Optum secure fax (866) 220-4495. The required authorization request forms are located on the Optum Website under MHP Provider Documents/ TBS Tab via this link: MHP Provider Documents. Authorization requests are then screened and assessed by Optum UM licensed clinicians for eligibility criteria according to California Department of Mental Health guidelines provided in DMH Letter 99-03 and DMH Notice 08-38. Optum UM licensed clinicians will then send authorization response to the referring party within 5 business days of receipt of request. The provider assigned to the client/family will conduct an assessment to ensure the client meets the class, service, and other TBS criteria prior to services being delivered.

If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Utilization Review

Authorization management for extended Therapeutic Behavioral Services is retained by the MHP. If a client requires more than 25 hours of coaching per week of TBS, the Contractor shall contact COR for approval. But if client requires more than 4 months of services, provider will use internal/tracking request system that does not require COR approval.

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

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

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

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

https://www.dhcs.ca.gov/formsandpubs/forms/Forms/MCED/Info_Notice/MC003_ENG.pdf
https://www.dhcs.ca.gov/formsandpubs/forms/Forms/MCED/Info_Notice/MC003_SPA.pdf

Pathways to Well-Being and Continuum of Care Reform

Overview

Pathways to Well-Being (PWB) was prompted by the Katie A. class action lawsuit, which was filed in 2002 against the County of Los Angeles and the State of California by a group of foster youth and their advocates, alleging violations of multiple federal laws. The lawsuit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. Katie A., the youth identified in the name of the lawsuit, was a foster youth in the County of Los Angeles who had over 30 out of home placements, including psychiatric hospitalizations and placement in residential treatment, between the ages of 4 and 14 years-old, due to unmet behavioral health needs. The State of California settled the lawsuit in December 2011, and in March 2013, issued the Core Practice Model (CPM) Guide. In May 2018, the CPM was revised and renamed the Integrated Core Practice Manual (ICPM). The ICPM provides practical guidance and direction to support county child welfare, juvenile probation, behavioral health, and partners in the delivery of timely, effective, and collaborative services.

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

PWB services are available to youth up to age 21 across the System of Care, including Transitional Age Youth (TAY) who are involved in County of San Diego Behavioral Health Services.

California's Continuum of Care Reform

California's Continuum of Care Reform (CCR), which was initiated across California on January 1, 2017, builds on the efforts made through the Katie A. class action suit. CCR is mandated through AB403 (2015) and AB1997 (2016) and integrates the positive practices identified through the implementation of PWB. CCR strives to help all children live with permanent, nurturing and committed families, and to reduce the time children spend living in congregate care. CCR adheres to fundamental principles including youth and family receiving collaborative and comprehensive supports through teaming and youth not having to change placement to get services and support. CFWB and Probation have mandated timelines for CCR, Child and Family Team (CFT) meetings that include specific case decision making situations such as**:**

- Court hearing schedules
- Placement changes
- Child removed from his or her home and a plan is needed for the youth and family
- Child is in out of home care and a change in placement is required or requested
- Child returning home
- Permanent plan for a child needs to be made
- Child/youth's mental health needs or placement in a group home should be assessed
- Any family member involved in a child's case requests to meet to talk about the child's placement or the family's service plan.

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

To further build on the efforts of California's CCR, Assembly Bill 2083 was released in 2018. AB2083 requires counties to develop and implement an MOU outlining the roles and responsibilities of local systems to serve youth in foster care who have experienced severe trauma. The goal of the MOU is to address systemic barriers to the traditional provision of interagency services and ensure services provided to children and youth are coordinated, timely, and trauma informed. The County of San Diego AB2083 System of Care MOU, executed in March 2021, partners include Behavioral Health Services, Child and Family Well-Being, Probation Department, San Diego County Office of Education, and San Diego Regional Center, as well as representatives from Voices for Children, Special Education Local Plan Area (SELPA), and Tribal Communities.

Serving Youth with an Open Child and Family Well-Being Services Case

Per BHIN 21-058, MHP's must make individualized determinations for each child/youth's need for ICC, IHBS or TFC upon intake and at each assessment interval. Having an open child welfare services case is not required for a child or youth to receive ICC, IHBS or TFC. MHP's are obligated to provide ICC, IHBS, and TFC to all children and youth under the age of 21 eligible for full scope Medi-Cal and who meet medically necessity criteria for these services. The MHP cannot develop or utilize a screening or assessment tool or policy that narrows the eligibility for ICC, IHBS or TFC *beyond medical necessity.* Providers should be considering ICC and IHBS services for all youth as part of the assessment process and indicate as such in their documentation at intake and re-assessment.

Clients identified as meeting criteria for these services will be indicated as a "Special Population" in the EHR.

Furthermore, while DHCS does not require MHPs to determine if a child or youth is a Katie A. subclass member, MHPs are encouraged to track all children and youth who are receiving ICC, IHBS, and TFC to facilitate data collection and reporting of all services provided. MHPs must continue to ensure appropriate claiming of ICC, IHBS, and TFC services.

Under Pathways to Well-Being, all children entering the CFWB system receive a mental health screening conducted by CFWB and based upon need, are part of a collaborative, youth and family-centered teaming process, referred to as the **Child and Family Team (CFT)**. There is a distinction between a CFT and a CFT meeting. The CFT consists of people identified to ensure the youth has access to appropriate mental health and supportive services to promote safety, permanency, and well-being. The CFT, including the Intensive Care Coordinator, makes individualized determinations of each child/youth's need for Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS), based on strengths/needs and reassesses the strengths and needs of child/youth's, and their families, at least every 90 days and as needed. The CFT meeting is just one way in which the team members communicate. The team composition is guided

by the youth and family's needs and preferences. **For children or youth who are receiving ICC, IHBS, or TFC, a CFT meeting must occur as needed, but at least every 90 days.**

The CFT meeting process is initiated through completion of the CFT Meeting Referral Form, which is sent to the CFT Meeting Facilitation Program, unless the provider has been granted written COR approval to facilitate their own CFT meetings. The BHS provider maintains a copy of the CFT Meeting Referral Form in the hybrid medical record chart. If the BHS provider did not initiate the CFT Meeting Referral Form, they request a copy of the form from the CFT meeting facilitator. Following a CFT meeting, the CFT Meeting Facilitation Program is responsible for all members of the team receiving a copy of the **Child and Family Team Meeting Progress Summary and Action Plan** which includes specific action steps and timelines developed for the team members. If the provider has a COR-approved exemption from utilizing the CFT Meeting Facilitation Program, the BHS clinician is responsible for all members of the team receiving a copy of the CFT Meeting Summary and Action Plan. There are some circumstances in which CFWB facilitates CFT meetings and when this occurs and the provider attends, the CFWB facilitator is responsible for ensuring all members receive a copy of the Child and Family Team Meeting Summary and Action Plan. The clinician also completes a service note in the EHR using the TCM/ICC procedure code.

The CFT is comprised of the following members (^{M}indicates mandatory member):

- Child/youth/TAY^{M}
- Family/caregiver^{M}
- CWS social worker^{M}
- BHS provider^{M}
- Probation^{M} (when youth is a ward of the court)
- Tribal Members (When applicable)
- Court Appointed Special Advocate (CASA) ^{M} (When assigned by a judge)
- Natural supports
- Education and Other Formal Supports

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

CFT Meeting Facilitation Program

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

Intensive Care Coordination

The MHP is obligated to provide ICC to all children and youth under the age of 21 eligible for full scope Medi-Cal and who meet medically necessity criteria for these services. ICC is provided through collaboration between the members of a CFT.

A Child and Family Team must be identified to provide ICC. ICC requires active, integrated, and collaborative participation by the provider and at least one member of the CFT. ICC is a service that is used for the identification and coordination of ancillary supports and systems which promote safety, permanency, and well-being. ICC services are offered to clients with significant and complex functional impairment and/or whose treatment requires cross-agency collaboration. Examples of ICC include facilitating or attending a collaborative team meeting or CFT Meeting, collaboration with formal and/or informal supports to ensure the complex behavioral health needs of youth are met and collaboratively developing Client Plan/Teaming Goals to address identified needs.

BHS providers comply with both the California Department of Health Care Services (DHCS) Medi-Cal Manual, Second Edition (09/2016) as well as the DHCS Medi-Cal Manual Third Edition (01/2018) or current edition, in adherence to considerations for when to provide ICC, Intensive Home-Based Services, and Therapeutic Foster Care (TFC) services for Medi-Cal Beneficiaries. Both manuals provide guidelines for ICC, Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries. The Second Edition includes ICC provision considerations such as multiple mental health diagnosis, recent emergency room visits, and specifications related to the 0-5 population. The Third Edition includes how ICC differs

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

Intensive Home-Based Services

Intensive Home-Based Services (IHBS) are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child's or youth's family's ability to help the child or youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the ICPM by the Child and Family Team (CFT) in coordination with the family's overall service plan. They may include but are not limited to assessment, plan development, therapy, rehabilitation, and coordination of care services. IHBS is provided to beneficiaries under 21 who are eligible for full-scope Medi-Cal services and who meet access criteria.

Prior authorization is required to access IHBS services. IHBS Prior Authorization Request form process is the following:

- BHS Mental Health Organizational Treatment Provider submits the IHBS Prior Authorization Request form to Optum via FAX (866) 220-4495 or electronically via the IHBS Prior Authorization Request Web-Based form
- Optum reviews and provides authorization determination within 5 business days of receipt
- Authorization is forwarded to the requesting provider to be filed in the client's hybrid medical record
- Optum issues a NOABD to provider and Medi-Cal beneficiary if IHBS request is denied, modified, reduced, terminated, or suspended.

If a request for authorization is considered incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable. The required authorization request forms are located on the Optum Website under MHP Provider Documents/ UCRM Tab via this link: MHP Provider Documents

Additionally, a Child and Family Team must be identified to provide IHBS. IHBS are individualized, strength-based interventions that assist the client in building skills necessary for successful functioning in the home and community. IHBS is offered to clients with significant and complex functional impairment. These services are primarily delivered in the home, school, or community and outside an office setting. Examples of IHBS include providing support to address obstacles that interfere with being successful in the home, school, and community such as maintaining housing, gaining employment, and/or achieving educational goals.

There are situations where ICC or IHBS are a lock out, including youth currently incarcerated and when the service is provided during day treatment hours, which is inclusive of these services. If a CFT meeting is provided during (IOP/PHP)Intensive/Day Rehab hours, a Service Note will be completed, utilizing the Procedure Code "CFT/MDT".

Therapeutic Foster Care

The Therapeutic Foster Care (TFC) service model allows for the provision of short-term, intensive, highly coordinated, trauma-informed and individualized Specialty Mental Health Service (SMHS) activities to children and youth up to 21 years of age who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. Prior authorization through Optum is required preceding the provision of TFC services. An authorization request form shall be completed and returned to the Administrative Services Organization (ASO) who provides authorization for TFC. Optum acts as the ASO. Authorization requests are then screened and assessed by Optum UM licensed clinicians for eligibility criteria. Optum UM licensed clinicians will then send authorization determination to the requestor within 5 business days or receipt of request.

Prior authorization must be submitted prior to the opening of the assignment or the provision of services. The Optum Provider Line for authorization requests is 1-800-798-2254. The required authorization request forms are located on the Optum Website under MHP Provider Documents/TFC Tab via this link: MHP Provider Documents

The TFC service model is intended for children and youth who require intensive, individualized, and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS services available under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit as a home-based alternative to high level care in institutional settings such as group homes and, in the future, as an alternative to Short-term Residential Therapeutic Programs (STRTPs). The TFC home also may serve as a step down from STRTPs. The TFC service model components consist of plan development, rehabilitation, and coordination of care. The SMHS service activities provided through the TFC service model are ancillary to other SMHS that the child or youth receives. Children and youth receiving SMHS

service activities through the TFC service model must receive Intensive Care Coordination (ICC) and other medically necessary SMHS, as set forth in the client plan.

A Child and Family Team (CFT) must be identified to provide TFC. CFT members will work collaboratively to determine whether TFC may be appropriate to address the child's or youth's mental health needs to prevent placement disruption. TFC services can be accessed through a referral to the BHS approved TFC program. During the assessment process, and as recommended by the CFT, the BHS approved TFC program will screen for medical necessity and appropriateness of TFC to meet the youth's mental health needs, as well as assess the parent's willingness and training needs for providing TFC services. Once the child or youth is authorized by Optum to receive TFC service model, CFT team members are responsible for reviewing a child's or youth's progress in meeting client plan goals related to the provision of TFC.

The TFC program is responsible for the oversight of the interventions provided by the TFC parent and for ensuring that the TFC parent follows the client plan. Additionally, the TFC program is responsible for ensuring the TFC parent receive competency-based trainings both initially and ongoing, as outlined in DHCS Medi-Cal Manual. The TFC program conducts an annual TFC parent evaluation, as outlined in DHCS Medi-Cal Manual, to determine if any additional training or needs must be addressed in order for the TFC parent to continue to be successful in their role.

The TFC clinician employed by the TFC program provides ongoing supervision and intensive support to the TFC parent regarding the interventions that the TFC parent provides to the child/youth, as identified in the client plan. The TFC clinician meets with the TFC parent, face-to-face, in the TFC parent's home, at a minimum of one (1) hour per week. Additionally, the TFC clinician reviews and co-signs daily progress notes to ensure progress notes meet Medi-Cal SMHS and contractual requirements.

The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent provides trauma-informed interventions daily, up to 7 days a week, including weekends, at any time of the day, as medically necessary for the child or youth. The SMHS provided through the TFC service model assists the child or youth in achieving client plan goals and objectives; improving functioning and well-being; and helps the child or youth to remain in a family-like home in a community setting; thereby avoiding residential, inpatient, or institutional care. As a member of the CFT, the TFC parent participates in planning, monitoring, and reviewing the child/youth's progress in TFC and informing the team of any changes in the child's needs during CFT meetings.

Data Reporting

While DHCS does not require MHP's to determine if a child or youth is Katie A subclass member, MHPs are encouraged to track all children/youth who are receiving ICC, IHBS, and TFC to

facilitate data collection and reporting of all services provided. When the client is identified as "Katie A ICC/IHBS" in the service note, the "KTA" revenue tracking code is added to the claim. These clients can then be tracked using the "CalMHSA Special Populations Report".

Bulletins

PWB Bulletins are used to inform and provide procedures. Bulletins are located on the BHS Pathways to Well-Being Website:
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/workforce/pathways.html

Current PWB Forms include the following:

IHBS Prior Authorization Request
IHBS Prior Authorization Request Explanation

Pathways to Well-Being BHS/CFWB Information Exchange Form Fill
Pathways to Well-Being BHS/CFWB Information Exchange Form Explanation

Trainings

All Program Managers and direct service staff shall complete the one-time Pathways to Well-Being and Continuum of Care Reform (San Diego) eLearning training. All mental health Program Managers shall complete the AB 2083 online training within 90 days of hire. Both of these trainings are located on the located on the Pathways to Well-Being website.

Forms

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

Form (Please always refer to BHS Training and Technical Assistance website for current version)	**Details**
Child and Family Meeting Facilitation Program Child and Family Team Referral	Completed any time there is an identified need for a CFT meeting for a youth in a mental health treatment program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Child and Family Team Meeting Summary and Action Plan	Initiated by CFT Meeting Facilitation Program unless provider has an exception to facilitate their program CFT meetings, approved by COR.

Child and Family Team Meeting Confidentiality Agreement	Initiated by CFT Meeting Facilitation Program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Pathways to Well-Being BHS/CFWB Information Exchange Form	Provider completes and submits form to CFWB (see secure region fax numbers on form) initially within 30 days of determining eligibility and for any update (upon significant change or revision to either a client plan or problem list).

Resources:

DHCS Medi-Cal Manual Third Edition (2018):
https://www.dhcs.ca.gov/Documents/ChildrensMHContentFlaggedForRemoval/Manuals/Medi-Cal_Manual_Third_Edition.pdf

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

Forms referenced above are located on the BHS Pathways to Well-Being website under the Tools and Forms tabs. The page includes general information, required forms, training, schedules, and contact information for BHS Pathways to Well-Being staff:
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/workforce/pathways.html

Short Term Residential Therapeutic Programs (STRTP)

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

IPC and CFT Meeting

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

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

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

STRTP Services

Family First Prevention and Services Act

On February 9, 2018, the Bipartisan Budget Act of 2018 – Public Law (P.L) 115-123, which includes the Family First Prevention and Services Act (FFPSA), was signed into law. The FFPSA amends Title IV-B of the Social Security Act, subparts1 and 2 programs, and makes other revisions to the Title IV-E foster care program.

FFPSA is designed to enhance support services for families to help children remain at home and reduce the use of unnecessary congregate care placements by increasing options for prevention services, increasing oversight and requirements for placement, and enhancing the requirements for congregate care placements.

As of October 1st, 2021, per the FFPSA Part IV and Welfare and Institutions Code 4096, as outlined in Behavioral Health Information Notice (BHIN) NO. 21-060, a **Qualified Individual (QI)** shall **conduct an independent assessment and determination** regarding the **needs of a child prior to placement in a Short-Term Therapeutic Residential Program (STRTP)** or in an out-of-state residential facility. The Qualified Individual shall include engagement with the child and family team members and, in the case of an Indigenous child,

the Indigenous child's tribe, in conducting the assessment. The QI shall conduct the independent assessment and determination prior to placement in a STRTP. In the case of emergency placement, the QI shall conduct the independent assessment and determination within 30 days of the start of the placement.

Also, effective **October 1, 2021**, per FFPSA Part IV, **Short-Term Residential Therapeutic Programs (STRTPs) aftercare component will routinely extend for at least six (6) months post discharge and will include a connection to wraparound services** as the youth transitions out of the STRTP. The goal of the aftercare component is to support youth in the transition from congregate care to a family-based setting. STRTPs are responsible for discharge planning and ensuring family-based aftercare supports are in place for at least 6 months. STRTPs have authorization to make direct referrals to BHS contracted wraparound programs and shall routinely discuss the implementation of wraparound services in the Child and Family Team (CFT) meeting during the transition period from the STRTP to aftercare to ensure the team is a part of the recommendation. Wraparound providers can begin providing services up to three months prior to a youth's planned discharge from the STRTP in order to prepare for the transition to a family-based placement.

Mental Health Program Approval

STRTPs must have a contract with the MHP to provide Specialty Mental Health Services (SMHS) and must apply for and maintain STRTP **Mental Health Program Approval from DHCS**. Children/youth placed in an STRTP must receive intensive treatment services in a therapeutic milieu, outlined in **Section D: Intensive Services**. The Utilization Management process for STRTPs is outlined in **Section D**: **Authorization Process for Intensive Services**. The process for serving out of county Medi-Cal Clients in an STRTP is outlined in **Section D: Out of County Medi-Cal Clients**.

STRTPs are required to comply with the program, documentation and staffing requirements outlined in the most current **Interim STRTP Regulations** provided in Behavioral Health Information Notice No: 20-005.

References

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

Behavioral Health Information Notice No:20-005, Statewide Criteria for Mental Health Program Approval for Short-term Residential Therapeutic Programs:

https://www.dhcs.ca.gov/Documents/BH-Information-Notice-No.-20-005-STRTP-Interim-Regulations.pdf

Interim STRTP Regulations (Version II):
https://www.dhcs.ca.gov/Documents/STRTP-Regulations-version-II.pdf

All County Information Notice NO. I-06-16, Pathways to Mental Health Services Implementation and Continuum of Care Reform (CCR) Implementation Updates:
https://www.dhcs.ca.gov/formsandpubs/Documents/Joint_Info_Notice_MHSUDS_IN_16-002_CDSS_ACIN%20_06-16_Re_Pathways_CCR.pdf

MHSUDS Information Notice NO.: 18-017, Mental Health Plan Claiming for Participation in Child and Family Teams and Completing Assessments for Children Prior To Placement in Short-Term Residential Therapeutic Programs:
https://www.dhcs.ca.gov/services/MH/Documents/MHSUDS_Info_Notice_18-017_Participation_in_CFT_Assessments_Claiming.pdf

Behavioral Health Information Notice (BHIN) NO. 21-060.: Assessment by a Qualified Individual (QI) For Placements in Short-Term Residential Therapeutic Programs (STRTPs) Under the Requirement of the Family First Prevention Services Act (FFPSA) and Assembly Bill (AB) 153 (Chapter 86, Statues of 2021).

Behavioral Health Information Notice (BHIN) NO. 21-061.: FFPSA Part IV Aftercare Requirements

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

BHS PWB and CCR Program staff are available to provide outreach assistance to BHS providers in all aspects of PWB and CCR implementation. This includes assisting providers with utilizing ICC and IHBS in accordance with the DHCS Medi-Cal Manual, as well as technical assistance for STRTPs and group home providers who are transitioning to a STRTP. The PWB and CCR Program teams work collaboratively and in partnership with BHS providers, CFWB, Probation, and Youth/Family Support Partners. Program staff can be reached through the BHS Pathways to Well-Being Website link below.
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/workforce/pathways.html

QA PROGRAM MONITORING

The BHS Quality Assurance Unit shall monitor each organizational provider and county operated program for compliance with these requirements, to assure that activities are conducted in

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

Financial Eligibility and Billing Procedures

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

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

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

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

E. INTEGRATION WITH PHYSICAL HEALTH CARE

COORDINATION WITH PRIMARY CARE PHYSICIANS

Coordination of care between physical and behavioral health providers is necessary to optimize the overall health of a client. All providers are expected to coordinate mental health care with a client's Primary Care Physician and should have a policy and procedure in place regarding this coordination of services. Almost all of Medi-Cal beneficiaries are enrolled in one of the Medi-Cal Managed Care Plans (MCPs) that are part of Healthy San Diego (HSD). To find a list of included MCPs go to the Healthy San Diego website:

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

The "Healthy San Diego Medi-Cal Managed Care Plan Contact Card" is a helpful tool to use for coordination of care and is located on the HSD website under Resources. The Coordination of Physical & Behavioral Health Form is available in the threshold languages and can be found on the Optum website in the UCRM tab:

https://www.optumsandiego.com/content/sandiego/en.html

Contracted providers are required by the MHP to complete the Coordination with Primary Care Physicians and Behavioral Health Services form with the client within 30 days of assignment opening to facilitate coordination with the client's Primary Care Physician. For clients that do not have a primary care physician, provider shall connect them to a medical home. Users of the form shall check the appropriate box at the top of the form noting the nature of the referral Requesting client/guardian authorization to exchange information with primary care physicians is mandatory.

Pharmacy and Lab Services

Managed Care Plan Medi-Cal Beneficiaries

Each MCP has contracts with specific pharmacies and laboratories. Providers prescribing medication or lab tests need to be aware of which pharmacy or laboratory is associated with each client's MCP in order to refer the client to the appropriate pharmacy or lab. HSD website lists all the contracted pharmacy or lab services for each Medi-Cal MCP. Additionally, the client's MCP enrollment card has a phone number that providers and clients can call to identify the contracted pharmacy or lab. Providers must use the health plans contacted lab vendor.
Psychiatrists may order the following lab studies without obtaining authorization from the client's Primary Care Physician:

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

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

Enhanced Care Management (ECM)

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit available to eligible members with complex needs often engaged with several systems of care. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services.

While this benefit is provided by the member's Managed Care Plan (MCP) – it may include engagement and collaboration with our MHP system of care providers to refer clients and coordinate care.

MHP providers should be familiar with the basics of ECM and the Populations of Focus that are eligible for this benefit and make the appropriate referral to the member's Managed Care Plan for ECM services, when appropriate.

Enhanced Care Management is available to specific groups (aka "Populations of Focus"):

- Adults and families experiencing homelessness
- Adults, youth and children at risk for avoidable hospital or emergency department care
- Adults, youth and children with serious mental health and/or substance use disorder needs
- Adults living in the community and at risk for long-term care institutionalization.
- Adults transitioning back to the community from a residential nursing facility

- Children and youth enrolled in California's Children's Services (CCS) or CCS Whole Child Model with additional needs beyond their CCS condition(s).
- Children and youth involved in child welfare (foster care)
- Adults and youth transitioning back to the community after incarceration
- Pregnant and post-partum individuals, birth equity population of focus (starting 2024)

- Additional information and definitions can be found here: ECM Policy Guide Updated September 2023.pdf (ca.gov)

Managed Care Plan (MCP) Enhanced Care Management (ECM) Referral Forms / Contacts

Providers should utilize the below links for ECM referrals and contacts – all referrals should be directed to the MCP using the below forms/email contacts:

Medi-Cal Managed Care Plan	Referral Form	Email Address
Blue Shield Promise	ECM Referral Form (blueshieldca.com)	Email: ECM@blueshieldca.com
Community Health Group	ECM Referral Form (chgsd.com)	Email: ecm-cs@chgsd.com
Kaiser	ECM Referral Form (kaiserpermanente.org)	Email: RegCareCoordCaseMgmt@KP.org
Molina	ECM Referral Form (molinahealthcare.com)	Email: MHC_ECM@Molinahealthcare.com

Medi-Cal Beneficiaries Not Enrolled in an MCP

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

Non-Medi-Cal Beneficiaries

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

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

programs available through pharmaceutical companies or obtain free samples to offset the cost of medication.

PHYSICAL HEALTH SERVICES WHILE IN A PSYCHIATRIC HOSPITAL

Healthy San Diego Recipients

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

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

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

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

TRANSFERS FROM PSYCHIATRIC HOSPITAL TO MEDICAL HOSPITAL

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

Medical Transportation

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

HOME HEALTH CARE

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

Clinical Consultation with Primary Care

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

F. BENEFICIARY RIGHTS, GRIEVANCE AND APPEALS

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

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

On January 1, 2022, the Department of Health Care Services (DHCS) initiates the implementation of the California Advancing & Innovating Medi-Cal (Medi-Cal Transformation) initiative. The MHP will implement Medi-Cal Transformation and applicable updates to criteria for access to specialty mental health services for beneficiaries 21+ and beneficiaries under 21. The MHP will implement Medi-Cal recoupment requirements as indicated by the Medi-Cal Transformation initiative.

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

- *Easily understandable information.* Each managed care enrollee is guaranteed the right to receive all enrollment notices, information materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.

- *Dignity, respect, and privacy*. Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

- *Receive information on the managed care plan and available treatment options*. Each managed care enrollee is guaranteed the right to receive information on the managed care plan and its benefits, enrollee rights and protections, and emergency care, as well as available treatment options and alternatives. The information should be presented in a manner appropriate to the enrollee's condition and ability to understand.

- *Participate in decisions*. Each managed care enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

- *Free from restraint or seclusion*. Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulation on the use of restraints and seclusion.

- *Copy of medical records*. Each managed care enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR, 164.524 and 164.526.

- *Right to health care services*. Each enrollee has the right to be furnished health care services in accordance with CFR, Title 42, Sections 438.206-210.

- *Free exercise of rights*. Each managed care enrollee is guaranteed the right to free exercise of his/her rights in such a way that those rights do not adversely affect the way the MHP and its providers treat the enrollee.

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

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

Process Definitions (Title 42 CFR § 438.400 (b))

- Grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination as defined below (under appeal). Grievances may include but are not limited to: the quality of care of services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, failure to respect the rights of the client regardless of what remedial action is requested, including the client's right to dispute an extension of time proposed by the plan to make an authorization decision. A grievance can be filed at any time, orally or in writing. (42 CFR § 438.402)

- Discrimination Grievance is when a client believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance with the county plan, the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights. San Diego County complies with all State and Federal civil rights laws. (45 CFR §§ 92.7 and 92.8; WIC§14029.91). Discrimination Grievance posters can be found in the Beneficiary Handbook and printed for posting.

- Grievance Exemption is when grievances are received over the telephone or in-person that are resolved to the client's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter. Note: Grievances received via mail are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If a complaint is received pertaining to an Adverse Benefit Determination, as defined under 42 CFR Section 438.400, the complaint is not considered a grievance and the exemption does not apply.

- Appeal means a review of an adverse benefit determination or "action" which may include:

    - Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medically necessary specialty mental health services , appropriateness, setting, or effectiveness of a covered benefit.
    - The reduction, suspension, or termination of a previously authorized service.
    - The denial, in whole or in part, of payment for a service.
    - The failure to act within the timeframes regarding the standard resolution of grievances and appeals.
    - The failure to provide services in a timely manner.
    - The denial of a client's request to dispute financial liability.

- Grievance and appeal system are the processes the county and providers implement to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

- State Fair Hearing is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal beneficiary is required to exhaust the MHP problem resolution process prior to requesting a State Fair Hearing and only a Medi-Cal beneficiary may request a state fair hearing.

Additional Client Rights

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

- **Second Opinion**
  If the MHP or its designee determines that a client does not meet criteria for access to inpatient or outpatient specialty mental health services, a client or someone on behalf of the client, may request a second opinion. A second opinion from a mental health clinician provides the client with an opportunity to receive additional input on his or her mental health care at no extra cost. As the MHP designee, Optum is responsible for informing the treating provider of the second

opinion request and for coordinating the second opinion with an MHP contracted individual provider.

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

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

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

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

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

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

- **Open Payments Database Physician's Notice to Clients**
  As required by State Assembly Bill AB1278, physicians are required to provide notice to patients regarding the Open Payments Database which is managed by the U.S. Centers for Medicare and Medicaid Services (CMS). The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten

dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public. The Open Payments Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. If can be found at https://openpaymentsdata.cms.gov

Advance Health Care Directive Information

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

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

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

The MHP is providing an informational brochure on Advance Directives, available in the threshold languages, which can be given out to new clients or members of the community who request it. All brochures are available on the Optum website at www.optumsandiego.com under the County Staff and Providers tab, under Organizational Provider Documents. *To receive the materials in the audio or large*

print format contact QIMatters.HHSA@sdcounty.ca.gov, or providers may duplicate their own copies. The MHP will also be responsible for notifying providers of any changes in State law regarding Advance Directives within 90 days of the law change.

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

Periodic Notice of Clients' Rights

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

BENEFICIARY GRIEVANCE AND APPEAL PROCESS

San Diego County Mental Health Services is committed to honoring the rights of every client to have access to a fair, impartial, effective process through which the client can seek resolution of a grievance or adverse benefit determination by the MHP. All county operated and contracted providers are required to participate fully in the Beneficiary and Appeal Process. Providers shall comply with all aspects of the process, including the distribution and display of the appropriate beneficiary protection materials, including posters, brochures and grievance/appeal forms as described in the process. (Beneficiary Packet Materials Order Form and Grievance/Appeal Forms are available on the Optum website: https://www.optumsandiego.com).

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

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

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

Grievance Resolution at Provider Sites

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

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

Providers shall inform all clients about their right to file a grievance with one of the MHP's contracted advocacy organizations if the client has an expression of dissatisfaction about any matter, is uncomfortable approaching program staff, or the dissatisfaction has not been successfully resolved at the program. Clients should feel equally welcomed to bring their concerns directly to the program's attention or to seek the assistance of one of the advocacy organizations.

Complaints to Board of Behavioral Sciences (AB 630)

Effective on or after 7/1/20, mental health professionals licensed or registered with the Board of Behavioral Sciences (BBS), prior to providing psychotherapy, must give clients a notice in at least 12-point font telling them that BBS receives and responds to complaints about licensees and tells clients how to contact BBS to file complaints.

Providers should have a Policy and Procedure in place addressing this regulation and QA will be monitoring this during the Medi-Cal site visits.

Grievance Process

A "grievance" is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination. There is no distinction between an informal and formal grievance. A compliant is the same as a formal grievance. A compliant shall be considered a grievance unless it meets the

definition of an "adverse benefit determination". Even if a beneficiary expressly declines to file a formal grievance, their complaint shall be categorized as a grievance.

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

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

Grievance Resolution

Timeline: 90 days from receipt of grievance to resolution, with a possible 14-day extension for good cause. The MHP must resolve grievances within the established timeframes. The Plan must comply with the following requirements for resolution of grievances:

1. "Resolved" means that the Plan has reached a decision with respect to the beneficiary's grievance and notified the beneficiary of the disposition.
2. Plans shall comply with the established timeframe of 90 calendar days for resolution of grievances, except as noted below.
3. The timeframe for resolving grievances related to disputes of a Plan's decision to extend the timeframe for making an authorization decision shall no exceed 30 calendar days.
4. The Plan shall use the Notice of Grievance Resolution (NGR) to notify beneficiaries of the results of the grievance resolution. The NGR shall contain a clear and concise explanation of the Plan's decision.
5. Federal regulations allow the Plan to extend the timeframe for an additional 14 calendar days if the beneficiary requests the extension or the Plan shows (to the satisfaction of DHCS, upon request) that there is need for additional information and how the delay is in the beneficiary's interest. In the event that resolution of a standard grievance is not reached within 90 calendar days as required, the Plan shall provide the beneficiary with the applicable NOABD, and include the status of the grievance and the estimated date of resolution, which shall not exceed 14 additional calendar days. If the Plan extends the timeframe, not at the request of the beneficiary, it must complete all of the following: (a) give the beneficiary prompt oral notice of the delay, (b) within two calendar days of making the decision, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he/she disagrees with that decision, and (c) resolve the grievance no later than the date the extension expires.

Grievance Process Exemptions

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

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

Advocacy Services and Records Requests

In accordance with the Code of Federal Regulation (CFR) Title 42, Part 438, Subpart F – Grievance System, the JFS Patient Advocacy Program and CCHEA are required to conduct grievance investigations and appeals pursuant to State and Federal law. These processes may include, but are not limited to, consulting with facility administrators, interviewing staff members, requesting copies of medical records, submitting medical records to independent clinical consultants for review of clinical issues, conducting staff member trainings, suggesting policy changes, submitting requests for Plans of Correction (POC), and preparing resolution letters.

There are mandated timelines for grievances and appeals. Providers' quick and efficient cooperation will ensure compliance with these requirements. When requested, MHP providers shall provide copies of medical records to the JFS Patient Advocacy Program and CCHEA within seven (7) calendar days from the date of the medical record request. The Advocacy Agencies will provide the program with a signed release of information from the client with the request.

ADVERSE BENEFIT DETERMINATION (ABD)

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

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

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, meeting criteria for access to SMHS, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;

5. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
6. The denial of a beneficiary's request to dispute financial liability.

Written Notice of Adverse Benefit Determination (NOABD) Requirements

Beneficiaries must receive a written NOABD when the MHP takes any of the actions described above. The Plan must give beneficiaries timely and adequate notice of an adverse benefit determination in writing, consistent with the requirements in 42 CFR §438.10. The federal regulations delineate the requirements for content of the NOABDs. The NOABD must explain all of the following:

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

Decisions shall be communicated to the beneficiary in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively. For written notification to the provider, the Plan must also include the name and direct telephone number or extension of the decision-maker. Programs shall review the client's chart for an emergency contact. If the program has a Release of Information on file for the individual, they are to send the NOABD to the emergency contact. If not, document the inability to reach client on the NOABD log and place a copy of the NOABD in the log as well.

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

Timing of the Notice

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

1. For termination, suspension, or reduction of a previously authorized specialty mental health

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

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

Written NOABD Templates

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

1. **NOABD Denial of Authorization Notice** - Use this template when the Plan denies a request for a service. Denials include determinations based on type or level of service, requirements for criteria for access to medically necessary services , appropriateness, setting or effectiveness of a covered benefit.

2. **NOABD Payment Denial Notice** - Use this template when the Plan denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary.

3. **NOABD Delivery System Notice** - Use this template when the Plan has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health through the Plan. The beneficiary shall be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.

4. **NOABD Modification Notice** - Use this template when the Plan modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.

5. **NOABD Termination Notice** - Use this template when the Plan terminates, reduces, or suspends a previously authorized service. This notice is also required for all clients who have unsuccessfully discharged. Unsuccessful discharge includes, but is not limited to, client AWOL, client unwilling to continue with services, client terminates services AMA, etc.

6. **NOABD Delay Notice** - Use this template when there is a delay in processing a provider's request for authorization of specialty mental health service. When the Plan extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest.

7. **NOABD Timely Access Notice** - Use this template when there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service.

8. **NOABD Financial Liability Notice** - Use this template when the Plan denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.

9. **NOABD "Your Rights" Attachment -** the "Your Rights" attachment is a new form that informs beneficiaries of critical appeal and State hearing rights. There are two types of "Your Rights" attachments. One accompanies the NOABD and the other accompanies the Notice of Appeals Resolution. These attachments must be sent to beneficiaries with each NOABD or NAR.

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

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

The MHP programs shall have a written policy and procedure addressing the collecting, storing, filing, and mailing of Notice of Adverse Benefit Determinations. It is recommended that programs maintain all Notice of Adverse Benefit Determinations in a confidential location at the program site for no less than ten (10) years after discharge for adults. For minors, records are to be kept until they have reached the age of 18, plus seven (7) years.

- All MHP programs shall maintain on site a monthly NOABD Log.
- Programs shall include the following in their NOABD Logs:

  - Date NOABD was issued.
  - Beneficiary identification number/medical record number.
  - Mode of NOABD Delivery
  - Beneficiary response, requests, provisions for second opinions, initiation of grievance/appeal procedure, and/or request for a State Fair Hearing if known.
    - Logs to contain copies of each NOABD and "Your Rights" forms attached.
    - Logs to contain documentation of inability to contact the client, if applicable.
    - Log to reflect "NO NOABD ISSUED" if none are issued within a month.
    - NOABD Logs must be available for review at COR or QA request.
- Monthly logs are to be submitted to QA on a quarterly basis, along with Medication Monitoring Reports. Dates for submission are as follows:
  - Quarter One: October 15th
  - Quarter Two: January 15th
  - Quarter Three: April 15th
  - Quarter Four: July 15th
- QA has developed an Excel NOABD Log that programs can use to track monthly NOABD's. The NOABD log can be accessed at https://www.optumsandiego.com . If programs choose to create their own log, it must contain all the same elements listed above. All NOABD's will be stored in the Logbook, therefore not being stored in the beneficiary's individual chart.

APPEAL PROCESS

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

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

1. Denial or limited authorization of a requested service, including determinations based on the type or level of service, criteria for access to medically necessary services, appropriateness, setting, or effectiveness of a covered benefit;
2. Reduction, suspension or termination of a previously authorized service;
3. Denial of, in whole or in part, of payment for a service;
4. Failure to provide services in a timely manner;
5. Failure to act within the required timeframes of a standard resolution of grievances and appeals; or
6. Denial of a beneficiary's request to dispute financial liability.

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

beneficiary.

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

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

Authorized Representatives

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

Standard Resolution of Appeals

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

Extension of Timeframes

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

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

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

a. The Plan shall make reasonable efforts to provide the beneficiary with prompt oral notice of

the extension;

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

Expedited Resolution of Appeals

Timeline: 72 hours from receipt of expedited appeal request

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

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

General Expedited Requirements

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

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

Notice of Appeal Resolution (NAR) Requirements

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

NAR Adverse Benefit Determination Upheld Notice

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

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

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

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

NAR "Your Rights" Notice

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

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

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

NAR Adverse Benefit Determination Overturned Notice

For appeals resolved wholly in favor of the beneficiary, written notice to the beneficiary shall include the results of the resolution and the date it was completed. The MHP shall also ensure that the written response contains a clear and concise explanation of the reason, including why the decision was overturned. The MHP shall utilize the DHCS template packet for appeals, which contains the NAR for overturned decisions.

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

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

STATE FAIR HEARING (SFH)

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

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

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICES

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

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

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

Provider Appeal Process

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

Considerations for Minors

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

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

Monitoring the Beneficiary Grievance and Appeal Resolution Process

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

G. QUALITY ASSURANCE PROGRAM

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

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

- 42 CFR, (Code of Federal Regulations)
- Title 9, Chapter 11, of the California Code of Regulations
- Welfare and Institutions Code 14184.042
- State Department of Health Care Services (DHCS) Letters and Notices
- the MHP Managed Care contract with the State DHCS
- the Annual DHCS State Protocol for MHPs
- Mental Health Services Act (MHSA) requirements, and
- State DHCS mandated Performance Improvement Projects (PIP)
    - The State has mandated that each MHP undertake one administrative and one clinical PIP yearly.

The evaluation process has also expanded to meet a number of Federal regulations and legislative mandates under the new Medi-Cal Transformation as specified in Welfare and Institutions Code 14184.042 effective January 1, 2022, and the **Medicaid and CHIP Managed Care Final Rules**, effective July 5, 2016. The Federal Managed Care Regulations, specifically Part 438 of title 42 Code of Federal Regulations, applies to the provision of Medicaid Managed Care (MMC) programs and managed care organizations (MCOs), Pre-paid Inpatient Health Plans (PIHPs), and Pre-paid Ambulatory Health Plans (PAHPs). Mental Health Plans are PIHPs. Key goals of the final rule are:

- To support State efforts to advance delivery system reform and improve the quality of care
- To strengthen the beneficiary experience of care and key beneficiary protections
- To strengthen program integrity by improving accountability and transparency

- To align key Medicaid and CHIP managed care requirements with other health coverage programs

All providers shall adhere to the rules and regulations as stipulated in the W&I Code 14184.042, Medi-Cal Transformation and Medicaid and CHIP Managed Care Final Rules. Information about the final rule is available at the following link: https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html.

Information about the Medi-Cal Transformation is available at the following link: https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx

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

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

MEASURING CLIENT SATISFACTION

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

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

BHS selects a one-week time period annually in which all Outpatient providers, including Case Management, are required to administer the Mental Health survey. This survey consists of a Mental Health Statistics Improvement Program (MHSIP) section, which measures client satisfaction with services. This survey should be administered to **all** clients receiving services during the one-week period, **including clients receiving medications only.** UCSD Health Services Research Center (HSRC) is contracted by the MHP to handle the adult survey process. HSRC distributes the blank survey forms, collects the completed forms, and compiles provider and countywide satisfaction data. Providers will be notified by HSRC of the exact survey period. Survey returns are scanned and then tabulated, therefore, original printed forms provided by the

MHP must be used. Providers are strongly requested to send in completed surveys according to HSRC instructions at the end of the survey period. Each participating provider will receive a report comparing their results on the survey with the average results for their level of care.

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

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

Provider Feedback

All providers are also encouraged to provide feedback regarding their interaction with the MHP by direct communication with the Program Monitor/COR, Quality Assurance Team, and MH Contract Administration Unit. Communication can occur at the contractor's request, at scheduled meetings, and through the status report narrative. QA will provides opportunity for provider feedback via an online Provider Feedback Survey offered quarterly via a QR Link during the QA Quality Improvement Partners (QIP) Meeting.

COR Site Reviews are scheduled on an ad hoc basis to ensure that programs remain in compliance with State Standards. However, the Pharmaceutical Review will be completed annually and will be conducted by QA staff during the Quality Assurance Program Review (QAPR) process.

Medi-Cal Certification and Recertification

Contracted and County providers shall be familiar with the Short-Doyle/Medi-Cal delivery system and shall become Medi-Cal certified prior to commencing services and billing Medi-Cal. Providers who bill for Medi-Cal services will be recertified every three (3) years. For contracted programs, the Medi-Cal Site Certification or Recertification Site Review is completed by BHS QA staff; for county-operated programs, these site reviews are completed by DHCS.

At the beginning of the fiscal year, all providers up for their three-year Medi-Cal recertification will be notified they will be recertified at some point during the fiscal year and a fire clearance will be needed to allow them sufficient time to obtain one before their recertification site visit.

Recertification site visits will be scheduled no less than 30 days before the last Medi-Cal certification date.

Providers will be notified of the recertification site visit no less than 45 days before the last Medi-Cal certification date.

The re-certification review will include review of the following:

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

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

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

At the Short-Doyle Certification/Recertification site visit, the organizational provider must make available to the reviewer the most recent site fire clearance document. Providers will be in compliance if the most recent fire clearance document has been completed within three (3) years of the previous fire clearance document date. If the most recent fire clearance document has not been completed within the three (3) year period or fire clearance document is not found, the program will receive a Plan of Correction (POC) requesting the appropriate action(s) to be taken by the provider. The action(s) will be included in the POC and sent to San Diego County Mental Health Service's QA Unit for review. For any questions on this process, please contact QIMatters.hhsa@sdcounty.ca.gov.

MONITORING THE SERVICE DELIVERY SYSTEM

Uniform Medical Record – Forms and Timelines

All programs are required to utilize the forms specified in the San Diego County Mental Health Services Uniform Clinical Record Manual, and any updated forms, which are issued on an interim basis. The standards for documentation shall be consistent across all clinical programs, regardless of funding source. Programs may adapt forms for specific program needs upon review and

approval by the Health Plan Organization Quality Assurance Unit. The Hybrid Medical Record for each client must be maintained in a secure location, must be filed in the prescribed order, and must be retrievable for County, State, or Federal audit upon request, during and after the provision of services up to the limits prescribed in California law. Each legal entity shall develop forms for legal consents and other compliance related issues. **Out-of-county** mental health programs may utilize non-San Diego County medical record forms, but they must comply with all State and Federal and requested County guidelines.

DHCS, CMS, the Office of the Inspector General, the Comptroller General, the County, and their designees may, at any time, inspect and audit any records or documents, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related services (i.e., Drug Medi-Cal) are conducted. The right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. County providers are required to retain all Billing Records for a minimum of 10 years when the program is funded with State or Federal dollars. Therefore, contracted providers are to retain medical records for no less than ten (10) years after discharge date for adults. For minors, records are to be kept until they have reached the age of 18, plus seven (7) years. [ref: *MHSUDS IN 18-012; 42 CFR §425.314; 22 CCR* §77143; *CCR 438.3(u)*]

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

Staff Signature Logs

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

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

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

To ensure that the log is kept current, it is the organizational provider's responsibility to update and maintain the log in a timely manner to reflect any changes, i.e., licensure, degree, job title, name, or signature. The staff signature log must be maintained onsite at the organizational

provider's program location, and be made available at the request of the MHP for purposes of site visits, medical record reviews, etc. Failure to maintain a staff signature log that is accurate and current will result in a plan of corrective action being issued to the organizational provider.

Timeliness of Documentation Standard

All services provided to a client shall be documented into the client's medical record within 3 business days of providing the service with the exception of notes for crisis services, which shall be completed within 24 hours. Best clinical practice dictates progress notes be completed as soon as possible after a service is provided. With timely documentation, details and relevant information are captured that otherwise may be lost if too much time lapses between service provision and documentation of the service.

Medical Record Reviews

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

Program Responsibility

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

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

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

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

County Quality Assurance Program Reviews

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

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

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

During the Quality Assurance Program Review, a Quality Assurance Specialist will review clinical records for:

- Assessment/Appropriateness of Treatment
- Access Criteria/Medical Necessity
- Diagnosis(es)
- Clinical Quality
- Problem List, evidence of Care Planning, and Client Involvement
- Compliance with Medi-Cal, State, Federal, and County Documentation Standards
- Billing Compliance
- Medication Treatment/Medical Care Coordination
- Administrative/Legal Compliance
- Care Coordination
- Discharge

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

Program Quality Improvement Plan (QIP)

If patterns or trends related to meeting documentation or billing standards, , or other identified Quality of Care concerns such as coordination of care with other service delivery providers, client engagement, are identified, a request for a Quality Improvement Plan will be issued by the MHP to the provider. After receipt of the MHP's written report of findings, the provider will have a specified timeframe in which to complete and submit the QIP to the QA Unit. The QIP must describe the interventions or processes that the provider will implement to address items that have been identified out of compliance or that were identified as needing improvement. In some instances, the QA Unit will be making more specific process improvement recommendations to the provider that must be included in the QIP. When appropriate, the QIP must include all supporting documentation (i.e., copy of a policy and procedure that has been written, description of a system that program is implementing, copy of sign-in sheets from a training, etc.). Even when supporting documentation is not requested to be submitted with the QIP, the program is still required to keep this documentation on-file at their program. The QIP must also include identified timelines and/or dates as to when the out of compliance item or area needing improvement will be implemented or completed. Pursuant to the "Withholding of Payment" clause of the contract, failure to respond adequately and in a timely manner to a request for a QIP may result in withholding of payment on claims for non-compliance.

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

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

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

When a program's compliance issues are not improving as detailed in the program's written QIP, QA may request that the Program COR issue a Corrective Action Notice (CAN) to the program's Legal Entity. The CAN, given to the Legal Entity, will include a description of the noncompliance categories, history of program's QIP actions, and a statement about insufficient improvement

having been made. QA may recommend identified interventions or process changes to be implemented. If a CAN is issued to a Legal Entity, additional County Departments become involved in monitoring remedial activities. Failure to respond adequately and in a timely manner to a required Corrective Action Notice may result in a withholding of payment on the claims for non-compliance and could result in putting the contract at risk.

For billing disallowances or service corrections identified in the Medical Record review, programs will be required to submit evidence of correction as delineated in the medical record review protocol for that fiscal year as part of their QIP. Programs are responsible to follow-up on any pending corrections at QA Specialist direction. If there are additional billing concerns, the QA Specialist may conduct another medical record review prior to the next fiscal year.

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

Medi-Cal Recoupment and Appeals Process

In alignment with DHCS Compliance Monitoring requirements and CalAIM Medi-Cal Transformation initiatives, recoupment shall be focused on identified overpayments and patterns in documentation suggestive of fraud, waste or abuse. Fraud and abuse is defined in CFR, Title 42, section 455.2. W&I, section 14107.11, subdivision (d) also addresses fraud. Definitions for "fraud," "waste," and "abuse," as those terms are understood in the Medicare context, can also be found in the Medicare Managed Care Manual.

Evidence of fraud, waste, abuse may include but is not limited to:

- Billing for services not rendered or not medically necessary
- Billing separately for services that should be a single service
- Falsifying records or duplicate billing
- Overpayment may include but is not limited to:
    - Missing documentation of allowable service
    - Services not billable under Title 9
    - Medical Necessity
    - Claims submitted for service during a lock out

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

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

Medi-Cal Certification Site Reviews

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

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

Medication Monitoring for CYF and AOA SOC

State and County regulations require all organizational providers with programs prescribing medication in the course of their services to have a medication monitoring system. **Out of County Providers shall adhere to their own County's Medication Monitoring process.** Current State Department of Health Care Services (DHCS) requirements for Medication Monitoring are set forth in CCR, Title 9, Chapter 11, Section 1810.440; MHP Contract with DHCS, Exhibit A, Attachment 5, 1.H. The primary purpose of medication monitoring is to ensure the most effective treatment. Areas monitored include:

- Medication rationale and dosage consistent with community standards
- Appropriate labs
- Consideration of physical health conditions

- Effectiveness of medication(s) prescribed
- Adverse drug reactions and/or side effects
- Evidence of informed consent for use of psychotropic medication within prescriber documentation in client record
- Client adherence with prescribed medication and usage
- Client medication education and degree of client knowledge regarding management of medications.
- Adherence to state laws and guidelines

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

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

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

Procedures for Medication Monitoring Reporting:

- Send the following forms via secure email QIMatters.hhsa@sdcounty.ca.gov or fax (619) 236-1953 to QA:
    - Medication Monitoring Report
    - Medication Monitoring Screening Tools
    - Medication Monitoring Feedback Loop (McFloop)

Results of medication monitoring activities are reported quarterly to the QA unit by the 15th of each month following the end of each quarter (First quarter due October 15, second quarter due January 15, third quarter due April 15 and fourth quarter due July 15). The QA Medication Monitoring Reports for the CYF and Adult's Mental Health Systems of Care are located on the Forms Tab on the Optum Website: https://www.optumsandiego.com/ . For AOA SOC be sure the

criteria are met before completing the Benzodiazepine section of the Adult Medication Monitoring Tool.

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

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

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

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

Quality Assurance (QA) monitors the compliance of each program's medication monitoring practices. By completing the submission Quarterly, QA can monitor compliance during quarterly desk reviews and therefore not require the documents to be reviewed during the annual Quality Assurance Program Review process.
The assigned QA Specialist reviews the quarterly medication monitoring report, screening tools and McFloops for any identified variances and corrective actions taken. Programs will be monitored for trends and patterns in any areas found out of compliance or areas needing improvement and a QIP may be required.

A second level review by the QA Medication Monitoring Oversight Committee (MMOC), working in collaboration with the Medical Director(s) may occur if a program has an inordinately large number of variances, certain trends and patterns are noted, or is largely out of compliance with standards or contract requirements. Determination of an additional corrective actions will be determined by the MMOC and Medical Director(s).

The Health and Human Services Agency Pharmacy is responsible for performing the medication monitoring for County-operated facilities. The Chief of Pharmacy submits a written quarterly

report that includes results of screening and clinical review activities to the clinic program managers and the Health Plan Organization Quality Assurance Unit.

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

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

Only authorized California licensed personnel within the scope of their practice and in accordance with all Federal laws and regulations governing such acts shall administer medications. These licensed personnel include physicians, physician assistants, nurse practitioners, registered nurses, licensed vocational nurses, and licensed psychiatric technicians.
In instances where clients must take medications during the provision of mental health services, and licensed personnel are not present, the following procedures shall be in place:

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

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

3) ***Disposal of Medications***
   a) Disposal shall occur when the medications are expired, contaminated, deteriorated, unused, abandoned, or unidentifiable. Programs may return medications to pharmacy representatives for disposal or dispose of medications by placing them in biohazard

sharps containers for transportation to incineration. If neither of these methods is available, the program can contact a pharmaceutical disposal company for transport and disposal. Examples include Stericycle 1 (866) 783-9816 and KEM (619) 409-9292. Disposal by flushing medications into the water system or placing in the trash are both prohibited under environmental and safety regulations.

b) Disposal shall be documented and co-signed on "**Medication Disposal Log"** (Optum Website Forms Tab: https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/orgpublicdocs.html).

ACCESS TIMES MONITORING

BHS will monitor program data for compliance with access times standards monthly, that includes a review of NOABD data to ensure NOABD's are issued when lack of compliance is indicated. When noncompliant, programs will be notified, technical assistance will be provided. A written report documenting noncompliance will be issued by BHS and providers are required to submit a Corrective Action Plan (CAP) to BHS within 30 days of the report for approval. BHS shall verify corrections as resolved.

CLIENT AND PERFORMANCE OUTCOMES

Adult System of Care:

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

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

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

The A/OA outcomes measures include the Milestones of Recovery Scale (MORS). MORS is an evaluation tool used to assess clinician perception of a client's current degree of recovery. Level

of Care Utilization System (LOCUS). LOCUS is a short assessment of client current level of care needs. Recovery Markers Questionnaire (RMQ). RMQ is used to assess personal recovery of the client from the perspective of the client. Illness Management and Recovery (IMR). IMR is a 15-item assessment addressing differing aspects of the client's illness management and recovery from the perspective of the clinician.

Section N details the system-wide outcome measures. Additional performance requirements are described in that section. The outcomes measures manual is available on the Optum website at: https://www.optumsandiego.com Go to "BHS Provider Resources" "MHP Provider Documents" then the "Manuals" tab.

Child, Youth and Family System of Care:

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

Information on CANS certification, a requirement for administration, is available on the BHS CYF Outcomes website: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/workforce/cyf_outcomes.html

All outcomes' data will be completed within the electronic health record and then entered in the Other data is manually collected by providers and submitted on a quarterly basis (QSR).). The data is useful in determining trends and patterns in service provision and demand, as well as, identifying opportunities for improvement.

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

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

contacting your Program Monitor/COR and/or the Child and Adolescent Services Research Center (CASRC).

Monthly/Quarterly Status Report (M/QSR)

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

Mental Health Services Act (MHSA) Outcomes

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

Performance Improvement Projects (PIPs)

The State has mandated that each county be engaged in one administrative and one clinical performance improvement project each year in order to improve processes and outcomes of care. A PIP is a comprehensive, long-term quality improvement project includes a commitment to improving quality through problem identification, evaluating interventions, and making adjustments as necessary. It may provide support/evidence for implementing protocols for "Best Practices". The External Quality Review Organization (EQRO), contracted by the State, evaluates progress on each PIP annually.

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

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

SERIOUS INCIDENT REPORTING (SIR)

An incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community shall be reported to the BHS Health Plan Organization Quality Assurance Unit. There are two types of reportable incidents, 1) Serious

Incidents are reported to the BHS QA Unit and 2) Unusual Occurrences are reported directly to the program's Contracting Officer Representative (COR).

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

Serious Incident Categories: Level One and Level Two

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

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

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

A Level One serious incident shall be reported to the QA SIR Line at 619-584-3022 immediately upon knowledge of the incident. The provider shall submit the Serious Incident Report to the QA Unit within 24 hours of knowledge of incident.

A Level Two serious incident shall be reported to the QA SIR Line at 619-584-3022 no later than 24 hours of knowledge of the incident. The provider shall submit the Serious Incident Report to the QA Unit within 72 hours of knowledge of incident. A level two incident is any serious incident that does not meet the criteria of a Level One serious incident.

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

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

Serious incidents are categorized as follows:

- Incident reported in the media/public domain (e.g. on television, newspaper, internet)
- Suicide attempt by client that requires medical attention or attempt is potentially fatal

and/or significantly injurious.

- Death of client by suicide (includes overdose by alcohol/drugs/medications, etc.)
- Death of client under questionable circumstances (includes overdose by alcohol, drugs, medications, etc.)
- Death of client by homicide
- Alleged homicide attempt on a client (client is victim)
- Alleged homicide attempt by a client (client is perpetrator)
- Alleged homicide committed by a client (client is perpetrator)
- Injurious assault on a client (client is victim) occurring on the premises of the program resulting in death, severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.
- Injurious assault by a client (client is perpetrator) occurring on the premises of the program resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.
- Tarasoff Notification, the duty to protect intended victim, is made to the appropriate person(s), police, or other reasonable steps have been taken to protect the intended victim. ***Note:*** *Serious Incident Report of Finding not required unless indicated.*
- Tarasoff Notification, the duty to protect intended victim, is received by the program that a credible threat of harm has been made against a staff member(s) or program and appropriate safety measures have been implemented. ***Note:*** *Serious Incident Report of Finding not required unless indicated.*
- Serious allegations of or confirmed inappropriate staff (includes volunteers, interns) behavior such as sexual relations with a client, client/staff boundary issues, financial exploitation of a client, and/or physical or verbal abuse of a client.
- Serious physical injury to a client which may require hospitalization where the injury is directly related to the client's mental health or substance use functioning and/or symptoms. **Serious bodily injury** means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, limb, organ or of mental faculty (i.e., fracture, loss of consciousness), or requiring medical intervention,

including, but not limited to, hospitalization, surgery, transportation via ambulance, or physical rehabilitation.

- Adverse medication reaction resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.

- Medication error in prescription or distribution resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.

- Apparent overdose of alcohol/illicit or prescriptions drugs, whether fatal or injurious, requiring medical attention.

- Use of physical restraints (prone or supine) only during program operating hours (applies only to CYF mental health clients during program operating hours and excludes SUD programs, Hospitals, Long-Term Care Facilities, San Diego County Psychiatric Hospital/EPU, ESU and PERT)

- The Event has resulted in death on the program premises

- The event resulted in serious physical injury on program premises

- SIRs are not required for deaths that are a natural occurrence. Instead, the program shall maintain a Natural Death Log that QA will review during the Medi-Cal recertification site visit. However, if a death that is a natural occurrence happens on a program's premises an SIR is required.

- For Serious Incidents related to an overdose by an opioid or alcohol, the client must be provided an opportunity for a referral to Medication Assisted Treatment (MAT) if the client is not already receiving MAT services. Information on MAT programs can be access through the Provider Directory on the Optum website (www.optumsandiego.com) or by calling the Access and Crisis Line.

Serious Incident Reporting Procedures

1. Upon knowledge of incident, program shall report the incident and all known details to the SIR Line at 619-584-3022

2. All providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less.

3. A Level One serious incident shall be reported to the SIR Line immediately upon knowledge of the incident and followed up with the written SIR report to QA no later than 24 hours.

4. A Level Two serious incident shall be reported to the SIR Line no later than 24 hours of knowledge of the incident and followed up with the written SIR report to QA within 72 hours.

5. In the event of a serious incident, the program manager or designee will immediately safeguard the client's medical record. Program manager shall review chart as soon as possible. The client medical record shall not be accessed by unauthorized staff not involved in the incident.

6. All program staff will maintain confidentiality about client and serious incident. The serious incident should not be the subject of casual conversation among staff.

7. All serious incidents shall be investigated and reviewed by the program. The program shall submit a complete Report of Findings to QA within 30 days of knowledge of the incident. In the case of a client death, there is an exception to the Report of Findings report being due to QA within 30 days of knowledge of the incident when the program is waiting on the CME report. The provider must inform QA that the CME report is pending and request an extension.

8. Reports of Sexual Misconduct by a Healthcare Provider (SB 425, Business & Professions Code Section 805.8) Effective 1/1/20, a healthcare facility, health plan, or other entity that grants privileges or employs a healthcare professional must, within 15 days of receiving a written allegation of sexual abuse or sexual misconduct (inappropriate contact or communication of a sexual nature) against one of its healthcare providers, file a report with that professional's licensing board.

9. Tarasoff incidents do not require a SIROF unless the Program Manager, after review, has concluded one is indicated due to a systemic or client related treatment issue.

10. An SIR is never to be filed in the client's medical record. A Serious Incident Report shall be kept in a separate secured confidential file.

11. A serious incident that results in 1) a completed suicide or 2) an alleged client committed homicide will automatically trigger a chart review by the QA Unit and require the completion of a Root Cause Analysis (RCA) within 30 days of knowledge of the incident.

12. The Action Items because of the RCA shall be summarized and submitted to the QA unit with 30 days of knowledge of the incident. Do not submit the RCA worksheet, only a summary of action items.

Clinical Case Reviews

Under the direction of the BHS Clinical Director, a clinical case review convenes regularly to review cases involving a completed suicide, homicide, and other complex clinical issues. The purpose of the review is to identify systemic trends in quality and/or operations that affect client care. Identified trends are utilized to provide opportunities for continuous quality improvement. Program shall comply with requests for medical records that are reviewed in clinical case conference.
Stakeholders, including BHS Director, CORs, Deputy Directors, QA Chief, Program Managers, County or Contractor QA staff, or other designated staff may make a request at any time for a clinical case review. Specific requests for case reviews should be coordinated through the QA Unit by contacting QIMatters.hhas@sdcounty.ca.gov.

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

Level One Serious Incident Reporting on Weekends and Holidays

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

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

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

2. Each LE will identify key Senior Level staff (1-3) that are designated as the main contact person(s) for their programs needing to report a Level One incident on weekends and holidays. This LE designated staff will report the Level One incident by calling or leaving a message with all required information including a call back number for the County Designated Staff. Each LE will be provided the contact phone numbers of the County Designated Staff.

3. Program staff should only be reporting the Level One Serious Incident to their LE designated staff. Program staff should not be directly contacting the County Designated Staff.

4. Report Level One Serious Incidents to the County Designated Staff on weekends and holidays between the hours of 8:00am – 8:00pm (reporting hours). If you have a Serious Incident that occurs outside of reporting hours, then report the Serious Incident on the next or same day during reporting hours. This requirement is only for Level One Serious Incidents.

5. Weekend Coverage is defined as Saturday and Sunday. Holiday Coverage is defined as any designated County Holiday.
6. County designated staffs are identified in priority contact order as:
   1) Adult SOC Assistant Deputy Director – A/OA Providers
   2) CYF SOC Assistant Deputy Director – CYF Providers
   3) Director; BHS (third back up).

Privacy Incident Reporting (PIR) for Staff and Management

Programs shall follow the HHSA Privacy Incident Reporting Policy. When staff becomes aware of a suspected or actual privacy incident. Staff notifies Program Manager immediately. Program Manager immediately notifies COR.

If a County incident, Program Manager will:

1. If suspected or actual privacy incident involves 500 or more individuals, notify Agency Privacy Officer (APO) immediately by emailing: angie.devoss@sdcounty.ca.gov and Kathryn.Mahan@sdcounty.ca.gov. For all other suspected or actual privacy incidents, follow steps below.
2. Submit an Initial HHSA Privacy Incident Report (PIR) online via the web portal: https://www.sandiegocounty.gov/content/sdc/hhsa/hhsa-privdb-landing.html.
   Complete initial PIR web-form to the best of your ability and submit within one business day. The PIR web-form landing page link is also available on the Agency Compliance Office's website: www.cosdcompliance.org. Upon submittal, a PIR Tracking # will appear on the confirmation screen. This number should be recorded by the reporting party as it will be needed to access the report in the future.
3. Submitter will receive an email with an Access Code. Use this information, along with the PIR # to access your PIR via the same web link above.
4. Continue to investigate and Update the PIR online within 72 hours, including required information missing from initial report and any additional information requested by APO.
5. Provide any pending or additional information needed to submit Final completed PIR within seven business days of initial discovery.

If a Contractor incident, COR will:

1. Direct Contractor to complete HHSA Privacy Incident Report Web-Form online and updates, as outlined above.
2. Direct Contractor to complete any other steps as directed by APO, including, but not limited to notifications or external reporting.

San Diego County contracted providers should work directly with their agency's legal counsel to determine external reporting and regulatory notification requirements and provide their determination to the HHSA Privacy Officer.

UNUSUAL OCCURRENCE REPORTING

An unusual occurrence is reported directly to your COR/Program Monitor within 24 hours of knowledge of the incident. An unusual occurrence is defined as an incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community that does not meet the criteria of a serious incident. Unusual occurrences may include but are not limited to:

- Alleged child abuse
- Police involvement
- Inappropriate sexual behavior
- Self-injury
- Physical injury
- Physical abuse
- AWOL
- Fire setting
- Poisoning
- Major accident
- Property destruction
- Epidemic or other infectious disease outbreak
- Loss or theft of medications from facility

Safety and Security Notifications to Appropriate Agencies

When an Unusual Occurrence occurs or are identified, the appropriate agencies shall be notified within their specified timeline and format:

1. Child and Elder Abuse Reporting hotlines.
2. Tarasoff reporting to intended victim and law enforcement
3. Law enforcement (police, sheriff, school police, agency security, military security/Naval Investigative Service, etc.) for crime reporting or requiring security assistance and inquiries.

4. Every fire or explosion that occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshall.

Child, Youth and Family: Additional Reporting

CYF providers may notify other outside agencies who serve the client upon consideration of clinical, health and safety issues. Notification should be timely and within 24 hours of knowledge of the incident. The required agencies include but are not limited to:

- Children Welfare Services
- Probation Officer
- Regional Center
- School District
- Therapeutic Behavioral Services (TBS) – Both County and Contractor
- Other programs that also serve the client

Reportable issues may include:

1. Health and safety issues
2. A school suspension
3. A student is taken to a hospital due to an injury or other medical issue which occurs at the program site or when the TBS worker is present
4. A referral for acute psychiatric hospital care
5. An issue with direct service provider staff, which may lead to worker suspended or no longer providing services
6. A significant problem arising while TBS worker is with the child

QUALITY REVIEW COMMITTEE (QRC)

The Quality Review Committee (QRC), mandated by State regulation, is a collaborative group that is chaired by the MHP Clinical Director and consists of MHP stakeholders including clients and family members, County and contracted providers, associations and advocacy groups representing the mental health community, and hospital providers. The QRC meets regularly to review, discuss, and make recommendations regarding quality improvement issues that affect the delivery of services through the MHP. Participation in the QRC is encouraged. If you would like to participate in the QRC, email QIMatters.hhsa@sdcounty.ca.gov

NATIONAL VOTER REGISTRATION ACT (NVRA)

Per the National Voter Registration Act (NVRA) of 1993, providers are required to offer voter registration materials at intake (except in a crisis), renewal and anytime a change of address is reported. For TAY and Adult programs, voter registration services shall be provided to clients who are:

- A citizen.
- Live in California

- At least 18 years of age by the date of the next election; and
- Not currently on parole for a felony conviction or formally judged by a court to be mentally incompetent to vote.

For Children's programs, voter registration services shall be offered to parents/guardians of clients less than 18 years of age.

Mental Health Programs shall have Voter Registration Forms and General Instruction Forms available to clients in English, Spanish and Tagalog as required by the County of San Diego Registrar of Voters. An attached Voter Registration Form, General and State Instructions Form and DSS 16-64 form shall be included in all intake/admission packets. Additionally, the same level of assistance shall be provided to mental health consumers registering to vote as is provided for completing other forms for mental health services. When a client requests a form in a language other than those available from the County's Registrar of Voters, staff shall provide the client with the Secretary of State's toll-free number: 1-800-345- VOTE. Voter Registration forms in the threshold languages can be found on the Optum Website under the Forms Tab: https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/orgpublicdocs.html

Training on the legal requirements and County expectations under this Act is required to be taken by provider staff once each year. The NVRA training is available on the HHSA BHS webpage: http://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/. For more information, refer to Medi-Cal Eligibility Division Information Letter I 12-02 (https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/cI12-02.pdf).If you have additional questions about this requirement, please contact your Contracting Officer Representative (COR). Failure to implement the NVRA may subject the agency to legal liability.

H. CULTURAL COMPETENCE

Cultural Competence is recognizing that culture impacts our relationships and interactions in ways that may be subconscious or outside our awareness. It is a continual growth process that involves self-awareness, knowledge, skills, advocacy, and the examination of all those factors within a larger context. Recognizing the complex nature of personal identity, how each of us manages our multiple identities, and how the intersection of our experience can be a powerful tool for healing and change, helps those providing services within San Diego County Behavioral Health Services (SDCBHS) to provide more culturally relevant and responsive care to the people being served.

Another focus that SDCBHS has incorporated is cultural humility to further support the progress toward reducing disparities in mental health services, DMC-ODS and the Cultural Competence Plan. The term is based on the idea that we must be open to the identities and experiences of others as a primary way of being in the world through a lifelong commitment to self-evaluation, a desire to fix power imbalances, and a willingness to develop partnerships with people and groups who advocate for others.

History and Background

Cultural norms, values, beliefs, customs and behaviors may influence the manifestation of mental health problems, the use of appropriate levels of care/services, the course of treatment and the successful attainment of positive outcomes. The County's dynamic demographics combined with the recognition that culture is a key factor in service delivery pose an ongoing challenge for the Mental Health Plan (MHP) and its contracted mental health care providers. The latest estimates for San Diego County from 2021 show that the overall population estimate of the County decreased by 0.83% compared to the 2020 estimate. According to the San Diego Association of Governments *SANDAG Demographic and Socio-Economic Estimates, 2021 Estimates, San Diego Region,* 45.8% of the population identified as White, 34.3% as Hispanic, 4.7% as Black, 0.45% as Native American, 11% as Asian/Pacific Islander, and 3.6% as other.

SDCBHS continuously monitors its progress toward reducing disparities and identifies gaps between the demand for and the availability of services. To understand the needs of the whole County mental health population for Mental Health Services Act (MHSA) planning, SDCBHS and the University of California, San Diego (UCSD) Research Centers analyze service disparities on a triennial basis in a report titled *Progress Towards Reducing Disparities in Mental Health Services*. The most recent report covers three time points spanning across 8 years (Fiscal Years 2009-10, 2012-13, and 2015-16). The report provides breakdown information by age, gender, race/ethnicity, and diagnosis, as well as service utilization and service engagement, which is used to supplement the State required information. The report has since been reimagined as the

Community Experience Partnership, with a set of dashboards that allow flexible queries regarding health equity information that will provide timely, accessible, and actionable data for system policy development and decision making. With the County's renewed commitment to patient-centered care, these tools will provide support for initiatives that focus on the clients' specific long-term needs and community level services.

The Community Experience Partnership (CEP) is a joint initiative between County of San Diego Behavioral Health Services (BHS) and UC San Diego. The vision of the CEP is the integration of data and community engagement to promote behavioral health equity in San Diego County. The mission of the CEP is to promote a continuous feedback process by which issues can be identified, further informed by community engagement, and mediated by actionable plans. The goal of the CEP is the integration of data and community engagement to promote behavioral health equity in San Diego County. The CEP allows the public to explore, monitor, and visualize behavioral health equity data through a series of interactive dashboards. Data sources include surveys, vital records, hospitalization and emergency department data, and service and outcome data for individuals served by the Behavioral Health Services system. Users can explore indicators of equity over time, across neighborhoods, and for numerous subpopulations, including by race/ethnicity, gender, sexual orientation, age, justice involvement and more. This dashboard was made available to the public in June 2022 and can be viewed at cep.ucsd.edu.

Cultural Competence Plan

SDCBHS has a long-term commitment to creating and maintaining a culturally relevant and culturally responsive system of care; incorporating the recognition and value of racial, ethnic, and cultural diversity within its system since 1997 in its first Cultural Competence Plan. The Cultural Competence Plan summarizes SDCBHS's present activities and highlights future initiatives and next steps. It includes information on the eight criteria set by the State as indicators of cultural competence. San Diego County updates the Cultural Competence Plan annually with new objectives to improve cultural competence in the provision of behavioral health services. The Cultural Competence Plan can be found on the TRL in the Cultural Competency section.

Current Standards and Requirements

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization and in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable about, the clients' culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

CULTURAL COMPETENCE

***National Culturally and Linguistically Appropriate Services (CLAS) Standards**:*

The National Culturally and Linguistically Appropriate Services (CLAS) Standards have replaced the Culturally Competent Clinical Practice Standards. The CLAS Standards are a series of guidelines that are intended to inform and facilitate the efforts towards becoming culturally and linguistically competent across all levels of a health care continuum. The CLAS Standards were originally developed by the Health and Human Services Office of Minority Health and are comprised of 15 Standards. All Statements of Work include the language on the requirement of the programs to implement the CLAS Standards.

The Standards are as follows:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Cultural Competence Training Opportunities through the MHP

- Cultural Competence Trainings are available through the County Knowledge Center (TKC) for County operated program staff at no cost and for a small number of providers on a fee basis.
- Cultural Competence Trainings are available through some of SDCBHS's larger contractors. Community Research Foundation, New Alternatives, and Mental Health Systems, Inc. offer such trainings to their own program staff, but other providers may send staff on a fee basis.
- SDCBHS Contracted Trainings are available through the BHS Workforce Education and Training Website at https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/workforce.html
- Cultural Competency trainings are offered through Academy of Professional Excellence (APEX) Learning Management System (LMS) located on the BHS Workforce education and Training Website.
- Specific training for the Cultural Competency Academy is available through the Academy for Professional Excellence for BHS and BHS Contractors at no cost. https://theacademy.sdsu.edu/programs/cultural-competency-academy/

Cultural Competence Monitoring and Evaluation:

The MHP QA Unit and the CORs are responsible for monitoring and evaluating compliance with cultural competence standards as outlined in the County's Cultural Competence Plan and with State and Federal requirements. The QA Unit and the CORs utilize both the medical record review

and the annual Contract Review to monitor providers regarding cultural competence. In addition, provision of/usage of the tools listed below is now cultural competence requirement:

Program Level Requirements:

1. Cultural Competence Plan (CC Plan). CC Plans are required for all legal entities. If your organization does not have a CC Plan, the CC Plan Component Guidelines outlined below may be used to assist you in developing a CC Plan. They are available in the Cultural Competence Handbook (pages 12-13) on the Technical Resource Library (TRL) website at: http://www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html The CC Plan Component Guidelines are as follows:

   - Current Status of Program
     - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
     - Identify how program administration prioritizes cultural competence in the delivery of services.
     - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
     - Goals accomplished regarding reducing health care disparities.
     - Identify barriers to quality improvement.
   - Service Assessment Update and Data Analysis
     - Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
     - Comparison of staff to diversity in community.
     - A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.
     - Use of interpreter services.
     - Service utilization by ethnicity, race, language usage, and cultural groups.
     - Client outcomes are meaningful to client's social ecological needs.
   - Objectives
     - Goals for improvements.
     - Develop processes to assure cultural competence (language, culture, training, and surveys) is developed in systems and practiced in service delivery.
       - Trauma-informed principles and concepts integrated
       - Faith-based services

   New contractors need to submit a CC Plan, as specified in their Statement of Work, unless their legal entity has already provided one. As new programs are added, legal entities are expected to address their unique needs in the CC Plan.

Plans should be sent via email to BHS-HPA.HHSA@sdcounty.ca.gov.

2. Annual Program Evaluation – every year, program managers are required to complete a cultural competence assessment of each program, using the tool which will be provided by SDCBHS electronically to each program manager. Every program manager is provided three weeks to complete the survey. The survey can be completed in approximately one hour or less. The tool is available in the CC Handbook on TRL for reference.

3. In order to present a welcoming appearance to unique communities, providers are required to ensure that their facility is comfortable and inviting to the area's special cultural and linguistic populations. Program hours of operation must be convenient to accommodate the special needs of the service's diverse populations.

Staffing Level Requirements

Biennial Staff Evaluation – every two years, staff members of the County-contracted and County-operated behavioral health programs are required to self-assess their cultural competence in providing behavioral health services, by completing the Promoting Cultural Diversity Self-Assessment (PCDSA). The PCDSA supports the San Diego County Behavioral Health Services commitment to a culturally competent workforce and upholds the guidelines described in the Cultural Competence Plan and Handbook. The assessment's goal is to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. The staff are provided two weeks to complete the survey. The tool is available in the Cultural Competence Handbook on TRL for reference PCSDA

Annual Program Manager Evaluation - One of the Quality Improvement strategies in the County of San Diego Behavioral Health Services (BHS) Cultural Competence Plan is to survey all program managers annually to evaluate their perception of their programs' cultural and linguistic competence. Accordingly, all County and County-contracted programs are required to complete the Cultural and Linguistic Competence Policy Assessment (CLCPA). The goal of the CLCPA is to enhance the quality of services within culturally diverse and underserved communities; promote cultural and linguistic competence; improve health care access and utilization; and assist programs with developing strategies to eliminate disparities. The tool is available in the Cultural Competence Handbook on the TRL for reference CLCPA

A Minimum of 4 hours of Cultural Competence Training Annually. Contractors shall require that, at a minimum, all provider staff, including consultants and support staff interacting with clients or anyone who provides interpreter services must participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written coursework, a review of published articles, web training, viewed videos, or attending a conference can count the

amount of time devoted to cultural competence enhancement. A record of annual minimum four hours of training shall be maintained on the Monthly Status Report. The following conditions also apply:

a. All new staff have one year to complete the 4 hours of cultural comp training.
b. Staff hired after May 15 are exempt from the requirement for that fiscal year but must meet requirement "a".
c. Volunteers, Temporary Expert Professionals (TEP), Retire-Rehires, Certified Temporary Appointments, and Student Workers who have served or are expected to serve 100 or more hours at the program must meet the requirement.

***Consumer Preference – Cultural/Ethnic Requirements**:*
Consumers must be given an initial choice of the person who will provide specialty mental health services, including the right to use culturally specific providers. Providers are also reminded that whenever feasible and at the request of the beneficiary, clients have the right to request a change of providers. Requests for transfers are to be tracked on the Suggestion and Transfer section attached to the Quarterly Status Report.

***Consumer Preference – Language Requirements**:*
Services should be provided in the client's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free interpreter services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. The offer of interpreter services and the client's response must be documented.

Progress notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the beneficiary, consumers must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers.

All County and Contracted providers must at a minimum be able to link clients with appropriate services that meet the client's language needs whether the language is a threshold language or not.

Additional Recommended Program Practices

Programs will also be encouraged to do the following:

- If there is no process currently in place, develop a process to evaluate the linguistic competency of staff that is providing service or interpretation during services, in a language

other than English. This may be accomplished through a test, supervision or some other reliable method. The process should be documented. A suggested process for certification of language competence can be found on page 51 of the CC Handbook on TRL.

- Conduct a survey or client focus group every couple of years and include clients who are bi-lingual and monolingual to assess program and staff cultural competence, community needs and the success of efforts the program is making to meet those needs. Suggestions surveys and discussion questions are available on pages 53, 57, and 59 of the CC Handbook on TRL.

I. MANAGEMENT INFORMATION SYSTEM

Cerner Community Behavioral Health (CCBH)

The County of San Diego BHS manages an electronic health record (EHR) for the MHP County and Contracted providers. The electronic Mental Health Management Information System (MH MIS) utilized by the MHP is Streamline SmartCare. All client information, including clinical documentation, is entered into SmartCare allowing for improved coordination of care across the MHP System of Care.

For the complete **Management Information System: CCBH User Manual**, go to the Optum Health Public Sector Website at https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/orgpublicdocs.html

User Account Setup and Access

The Mental Health Management Information System (MH MIS) is used by County and contract operated programs for client tracking, managed care functions, reporting and billing. An electronic health record (EHR) will replace much of what is contained in the paper medical record. Many controls are built into the software and hardware to safeguard the security and privacy of client personal health information.

CCBH Software is a web-based application that is managed by Cerner. Access to CCBH is through a secure portal which requires a user to establish an account in order to obtain an identification number, menu group, and password. Access to CCBH is granted through the MH MIS Unit by completing the appropriate access and security forms. Users are required to attend and pass a CCBH training class prior to access.

System Administration for CCBH is shared between the Administrative Services Organization (ASO) and the County's Mental Health MIS Unit.

The Mental Health MIS (MH MIS) Unit is responsible for managing access, security, and menu management in CCBH in accordance with County, State and Federal HIPAA regulations. The MH MIS Unit is also the gatekeeper who ensures that staff is only given access pursuant to contract agreements. In addition, the MH MIS Unit is responsible for coordination among the County Technology Office, Cerner and the ASO.

The ASO is responsible for other system administration activities such as table management, system maintenance, updates to the application, managing the five CCBH environments, producing reports for legal entities, electronic submission of state reporting, coordination with CCBH Software, and providing the User Support Help Desk.

Technical Requirements to Access SmartCare

Prior to accessing the SmartCare application via the internet, there are some basic technical requirements. For questions about whether an individual user or program site meets the basic technical requirements,

it is recommended that the individual or program contact their company's IT department. The ASO may also be able to provide some technical assistance. Additional support regarding SmartCare's hardware, software and network requirements can be found on the Optum Website. Smartcare Hardware_Software and Network Requirements - March 2024 update.pdf (optumsandiego.com)

Staff Set Up and User Account Access

All individuals who provide services or perform some other activity to be recorded SmartCare as well as those who are authorized to access SmartCare must have a staff account. A "staff" in SmartCare is defined as an individual who is employed, contracted or otherwise authorized by his or her designated legal entity or County business group to operate within the County of San Diego public mental health System of Care and whose primary job function may include any one of the following: to provide Mental Health Services, Quality Assurance activities, enter data, view data, or run reports. This includes clinicians, doctors, nurses, office support staff, financial/billing staff, research/analyst staff and program managers/administrative staff. All Staff providing services must provide National Provider Identifier (NPI) and taxonomy numbers. All staff will be assigned a staff ID, which is a numerical ID ranging from 15 numbers. (**Note:** If a person is employed by more than one legal entity, he/she will have a unique staff ID for each legal entity.)

Staff is given access to specific programs based upon the program(s) where they work. Staff is also given access to specific menus based on their respective job functions. A list and definition of menus is available on the Request Form.

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

User Access requires the following steps:

1. Program manager completes the "SmartCare Request Form" (ARF).

2. All new users must successfully complete the required SmartCare Training Modules after creating a CalMHSA LMS Account.

3. Contractor employee and employee's supervisor must read and sign the "Staff Electronic Signature Agreement".

4. Contractor employee and employee's supervisor must also read and sign the County's "Summary of Policies" (SOP) form.

5. Fax all completed forms to the **MH MIS Unit Fax at (858) 467-0411 or SCAN and EMAIL to MHEHRAccessRequest.HHSA@sdcounty.ca.gov and BHSCredentialing@optum.com**

All forms **must** be typed and contain all necessary information. Incomplete forms will be returned to the

contact person listed on the form. Once completed correctly, the forms must be re-faxed to MH MIS Unit. Please ensure forms are completed correctly to avoid delay in user account setup.

Once all forms have been submitted, the MH MIS Unit will:

1. Set up of a Citrix User Account with ID/password.
2. Set up CCBH User Account with ID/password.
3. User will be provided his/her Citrix/CCBH ID/passwords at the CCBH training.

Program managers and other supervisors are responsible to:

1. Register new staff who will be users to attend the SmartCare training
2. Confirm that employee has successfully completed SmartCare training.

All forms with instructions are available electronically on the ASO's (Optum) Public Sector website athttps://www.regpack.com/reg/templates/build/?g_id=100850646.

Staff Assignment to Programs

On the ARF, the program manager will be assigning each staff to specific programs based upon the program(s) where the staff performs work. Staff may be assigned to a single or multiple programs. The programs must be reflected on the CCBH Request Form. The MH MIS Unit will monitor staff access to programs to ensure that staff has been assigned correctly. Under no circumstances, should a staff person be assigned to a CDAG or program if that staff person does not perform work for that program. This would constitute a violation of security and client confidentiality.

User Assignment to a Clinical Data Access Group (CDAG)

Each user is granted restricted access to MH MIS based on his/her job requirements. One of the ways that access is restricted is through assignment to programs described above. In addition, access is further restricted by assignment to a clinical data access group or CDAG. A CDAG defines the screens and reports the user will be able to access and whether the user can add/edit or delete for each of those screens. For example, the user may only be able to view but not change data in one screen but may have rights to add data or edit previously entered data for another screen. Menu groups are created based on multiple criteria such as security, level of access to client information, staff job functions, staff credentials and state and federal privacy regulations.

On the ARF, the program manager or supervisor is responsible for requesting the CDAG assignment for each user based on his/her job functions. A user may only be in one menu group at a time. Therefore, it is important for the program manager/supervisor to determine which menu group is the best match for the job functions performed by his/her staff.

For example, there will be CDAGs for:

- Data entry staff with full client look up rights
- Data entry staff with limited client look up
- Clinicians
- Program managers and supervisors
- Quality Assurance
- Billing staff
- Billing only (For Billing Purposes Only – It has no views)
- Research and Analysts

Refer to the ARF Instructions for a list and definition of available menus. The MH MIS Unit will review menu group requested by the program manager/supervisor and approve or modify the request.

Limitation of Staff Assignment to "Data Entry – Add New Clients" Menu Group

Program staff will be allowed to view information about a client currently or previously served by their program. Designated program staff will be given access to the "full client look up" in order to add new clients and assign existing clients to their subunit (program). These individuals will be allowed to view all clients in the system, including those not served by their program. This access allows for data entry, adding new clients, full client lookup; entering demographic, diagnosis, insurance, and financial information (UMDAP); opening assignments; and running reports.

Staff Access to Live Production and Training Environment in SmartCare

For most users, after logging on to CCBH through the Citrix Access Gateway, two visible CCBH icons will be available for selection. One icon provides access to the Live Production environment used for data entry and reporting. The other icon provides access to the Training environment which is a copy of the setup of the live environment populated with fictitious client data. The training environment is used to train all new and returning users. Access to the training environment will remain available for ongoing training purposes. For example, on occasion, when there are upgrades to the CCBH application, it may be necessary for staff to first practice in the Training environment prior to utilizing new functionality in the Live Production environment. Program managers and staff will be notified of changes to application functionality and will be instructed as to when the training environment should be utilized.

Program Manager/Supervisor Responsibility for Staff Access and Security

The program manager/supervisor shall ensure that staff is in compliance with all County, State and Federal privacy and confidentiality regulations regarding security, providers protected health information (PHI). In addition, the program manager shall ensure that his/her staff is aware of the County's Security Policy regarding the protection of network/application passwords and use of County systems and data as outlined when staff within San Diego County's "Summary of Policy". The program manager shall immediately notify the MH MIS Unit whenever there is a change in information such as staff demographics, email, job title, credential/licensure, and jobs, or are Unit/Subunit assignment. This

includes the initial staff setup, modifying or terminating existing staff accounts**.**

Under no circumstances shall a staff person who has terminated employment have access to the EHR through CCBH. This would constitute a serious violation of security which may lead to disciplinary actions.

Staff Termination Process

- **Routine User Termination –** In most cases, staff employment is terminated in a routine manner in which the employee gives an advanced notice. Within one business day of employee termination notice, the program manager shall fax to the MH MIS Unit (858) 467-0411 or scan and email to MHEHRAccessRequest.HHSA@sdcounty.ca.gov and BHSCredentialing@optum.com a completed ARF with the termination date *(will be a future date).* The MH MIS Unit will enter the staff expiration date in CCBH which will inactivate the staff account at the time of termination and process the CSRF to delete the County network Citrix account.

- **Quick User Termination –** In some situations, a staff person's employment may be terminated immediately. In this case, the program manager must immediately call the MH MIS Unit at (619) 584-5090 to request the staff account be inactivated immediately. Within one business day, the program manager shall fax a completed ARF to the MH MIS Unit (858) 467-0411 or scan and email toMHEHRAccessRequest.HHSA@sdcounty.ca.gov and BHSCredentialing@optum.com.

The MH MIS Unit is responsible for inactivating SmartCare staff accounts.

Application Training

Prior to staff obtaining access toSmartCare, he/she shall successfully complete the SmartCare training. Program managers are responsible for registering new and returning CCBH users for training on the CCBH application. Previous users returning to employment (including maternity leave) after more than 90 days of absence will be required to resubmit new paperwork including an updated ARF and be evaluated for a skills assessment or retraining.

User Manuals

Users should be familiar with the Financial Eligibility and Billing Procedures Manual, which contain detailed information about program workflow requirements. The Financial Eligibility and Billing Procedures is available here:

https://www.optumsandiego.com/content/dam/san-diego/documents/organizationalproviders/billing-unit/billing-unit-manuals/Financial%20Eligibility%20and%20Billing%20Manual%20rev.%20110821-003.pdf

Security and Confidentiality

The County of San Diego is responsible for the protection of County technology and data and to monitor through its own policies and procedures user compliance with state and federal privacy and confidentiality regulations.

The County's Security mandates state that access will be given to a user at the least minimum level required by the user to execute the duties or job functions and that only those individuals with a "need to know" will be given access. Protection of County data and systems is also achieved via the use of unique user identification and passwords as well as other tracking methods.

Passwords

The sharing of passwords or allowing unauthorized individuals access into the system is strictly prohibited. A user's password is his/her electronic signature that is not to be shared or made available to anyone. Programs must ensure that the County's Policy and Procedures regarding security and confidentiality as stated in the Summary of Policies is complied with at all times. Failure to comply with these policies and procedures can result in the temporary or permanent denial of access privileges and/or disciplinary action.
MH MIS passwords:

- Must be changed every 90 days
- Must have a minimum of 7 characters
- Must contain a mix of letters & numbers
- May NOT be reused
- Are case sensitive
- Will be rejected if common words or acronyms are used

Unauthorized Viewing of County Data

All terminals and computer screens must be protected from the view of unauthorized persons. All confidential client information, electronic or printed, shall be protected at all times.

User Support

Users can obtain support through the CalMHSA HelpDesk. The CalMHSA HelpDesk can assist a user with the MH MIS application (technical assistance), MH MIS password issues, connectivity/access problems, printer problems, data entry questions, special requests, such as reports and Citrix access issues for contractors. For Citrix access issues (i.e. password reset), County employees must contact the County IT vendor.

In some cases, the Optum Support Desk may refer the caller for second level user support, i.e. to the Mental Health Quality Assurance Unit for clinical issues and to the Mental Health Billing Unit for

financial eligibility and billing issues.

The Optum Support Desk may be contacted as follows:
Phone: 1-800-834-3792 Fax: (619) 641-6975
Emails: sdhelpdesk@optumhealth.com

Optum Support Desk hours: Monday through Friday, from 6:00 am to 6:00 pm except on holidays. The Optum Support Desk will provide after-hour cell phone emergency support for urgent Citrix and CCBH issues.

- For after-hour support use cell (800) 834-3792 on weekdays 4:30 am – 6:00 am and 6:00 pm – 11:00 pm and on weekends 4:30 am – 11:00 pm

For an operating system failure, contact your company's IT department. The IT department will determine the need for Optum Support Desk involvement.

NOTE: Printing issues, password resets technical and CCBH application questions are not considered an emergency and will be handled the next business day.

QUICK RESOURCE GUIDE

1. MH MIS Unit Phone: 619-584-5090
2. MH MIS Unit Email: MHEHRSupport.HHSA@sdcounty.ca.gov
3. MH MIS FAX (ARFs and SOPs): 858-467-0411
4. MH MIS Email (ARFs and SOPs): MHEHRAccessRequest.HHSA@sdcounty.ca.gov
5. Optum Support Desk Phone: 1800-834-3792
6. Optum Support Desk 24 Hour Pager: 619-893-4839
7. Optum Support Desk email: sdhelpdesk@optumhealth.com
8. CCBH website: https://cosdcasf.cernerworks.com/Citrix/PRODWeb/
9. Optum Public Sector Website: www.optumsandiego.com

J. PROVIDER CONTRACTING

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

All contracted providers, including subcontractors, shall adhere to the Mental Health Plan contract executed between San Diego County and the California State Department of Health Care Services (DHCS).

All non-County-operated organizational providers must contract with the County of San Diego in order to receive reimbursement for Specialty Mental Health Services. Please read your contract carefully. It contains:

- General terms applicable to all contracts;
- Special terms specific to a particular contract;
- A description of work or services to be performed;
- Payment Schedule and/or budget; and
- Statutes and/or regulations particular to the Medi-Cal managed mental health care programs as well as programs supported by other funds.

Selection and monitoring of organizational agencies are governed by contracting procedures, which require a review of the organization's fiscal soundness, resumes of principal administrators and supervisors, the agency's experience with similar services, and a proposed staffing plan. All contracted providers will be expected to adhere to these requirements. Please contact your Behavioral Health Services Contracting Officer's Representative (COR) if you have any questions regarding your contract.

Disclosure Requirements

The Managed Care Plan (MCP) providers and contractors shall disclose to the state any persons or corporations with an ownership or control interest that:

- Has direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Legal Entity's equity;
- Owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Legal Entity if that interest equals at least 5% of the value of the MCP's assets;
- Is an officer or director of a Legal Entity organized as a corporation; or
- Is a partner in a Legal Entity organized as a partnership.

Any person with a 5% or more direct or indirect ownership of the Legal Entity's equity must submit to a criminal background check, including submitting fingerprints. See section 42 CFR 455.434(b)(1).

The contract requires the MCP to submit:

- The name and address of any person (individual or corporation) with an ownership or control interest in the managed care entity and its subcontractors.
- The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
- The date of birth and Social Security Number (SSN) of any individual with an ownership or control interest in the MCP and its subcontractors.
- Other tax identification number of any corporation with an ownership or control interest in the MCP and any subcontractor in which the MCP has a 5 percent or more interest.
- Information on whether an individual or corporation with an ownership or control interest in the MCP is related to another person with ownership or control interest in the MCP as a spouse, parent, child, or sibling.
- Information on whether a person or corporation with an ownership or control interest in any subcontractor in which the MCP has a 5 percent or more interest is related to another person with ownership or control interest in the MCP as a spouse, parent, child, or sibling.
- The name of any other disclosing entity in which an owner of the MCP has an ownership or control interest.
- The name, address, date of birth, and SSN of any managing employee of the MCP.

Disclosure to the State shall be done during the following:

- When the Legal Entity submits a proposal in accordance with the County's procurement process or when the contractor submits a provider application.
- When the Legal Entity executes a contract with the County or when the provider executes a provider agreement with the state.
- When the County renews or extends the Legal Entity contract.
- Within 35 days after any change in ownership of the Legal Entity or contractor/disclosing entity.
- Upon request of the state during the revalidation of the provider enrollment.
- Within 35 days after any change in ownership of the disclosing entity.

See Section 1124(a)(2)(A) of the Act; section 1903(m)(2)(A)(viii) of the Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 104]

CONFLICT OF INTEREST.

Contractor shall not utilize any State officer or employee in the State civil service or other appointed State official for performance of the contract unless specific criteria is met, as per Pub. Con. Code § 10410; 42 C.F.R. § 438.3(f)(2). Contractor shall inform their COR of current and former State employees who are working under a program that is funded by County BHS.

Contractor Compliance Attestation:

Contractors shall complete the compliance attestation form attesting to compliance with all applicable Federal, State, County, and local laws, rules, and regulations and County contract requirements, including those from the County of San Diego Services Agreement and the Organizational Provider Operations Handbook, including but not limited to, the requirements below.

- Prohibition of Political Activities
- Byrd Anti-Lobbying Amendment
- Disclosure Requirements re: 5% or Greater Ownership and Controlling Interest (OPOH Section J)
- Conflict of Interest re: current or former State employees working under a program funded by County BHS (OPOH Section J)
- Comprehensive Continuous Integrated System of Care (OPOH section L)
- Cultural and Linguistically Appropriate Services Standards (OPOH Section H)
- Access to Services for Persons with Disabilities
- National Voter Registration Act (OPOH Section G)
- False Claims Act training and reporting (OPOH Section B)
- Privacy Breach and Suspected Security Incident
- Criminal Background Check & Subsequent Arrest Notification (Both Contractor & Subcontractor staff) (OPOH Section M).

Program Monitoring

Each provider will have assigned to their program a Program Monitor (also known as Contracting Officer's Representative - COR), who will monitor compliance with outcome measures, productivity requirements and other performance indicators, analyze reports from providers, and provide programmatic review for budgets and budget variances in accordance with contract terms and conditions. Program monitors/CORs hold regular providers meeting to keep providers informed on the System of Care. All provider contract questions should be directed to the assigned Program Monitor/COR.

Contractor Orientation

All new contracts require a contractor orientation meeting within 45 calendar days of contract execution. The COR, in conjunction with the BHS Contract Support Team and Agency Contract Support shall, be responsible for contractor orientation. Contractor will designate a contact person to coordinate attendance of necessary contractor staff at the orientation.

Notification in Writing of Status Changes

Providers are required to notify BHS Contract Support, (BHSCS) COR and QM in writing if any of the following changes occurs:

- Change in office address, phone number or fax;
- Addition or deletion of a program site;
- Change of tax ID number or check payable name (only to BHSCS);
- Additions or deletions from your roster of Medi-Cal billing personnel (BHSCS& MIS); or
- Proposed change in Program Manager or Head of Service.

Site Visits

The County MHP will conduct, at a minimum, an annual site visit to all organizational providers. The County MHP includes BHS Program Monitor/COR/Designee, MHS Administrative Services Unit, BHS Quality Improvement (QM) Unit, and the Health and Human Services Agency (HHSA) Contract Support. The site visit may include, but is not limited to, a review of:

- Compliance with contractual statement of work;
- Client medical records (where applicable);
- Building and safety issues;
- Staffing changes;
- Insurance, licensure, NPI, and certification validation;
- Fiscal and accounting policies and procedures;
- Beneficiary informing materials requirement;
- Compliance with standard terms and conditions.

Information from the QM site visit will be included in the contract monitoring process. When a Medi-Cal certification or re-certification is due, an in-depth site review will be completed. Please see Section G of this handbook for a more detailed discussion of Medi-Cal provider site visits.

An additional note: Contractor's Program Manager shall be available during regular business hours and respond to the Program Monitor/COR or designee within 2 business days. Contractor shall have the technological capability to communicate, interface and comply with all County requirements electronically using compatible systems, hardware and software.

Corrective Action Notice

Corrective Action Notice (CAN) is a tool identifying deficiencies in compliance with contractual obligations and requires corrective actions within a specified time frame. A CAN may result from site visits or information derived from reports. Contractors are required to respond to the CAN specifying course of actions initiated/implemented to comply within the specified time frame.

Monthly and Quarterly Status Reports

Contracted providers are required to submit a completed Monthly Status Report (MSR) and/or

Quarterly Status Report (QSR) within 20 calendar days after the end of the report month. The COR reviews the status report for needed information on compliance and contractual requirements. The Quality Assurance Unit (QA) tracks and trends data, provides analysis and issues reports as needed for the Department of Health Care Services (DHCS), BHS Administration, the Quality Review Council and other groups. The status reports include: 1) A narrative (including General Information, Program Description, Activities/Events, Community Outreach, Emerging Issues, Quality Improvement Activities), 2) Outcomes, 3) Data Summaries for Units/Subunits, 4) Staffing & Personnel, 5) Client Suggestions & Transfer Requests, 6) Notices of Action, and 7) Additional Information Requested by the COR. It is important to become familiar with the status reports to document pertinent information as required. The Status Report templates offers drop-down boxes including codes to make data entry collection easier. Please see Section C on Accessing Services on Clients who must transfer to a new provider for more detail on Provider Transfers.

Contract Issue Resolution

Issues, problems or questions about your contract shall be addressed to your COR.

Local Emergency Response

In the event that a local health emergency or local emergency is declared, or when the State or federal government has declared an emergency that includes areas within the County of San Diego, the prompt and effective utilization of Contractor resources essential to the safety, care and welfare of the public shall occur at the direction of the County, to the extent possible. Contractors shall provide assistance in the prevention of, response to, and recovery from, any public health emergency, as applicable. Contractors' staff shall be available upon request of BHS to assist in any necessary tasks during a public health disaster or County emergency state of alert. Providers shall work with the County to initiate processes and develop and implement plans, guidelines and procedures as required. As relevant, Contractors shall also refer to disaster preparedness and disaster response language outlined in this section of the Handbook.

Disaster Response

- In the event that a local, state, or federal emergency is proclaimed within San Diego County, contractors shall cooperate with the County in the implementation of a Behavioral Health Services response plan. Response may include staff being deployed to provide services in the community, out of county under mutual aid Contracts, in shelters, and/or other designated areas.
- Contractors' staff shall be available upon request of BHS to assist in any necessary tasks during a disaster or County emergency state of alert.
- Contractor shall provide BHS with a roster of key administrative personnel's after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional emergency or local disaster. These numbers will be held confidential and never given out to other than authorized personnel.

- Contractor shall identify 25% of direct service staff to prepare for and deploy (if needed and available) to a critical incident. These staff shall participate in County provided Disaster Training (or other approved training) and provide personal contact information to be included in the Disaster Personnel Roster maintained by the County. Contractor shall advise COR of subsequent year training needs to maintain 25% trained direct service staff in the event of staff turnover. Contractor shall maintain 25% staff deployment capability at all times.
- In the event that contractor's program site is closed due to disaster or emergency, contractor shall call the Access and Crisis Line and their COR to inform them of this.

Transportation of Clients

Contractors shall not use taxi cabs to transport unescorted minors who receive services funded by the County of San Diego.

CLAIMS AND BILLING FOR CONTRACT PROVIDERS

Contractor Payments

Contractors will be paid in arrears. After the month for which service has been given, the BHS Strategy and Finance will process claims (invoice) in accordance with the contract terms.

Budgets, Claims (Invoices) and Supplemental Data Sheets

- Budgets, claims (invoices) and supplemental data sheets must comply with the established procedures and requirements
- Final claim is due by August 31 or as specified on year-end information notice.
- Quarterly claims for MAA, QA and Admin – 60 .calendar days after end of each service quarter and actual final actual cost in December which is six months after the end of the fiscal year . for QA and Admin. MAA claim is due December 31 of each fiscal year for all quarterly claims.
- Final reconciliation for CalAIM Fee-For-Service contracts shall occur 13-months after the end of each contract term.

Gift Card Usage

Gift cards may be used to directly benefit clients and program objectives (i.e., grocery store vouchers). Gift cards may not be used as an incentive for Drug Medi-Cal billed services (i.e., as prizes for opportunity drawings for group attendance).

Programs with cost reimbursement contracts or with gift cards being reimbursed at cost must comply with the following:

- Have adequate internal controls and procedures in place to mitigate misappropriation of Gift Cards
- Gift Cards maintained in a secured and locked environment accessible only to the designated Contractor employees
- Gift Cards are accounted for by receipts, tracking system, and follow the Contractor's internal purchase policies
- Disbursement of Gift Cards are accounted for by a tracking system that indicates at a minimum:
    - Full name of the recipient
    - Amount of the Gift Card
    - Date disbursed
    - Two full signatures (one of which must be a Contractor employee). If both signatures are those of contract employees, one must be a supervisor.

- In the event Contractor discovers misappropriation of Gift Cards, Contractor must contact assigned BHS COR within one workday of the occurrence.
- Gift card purchase receipts, tracking log and internal polices shall be available to COR or Designee for review and inspection at any time
- Records to support the use of gift cards shall be available for in-depth review visits. Gift Cards that are not used or disbursed at the end of their original approved contract year must be justified and pre-approved (again) prior to being used in the next or any future contract years.
- Bus passes that are purchased in advance will follow the gift card policy requirements.

Medi-Cal Billing to the State

- Direct service claims can be submitted to the State up to a year from the date of service. Replacement of a denied service can be submitted up to 15 months.
- If the service was denied and the error is with the State's system, services can be replaced up to 36 months with a DRC 9. Voids can be process at any time and no limitation.

Submitting Claims (Invoice) for Services

Please submit all claims (invoice) for payment to:

Email: BHSClaims.HHSA@sdcounty.ca.gov

Fax: (858) 999-8929

Overpayment

In the event of overpayments, excess funds must be returned or offset against future claim payments.

Certification on Disbarment or Exclusion

All claims for reimbursement submitted must contain a certification about staff freedom from federal debarment, exclusion, suspension or ineligibility from services. In order to be in compliance with these federal regulations, all organizational providers must verify monthly the status of employees with the Government Services Agency (GSA) Federal System for Award Management (SAM) list, the Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), and the State of California Medi-Cal Suspended and Ineligible (S&I) list. Providers will report immediately to their COR any individual or entity that appears on any government excluded list and take the appropriate corrective action. Providers shall maintain documentation that evidences the required monthly verification.

To verify online if someone is on the Federal System for Award Management (SAM) list go to .http://SAM.gov the OIG Exclusion list and the GSA debarment list go to: https://exclusions.oig.hhs.gov. To view the list of what will get someone placed on the OIG list, go to: https://oig.hhs.gov/exclusions/authorities.asp.
To verify if a provider of health care services is subject to suspension from participation in the Medi-Cal program, go to: https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp. This would be due to:

- Been convicted of a felony;
- Been convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;
- Been suspended from the federal Medicare or Medicaid programs for any reasons;
- Lost or surrendered a license, certificate, or approval to provide health care; or
- Breached a contractual agreement with the Department that explicitly specifies inclusion on this list as a consequence of the breach, verification can be access by clicking on the link.

Federal and State Database Checks

During the provider enrollment/reenrollment process, it is required that the MHP checks the following databases to verify the identity and determine the exclusion status of all providers:

• Social Security Administration's Death Master File.
• National Plan and Provider Enumeration System (NPPES).
• List of Excluded Individuals/Entities (LEIE).
• System for Award Management (SAM).
• CMS' Medicare Exclusion Database (MED).
• DHCS' Suspended and Ineligible Provider List.
• Restricted Provider Database (RPD).

In addition to checking all the databases upon a provider's enrollment/reenrollment, the MHP will

review the SAM, LEIE, and RPD databases on a monthly basis. All databases will be reviewed upon a provider's enrollment/reenrollment to ensure that the provider continues to meet enrollment criteria. An MHP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate as a provider within the MHP's network.

National Provider Identification Verification

All HHSA contractors are required to verify that all clinical staff, licensed or not, have an active National Provider Identification (NPI) number. For new employees, contracted programs are to provide employee with necessary paperwork needed to apply for an NPI number, should they not already have one. If the new employee has an NPI number, the contractor shall verify in the National Plan and Provider Enumeration System (NPPES) for accuracy. Contractors must update the NPPES system as needed when the employee's information changes. The MHP is required to complete the same verification process for the contracted providers. When contractor submits their Access Request Form (ARF) for staff account set up in the electronic health record, the MHP MHMIS unit preforms validation through the NPPES database. Staff shall not have access to the electronic health record without a valid NPI number.

License Verifications

All HHSA contractors are required to verify the license status of all employees who are required by the contract Statement of Work to have and maintain professional licenses. The verification must be submitted at the time of contract execution, renewal or extension. In order to ensure the license is valid and current, the appropriate website(s) shall be checked. For county operated programs, license verification is completed by the Human Resource department. All providers are responsible for ensuring that all staff licenses are active and valid. Providers shall keep documentation that evidences active licensure for staff.

SHORT-DOYLE MEDI-CAL

I. Definitions

Provider means the program providing the mental health services. It is part of a legal entity on file with the State Department of Mental Health.

Federal Financial Participation per Title 9 CCR Chapter 11 means the federal matching funds available for services provided to Medi-Cal beneficiaries under the Medi-Cal program.

II. Medi-Cal Revenue

The Fiscal Services Unit will bill Medi-Cal for covered services provided to Medi-Cal beneficiaries by Short-Doyle Medi-Cal certified programs. The State will deny services that do not

clear the billing edits, programs have 15 months from the date of service to fix denied services. Once the program has fixed the error, in order to rebill for the service, the program must complete the current Replace Service Request form located on the Optum Website at https://www.optumsandiego.com/ and email the form to the email addresses stated on the form. After the form has been received and the replace processed, the program will be faxed back the form, this serves as notification that the replace was processed. If the reason for the denial is for Other Health Coverage or Medicare, the explanation of benefits (EOB) must be faxed to the billing unit with a copy of the denial report – fax to BHSBU/F (858) 467-9682.
County of San Diego HHSA – Mills Bldg. Behavioral Health Services Billing Unit Fiscal Services (BHSBU/F)

1255 Imperial Ave.
San Diego, CA 92101
Attn: Fiscal Services 6th Floor Rm. 633

III. Medi-Cal Disallowance/Recoupment of Federal Financial Participation (FFP) Dollars

BHS is obligated to disallow Specialty Mental Health Services (SMHS) for Medi-Cal reimbursement per the current California State DHCS Reasons for Recoupment of FFP dollars categories:

- Criteria for access to Specialty Mental Health Services
- Claim submitted for service during a lock-out
- Missing documentation of allowable service
- Service not billable under Title 9
- Evidence of fraud, waste, abuse

Organizational providers shall be responsible for ensuring that all medical records comply with federal, state and county documentation standards when billing for reimbursement of services.

The claims for the above circumstances will be deducted from your contract payment.

Contractor shall reimburse BHS for any disallowance of Short-Doyle/Medi-Cal payments, and reimbursement shall be based on the disallowed units of service at the Contractor's contracted fee-for-service rates.

IV. Billing Disallowances – Provider Self Report

The policy of San Diego County Behavioral Health Services Administration (SDCBHS) is to recoup payments for disallowed units identified and reported to the SDCBHS by the Contracted Organizational Providers in accordance with documentation standards as set forth in the current California State Department of Mental Health "Reasons for Recoupment of Federal Financial Participation Dollars."

Procedures

The following are the procedures to be followed for Self-Reporting of Billing Disallowances to ensure consistent procedures are used when the information is reported to Behavioral Health Services Administration by providers.

Provider Requirements

1. Providers are required to conduct internal review of medical records on a regular basis (i.e., monthly) in order to ensure that the documentation meets all County, State and Federal standards and that billing is substantiated.
2. If the review of a Medi-Cal client's chart results in a finding that the clinical documentation does not meet the documentation standards as set forth in the current California State Department of Health "Reasons for Recoupment of Federal Financial Participation Dollars" the provider shall be responsible for addressing the issue by filing a self-report of billing disallowances with SDCBHS.
3. To file a self-report of billing disallowances request with SDCMH, providers shall fill out the Provider Self-Report Billing Disallowance and a Void Service Request form if the service was billed and paid. E-mail the applicable form to MH Admin email addresses as directed on the form, who will forward the form to BHSBU. Providers shall ensure that the services listed on the form as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services must be listed on the form exactly as they were billed.
4. All services that are disallowed will also be voided from EHR. Providers are responsible for re-entering corrected service information; services can be re-entered as non-billable or no re-entry as applicable based on the void/replace reasons (found on the EHR Void - Replace Service Forms document located on the Optum San Diego Website at https://www.optumsandiego.com/). Services that are submitted for corrections because of clerical errors may be replaced and programs will need to complete the replacement service request form and submit to MH Admin who forwards to the BHSBU.
5. Providers shall check if applicable, see disallowance instructions and re-enter the services.

BHS Strategy & Finance (S&F) Procedures

1. On a monthly basis, BHS S&F staff process invoices based on Year-To-Date units. Any disallowances adjusted out from the Electronic Health Records will automatically reduce the payment to the providers. In any circumstances that disallowance can't be adjusted out from the Electronic Health Record, a manual disallowance calculations will be prepared and will prepare a letter pertaining to disallowances that will be sent to Contractors indicating that the County shall be entitled to recoup the disallowances.

2. Within 13-month after end of the fiscal year, S&F staff will reconcile units to ensure that all disallowances are included in the calculation of the year-end provider payment settlement. Notices will be sent to all Contractors that are entitled to additional payment or are subject to recoupment because of overpayment to the Contractor.
3. Contractors that have been overpaid may elect to repay the recoupment via check or an offset from future payments.
   - If the contractor pays by check, the check is received by S&F Fiscal Team staff and will forwarded to S&F Budget Team staff for deposit. The payment is logged in the contract file along with a copy of the payment.
   - If no check is received by S&F within 15 business days from the date of the letter to the Contractor; the recoupment amount is deducted from the next scheduled provider payment.

Billing Inquiries

Questions regarding claims (invoice) for payment should be directed in writing to:

Email: BHS-Claims.HHSA@sdcounty.ca.gov

Questions can also be addressed by calling the S&F Fiscal Team Fiscal Analyst

Inventory Guidelines for County Contracts

All Capital Assets/Equipment, Minor Equipment, and Consumable Supplies purchases shall be included in Cost Reimbursement contract budgets and shall be approved by the Contracting Officer's Representative (COR) upon budget submission. The equipment and supplies shall directly benefit clients and program's objectives.

County retains title to all non-expendable property provided to Contractor by County, or which Contractor may acquire with contract Agreement funds if payment is on a cost reimbursement basis, including property acquired by lease purchase Agreement. Internal Controls and Procedures below provide guidelines on handling Capital Assets and Minor Equipment.

1. Definitions

   a) **Capital Assets/Equipment**: Tangible non-expendable property that has been purchased with County funds and has a normal life expectancy of more than one year **and** a unit cost of $5,000 or more. Prior written approval from the COR is required for the acquisition of Capital Assets/Equipment. Examples of Capital Assets/Equipment include, but are not limited to: building improvements, vehicles, machinery, furnaces, air conditioners, multifunction copy machines, furnishings, etc.

   b) **Minor Equipment**: Any non-consumable implement, tool, or device that has a useful life

of more than one year **and** an acquisition amount of $500 to $4,999. Examples of Minor Equipment include, but are not limited to: televisions, video recorders and players, computer monitors, therapy equipment, refrigerators, hand-held electronic devices, electronic games, modular furniture, desks, chairs, conference tables, etc.

c) **Consumable Supplies**: Goods that have a useful life of one year or less **and** an acquisition value under $500. Examples of consumable supplies include, but are not limited to: pens, pencils, paper, notepads, file folders, post-it notes, toner or ink cartridges, waiting room supplies, etc.

2. Internal Controls and Procedures

Contractors shall have the following internal controls and procedures in place for managing contract-funded Capital Assets/Equipment and Minor Equipment, whether acquired in whole or in part with County funds, until disposition takes place:

a) Prior written approval from the COR is required for the acquisition of Capital Assets/Equipment through budget development requests or Administrative Adjustment Requests.
b) Contractors shall place *County of San Diego Property* tags on Capital Assets/Equipment and Minor Equipment to identify items purchased with County funds. These tags can be requested through the COR.
c) Contractors shall include the expenditure of Capital Assets/Equipment and Minor Equipment on the monthly invoice/cost report that immediately follows the acquisition.
d) Contractors shall maintain inventory records that include a description of the item, a serial number or other identification number (if applicable), the acquisition date, the acquisition cost, location of the item, condition of the item, program funding for the item, and any ultimate disposition data including the date of disposal.
e) Contractors shall submit an Inventory Report of Capital Assets/Equipment and Minor Equipment purchased using County funds annually to the COR no later than thirty (30) calendar days into each new contract year, and when any updates occur throughout the year (e.g., new items charged to the contract or when items are stolen, lost, damaged, missing, and upon disposal completion. The COR will review the Inventory Report to determine if the information is reasonable and complete based on their knowledge of the contract and approval of invoices containing charges for equipment.
f) The Inventory Report is to include all Capital Assets/Equipment and Minor Equipment items purchased since inception of the cost reimbursement contract, including all vehicles purchased and/or leased.
g) Inventory records on non-expendable equipment shall be retained and shall be made available to the County upon request, for at least 10 years following date of disposition.
h) Contractors may choose to utilize their own Inventory Report as long as the required information above is included. Otherwise, contractors can utilize the BHS Inventory Form.
i) Contractors shall include in the Inventory Report any items that were transferred from one County program to another and note the transfer date and program. A DPC 204 form shall

be completed.

j) Contractors shall make all purchased items available to the COR (or their designee) for inspection at any time.

k) Contractors shall be responsible for accounting of all county-funded items, whether acquired in whole or in part with County funds.
Contractors that are required to work with computers, laptops, portable devices or media that contain personal information relating to clients, patients and residents shall have a duty to protect this data from loss, theft or misuse (refer to Article 14 Information Privacy and Security Provisions in the contract). All electronic property and information technology

(IT) related items capable of storing information, regardless of acquisition price and useful life, must be included in the Inventory Report. . Examples of electronic property and IT related items capable of storing information include, but are not limited to: cellphones, laptops, tablets, USB memory devices, cameras, etc.

l) Contractors do not need to include in the Inventory Report consumable supplies valued under $500 except for electronic property and IT related items specified in item #k above such as cell phones, laptops, anything that hold PII, and items subject to misuse or theft.

3. Disposition

a) Contractors should not remove or dispose the items previously listed on their Inventory Report submitted to the County, unless the COR approved the salvage or transfer of those items, or a County Behavioral Health Services policy provided such instructions.

b) Minor Equipment not meeting the requirement to be listed on the Inventory Report and Consumable Supplies do not need to be disposed through the County process.

c) Non-expendable property that has value at the end of a contract (e.g., has not been depreciated so that its value is zero), and which the County may retain title, shall be disposed of at the end of the contract Agreement as follows:

At County's option, it may:

i) Have Contractor deliver to another County contractor or have another County contractor pick up the non-expendable property;

ii) Allow the Contractor to retain the non-expendable property provided that the Contractor submits to the County a written statement in the format directed by the County of how the non-expendable property will be used for the public good; or

iii) Direct the Contractor to return to the County the non-expendable property.

4. Stolen, Damaged or Missing Equipment

a) Contractor shall inform the COR in writing within 48 hours of any stolen, damaged or missing equipment purchased with County funds. *Exception*: Any lost or missing item that contains personal information shall be reported in writing to the COR within 24 hours. Article 14 Information Privacy and Security Provisions requirements shall be followed when appropriate.

b) Contractor may be responsible for reimbursing the County for any stolen, damaged or

missing equipment at the current book value of the asset.

5. Vehicles

a) The preferred method for Contractor(s) to acquire vehicles is through a lease arrangement. COR and County Management preapproval must be obtained for Contractor to acquire a vehicle. Vehicles shall be registered with the Contractor as the lien holder and registered owner. Whether vehicles are leased or purchased, Contractor shall maintain appropriate insurance on vehicles, follow maintenance schedule, as required by the automobile manufacturer. Vehicle(s) usage and insurance requirement language will be included/amended in the contract.

i) If vehicle will be purchased, COR must obtain written pre-approval from:

- ACS Director, and
- DPC Director

At contract termination, or when the original or replacement equipment/vehicle is no longer needed, or has become obsolete, or is inoperable and impractical to repair, a formal disposition process will be required (refer to BHS Property Transfer/Disposal Process). Contractors shall work with the COR, who will determine the final disposition of the item(s).

6. Inventory Disposition:

a) Contact the COR before disposing of property purchased with County funds, and which the County may retain title under this paragraph, shall be disposed of at the end of the Contract Agreement as follows:

i. Contact the COR before disposing of property purchased with County funds, and which the County may retain title under this paragraph, shall be disposed of at the end of the Contract Agreement as follows:

ii. At County's option, it may:

1. Have contractor deliver to another County contractor or have another County contractor pick up the non-expendable property;
2. Allow the contractor to retain the non-expendable property provided that the contractor submits to the County a written statement in the format directed by the County of how the non-expendable property will be used for the public good;
3. Direct the Contractor to return to the County the non-expendable property.

b) BHS Property Inventory Form: Available for download from the Optum website https://www.optumsandiego.com > BHS Provider Resources > MHP Provider Documents > OPOH tab.

i. As the contractor disposes of equipment the following column on the BHS Inventory form must be completed and a copy provided to the COR.

ii. ."Approved Date of Item Transfer or Disposition." This is the date of the COR approval.

c) DPC 203 Disposition of Minor Equipment and DPC 204 Transfer of Minor Equipment, Forms and Procedures:

NOTE: Procedure for Property Transfer to the County of San Diego – Property Disposal or Transfer to another contractor. *For purposes of this section on disposal of minor equipment, "contractor" refers to the specific numbered County contract, and that contract's County-owned property, not to the combined County-owned assets of multiple County contracts held by a parent organization/organizational provider.*

Versions of the forms, DPC 203, IT Supplemental and DPC 204 can be:

- Provided to the contractor by BHS staff;
- Downloaded from the link in the Technical Resource Library (TRL);
- Downloaded from the Department of Purchasing & Contracting public facing page https://www.sandiegocounty.gov/content/sdc/purchasing/property_disposal.html; or
- Downloaded from the Forms tab on the BHS Provider Resources > MHP Provider Documents on the Optum Website: (https://www.optumsandiego.com).

BHS Contract Support administrators will keep an internal record of any County-owned property and conduct an inventory of all County-owned property during selected site visits.

There are three distinct transfer/disposition procedures in place for minor equipment. These are for disposal of Non-IT items that do not have memory, IT items containing memory, and IT Mobile Devices. All minor equipment salvage requests are to be completed by the contractor on the appropriate version of the DPC form and forwarded to their Contracting Officer's Representative (COR) who will review, approve, sign and forward the DPC form to the appropriate County staff. Once processed and approved by BHS and/or the Department of Purchasing and Contracting (DPC), the COR will notify the contractor of further steps. All DPC forms must include the program name, contract number, COR name, address (with Zip Code) identifying the physical location of the items, and full site contact information including name, phone number and email. Directions for transfers between contracts are included below for each procedure. *A fillable version of the DPC form is now available for use for Non-IT, IT and Mobile Device disposal.* ***Contractors are not to make changes to the DPC forms, including changing pre-filled wording or making any entries in the forms' boxes #7 through #16.*** **Non-IT equipment, IT equipment and Mobile Devices cannot be listed on the same DPC 203 form.**

DPC 203 forms used for minor equipment disposal are located on the Optum Website (**https://www.optumsandiego.com**) **under BHS Provider Resources > MHP Provider Documents > Forms**.

i. **Non-IT Disposal Requests** (furniture, office equipment without memory, printers, most copiers, non-memory-containing computer accessories [computer monitors, keyboards, mice], routers, docking stations, wireless access points, DVD players, etc.):

- **Requests** are to be completed on the DPC 203 Fillable form, checking the Non-IT box, and sent to the COR for review, approval, electronic signature and forwarding.
- Non-IT requests require the condition of the items to be noted and must be accompanied by photos in .jpg format, (file size must be smaller than 5 MB for posting purposes) preferably with like items grouped but individually identifiable in the photos. The purpose of the condition statement and photos is to give other County departments information useful in deciding if they want to acquire items - photos should provide a clear image of the item(s) and condition should be appropriate for the kind of item – any damage and age issues for furniture, working and functionality issues for equipment, and any contamination issues for all items.
- Once DPC's approval is final, the COR will provide the program with the approved DPC 203 form (with a Control No.) and directions for delivery by the program, per pre-scheduled appointment, accompanied by the approved DPC 203 form, to the County's disposal contractor.
- **Contractors are to retain the disposal contractor's signed proof of delivery and then forward that documentation to the COR team**.
- *[Transfers of Non-IT items between contracts/programs require the sending program/COR team to complete the DPC 204 Fillable form, entering both the sending and receiving programs' names, contract numbers, COR names, current and future addresses of property, the site contact names, phone numbers and email addresses, and forward to the sending COR. The sending COR reviews, approves, electronically signs the form, and secures the receiving COR's approval and electronic signature (if different). The COR then forwards the approved form to BHS staff for further processing. Transfers of Non-IT items do not require photos or condition.]*

ii. **IT Disposal Requests** (those items with memory: computers, laptops, notebooks, servers, zip drives, higher-end copiers with memory, etc.)

- **Requests** are to be completed on the DPC 203 Fillable form, checking the IT box, and then sent to the COR for review, approval, electronic signature and forwarding. The DPC 203 Fillable form includes a section for Wipe Certification for use with IT disposals. (HHSA only recognizes Department of Defense (DoD) level wiping done by its

approved IT Wipe Vendor). IT items must be physically located at the address provided on the DPC 203 and retained at that site for pick up.

- Use DPC 203 form as a cover sheet: no itemizing on the form.
- On the DPC 203, the "Sender Information, Equipment Location and Contract Information" section is to be completed with full contract and contact information.
- The DPC IT SUPPLEMENTAL form is to be completed, listing individual items by Description (brand and model), Serial Numbers (NOT model numbers), "N/A" under Password to Unlock (passwords must be removed on all IT devices), and indicating "N" (for No) in the "Grant Funded" column.
- Group pictures are required for IT items, they do not to be individual.
- Following receipt of the disposal form with COR approval, the contractor will be contacted by CoSD HHSA IT's Wipe Vendor, to arrange for pick up for disposal. *(Include the power cords for all types of computers at point of pick-up. Note the physical location of the serial numbers on each unit, as the Wipe Vendor must verify serial numbers as a condition for pick up).*

- The contractor must ensure that the IT Wipe Vendor completes the first box of the Wipe Certification of the DPC 203 form at point of pick-up.
- Once the equipment is picked up, the contractor will send a copy of the form with the completed wipe pick-up confirmation to the COR.
- Transfers of IT items between contracts/programs following DoD wiping, require the sending program to complete the DPC 204 Fillable, entering both the sending and receiving programs' names, contract numbers, COR names, current and future addresses of property, the site contact names, phone numbers and email addresses, and forward to the sending COR. The sending COR reviews, approves, signs the form and secures the receiving COR's approval and signature (if different), and forwards the DPC 204 form to BHS staff. BHS staff then arrange for HHSA IT's Wipe Vendor to pick up the items, do the DoD wipe, and return the wiped items to the contractor at the pick-up location. The contractor secures the DoD Wipe Vendor's signature on the DPC 204 at point of pick up (first box of Wipe Certification) and again when wiped items are returned (second box of Wipe Certification). Following DoD wiping, the sending program sends the COR the DPC 204 with both sections of the Wipe Certification completed. The sending and receiving programs then coordinate transfer of wiped equipment. Contractors should discuss situations with their CORs when the wiping requirement may potentially be waived, for example certain same provider re-procured (rollover) contracts, or when a new provider will

be serving the identical client base and providing identical services. In these situations, a wipe waiver from the HHSA Compliance Office is required.

iii. **Mobile Devices Disposal Requests** (cell phones, flip phones, smart phones, hotspots, Wi-Fi cards, tablets, etc.)

- **Requests** are to be completed using, the DPC 203 IT and the DPC IT SUPPLEMENTAL, and sent to the COR team for review, approval and forwarding.
  - Use DPC 203 form as a cover sheet: no itemizing on the form.
  - On the DPC 203, the "Sender Information, Equipment Location and Contract Information" section is to be completed with full contract and contact information.
  - The DPC IT SUPPLEMENTAL form is to be completed, listing individual items by brand, model and type, providing serial numbers (NOT model numbers) and "N/A" under passwords (passwords must be removed on IT devices), and indicating "N" (for No) in the "GRANT FUNDED" column. This salvage process requires a group photo, in .jpg format, of the listed Mobile Devices.
  - This results in a disposal approval email which must be forwarded by the COR to the contractor along with the approved DPC 203 and IT Supplemental forms. The email includes a FedEx prepaid shipping label that must be printed only by the contractor, attaches it to the package of devices, encloses a copy of the approved Mobile Devices DPC 203 and IT Supplemental (approval with the Control No.) in the package, writes the Control No. on the outside of the package, and takes the package to the FedEx outlet for shipping to the County's Mobile Devices Salvaging Vendor.
  - *[The contractor packages the devices for secure, cushioned shipping, encloses a copy of the approved Mobile Devices DPC 203 and IT Supplemental form with the Control No. in the package(s) and writes the Control No. on the outside of the package(s).]*
  - **NOTE: DPC requires that all Mobile Devices be reset to their factory default setting prior to shipping**.
  - *[Transfers of Mobile Devices are limited to situations where: either the provider, program and services remain the same and only the contract number changes; or where a new provider will be assuming identical services for an identical client population. For Mobile Device transfers where a provider has changed, a wipe waiver must be secured by the COR from the HHSA Compliance Office before the devices can be made available to the new provider.]*

7. Electronic Property/IT:

Contractors Inventory Minimum Guidelines on A Cost Reimbursement and Fixed PRICE Contract

Inventory responsibility includes these minimum guidelines for the security of client information and portable electronic and data storage devices. This responsibility exists whether the information is in paper or electronic form. Additionally, all Contractor employees have the duty to protect any County assets assigned to them or in their possession, including desktop computers, portable devices and portable media.

Definitions

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

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

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

Minimum Guidelines

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

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

K. PROVIDER ISSUE RESOLUTION

The MHP recognizes that at times providers may have or be made aware of complaints, problems or issues with Fee-For-Service Individual Providers. Providers are encouraged to communicate any complaints, problems or issues to Optum which provides oversight for Fee-For-Service Providers. Please report any complaints to Optum Provider Services at 800-798-2254 option 7.

The MHP recognizes that at times providers may disagree with the MHP over an administrative or fiscal issue and will be happy to work with them to solve the problem. There is both an informal and formal Provider Problem Resolution Process for providers who have concerns or complaints about the MHP.

Informal Process

Providers are encouraged to communicate any concerns or complaints to the Program Monitor or designee. The Program Monitor or designee shall respond in an objective and timely manner, attempting through direct contact with the provider to resolve the issue. When issues are not resolved to the provider's satisfaction informally, a formal process is available. A copy of complaint materials will be sent to the County Mental Health QA Unit.

If the provider is not satisfied with the result or the informal process or any time, the formal process below is available:

Formal Provider Problem Resolution Process

1. Providers shall submit in writing any unresolved concerns or complaints to the MHS Contracts Manager Chief, Behavioral Health Services Contracts Support or designee, using the Formal Complaint by Provider form (Appendix located on the Optum Website: (https://www.optumsandiego.com). BHS Provider Resources > SMH & DMC-ODS Health Plans> OPOH/SUDPOH
2. Written narration shall include all relevant data, as well as attachment of any documents which support the provider's issue(s).
3. Formal complaint shall be submitted within 90 calendar days of original attempt to resolve issue(s) informally.
4. The Contracts Manager Chief, BHS Contracts Support or designee shall have 60 calendar days from the receipt of the written complaint to inform the provider in writing of the decision, using the Formal Response to Complaint form (Appendix located on the Optum Website: (https://www.optumsandiego.com) . BHS Provider Resources > SMH & DMC-ODS Health Plans> OPOH/SUDPOH > MH (OPOH) > Appendix > Appendix

K.4. The written response from the Contracts Manager, Chief, BHS Contracts Support or designee shall include a statement of the reason(s) for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

5. Formal Provider Problem Resolution documentation is to be directed to:

Mental Health Services Contracts Manager Chief, BHS Contracts Support
P.O. Box 85524
San Diego, CA 92186-5524
Mail Stop: P531-K

6. A copy of all complaint materials shall be sent to the County Mental Health QA Unit.

Formal Provider Appeal Process

1. Provider may submit an appeal within 30 calendar days of written decision to the Formal Complaint.
2. Formal Provider Appeals from an adult services provider shall be submitted in writing, using the Formal Appeal by Provider form (Appendix located on the Optum Website: (https://www.optumsandiego.com) BHS Provider Resources > SMH & DMC-ODS Health Plans> OPOH/SUDPOH > MH (OPOH) > Appendix > Appendix K.3 & K.4
3. The Appeal Form shall summarize the issue(s) and outline support for appeal. Previous documents on the issue(s) shall be attached.
4. The ADD shall notify the provider, in writing, of the decision within 60 calendar days from the receipt of the appeal and supporting documents, using the Formal Appeal Response Complaint Form (located on the Optum Website: https://www.optumsandiego.com BHS Provider Resources > SMH & DMC-ODS Health Plans> OPOH/SUDPOH > MH (OPOH)
5. The written response from the ADD shall include a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.
6. Formal Provider Appeal documentation is to be directed to:

Assistant Deputy Director of Adult Mental Health Services
P.O Box 85524
San Diego, CA 92186-5524 Mail Stop: P531-A

Assistant Deputy Director of Children, Youth and Families Services
P.O Box 85524
San Diego, CA 92186- 5524
Mail Stop: P531-C

7. A copy of all appeals materials should be sent to the County Mental Health QA Unit:

Quality Assurance Unit
P.O. Box 85524
San Diego, CA 92186-5524
Fax: (619) 236-1953
Mail Stop: P531-Q (Children)
Mail Stop: P531-G (Adults)

Quality Assurance Process

1. The Quality Assurance Unit shall gather, track and analyze all formal provider problem resolution issues.
2. All Organizational Providers who submit a formal complaint, and/or formal appeal, shall send a copy to the Quality Assurance Unit.
3. All Program Monitors or designees, the Chief, BHS Contracts Support who obtains a formal complaint, and/or the ADD who handles an appeal shall forward a copy to the Quality Assurance Unit, attaching the response.
4. The Quality Assurance Unit will log all formal complaints and appeals as it pertains to issue, timeline compliance, resolution disposition and action plan. This unit will identify opportunities for improvement and decide which opportunities to pursue, design and implement interventions to improve performance, and measure the effectiveness of any interventions.

Contract Administration and Fiscal Issues with MHP Contracts

Please see the Provider Contracting section of this Handbook.

L. PRACTICE GUIDELINES

Practice guidelines refer to methods and standards for providing clinical services to clients. The MHP applies guidelines that comply with 42 C.F.R. 438.236(b) and Cal. Code Regs.,Welfare and Institutions Code 14184.402. 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.

Co-Occurring Disorder Population

Co-occurring disorders (COD) are defined as the occurrence of a combination of any mental health condition and substance use (SUD). The significant co-morbidity of SUD and mental illness (typically reported as 40% - 80% depending on study characteristics and population) and the growing body of research associating poorer outcomes with a lack of targeted treatment efforts have highlighted the importance of addressing the unique needs of this population. Integrated treatment coordinates mental health and substance use interventions to treat the whole person more effectively. As such, integrated care broadly refers to the process of ensuring that treatment interventions for COD are combined within a primary treatment relationship or service setting. Research has generally supported that the ideal approach toward treatment for CODs is to address all conditions simultaneously, as opposed to addressing the mental health condition and SUD separately and in a silo of separate treatment approaches. When providers have staff who possess the skills and training to adequately address the needs of the COD population within their scope of practice, integrated care is best provided inhouse. It is the expectation that all programs be, at a minimum, Co-Occurring Capable with the goal of becoming Co-Occurring Enhanced. To aid in serving the needs of the COD population in San Diego County, programs are required to participate in the Comprehensive, Continuous, integrated System of Care (CCISC) CADRE.

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

Medi-Cal Transformation Initiative for Co-Occurring Treatment Disorders

The Medi-Cal Transformation initiative seeks to reduce or eliminate barriers to treatment for clients with co-occurring disorders. Therefore, services provided in the presence of co-occurring

disorders will be reimbursable when a medically necessary service is documented. Specialty mental health program providers must still deliver covered specialty mental health services at sites that have specialty mental health certifications, and contracted DMC-ODS providers must still deliver covered DMC-ODS services at sites that are at DMC certified. Department of Health Care Services is not removing all distinctions between the two programs or allowing specialty mental health providers to automatically bill for DMC services or DMC-ODS providers to bill for specialty mental health services. Programs must also provide linkage to the system of care that meets the client's primary needs. The County of San Diego is in process of developing policy and procedure for billing and linkage for clients with co-occurring disorders and will be communicated in coming months.

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 use 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 (Note: If a diagnosis is undetermined at the time of assessment, services will be reimbursable with the use of Z03.89 until the diagnosis is established) is nationally recognized as evidenced based practice.

For children/youth clients 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 (Note: If a diagnosis is undetermined at the time of assessment, services will be reimbursable with the use of Z03.89 until the diagnosis is established), particularly in high-risk family situations. Additionally, children and youth may be impacted by substance use or abuse on the part of their caretakers.

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, that outlines the programs capacity to address co-occurring needs as well as physical health needs, including tobacco use.
- 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. For beneficiaries under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the assessment domain requirements.

- If both types of disorders are indicated for the client at diagnostic levels, list the mental health diagnosis or Z03.89 Deferred 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 all clients** who do not meet the criteria for access to Specialty Mental Health services, 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 the client's problem list and service may be provided in relation to how it impacts the functional impairment related to the mental health diagnosis.
- Documentation of treatment services and interventions must meet the federal and W&I Code 14184.402 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 concerns 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.
- 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.

Medically Necessary Specialty Mental Health Services for Child/Youth:

- For beneficiaries under age 21, a service is medically necessary if it meets criteria of Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct and ameliorate mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan.
- Mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are covered as EPSDT.
- Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria below. If a beneficiary under age 21 meets the criteria as described in (1), the beneficiary meets criteria to access SMHS. It is not necessary to establish that they also meet criteria in (2).:

(1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following:

- Scoring in the high-risk range under a trauma screening tool approved by the department,
- Involvement in the child welfare system (open child welfare or prevention services case),
- Juvenile justice involvement (has ever been detained or committed to a juvenile justice facility or is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency),
- Experiencing homelessness (Literally homeless, imminent risk of homelessness, unaccompanied youth under 25 who qualify as homeless under other Federal statues, fleeing/attempting to flee domestic violence)

OR

(2) The beneficiary meets both of the following requirements in a) and b) below:
a) The beneficiary has at least one of the following:

- A Significant impairment
- A reasonable probability of significant deterioration in an important area of life functioning
- A reasonable probability a child will not progress developmentally as appropriate
- A need for specialty mental health services, regardless of impairment, that are not included in the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

b) The beneficiary's condition as described in subparagraph (2) above is due to one of the following:

- A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the Internal Statistical Classification of Diseases and Related Health Problems
- A suspected mental disorder that has not yet been diagnosed
- Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional

This criterion shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

- Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.
- The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.
- The beneficiary has a co-occurring substance use disorder.

For more information, please reference DHCS Behavioral Health Information Notice BHIN 21-073 which addresses criteria for beneficiary access to SMHS, medical necessity and other coverage requirements and BHIN 22-011 No Wrong Door for Mental Health Policy.

Documentation Guidelines when the Electronic Health Record (EHR) is Unavailable

Programs are expected to adhere to County and Medi-Cal Documentation standards. There may be occasions when the EHR is temporarily out of operation causing delays or a potential work stoppage. When an unplanned disruption occurs, programs will receive an email alert from the CalMHSA Helpdesk with the following guidelines:

- Consider the circumstances and apply best judgement to determine if it is prudent to use paper methods for documentation of services.
- Review UCRM to determine if the documentation/data is required to be entered manually into the EHR or can be scanned into the EHR/maintained in paper format in the Hybrid Chart. Paper **billing records** should be given to administrative staff for later entry in the EHR. Services may be claimed **after** documentation on paper notes or signature in the EHR.
- It is strongly recommended that programs Save and Sign documentation as soon as possible within the stated timelines, in order to avoid risk of late entry and being out of compliance.
- Continued problems with the EHR should be reported directly to the CalMHSA Helpdesk.
- Questions about the documentation process may be sent to: QImatters.hhsa@sdcounty.ca.gov.

Dual Diagnosis Capable Programs

It is the expectation that all programs be, at a minimum, Co-Occurring Capable. Certain programs within the HHSA/BHS system are certified as 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

Comprehensive, Continuous, Integrated System of Care (CCISC) CADRE

Each organization shall have a minimum of one (1) current staff person complete the CCISC CADRE, within the life of the contract.

Completion of CCISC CADRE

- When an Agency has completed the CCSC CADRE change agent training, it shall be expected to meet the following minimum requirements:
    - Programs shall use an approved tool to measure progress toward co-occurring capability or enhancement and shall identify specific objectives that are measurable and achievable in that time frame. Each program shall document what actions they are taking toward co-occurring capability or enhancement, at a minimum annually and submit to the COR by July 15th of every option year.
    - Annual development of Quality Improvement Action Plan for achievement of progress, in consultation with COR and/or designee will identify Program specific objectives that are measurable and achievable to be reviewed by the COR and/or designee.
    - Ongoing Agency participation in CADRE committees and activities, following CADRE change agent training completion.

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.

<u>Antipsychotic Medications</u>

- 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 mm/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.courts.ca.gov/documents/BTB24-1G-12.pdf

Appendix A of this document "Prescribing Standards with Children and Youth in Foster Care" provides guidelines regarding the number of allowable medications 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. The document is available for download from the Optum website in the OPOH tab, Appendix A.L.1

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/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. As of July 1, 2021, 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 six (6) months thereafter, if the prescribed controlled substance remains part of the patient's treatment, with specified exemptions. Additionally, this law requires reporting the dispensing of Schedule V drugs. This requirement applies to pharmacists and prescribers who dispense controlled substances.

Starting January 1, 2021, the dispensing of a controlled substance must be reported to the Controlled Substance Utilization Review and Evaluation System (CURES) within one working day after the medication is released to the patient or the patient's representative. (Previously, the deadline to report was seven days after dispensing.) The County of San Diego expects prescribers to document monitoring efforts consistent with this law.

M. STAFF QUALIFICATIONS

Each provider is responsible for ensuring that all staff meets the requirements of Federal, State, and County regulations regarding licensure, training, clinician/client ratios and staff qualifications for providing direct client care and billing for treatment services. Documentation of staff qualifications shall be kept on file at the program site. Provider shall adhere to staff qualification standards and must obtain approval from their Program Monitor or designee for any exceptions.

Provider shall comply with the licensing requirements of the California Welfare and Institutions Code Section 5751.2. Provider shall have on file a copy of all staff licenses and relevant certificates of registration with the Board of Behavioral Sciences. For staff positions requiring licensure, all licenses and registrations must be kept current and be in active status in good standing with the Board of Behavioral Sciences.

County-operated programs may undergo Medi-Cal site certifications by the California DHCS and/or SDCBHS. This process includes a review of provider licenses where required. County hiring procedures shall include extensive background checks, including but not limited to, a review of license status, work history and references. Providers shall not be discriminated against on the basis of moral or religious beliefs or their practice of high-cost procedures.

CREDENTIALING AND RECREDENTIALING AND PROVIDER ENROLLMENT

San Diego County Behavioral Health Plan (SDCBHP) program for credentialing, re-credentialing and provider enrollment is designed to comply with national accrediting organization standards as well as local, state and federal laws. The process described below applies to all Legal Entities which opted to complete credentialing, recredentialing and provider enrollment using Optum's centralized process.

Please note that Legal Entities are responsible to ensure successful completion of credentialing activities for all new staff upon hire.

Per DHCS Information Notice 20-069, credentialing/recredentialing requirements outlined below are applicable to Medi-Cal Programs and is requiring Licensed, Registered, Certified or Waivered Providers that provide direct billable services to be credentialed and re-credentialed every 3 years.

Credentialing via Optum

Initial credentialing processes begin with submission of completed and signed applications, along with all required supporting documentation. Providers are to call Optum's Behavioral Health Services Credentialing Department at (800) 482-7114 or send a notification email to

BHSCredentialing@optum.com. Entities can also choose to work with their assigned Optum Credentialing Representative directly by sending timely notice of any changes in provider status such as but not limited to terminations, changes in license/registration, new hire notifications, etc.

The credentialing process includes without limitation attestation as to: (a) any limits on the provider's ability to perform essential functions of their position or operational status; (b) with respect to individual practitioner providers, the absence of any current illegal substance or drug use; (c) any loss of required state licensure and/or certification; (d) with respect to individual practitioner providers, any loss or limitation of privileges or disciplinary action; and (f) the correctness and completeness of the application.

Optum will also be conducting primary source verification of the following information:

- Current and valid license to practice as an independent practitioner at the highest level certified or approved by the state for the provider's specialty or facility/program status;
- Professional License current and valid and not encumbered by restrictions, including but not limited to probation, suspension and/or supervision and monitoring requirements;
- Clinical privileges in good standing at the institution designated as the primary admitting facility if applicable, with no limitations placed on the practitioner's ability to independently practice in his/her specialty;
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline or licensure;
- Board Certification, if indicated on the application;
- A copy of a current Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) Certificate, as applicable;
- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the practitioner, which disclose an instance of, or pattern of, behavior which may endanger patients.
- No exclusion or sanctions/debarment from government programs.
- Current specialized training as required for practitioners.
- No Medicare and/or Medicaid sanctions.

SDCBHP also requires:

- Current, adequate malpractice insurance coverage.
- Work history (past 5 years) for the provider's specialty.
- No adverse record of failure to follow SDCBHP policies, procedures, or Quality

Management activities.

- No adverse record of provider actions which violate the terms of the provider agreement.
- No adverse record of indictment, arrest or conviction of any felony or any crime indicating patient endangerment.
- No criminal charges filed relating to the provider's ability to render services to patients.
- No action or inaction taken by provider that, SDCBHP's sole discretion, results in a threat to the health or well-being of a patient or is not in the patient's best interest,
- Residential Programs (facilities) must be evaluated at credentialing and re-credentialing. Those who are accredited by an accrediting body accepted by Optum (currently JCAHO, CARF, COA and AOA) must have their accreditation status verified. On-accredited Residential Facilities/Sites providers must provide documentation from most recent audit performed by DHCS, DHS or CMS as applicable.

Re-credentialing via Optum

- SDCBHP requires that individual practitioners and Residential Programs Sites undergo re-credentialing every three (3) years.

- Re-credentialing will begin approximately six (6) months prior to the expiration of the credentialing cycle.

Required documentation includes without limitation attestation as to: (a) any limits on the participating provider's ability to perform essential functions of their position or operational status; (b) with respect to individual practitioner participating providers, the absence of any current illegal substance or drug use; and (c) the correctness and completeness of the application (including without limitation identification of any changes in or updates to information submitted during initial credentialing).

Failure of a participating provider to submit a complete and signed re-credentialing application, and all required supporting documentation timely and as provided for in the re-credentialing application and/or requests from Optum, may result in termination of participation status with SDCBHP and such providers may be required to go through the initial credentialing process.

Credentialing information that is subject to change must be re-verified from primary sources during the re-credentialing process. The practitioner must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use.

Provider Enrollment via Optum

Consistent with DHCS Information Notice 20-071, Optum will enroll all applicable network

providers, including individual rendering providers, through the DHCS Provider Application and Validation for Enrollment (PAVE) portal. Billing providers are subject to the rules, processing requirements, and enrollment timeframes defined in Welfare and Institutions Code Section 14043.26, including the timeframe within Section 14043.26(f) that generally allows DHCS up to 180 days to act on an enrollment application. For Applicable Providers, Optum's Enrollment Coordinator will begin an Ordering Referring Prescribing (ORP) Application or an Affiliation Application as applicable in PAVE within 5 business days from the date the provider returned an application for credentialing complete to Optum. Providers will receive an email from PAVE asking them to log in and respond to the disclosure questions and sign their application. Providers shall respond to the notification email from PAVE and complete their application within 5 business days.

Delegates and Delegation

Entities –that have opted to be delegates for credentialing their own providers will have to adhere and continue adherence to state and local regulations, SDCBHP requirements, and National Committee of Quality Assurance Standards (NCQA) while performing their duties as Credentialing Delegates.

Delegated Entities will be audited by Optum on behalf of the County of San Diego County Behavioral Health Services and must receive a score of 85% or higher as a result of each audit. The Delegation Oversight Audits will be on an annual basis and Delegated Entities will receive at a minim thirty (30) days prior notice to allow for proper preparation. Any scores below 85% will be given Corrective Action Plans to address any deficiencies and to ensure continuance of the programs' integrity and compliance.

Delegated Entities shall be responsible for enrolling all applicable new and existing providers through the DHCS Provider Application and Validation for Enrollment (PAVE) portal and maintain compliance with the requirements outlined in DHCS Information Notice 20-071

ADULT AND CYF SYSTEMS OF CARE

PROFESSIONAL LICENSING WAIVER REQUIREMENTS

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

Complete professional licensing waiver requirements and instructions on how to request these waivers are available in BHIN 24-033: https://www.dhcs.ca.gov/Documents/BHIN-24-033-Mental-Health-Professional-Licensure-Waiver.pdf. This document is also posted on the OPTUM website.

Waiver Eligibility:

Professional License Waivers (PLW) are required for the following persons employed or under contract with the Mental Health Plan (MHP), Local Mental Health Department (LMHD), or provider subcontracting with the MHP or LMHD to provide mental health services under the Bronzan-McCorquodale Act (BMA):

1) Psychologists who are gaining the "experience required for licensure".

or

2) Psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors who have been recruited for employment from outside California and whose experience is sufficient to gain admission to a licensing examination. "Experience required for licensure" for purposes of waiver means an experience that meets the requirements of Bus. & Prof. Code section 2914, subdivision (d).

Persons are subject to the PLW requirements found in W&I section 5751.2 and, in this BHIN, only when engaged in a formal employee/employer or individual contractual relationship with a local mental health program, including a MHP or LMHD, or provider subcontracting with the MHP or LMHD. Students in formal graduate programs who are not employed or under contract with a local mental health program, as specified, may not be subject to these PLW requirements. This may include, for example, pre-doctoral students gaining "experience required for licensure" in a formal internship placement, as well as practicum-level students gaining experience required for graduate study, as long as they are not employed or contracted as described in section (1)(iii) below. Providing services through a DHCS PLW is only one way of obtaining predoctoral supervised professional experience (SPE) to satisfy psychology licensing requirements.[3]

DHCS shall grant a PLW to the following eligible individuals:

- Unlicensed individuals who:
  - Will be employed or under contract with the MHP or LMHD or provider subcontracting with the MHP or LMHD to provide mental health services under the BMA as psychologists for the purpose of acquiring the SPE required for licensure, as required by Bus. & Prof. Code section 2914, subdivision (d)(1) and CCR, Title 16, section 1387; **and**
  - Will provide mental health services under the BMA under the clinical supervision of an approved licensed psychologist (or other supervisor approved by the Board of Psychology).

AND

- Have earned a doctorate degree from an accredited or approved university, college, or professional school as set forth under Bus. & Prof. Code section 2914, subdivisions (b)-(c), in the following subject areas: (1) psychology, (2) educational psychology, or (3) education with the field of specialization in counseling psychology or educational psychology; **or**
- Have completed at least a minimum of 48 semester/trimester or 72 quarter units of graduate coursework in psychology (not including thesis, internship or dissertation), as required by Title 16 of the CCR, section 1387(a)(1), from an accredited or approved university, college, or professional school as set forth under Bus. & Prof. Code section 2914, subdivisions (b)-(c), in the following subject areas: (1) psychology, (2) educational psychology, or (3) education with the field of specialization in counseling psychology or educational psychology.

OR

- Psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors who:
  - Have been recruited for employment from outside of California and employed or under contract with the MHP or LMHD or provider subcontracting with the MHP or LMHD to provide mental health services under the BMA; **and**
  - Have the minimum amount of professional experience, to gain admission to the applicable California licensing examination for their profession.

Waiver Duration:

- PLWs granted by DHCS are valid for five (5) years from the first date of employment by, or contract with, a local mental health program, including a MHP or LMHD, or provider subcontracting with the MHP or LMHD, unless the individual seeking waiver obtains appropriate licensure prior to the expiration of the five (5) year-waiver timeframe.[4] PLWs cannot be extended beyond this five (5) year timeframe and must run continuously from the start date. The five (5) year term may not be backdated, postponed, paused, deferred, or extended for any reason.

How To Apply:

- The director or designee of a MHP or county mental health department may apply on behalf of an individual seeking a PLW. The employer shall not allow an individual seeking a waiver to begin work for which a license or waiver is required until DHCS has approved the PLW application. Applicants must complete and submit DHCS Form 1739 to the Department.

- For individuals that are employed or under contract with the MHP, LMHD, or provider subcontracting with the MHP or LMHD to provide Medi-Cal SMHS or community mental health services, and are working to complete their post-doctoral SPE as defined by CCR, Title 16, section 1387, subdivision (a)(2):

    - A certified copy of the individual's most current doctoral program transcript from an accredited or approved educational institution that meets the requirements within Bus. & Prof. Code section 2914, subdivisions (b)-(c). The transcript must include the individual's full name and demonstrate that the individual has completed the doctoral program.

- For individuals that have completed 48 semester/trimester or 72 quarter units of graduate coursework in psychology (not including thesis, internship, or dissertation), are employed or under contract with the MHP, LMHD, or provider subcontracting with the MHP or LMHD to provide Medi-Cal SMHS or community mental health services, and are working to complete up to one year of pre-doctoral SPE as defined by CCR, Title 16, section 1387, subdivision (a)(1):

    - A certified copy of the individual's most current doctoral program transcript from an accredited or approved educational institution that meets the requirements within Bus. & Prof. Code section 2914, subdivisions (b)-(c). The transcript must include the individual's full name and demonstrate that the individual has completed a minimum of 48 semester/trimester or 72 quarter units of graduate coursework in psychology (not including thesis, internship, or dissertation).

- Psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors who have been recruited for employment from outside of California, are employed or under contract with the MHP, LMHD, or provider subcontracting with the MHP or LMHD to provide Medi-Cal SMHS or community mental health services, and whose experience is sufficient to gain admission to the appropriate California licensing examination for their profession:

    - Notification from the appropriate California licensing board that the individual has been accepted to sit for the applicable California licensing exam for their

profession. A copy of the email from the licensing board confirming the individual's licensing exam date is sufficient to meet this requirement.

- Evidence of the issued license that includes the individual's full name, license number, and name of the state they are licensed in.

The application and supporting documentation must be submitted via email to MHLicensingWaivers@dhcs.ca.gov.

The following general points should be noted:

- Mental Health Plans (MHPs) should submit and receive approval for waivers under subdivisions 5751.2(d) [psychologist candidates] and 5751.2(e) [candidates recruited from outside California whose experience is sufficient to gain admission to the appropriate licensing examination] *prior to allowing candidates to begin work for which a license or waiver is required.*

- Waivers are not transferable from one MHP to another. If an individual who obtained a waiver while working for one MHP terminates employment and is subsequently hired by a second MHP, an application for a new waiver must be submitted by the second MHP prior to allowing the candidate to begin work for which a license or waiver is required.

- When requesting a waiver under a new MHP, the applicant must complete the DHCS-1739 form including the following information: name, name of county where services are provided, new employer contact, and applicant return address.

- If an applicant changes employer within the same county/MHP no notification to DHCS is needed and a reapplication is not required.

- Once a waiver is granted, the waiver period runs continuously to its expiration point unless the MHP requests that it be terminated earlier.

Use the "DHCS 1739 Mental Health Professional Licensing Waiver Request" form (and instruction sheet) which can be found on the Optum website, MHP Provider Documents, Forms Tab. Please review the instructions prior to faxing the waiver requests to the QA Unit, Attn: Waiver Requests at (619) 236-1953 or email documents to QIMatters.hhsa@sdcounty.ca.gov. For additional questions, please contact your QA Specialist.

STAFF QUALIFICATIONS AND SUPERVISION

Clearances for Work with Minors

Contractor's employees, consultants, and volunteers, who work under given contract and work directly with minors, shall have clearances completed by the contractor prior to employment and annually thereafter.

- Employees, consultants, and volunteers shall successfully register with and receive an appropriate clearance by "Trustline" (http://www.trustline.org/) or equivalent organization or service that conducts criminal background checks for persons who work with minors. Equivalent organizations or services must be approved by the COR prior to use by contractor.
- Employees, consultants, and volunteers shall provide personal and prior employment references. Contractor shall verify reference information, and employees, consultants, and volunteers shall not have any unresolved negative references for working with minors.
- Contractor shall immediately remove an employee, consultant, or volunteer with an unresolved negative clearance.

Documentation and Co-Signature Requirements

Staff who provide mental health services are required to adhere to certain documentation and co-signature requirements. For the most current information on co-signature requirements, please refer to the Uniform Clinical Record Manual. This manual will instruct staff on form completion timeframes, licensure and co-signature requirements, and staff qualifications necessary for completion and documentation of certain forms.

In general, staff that hold the license of an M.D., D.O., N.P., R.N., Ph.D., Registered Psychological Associate, LCSW, LPCC, or MFT do not require a co-signature on any documentation in the medical record. This also holds true for registered associates with the Board of Behavioral Sciences (ASW, APCC or AMFT), or staff waivered according to State guidelines. These above referenced staff may also provide the co-signature that is required for other staff, excluding clinical trainees. Staff that does not meet the minimum qualifications of an MHRS shall have adequate clinical supervision and co-signatures from a licensed/registered/waivered staff.

CO-SIGNATURE REQUIREMENTS

(From Documentation and Uniform Clinical Record Manual)

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

STAFF DISCIPLINE	CalAIM Assessment	Care Plan	Discharge Summary

	STAFF QUALIFICATIONS AND SUPERVISION		
M.D.	NO	NO	NO
Doctor of Osteopathic Medicine (D.O. or DO)	NO	NO	NO
Ph.D. Psy.D licensed/waivered/Registered Psychological Associate	NO	NO	NO
Ph.D. Psy.D registered	YES	YES	YES
LCSW, LMFT licensed/registered/waivered	NO	NO	NO
Licensed Professional Clinical Counselor (LPCC) Associate Professional Clinical Counselor (APCC)	NO	NO	NO
Nurse Practitioner (NP)	NO	NO	NO
Registered Nurse (RN) **See consideration below	NO	NO	NO
Licensed Vocational Nurse (LVN)	YES	YES	YES
Licensed Psychiatric Technician (LPT)	YES	YES	YES
Mental Health Rehab Specialist (MHRS) *ADULT programs*	YES	YES	YES
Mental Health Rehab Specialist (MHRS) *AOA/CYF programs*	YES	YES	YES
Clinical Trainees include the allowed disciplines: MFTCT, SWCT, PCCCT, PSYCT	YES	YES	YES
Medical Assistant	YES	YES	YES
Other Qualified Provider	N/A	N/A	N/A
**** According to DHCS guidelines, providing a mental health diagnosis is out of the scope of practice of R.N., LVN, MHRS and LPT staff.**			

For a social worker candidate, a marriage and family therapist candidate, or a professional clinical counselor candidate, "registered" means a candidate for licensure who is registered, or hassubmitted a registration application and is in the process of obtaining registration in accordance

with the criteria established by the corresponding state licensing authority for the purpose of acquiring the experience required for licensure, in accordance with applicable statutes and regulations and "waivered" means a candidate who was recruited for employment from outside California, whose experience is sufficient to gain admission to the appropriate licensing examination and who has been granted professional licensing waiver approved by the Department of Health Care Services to the extent authorized under state law.

Clinical Social Worker (CSW), Marriage and Family Therapist (MFT), and Professional Clinical Counselor (PCC) Candidates who have graduated from a master's program and are completing their required hours for licensure must register with the BBS as an associate. The "90 Day Rule" set by the BBS allows candidates to count supervised experience toward licensure when gained during the window of time between the degree award date and the issue date of the associate registration number if BBS receives the associate application within 90 days of the degree award date. Services rendered by CSW, MFT, and PCC candidates completing supervised experience can be reimbursed while their BBS application is pending. In the event the BBS application is not approved by BBS, the services provided by the candidate are not Medi-Cal reimbursable.

A Clinical Trainee is an unlicensed individual who is enrolled in a post-secondary educational degree program in the State of California that is required for the individual to obtain licensure as a Licensed Mental Health Professional or Licensed Practitioner of the Healing Arts; is participating in a practicum, clerkship, or internship approved by the individual's program; and meets all relevant requirements of the program and/or applicable licensing board to participate in the practicum, clerkship or internship and provide rehabilitative mental health services or substance use disorder treatment services, including, but not limited to, all coursework and supervised practice requirements. The county must ensure that the clinician supervising the Clinical Trainee meets the minimum qualifications described by the applicable licensing board. Medi-Cal behavioral health delivery systems and trading partners may submit claims to Short Doyle for services rendered by the new Clinical Trainee provider types listed below:

- Nurse Practitioner Clinical Trainee
- Licensed Psychologist Clinical Trainee
- Licensed Clinical Social Worker Clinical Trainee
- Licensed Marriage and Family Therapist Clinical Trainee
- Licensed Professional Clinical Counselor Clinical Trainee
- Licensed Psychiatric Technician Clinical Trainee
- Registered Nurse Clinical Trainee
- Licensed Vocational Nurse Clinical Trainee
- Licensed Occupational Therapist Clinical Trainee
- Licensed Physician Clinical Trainee (Medical Student)
- Registered Pharmacist Clinical Trainee

- Physician Assistant Clinical Trainee
- (Certified) Clinical Nurse Specialist Clinical Trainee

Short Doyle will validate the supervisor's NPI against the data in the National Plan & Provider Enumeration System (NPPES). Claims for Clinical Trainees that do not contain a valid supervisor's NPI will be denied.

Clinical Trainees must be under formal agreement between the Masters' program and the Provider to serve as clinical trainees. This agreement allows for the Clinical Trainee staff, at the program's discretion, to complete documentation such as the Behavioral Health Assessment, Client Plan, Discharge Summary, and Progress notes with a co-signature.

Medical Assistant (MA) is an individual who is at least 18 years of age, meets all applicable education, training and/or certification requirements, and provides administrative, clerical, and technical supportive services according to their scope of practice, under the supervision of a licensed physician and surgeon, or to the extent authorized under state law, a nurse practitioner or physician assistant that has been delegated supervisory authority by a physician and surgeon. The licensed physician and surgeon, nurse practitioner or physician assistant must be physically present in the treatment facility (medical office or clinic setting) during the provision of services by a medical assistant.

Mental Health Rehabilitation Specialist (MHRS) is an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis. Up to two years of post-associate arts clinical experience may be substituted for the required educational experience (as defined by Title 9) in addition to the requirement of four years of experience in a mental health setting.

It is out of scope for a MHRS/LVN/LPT/MA to complete the CalAIM Assessment, the MSE and/or diagnostic impressions. These assessments must be completed by a licensed/registered/waivered clinician. A MHRS/LVN/LPT/MA may contribute to the CalAIM assessment by gathering information that supports the assessment domains *within their scope of practice*. This information can be entered into their service note and claimed using the "Assessment by non-LPHA" procedure code.

Licensed/waivered/registered staff may then review and copy this information to relevant domains of the CalAIM assessment and complete the assessment with the client, claiming for their direct client time.

STAFF QUALIFICATIONS AND SUPERVISION

Staff Supervision and Management Requirements

- Programs must provide supervision in amount and type that is adequate to ensure client safety, maximize gains in functioning, and meet the standards of the professions of those staff employed in the program.
- Programs who employ waivered/registered staff receiving supervision for licensure must offer experience and supervision that meet the requirements of the licensing board to which the person is registered.
- Contractor shall ensure provision of required supervision for Nurse Practitioner staff or intern.
- Supervisors may supervise up to 8 clinical staff (licensed, registered, waivered, and Clinical Trainees) and up to 12 total staff, to include clinical staff.
- Programs must provide adequate training, supervision, and co-signatures by a licensed/registered/waivered staff for staff that does not meet the minimum qualifications of an MHRS.
- Any exceptions to these requirements must be approved by the COR.
- Contractor shall notify COR prior to personnel change in the Program Manager position. A written plan for program coverage and personnel transition shall be submitted to COR at least 72 hours prior to any personnel change in the Program Manager position.
- Program shall provide the COR an organizational chart identifying key personnel and reporting relationships within 2 weeks of any changes to organizational structure.

Staffing Requirements

- All providers shall have staff in numbers and training adequate to meet the needs of the program's target population.
- Psychiatry time: Day Treatment programs, including Intensive and Rehabilitation, shall have psychiatry time sufficient to provide psychiatrist participation in treatment reviews, plus one hour per week for medication management per 8 clients on medication (Intensive) or 10 clients on medication (Rehab). Outpatient programs must also have psychiatry time sufficient to allow the psychiatrist's participation in treatment reviews, especially where medications may be discussed, plus up to one hour per month for each new client to be assessed and one half hour per month per client on medications, for medication follow up.
- Head of Service and providing clinical direction: Most programs' contracts require that the Program Manager (Head of Service) be licensed. If the Program Manager is not licensed, there must be a Clinical Lead who can provide clinical supervision and perform certain tasks, such as diagnosing, that are within the scope of practice of licensed and waivered persons.

- Day Treatment staffing: per the requirements of Title 9, the program must maintain a client to staff ratio of 8:1 (for Intensive programs) and 10:1 (for Rehab programs) at all times.

- Staff counted in the ratio must be Qualified Mental Health Professionals or licensed or waivered. In addition, County guidelines require that at least half the clinical staff in Intensive programs be licensed/waived.

- Short Term Residential Treatment Program (STRTP) staffing: per Interim STRTP Regulations (Version II), STRTP shall have at least one full-time equivalent STRTP mental health program staff from the following list for each six children or fraction thereof admitted to the program.
  i. Physicians
  ii. Psychologist: licensed or waivered,
  iii. LCSW, LMFT, and LPCC: licensed/registered/waivered
  iv. RN
  v. LVN
  vi. Psychiatric Technicians
  vii. MHRS
  viii. Clinical Trainees
  ix. Medical Assistants

- Outpatient providers' ratio of clinicians/therapists to Clinical Trainees shall be no more than 1:3 FTE, i.e., there must be at least one FTE licensed clinician per 3 FTE Clinical Trainees. Clinical Trainees may provide psychotherapy services, under the close supervision of the clinician/therapist.
- CYF Contractors shall **budget 49 unduplicated clients per direct clinical FTE** (excluding trainees/students); with any exceptions requiring written rationale by program and written COR pre-authorization, noting that billable minutes based on the 1:49 ratio shall be maintained.
- Contractor AOA programs shall follow client to direct clinical FTE ratios as outlined in executed contract exhibits A &C.
- Interdisciplinary Teams: Programs must have an interdisciplinary team, mandated by standards of participation within the program SOW. Members must participate in the regularly scheduled interdisciplinary team meetings where cases are reviewed.
- Any exceptions to these requirements must be approved by the COR.

Use of Volunteers and Clinical Trainees

- Provider shall utilize family and community members as volunteers in as many aspects of the programming as possible, including teaching a special skill and providing one-on-one assistance to clients. Particular emphasis shall be made to recruit volunteers from diverse communities within program region.
- Particular emphasis shall be made to recruit volunteers from diverse communities within program region.
- Provider shall have policies and procedures surrounding both the use of volunteers and the use of employees who are also clients/caregivers.
- Licensed staff shall supervise volunteers, students, interns, mental health clients and unlicensed staff involved in direct client care.
- Clinical Trainees assigned to a program must have on file the written agreement between the school and agency with specific timelines which will act to demonstrate the official intern status of the student which determines scope of practice. Copy of document can be maintained in the Signature Log which often stores copies of staff qualifications.
- Signature Log and Documentation of Qualifications
- Each program shall maintain a signature log of all individuals who document in the medical record.
- Signature log contains the individual's typed/printed name, credentials/job title and signature.
- Included with the signature log, or in another accessible location, a copy of each individual's qualifications shall be stored (license, registration, waiver, resume, school contract, high school or bachelor's degree, documentation of COR waiver, etc.). This documentation is used to verify scope of practice.
- Program is responsible to ensure that current copy of qualifications (i.e., license, registration, etc.) is kept on file. Expired documents are to be maintained as they demonstrate qualifications for a given timeframe.

SIGNATURE ENTRIES AND COPIES OF QUALIFICATIONS OF STAFF THAT ARE NO LONGER EMPLOYED BY THE PROGRAM ARE TO BE MAINTAINED, AS THEY DOCUMENTED IN THE MEDICAL RECORD.

ADULT /OLDER ADULT SYSTEM OF CARE

Staffing

Commensurate with scope of practice, mental health and rehabilitation services may be provided by any of the following staff:

- Physician
- Licensed/Registered/Waivered Psychologist
- Registered Psychological Associate
- Licensed/Registered/Waivered Clinical Social Worker
- Licensed/Registered/Waivered Marriage and Family Therapist
- Licensed/Registered/Waivered Professional Clinical Counselor
- Nurse Practitioner
- Registered Nurse
- Licensed Vocational Nurse
- Medical Assistant
- Licensed Psychiatric Technician
- Mental Health Rehabilitation Specialist
- Other Qualified Provider (An individual at least 18 years of age with a bachelor's degree, high school diploma or equivalent degree plus two years of related paid or non-paid experience (including experience as a service recipient or care giver of a service recipient), or related secondary education. (see supervision and co-signature requirements)

CYF SYSTEM OF CARE

Staffing

- Contractor's program staff shall meet the requirements of Title 9, Division 1, Article 8 and Title 9, Chapter 11 of the California Code of Regulations as to training, licensure, and clinician/client ratios. All staff shall operate within the guidelines of ethics, scope of practice, training and experience, job duties, and all applicable State, Federal, and County standards. Contractor shall provide sufficient staffing to provide necessary services and Medicare approved services to Medicare covered clients. Current and previous documentation of staff qualifications shall be kept on file at program site.
- Psychotherapy shall be performed by licensed, registered, waivered, or Clinical Trainee (with co-signature by LPHA) staff in accordance with State law.
- Psychiatrists shall have completed a training program in a child or adolescent specialty (must be Board eligible in child and adolescent or adolescent psychiatry), for programs that serve youngsters under 13 years of age or have 5 years of experience offering psychiatric services to children and adolescents. Any exception to this must be approved by the Mental Health Services Clinical Director and the COR.
- Nurses and Psychiatric Technicians may bill Medication Support to Medi-Cal under the Medication Training and Support service code, as long as the service provided is within the individual's scope of practice and experience and documentation supports the service claimed. Qualified Mental Health Professionals (QMHP) / Mental Health Rehabilitation Specialist who provide direct, billable service must hold a BA and 4 years of experience in

- a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirements on a year for year basis. Up to two years of post-associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years of experience in a mental health setting. Staff work under the direction of a licensed or waivered staff member.
- Other Qualified Provider also referred to as Para Professional (An individual at least 18 years of age with a bachelor's degree, high school diploma or equivalent degree plus two years of related paid or non-paid experience (including experience as a service recipient or care giver of a service recipient), or related secondary education.
- Family / Youth Support Partners who provide direct, billable service must have direct experience as the parent, care giver, or consumer in a public agency serving children, and demonstrate education and/or life experience commensurate with job duties. Youth (at least 12 years of age and up to 25 years of age) must meet work permit requirements when applicable. Partners must receive ongoing training and work under the direction of a licensed or waivered staff member.
- All direct service staff shall have had one year of supervised experience with children and adolescents.
- Any exceptions to these requirements must be approved by the COR.

Peer Support Services

Provision of Peer Support Services.
Peer Support Services may be provided face-to-face, by telephone or by telehealth with the beneficiary or significant support person(s) and may be provided anywhere in the community.

Peer Support Specialists.
Contractor shall ensure that Peer Support Services are provided by certified Peer Support Specialists as established in BHIN 21-041.

Behavioral Health Professional and Peer Support Specialist Supervisors.
The Contractor shall ensure that Peer Support Specialists provide services under the direction of a Behavioral Health Professional. A Behavioral Health Professional must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of SMHS and DMC-ODS. Peer Support Specialists may also be supervised by Peer Support Specialist Supervisors, as established in BHIN 21-041.

Practice Guidelines.

Peer Support Specialists are required to adhere to the practice guidelines developed by the Substance Abuse and Mental Health Services Administration, What are Peer Recovery Support Services (Center for Substance Abuse Treatment, What are Peer Recovery Support Services?

HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services), which may be accessed electronically through the following Internet World Wide Web connection: www.samhsa.gov/resource/ebp/what-are-peer-recovery-support-services.

Peer Support Specialist Certification Qualifications

- Be at least 18 years of age
- Possess a high school diploma or equivalent degree
- Be self-identified as having experience with the process of recovery from mental illness or substance use disorder, either as a consumer of these services or as the parent, caregiver or family member of a consumer.
- Be willing to share their experience
- Have a strong dedication to recovery
- Agree, in writing, to adhere to a code of ethics
- Successfully complete the curriculum and training requirements for a peer support specialist
- Pass a certification examination approved by DHCS for a peer support specialist

Legacy Clause and Out of State Reciprocity

Criteria for individuals who are employed as a peer as of January 1, 2022, or individual certified out of state and are seeking to be certified:

- 1 year of paid or unpaid work experience (1550 hours) as a peer specialist AND 20 hours of continuing education (CEs), including law and ethics.

OR

- 1550 hours in 3 years, with 500 hours completed within the last 12 months, working as a peer specialist AND 20 hours of continuing education (CEs), including law and ethics.

And has all the following:

- Completion of a peer training(s)
- 3 Letters of Recommendation as outlined:

  - One from a supervisor
  - One from a colleague/professional
  - One self-recommendation describing their current role and responsibilities as a peer support specialist
- Pass the Medi-Cal Peer Support Specialist Certification Program Exam

Peer Support Specialist Supervisors

Supervisors must meet one of the following criteria:

- Have a Medi-Cal Peer Support Specialist Certification Program certification; have two years of experience working in the behavioral health system; and have completed a DHCS approved peer support supervisory training curriculum.

  OR

- Be a non-peer behavioral health professional (including registered & certified SUD counselors) who has worked in the behavioral health system for a minimum of two years and has completed a DHCS approved peer support supervisory training.

  OR

- Have a high school diploma or GED, four years of behavioral health direct service experience that may include peer support services; and have completed an approved peer support supervisory training curriculum.

N. DATA REQUIREMENTS

Data Collection and Retention

The contractor shall maintain daily records of services provided, including dates of service, times of service, total time of service, types of services provided, persons served, and progress of clients in meeting the objectives of the case plan. Data shall be recorded in accordance with the specifications in the EHR User's Manual. Service entry shall be kept up to date and the data shall be entered into the SmartCare Data System within a timely manner.

Accuracy of Data

Providers are responsible for ensuring that all client information, including addresses and demographic data, is accurate and meets State reporting requirements for Client Statistical Information (CSI). Providers must have processes for checking/updating client data and following the appropriate procedures when data corrections are needed. (See Section I)

In addition, Full-Service Partnership (FSP) programs are required to ensure that all required beneficiary data is current and up to date in both the EHR and State Database.

Financial Eligibility and Billing Procedures

Each provider is responsible for specific functions related to determining client financial eligibility, billing, and collections. The **Financial Eligibility and Billing Procedures - Organizational Providers Manual** is available on the Optum Public Sector website: https://www.optumsandiego.com/content/dam/san-diego/documents/organizationalproviders/billing-unit/billing-unit-manuals/FinancialEligibilityandBillingManualrev.110821-003.pdf for providers as a guide to determine financial eligibility, billing, and collection procedures. This manual includes the following procedure categories:

- Determining financial eligibility
- Billing, collections and payment procedures
- Corrections, adjustments and special requirements

This manual is not intended to replace the EHR User's Manual or intended to be a comprehensive "Insurance and Medicare Billing" guide. It is meant to augment existing resource materials.

Medi-Cal Administrative Activities (MAA)

Federal and State regulations (Welfare and Institutions Code, Section 14132.47, Medi-Cal

Administrative Activities) permit counties to earn federal Medi-Cal reimbursement for activities necessary to properly and efficiently administer a State's Medicaid (Medi-Cal) plan. These MAA activities are focused on assisting individuals in accessing the Medi-Cal Program and the services it covers through such functions as Medi-Cal and mental health outreach, facilitating Medi-Cal eligibility determinations, MAA coordination and claims activities, and other designated activities.

Organizational providers may be permitted to provide MAA services and claim them. The MHP requires that each organizational provider have a county-approved MAA Claiming Plan prior to claiming MAA services and that each provider complies with all applicable State and federal regulations. To claim for MAA activities, a provider must follow a set of procedures described in detail in the *MAA Instruction Manual* developed by the State Department of Health Care Services.

The MAA Coordinator provides technical assistance and training on MAA to providers. The coordinator can also assist with claiming and procedural questions or train staff on MAA.

There is a Medi-Cal Administrative Activities Procedures Handout for providers claiming MAA activities with an approved MAA claiming plan. This handout may be used for reference and training purposes. The handout and the MAA Community Outreach Service Record can be found on the Optum website.

Handout: https://www.optumsandiego.com/content/dam/san-diego/documents/organizationalproviders/references/MAA%20Procedures.pdf

MAA Community Outreach Service Record: https://www.optumsandiego.com/content/dam/san-diego/documents/organizationalproviders/references/MAA%20Service%20Record.pdf

Mental Health Services Act (MHSA)

MHSA Community Services and Support (CSS)
CSS providers are tasked with gathering program-specific information outlined in their contract and tracking data on the Quarterly Status Report (QSR). Additionally, CSS providers administer applicable treatment outcome data, and responses are recorded by the Contractor's staff within the EHR or as otherwise directed by the County. This database permits client results to be compiled for individual cases and by program.

MHSA Prevention and Early Intervention (PEI)
PEI providers are tasked with gathering specific demographic data and entering a four-question general survey into mHOMS. The mHOMS database is utilized to hold the data and is managed by the County's Data Centers (HSRC and CASRC). Data can be entered directly into the mHOMS database, or the Data Centers will extract from the contractor's database and enter it into mHOMS. Program-specific outcome and process data, as outlined in the contract, is captured in the Quarterly Status Report (QSR).

DATA REQUIREMENTS

MHSA Innovation

Innovation providers are tasked with gathering specific demographic data and entering a general question survey into mHOMS. The mHOMS database is utilized for gathering the data and is managed by the County's Data Centers (HSRC and CASRC). Data can be entered directly into the mHOMS database, or the Data Centers will extract data from the contractor's database and enter it into mHOMS. Program-specific data, as outlined in the contract, is captured in the Quarterly Status Reports (QSR).

MHSA Workforce Education and Training (WET)

WET providers are tasked with gathering specific demographic data. The mHOMS database is utilized for gathering the data and managed by the County's Data Centers (HSRC in conjunction with and CASRC). Data can be entered directly into the mHOMS database or the Data Centers will set up for extracts from contractor's database into mHOMS. Program specific data as outlined in contract is captured in the Quarterly Status Reports (QSR).

MHSA Full-Service Partnerships (FSP)

Several providers participate in MHSA Full-Service Partnerships, which provide mental health services to clients and link them with various community supports designed to increase self-sufficiency and stability. These providers are required to participate in a State data collection program (DCR), which tracks initial, specialized client assessments, ongoing key incident tracking, and quarterly assessments. The State has set timeframes for the provision of each type of data.

SYSTEMWIDE STATE REQUIRED PERFORMANCE MEASURES

External Quality Review Organization

California's External Quality Review Organization (EQRO) plays a crucial role in monitoring and evaluating the quality of care provided to Medi-Cal beneficiaries. CalEQRO is an independent entity contracted by the State to assess the performance of Behavioral Health Plans and ensure compliance with federal and state standards. The assessment of timeliness standards are detailed in the table below.

EQRO MH Metrics	Standard
First Non-Urgent Appointment Offered	10 Business Days
First Non-Urgent Appointment Rendered: *MHP Defined*	10 Business Days
First Non-Urgent Psychiatry Appointment Offered	15 Business Days
First Non-Urgent Psychiatry Service Rendered: *MHP Defined*	15 Business Days
Urgent Services Offered (Including all Outpatient Services)	48 Hours (Prior Authorization not Required); 96 Hours (Prior Authorization Required)
Non-Urgent Follow-up Appointments with a Non-Physician	Offered within 10 Business Days of the Prior Appointment

No show Rate-Psychiatry: *MHP Defined*	20%
No Show Rate-Clinician: *MHP Defined*	15%
Follow-Up Services After Psychiatric Hospitalization: 7 days & 30 days	MHP: 3 Business Days Reported: 7 + 30 Days

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a widely used set of performance measures in the healthcare system. These metrics are standardized by the National Committee for Quality Assurance (NCQA) and are used by health plans to assess performance in various areas of care and service. HEDIS metrics are updated annually by NCQA to reflect current clinical guidelines and healthcare priorities. HEDIS metrics provide a comprehensive framework for evaluating the effectiveness, safety, and patient-centeredness of healthcare services across different populations and settings. State required HEDIS metrics for Specialty Mental Health Services are detailed in the table below.

HEDIS State Metrics	Standard
AMM: Antidepressant Medication Management	1st year baseline reporting followed by >50th percentile (or 5% increase over baseline if <50th percentile)
SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia	
FUM: Follow-Up After Emergency Department Visit for Mental Illness	
FUH: Follow-Up After Hospitalization for Mental Illness	
APP: Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (SMHS + Foster care)	
APC: Use of Multiple Concurrent Antipsychotics in Children and Adolescents (SMHS: Foster care)	
ADD: Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (SMHS: Foster care)	
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics (SMHS: Foster care)	

State Required Patient Reported Outcomes, Adults

Consumer Satisfaction Surveys are valuable tools for assessing and enhancing patient-centered care within the mental health system. By systematically collecting and analyzing consumer feedback, they contribute to improved service delivery, better patient outcomes, and greater accountability in mental health care provision.

Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey

The MHSIP is a tool designed to gather feedback from individuals who have received mental health services. It aims to assess their satisfaction with various aspects of care and their experiences with mental health providers.

Outcome Mandated Metrics/Assessments	Frequency Standard
Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey	Annually

DATA REQUIREMENTS

State Required Patient Reported Outcomes, Children and Youth

Patient outcomes are fundamental measures used to assess the quality and effectiveness of healthcare services. These outcomes provide crucial insights into the impact of interventions, treatments, and overall care delivery on patients' health and well-being. Patient-reported outcomes (PROs) offer valuable perspectives directly from patients regarding their health-related quality of life, pain levels, functional status, and overall satisfaction with the care received. These indicators provide a holistic view of how well healthcare services meet the needs and expectations of patients beyond mere clinical effectiveness. Mandated assessments and patient-reported outcomes are included in the table below. Further details regarding each measure are also provided.

Data Collection and Retention

All treatment programs shall enter outcomes into the EHR for all clients. Data entry shall be completed promptly upon data collection at designated intervals, including intake, UM/UR authorization cycle, or every 6 months (whichever occurs first), and discharge.

Outcome Tools and Requirements

Measuring outcomes is an integral aspect of the System of Care principles. Standard outcomes have been established for all CYF treatment providers. Specialized programs may have individual program outcomes in addition to or in lieu of standard outcomes measured by all programs.

Outcome Mandated Metrics/Assessments	Frequency Standard
CANS-Child and Youth	Intake, 6 Months, Discharge
Pediatric Symptom Checklist, Parent/Caregiver (PSC): 3-18 years of age (Medication-only excluded)	Intake, 6 Months, Discharge
Youth Services Survey, Youth (YSS-Y): 13 years of age or older	Annually
Youth Services Survey, Family (YSS-F): Caregivers of youth up to age 18	Annually

The Child and Adolescent Needs and Strengths (CANS)

The CANS assessment is designed to support decision-making in child and adolescent services, particularly within mental health and child welfare systems. It evaluates the needs of children and youth, determines appropriate services, and monitors progress over time.

CANS Requirements

a) All child, youth, and transitional-age youth 6 to 21 years old in an outpatient treatment program shall have California-CANS completed within 30 days of their initial intake to the program and updated every 6 months and at discharge from the program. New admissions to a program who are within 6 months of turning 21 at intake are not required to complete the CANS assessment. California-CANS results shall be used to support medical necessity, treatment planning and clinical progress made in treatment. If the CANS was completed

within 60 days from the discharge date, a discharge CANS does not need to be administered. The prior CANS will be accepted as the discharge measure.

b) The 50 items in the CANS assessment are required. Follow-up modules are optional and can be an additional tool available to the program if it chooses to utilize them.
c) Staff who can complete the CANS: Licensed/Waivered Psychologist, Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist, Licensed/Registered Professional Clinical Counselor, Physician (MD or DO), and Nurse Practitioners.
d) The CANS' results shall be entered by program staff in the EHR, or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
e) As part of the CalAIM Assessment, CY clients shall have California-CANS completed within 30 days of their initial intake and updated at the UM/UR cycle (session-based for outpatient clients, 3 months for Day Treatment intensive, Day School Services and Residential OP, 6 months for Day Rehab) or every six months (whichever occurs first) and at discharge from the program. California-CANS results should be used to support medical necessity and clinical effectiveness.
f) The CANS' results shall be recorded by program staff in EHR, a web-based data entry system, or as the County directs. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
g) Data recorded in the database shall be supplied to CASRC via direct drop-off or traceable mailing to ensure compliance with HIPAA regulations.
h) CANS results are interrelated to the CalAIM Assessment and shall also be utilized as Service Necessity Criteria for Intensive Service Requests (ISR) and Specialty Mental Health DPRs.
i) Medication-only cases are excluded from the California-CANS measure**.**

Medication Only Clients

Outcome measures identify the effects of mental health treatment. Once clients transition from "Meds Plus" to "Meds Only," they will not be required to enter outcome measures in the EHR.

- Administer and record California-CANS and PSC as a discharge assessment upon transition to "Meds Only".
- Administer and record California-CANS and PSC as an intake assessment if the client returns to treatment services (Meds Plus) from meds only as a new episode in the EHR.

CANS Discharge Outcomes Objectives

- At discharge, 95% of clients ages 6-21 whose episode lasted 60 days or longer have CANS data available for initial and discharge assessment. At discharge, 100% of clients ages 6-21 whose episode lasted 60 days or longer, their initial CANS shall have at least one

actionable need (2 or 3) on the *Child Behavioral and Emotional Needs*, *Risk Behaviors,* or *Life Functioning* domain.

- For 80% of clients ages 6-21 whose episode lasted 60 days or longer, with an actionable need (rating of 2 or 3) on the *Child Behavioral and Emotional Needs, Risk Behaviors,* or *Life Functioning* domain, their number of needs shall lower by at least 3 from initial to discharge assessment, indicating improvement in symptoms/functioning.
- For 80% of clients ages 6-21 whose episode lasted 60 days or longer, with an actionable need (rating of 2 or 3) on the *Child Behavioral and Emotional Needs, Risk Behaviors,* or *Life Functioning* domains, their number of strengths shall increase by at least 1 from initial to discharge assessment, indicating the development of a strength.

Pediatric Symptom Checklist (PSC)

- Parents/Caregivers of all children and youth 3-18 years of age shall be administered the parent PSC shall complete at intake into the program, UM/UR cycle (session-based for outpatient clients, 3 months for Day Treatment intensive, Day School Services and Residential OP, 6 months for Day Rehab) or every six months (whichever occurs first) and at discharge from the program. When no parent/guardian is available, an individual in a caretaking capacity (i.e., residential staff, social worker, relative, etc.) may complete the measure.
- Most current PSC scores above the clinical cutoff should be considered during UM/UR Authorization, supporting medical necessity and clinical effectiveness.
- All responses shall be recorded by program staff in the EHR or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program

Youth Services Survey (YSS): Client Satisfaction

Currently administered annually to all clients and families who receive services during a selected one-week interval specified by the County MHP (excluding detention programs, medication-only cases, inpatient, and crisis services). The annual survey will be conducted in the Spring of each year. The survey returns are scanned to facilitate tabulation; therefore, the original printed forms provided by the MHP must be used.

a) Youth aged 13 and over complete the Youth Services Survey with the attached comments page.
b) Parents/caregivers of children and youth up to age 18 complete the Youth Services Survey-Family.
c) Surveys are to be administered to ensure full confidentiality, as directed by the Child and Adolescent Services Research Center (CASRC).
d) Completed surveys shall be completed via the secure link or delivered by hand to CASRC within 3 business days after each survey period has been completed, adhering to HIPAA regulations.

e) Medication-only cases are excluded from the YSS measure.
f) Programs exempt from completing the PSC (such as TBS or DEC) shall maintain written exception documentation from COR on file.

YSS Satisfaction Outcomes

- Submission rate of YSS-Y and YSS-F shall meet or exceed the 80% standard established by the County of San Diego Children's Mental Health.
- Aggregated scores on the YSS-Y and the YSS-F shall show an average of 80% or more respondents responding "Agree" or "Strongly Agree" for at least 75% of the individual survey items.
- Clients receiving services from a Substance Use Disorder counselor at an FSP Subunit shall show an average of 80% or more respondents responding "Agree" or "Strongly Agree" on each of the 7 supplemental items.

LEVEL OF CARE SPECIFIC OUTCOMES (ADULTS AND OLDER ADULTS)

Patient Reported Outcome Assessments, Adults and Older Adults

Adult Outcome Suggested Assessments	Frequency Standard
Milestones of Recovery Scale (MORS)	Intake, 6 Months, Discharge
Level of Care Utilization System (LOCUS)	Intake, 6 Months, Discharge
Recovery Markers Questionnaire (RMQ)	Intake, 6 Months, Discharge
Illness Management and Recovery (IMR)	Intake, 6 Months, Discharge

Milestones of Recovery Scale (MORS)
MORS is a single-item evaluation tool the clinician uses to assess a client's degree of recovery. Ratings are determined by considering three factors: the client's level of risk, their level of engagement within the mental health system, and their level of skills and support. The MORS form must be completed within 30 days of the client's admission, every 6 months thereafter, and at discharge. Clinicians at outpatient programs complete MORS.

Level of Care Utilization System (LOCUS)
The LOCUS is a short assessment of client current level of care needs and is completed by program staff. Program staff should complete a LOCUS for all clients within 30 days of their initial intake assessment, every 6 months thereafter, and at discharge.

Recovery Markers Questionnaire (RMQ)
A consumer-driven assessment of the client's own state of mind, body, and life, and involvement in the recovery process. The RMQ is used to assess the client's recovery from the client's

perspective. Program staff must collect the intake RMQ during the client's first 30 days in the program. All clients should complete follow-up RMQs every 6 months and at discharge.

Illness Management and Recovery (IMR)

The IMR is used to assess the client's recovery from the clinician's perspective. It ranks a client's biological vulnerability and socio-environmental stressors. The IMR also includes questions about changes in a person's residential, employment, or education status. Staff must complete the IMR within 30 days of their initial intake assessment. Follow-up IMRs should be completed every 6 months after intake and at discharge for all clients.

Outcome Measures Manual

For more information about outcomes measures, the Outcome Measures Manual is available on the Optum website at https://www.optumsandiego.com/content/dam/san-diego/documents/organizationalproviders/manuals/Outcome_Measures_Manual_San_Diego_CSS_Programs_UPDATED_20190619.pdf.

Patient Reported Outcome Assessments, Children and Youth

Child/Youth & TAY Outcome Assessments	Frequency Standard

Pediatric Symptom Checklist (PSC)

- The PSC is provided to caregivers of children and youth 3-18 years of age at intake into the program, UR cycle (session-based for outpatient clients, 3 months for Day Treatment intensive, Day School Services and Residential OP, 6 months for Day Rehab) or every six months (whichever occurs first) and at discharge from the program.
- Most current PSC scores above the clinical cutoff should be considered during UM/UR Authorization, supporting medical necessity and clinical effectiveness.
- All responses shall be recorded by program staff in the web-based CYF-mHOMS database or as otherwise directed by the County. This database, when utilized, shall permit client results to be compiled for individual cases and by program.
- Medication-only cases are excluded from the PSC measure.
- Programs exempt from completing the PSC (such as TBS or DEC) shall maintain written exception documentation from COR on file.

PSC Discharge Outcomes

- At discharge, 75% of clients ages 3-18 whose episode lasted 60 days or longer have Parent PSC data available for both Initial and Discharge assessments demonstrating completion rate.
- For 80% of discharged clients ages 3-18 whose episode lasted 60 days or longer, the Parent PSC total score shall show a 3-point improvement (reduction in symptoms) between Initial and Discharge assessments.

- Report the number of clients ages 3-18 who scored at or above the clinical cutoff on the initial PSC assessment.
- 80% of discharged clients whose episode lasted 60 days or longer shall show improvement on the PSC by either falling below the clinical cutoff or having a 3-point reduction in symptoms.
- Report the number of discharged clients ages 3-18 whose episode lasted 60 days or longer, whose Initial Parent PSC total score was above the clinical cutoff, and whose total score was below the clinical cutoff at discharge, demonstrating improvement.
- Report the number of clients ages 3-18 whose episode lasted 60 days or longer, with a 3-point improvement (reduction in symptoms) between Initial and Discharge assessments, demonstrating improvement.

Additional Children and Youth Outcome Objectives

All Providers

- 100% of all clients, ages 16 and older, shall be assessed for transitional service needs as evidenced by documentation in the medical record.
- 100% of all clients shall be assessed for domestic violence issues as evidenced by documentation in the medical record.
- 100% of all clients shall be assessed to determine the need for referral to a primary care physician as evidenced by documentation in the medical record.
- 80% or more of all clients shall receive at least one face-to-face family treatment contact/session per month with the client's biological, surrogate, or extended families (who are able).

Outpatient Providers

- 90% of clients will not require psychiatric hospitalization or re-hospitalization during the outpatient episode.
- Outpatient programs shall meet or exceed the minimum productivity standard for annual billable time by providing at least 54,000 minutes per year (50% productivity level) for clinic, school, and community-based programs per FTE, unless otherwise specified in the program's Statement of Work.
- Psychiatrist shall maintain a minimum of 75% productivity level.
- RN shall maintain a minimum productivity level of 55%.
- Case Management services provided by a case manager shall meet or exceed the minimum productivity for annual billable time by providing at least 32,400 minutes per year (30% productivity level) per FTE, unless otherwise specified in the program's Statement of Work.
- Clinical staff shall carry a minimum client load of 40 unduplicated clients per FTE per year unless otherwise specified in the program's Statement of Work.

- Case Managers shall carry a minimum client load of 20 unduplicated clients per FTE per year unless otherwise specified in the program's Statement of Work.

Day Treatment providers

- The contractor shall ensure that billable client days are produced for 90% of the annual available client days, based on five (5) days per week or a 230-day year.
- 95% of clients will be discharged to a lower level of care unless otherwise specified in the contract.
- 95% of clients will avoid psychiatric hospitalization or re-hospitalization during the Day Treatment episode.

Research Projects Involving Children's Mental Health Clients

Some providers may develop research projects or test additional outcome tools with methods that utilize MHP clients. All such projects must be reviewed by the MHP's Research Committee. Approval is required prior to implementation. For more information on BHS research procedures contact BHSResearch.HHSA@sdcounty.ca.gov.

Additional Outcome Measures

Additional statistical data may be required in your specific contract. This may involve using additional tools for Evidence-Based Programs or specific parts of the system. Your contract may also require the manual collection of data on certain outcomes from client charts, such as the number of hospitalizations, readmissions, arrests, or changes in the level of placement/living situation. The data collected should be submitted on your QSR or as directed by your Program's COR or Health Plan Operations, QA unit.

O. TRAINING

The increasing focus and requirements on cultural sensitivity, outcome measures, practice guidelines, electronic health record and evidence-based practice necessitates the need for ongoing training. Many providers have a contractual obligation to participate in identified trainings within 60 days of hire or when trainings become available. Some trainings are to be tracked on MSR/QSR:

- Cultural Competency Training – Minimum of four hours annual requirement for all staff. When an in-service is conducted, program shall keep on file a training agenda and a sign-in sheet for all those in attendance with sign-in/out times. For outside trainings, certificate of completion shall be kept on file at the program. Contractor shall maintain and submit a Cultural Competence Training Log annually.
- BHS Disaster Support Training e-learning access is available through the BHS Training and Technical Assistance website. A minimum of 25% of contracted staff need to be disaster trained.
- System of Care training e-learning access is available through the BHS Training and Technical Assistance website. All direct service staff shall complete e-learning about BHS System, CWS System, and Pathways to Well-being.
- Continuing Education Units (CEUs) -- Contractor shall require clinical staff to meet their licensing requirement. Other paraprofessional staff shall have a minimum of sixteen (16) hours of clinical training per year.
- Contractor shall attend trainings as specified in their Contract.
- CYF Contractor shall obtain training on the DCR System for FSP programs. Trainings are available through Child and Adolescent Services Research Center (CASRC) at: (http://www.casrc.org)
- Family and Youth Support Partners trainings are available through NAMI San Diego. Contact the Peer & Family Support Helpline at 1-800-523-5933.

The Quality Assurance Unit

The Quality Assurance Unit provides trainings and technical assistance on topics related to the provision of services in the Child, Youth & Family and the Adult/Older Adult Systems of Care.

Training and information is disseminated through:

- Basic Medi-Cal/County Standards Documentation Training
- Root Cause Analysis Training
- Smartcare Health Electronic Health Record User Trainings through CalMHSA LMS
- QA Specialized Trainings
- Regular QA Communications
- Organizational Provider Operations Handbook

- Provider Meetings
- TKC—The Knowledge Center

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

Electronic Health Record Trainings

Various hands-on trainings are available for the Electronic Health Record through CalMHSA LMS system and the CalMHSA Knowledge Base website .

All clerical staff are required to attend all SmartCare LMS Trainings as determined by their staff role in order to have access to the system for entering data and pulling reports with option supplemental live training.

Any staff entering billing for services are required to complete the CalMHSA LMS SmartCare for Billing Staff and Smartcare Basics for all Users.

Specialized staff are required to attend SmartCare Calendar Management for Providers training to be able to enter staff into the scheduling system and to set appointments for clients.

All clinicians and all other qualified staff are required to have completed all applicable training in the CalMHSA LMS System in order to complete assessments, and service notes. Clinicians will also learn how the Calendar Management will work for their caseload and services.

Psychiatrists and prescribing staff including Nurses are required to have training in CalMHSA LMS to complete the SmartCare Basics, SmartCare Calendar Management, Front Desk Staff Training, Clinical Workflow for Clinicians-Life Cycle of a Client, and SmartCare for Prescribers, Nurses, and Med Support Staff. , Additional specific training on the CalMHSARxfor e-prescribing is also required. Prescribers, and nurses who stage medications for prescribers, will have access toCalMHSARx. Prescribers who need to be set up to electronically prescribe controlled substances (EPCS) must additionally go through an identity proofing process and a soft or hard token must be established within their account. Both primary and backup tokens are required in SmartCare.

Information about SmartCare EHR trainings may be found on the Optum website under the "BHS Provider Resources" tab and selecting SmartCare Training. Additional resources can be found on the CalMHSA Knowledge Base website and MHP Provider Documents page under the 'SmartCare' site link also located on the Optum San Diego website at: https://www.optumsandiego.com

P. MENTAL HEALTH SERVICES ACT - MHSA

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA) which became law on January 1, 2005. The vision of the MHSA is to build a system in which mental health services are more accessible and effective, utilization of out-of-home and institutional care is reduced, and stigma toward those with serious mental illness (SMI) or serious emotional disturbance (SED) is eliminated. The MHSA was designed to provide funds to counties to expand services, develop innovative programs, and integrate service plans for children, adults and older adults with a serious mental illness. The MHSA provides resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth (TAY), adults, older adults, and families. It also addresses a broad continuum of prevention and early intervention needs, and the necessary infrastructure, technology, and training to effectively support the public mental health system.

The MHSA work plan consists of five components:

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Innovations (INN)
- Capital Facilities and Technological Needs (CF/TN)
- Workforce Education and Training (WET)

MHSA Full-Service Partnerships

A number of providers are participating in MHSA Full-Service Partnerships, which provide mental health services to clients and link them with a variety of community supports, designed to increase self-sufficiency and stability. Full Service Partnership (FSP) programs advance goals to reduce institutionalization and incarceration, reduce homelessness, and provide timely access to help by providing intensive wraparound treatment, rehabilitation, and case management. The FSP program philosophy is to do "whatever it takes" to help individuals achieve their goals, including recovery. Services provided may include, but are not limited to, mental health treatment, medical care, and life-skills training. Funds can also be used to fund permanent supportive housing or housing supports. These providers are required to participate in a State data collection program which tracks initial assessments, specialized client assessments, ongoing key incident tracking and quarterly assessments. The State has set timeframes for provisions of each type of data.

MHSA System Transformation

Under the MHSA, community-based services and treatment options in San Diego County have been improved, expanded, and transformed by:

1. Increasing Client and Family Participation
2. Serving More Clients
3. Improving Outcomes for Clients
4. Decreasing Stigmatization
5. Minimizing Barriers to Services
6. Increasing Planning and Use of Data
7. Increasing Prevention Programming
8. Including Primary Care in the Continuum of Care
9. Using of Proven, Innovative, Values-Driven and Evidence-Based Programs

With the passing of the Mental Health Services Act the law called for the establishment of the Mental Health Services Oversight and Accountability Commission (MHSOAC). The MHSOAC is responsible for oversight of the MHSA implementation. The MHSOAC holds counties accountable for a number of outcomes. The outcomes include decreases in racial disparities, hospitalizations, incarcerations, out-of-home placements and homelessness while increasing timely access to care. Other outcomes may be required as the State and County evaluate MHSA services. Contractors receiving MHSA funding are responsible for complying with all and any new MHSA requirements.

For current information on MHSA visit:

https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mental_health_services_act/mhsa.html

For current MHSOAC information visit: http://www.mhsoac.ca.gov/

Q 1. Budget & Fiscal Instructions for Cost Reimbursement Contract

This document includes additional instructions (*in italics*) to help clarify the intent of the requirements and guidelines.

Contractors prepare program budgets for County review and approval. The approved budget for each fiscal year serves as objectives and guidelines for contract performance, and determination of allowable and appropriate expenditures. The budget guidelines allow for flexibility within specified dollar limits, and states conditions when prior written County approval must be obtained before contractors are allowed to exceed the specified limits for discretionary variance from the approved budget. It is expected that budgets submitted by providers will include all expenses that are needed to support the program during the fiscal year.

Budget

The annual contract amount is specified in the contract and supported by an annual budget developed by the contractor. Contractor must obtain written prior approval from the County and a Contract Amendment must be executed before exceeding the fiscal year's approved budget. Unspent funds from one fiscal year may not be applied to subsequent fiscal year's expenditures unless authorized and supported by a Contract Amendment.

If expenses are within the allowable limits stated below, no prior approval or change to the budget is required, though all expenses must always be reasonable and appropriate for the contracted services and are subject to subsequent review and disallowance. Any expenditures requiring written approval must be requested in advance and approved by the COR. Approval is not effective, and contractor should not incur any requested expense, until notified.

Invoice

Where the term "invoice is used in Service Agreement Article 4, "cost report" may be substituted as appropriate.

Total Direct Labor Cost

Reimbursable direct labor cost for direct labor and program management staff incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such cost in Exhibit C, Contractor's Budget. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Salaries and Benefits category plus any allowable unexpended Operating Expenses without the prior written approval of the COR.

The contract does provide some flexibility to transfer funds between Direct Labor Costs and Other Direct Costs. An adjustment to Direct Labor costs is allowed if it results in no net change to the total annual contract maximum. Guidance for allowed budget adjustments is listed below.

- Unexpended Salaries and Benefits (S&B), up to 10% of total annual S&B budgeted amounts with a dollar value up to $100,000, may be applied to Operating Expenses.

Budget adjustments greater than 10% to Direct Labor cost; or 10% or less than to Direct Labor but with a dollar value greater than $100,000 require prior approval from the COR. Only budget adjustments up to 10% to Direct Labor cost with a dollar value up to $100,000 do not require prior approval from the COR. Example:

Example 1: The total Salaries and Benefits amount for a program budget equals $500,000, and contractor expects to spend less than $430,000. Of the $70,000 in projected unspent funds for this category, up to $50,000 (10% of the $500,000 Total Approved Budget with the dollar value less than $100,000), may be applied to Operating Expenses without requiring prior approval or change to the budget.

Example 2: The total Salaries and Benefits amount for a program budget equals $600,000, and contractor expects to spend less than $570,000. The entire $30,000 in projected unspent funds for this category, which is less than the limit of $60,000 and with the dollar value less than $100,000, may be applied to Operating Expenses without requiring prior approval or change to the budget.

- Unexpended Salaries and Benefits that may be applied to Operating Expenses may be from temporary vacancies of budgeted staff.

Contractor shall not purposefully keep positions vacant for the purpose of accruing savings to be used for Operating Expenses. When staffing levels are reduced due to reduced workloads, then it is expected that operating expenses would be similarly underspent. The intent is to fill all budgeted positions and to provide services to clients. Unspent funds due to other reasonable circumstances may be applied to Operating Expenses.

- Unexpended Salaries and Benefits may be applied directly to any temporary replacement staff and do not require prior County approval as long as costs do not exceed amounts budgeted for these positions.

Temporary and/or replacement staff should be listed in the Salaries and Benefits category and are not subject to prior approval as long as the total of Salaries does not exceed the budgeted amount

plus 10% with a dollar value less than $100,000 for this category.

- Staffing changes, including addition or deletion of budgeted staff, shall require prior COR approval. Individual salaries may be exceeded up to 5% without prior COR approval.

Adequate and appropriate staffing is normally the most important factor in the successful delivery of contracted services. Any permanent change to the number (FTEs) or classification of staff requires prior written approval. Salaries for each classification may be listed as averages, and individual salaries may be exceeded up to 5% without prior written approval by the COR, as long as the overall 10% rule is heeded. NOTE: Bonuses, incentive pay, and other types of special employee pay require prior written approval by the COR and must comply with Office of Management and Budget (OMB) Guidelines

Total Other Direct Cost

Reimbursable operating costs incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such expenses in Exhibit C. The sum of any and all such expenditures shall not exceed the total amount budgeted for the Operating Expenses category plus any allowable unexpended Salaries and Benefits without the prior written approval of the COR.

The contract does provide some flexibility to transfer funds between Direct Labor Costs and Other Direct Costs. An adjustment to Other Direct costs is allowed if it results in no net change to the total annual contract maximum. Guidance for allowed budget adjustments is listed below.

- Unexpended Operating Expenses (OE), up to 10% of total annual OE budgeted amounts with a dollar value up to $100,000, may be applied to Salaries and Benefits.

All budget adjustments greater than 10% to Operating Expense cost; or 10% or less than to Operating Expense Cost but with a dollar value greater than $100,000 require prior approval from the COR. Example:

Example: If the total Operating Expenses for a program budget equals $300,000, any unspent amount, up to a maximum of $30,000 (10% of the total budget for this category with the dollar value less than $100,000), may be applied to Salaries and Benefits without requiring prior COR approval.

- The budgeted amounts for Operating Expenses line items may be exceeded up to the amount stated in Behavioral Health Services Administrative Adjustment Request (AAR) Guidelines as long as the total of all items does not exceed the total budgeted Operating Expenses (including any allowable unexpended Salaries and Benefits, except for asterisked line items. Overspending by more than the allowable amount per AAR Guidelines on these Operating Expense budget line

items will require a one-page Administrative Adjustment Request (AAR) form. The AAR form must be submitted clearly describing the justification for overspending, the budget line items and amounts affected.

Example: If $1,000 is budgeted for Office Supplies AAR Guideline allowed to exceed up to $5,000, a total expense to date of $1,500, will not require prior approval or change to the budget unless the total Operating Expenses amount exceeds the approved amount in the budget. NOTE: all expenses must be reasonable and appropriate for the contracted services, and are subject to subsequent review and disallowance.

- Consulting expenses shall be budgeted on Agreement Budget and shall not be exceeded without prior COR approval, with the exception of temporary staffing. All other consulting services or Subcontracts not previously budgeted shall require prior written COR approval.

- Budgeted amounts for Leasehold Improvements, Consultants, Subcontracts, Interest Expense and Gift Cards and Depreciation shall not be exceeded without prior written COR approval.

- Budgeted amounts for Client's Flex Funds may exceed up to $1,000. Costs above $1,000 require prior written approval by the COR.

- No expense shall be allowed for any line item that does not have an amount currently budgeted.

Expenses without a budget require prior COR approval and detailed justification. Additional expenses due to emergencies and/or unforeseen circumstances for line item(s) that have a $0 budget will be reviewed on a case-by-case basis. These expenses are not allowed to be claimed in other line items that were not intended for these types of expenses.

Fixed Assets

All fixed asset expenses shall be budgeted and itemized on the Agreement Budget, and no fixed asset budget line item shall be exceeded without prior written COR approval.

The purchase of fixed assets that are not listed on the budget require prior written approval. Fixed assets include all non-expendable property with a value of $5,000 or more and a normal life expectancy of more than one year.

Purchase of fixed assets that are budgeted on the itemized Supplemental A and any assets not currently budgeted require written notification to the COR.

Total Indirect Cost

Reimbursable indirect costs incurred by Contractor in the performance of this Agreement shall be limited to the total amount budgeted for such cost in Exhibit C. The sum of any and all such costs shall not exceed the total amount budgeted for the Indirect Cost category without the written approval of the COR. Reimbursable indirect costs shall be limited such that the ratio of actual total Indirect Cost to actual total Gross Cost shall not exceed the ratio of budgeted Indirect Cost to budgeted Gross Cost.

If the total budget is underspent, it is expected that Indirect Costs would decrease proportionately.

Mental Health providers with Housing Budget: (applicable only for contracts that remained at Cost Reimbursement)

Member Housing Line Item. This amount is to be utilized exclusively for the member housing (i.e. 'brick and mortar') paid by the program and does not include Housing Staff and/or related costs. This line item will be reported in the Full Housing cost center. While all Housing Costs must be reflected in the Full Housing Cost Center, there will not be an amount specified in the allocation letter for the Full Housing Cost Center: programs will have the discretion to determine how much of the total program budget to allocate to the Full Housing Cost Center when completing program budgets. The goal is to increase flexibility for programs with regard to costs for Housing Staff (without reducing funding allocated to Member Housing), and to ensure the amount allocated for Member Housing is clear and consistent.

<u>Mental Health Budget Template and BHS Housing Budget Instructions:</u>

- All Housing costs must be reflected in the Full Housing Cost Center.
- The Operating Expenses budget tab now have a row labeled 'Member Housing'. This line should match the Member Housing allocation amount and is asterisked. It cannot be changed without COR preapproval.
- The Operating Expenses budget tab now have a row labeled 'Augmented Member Housing' cost. This line is expected to be blank at the start of fiscal year and will only be filled with COR approval via an AAR when the program receives one-time funding for additional Member Housing funding and/or is approved to move money in an AAR to cover additional Member Housing costs. This line is also asterisked and can't be changed without COR preapproval**.**

Units of Service

Units of Service are the most critical element of the program budget, and the budgeted units of service

may not be changed without prior written approval by the COR. Delivery of service below budgeted levels may be considered a performance matter and subject to corrective action.

Start-Up Funds (for Procurement Budget only)

Start-up funds shall be subject to available funding, negotiations and shall be at the sole discretion of the County. This shall be limited to one-time costs of newly awarded contracts and shall be used for the development and implementation of a new or expanded program or service.

- The budget and timelines for expending start-up funds must be approved by the county
- Shall not be available for option years
- Shall not exceed 10% of the annual budget of the first year of contract
- A separate cost center for start-up funds shall be included in the proposed budget for the initial contract period and expenditures shall be tracked separately from ongoing expenditures
- If multiple funding sources are identified within the contract, a plan to allocate the start-up costs amongst various funding sources shall be required and budgeted appropriately to reflect the funding ratios amongst the various funding sources
- Start-up costs will be reimbursed based on actual costs (cost reimbursement). Contractor shall comply with Cost Reimbursement Contract requirements. At a minimum, submit an acceptable Cost Allocation Plan and keep an Inventory List, according to Article 2.4 of the Service Template

<u>Examples of expenditures that may be approved include:</u>

- Costs of staff hiring
- Initial staff training and development related to a new program or operation (ongoing training and development should be included in the annual operating budget)
- Minor equipment
- Supplies and materials
- Licenses and permits
- Tenant Improvements

<u>Start-up funds shall not be used:</u>

- To supplant or supplement ongoing or routine operating expenses
- For ongoing or routine program activities
- To improve an existing program or service

At the end of the determined start-up period, an evaluation of the start-up expenditures shall be made and remaining start-up funding may be rescinded at that time. Expenditures that do not meet the start-up criteria may be disallowed and subject to reimbursement.

Other Revenue Sources

Behavioral Health Services Contractor shall determine and claim revenues from all other applicable sources other than the County as reimbursement for the cost of services rendered to clients pursuant to this Agreement and in compliance with all applicable rules and regulations (the current version of which can be found online at the BHS Technical Resource Library http://www.sandiegocounty.gov/content/sdc/hhsa/ programs/BHS/technical_resource_library.html). For further guidance, please refer to the below links.

- Mental Health - Financial Eligibility and Billing Procedures - Organizational Providers Manual
- Substance Use - Drug Medi-Cal Organizational Providers Billing Manual

Multiple Programs/Cost Centers

In agreements that have multiple programs with separate budgets submitted for each program, any adjustment between individual program budgets shall have the prior written approval of the COR. Any excess funds shall remain and be utilized in the program where originally allocated or may be reallocated by the COR for other appropriate services.

Accounting System

Contractor shall use an accounting and timekeeping system for segregating, supporting, controlling, and accounting of all funds, property, expenses, salaries, wages, revenues, and assets for each County of San Diego contract distinct from other contractor activities. Contractor shall have the ability to provide assurance that the system is in accordance with generally accepted accounting principles and federal Office of Management and Budget (OMB) Circulars, located within the applicable Code of Federal Regulations. Accounting and timekeeping systems are subject to review during in-depth invoice reviews and audits conducted by the County.

Other Fiscal Instructions: Invoices are due 30 days after end of invoice month unless other due dates are required by specific funding sources unless otherwise instructed by COR.

2. Budget & Fiscal Instructions for Fixed Price or Fee-For-Service (FFS) Contracts

The approved budget for each fiscal year serves as objectives and guidelines for contract performance, and determination of allowable and appropriate invoicing within the fixed Price or FFS set by the State o contracts as agreed in the Exhibit C of the contract. The Exhibit C provides budget guidelines that may allow flexibility within specified dollar limits, and states conditions when prior written County approval or amendment must be obtained before contractors are allowed to exceed the specified limits from the approved budget. It is expected that budgets submitted by providers will include all expenses that are needed to support the program during the fiscal yea

Budget & Fiscal Instructions for Contracts Only *(Contractor Instructions)*

Budget

The annual contract amount is driven by the Fixed Price or FFS set by the State or agreed in the contract. If the rate is driven by the State, the rate is automatically adjusted to match the rate. If the rate is based on negotiated rate between the County and Contractor or a Fixed Price, a Contract Amendment must be executed before exceeding the fiscal year's approved budget. Unspent funds from one fiscal year may not be applied to subsequent fiscal year's expenditures unless authorized and supported by a Contract Amendment.

Invoice

The reimbursable invoice submitted to the County includes the agreed rate multiply the units of service or the billing milestone completed.

Units of Service

Units of Service are the most critical element of the program budget for the FFS contract and may be necessary as well for Fixed Rate contract depending on the Statement of Work.

Other Revenue Sources

Contractor shall determine and claim revenues from all other applicable sources other than the County as reimbursement for the cost of services rendered to clients pursuant to this Agreement and in compliance with all applicable rules and regulations. For further guidance, please refer to SUDPOH and COSD BHS Drug Medi-Cal Organizational Providers Billing Manual.

Ancillary Claims:

Some contracts may allow ancillary expenses that can be claimed at cost. Please refer to your Exhibit C language for information of the ancillary expenses added to a FFS contracts.

Accounting System

Contractor shall have use of an accounting system for segregating, supporting, controlling, and accounting of all funds, expenses, and revenues for each County of San Diego contract distinct from other contractor activities. Contractor shall have the ability to provide assurance that the system is in accordance with generally accepted accounting principles and federal Office of Management and Budget (OMB) Circulars, located within the applicable Code of Federal Regulations.

Other Fiscal Instructions: Invoices are due 30 days after end of invoice month unless other due dates are required by specific funding sources unless otherwise instructed by COR. Contractor must comply with fiscal reporting requirements upon request by County, State, or Federal.

Budget & Fiscal Instructions for Hybrid Contract Only

Follow the requirements and guidelines under Cost Reimbursement and Fixed Price/ FFS Contract.

Behavioral Health Services Funding Source Requirements (Contractor Instructions)

Medi-Cal Requirements

Invoices for Payment of Medi-Cal Services. Contractor shall enter required data based on eligibility and services rendered to each Medi-Cal beneficiary into the appropriate County-designated County Data System. Contractor shall enter data on each beneficiary or group within the time required by the County.

The validity of Contractor's data input is subject to State, County, Federal or other funding source review and approval. County will make payments in advance of the State, Federal or other funding source review and approval, and in advance of the reimbursement by the State, Federal or other funding to County for sums expended thereunder. In the event the State, Federal, other funding source or County disapprove any billing, whether previously paid to Contractor, Contractor shall take all necessary actions to obtain approval of the disallowed billing. If Contractor is unsuccessful, Contractor shall reimburse County in the full amount of the disallowed billing within thirty days of County's request or, at the sole discretion of County, County may withhold such amounts from any payments due under this Agreement or any other agreement, including successor agreements, County has entered into or will enter into with Contractor.

Penalty for Failure to Qualify Short-Doyle/Medi-Cal & Drug Medi-Cal Visits. (Rev. 9/11/08)
If County experiences a payment reduction in a Short Doyle/Medi-Cal & Drug Medi-Cal claim due to Contractor's failure to qualify the visit under Short-Doyle/Medi-Cal & Drug Medi-Cal program (failure to claim or failure to respond to inquiry) then County will reduce Contractor's reimbursement by an amount commensurate with Contractor's budgeted unit cost and the prevailing Federal Financial Participation (FFP) of Medi-Cal and EPSDT for the Agreement period.

MH_UMDAP_Requirements Paragraph (rev 5-12-09)

Behavioral Health Services, Mental Health Requirements:
Mental Health contractors who utilize the electronic Mental Health Information System shall comply with the Organizational Provider Financial Eligibility and Billing Procedures Manual.

Uniform Method of Determining Ability to Pay (UMDAP)

If a Mental Health contractor provides mental health services and is not otherwise excluded from determining the financial eligibility of patients they shall request, and assist in processing, UMDAP fees from patients as set forth in this Paragraph and this Agreement and comply with the Organizational Provider Financial Eligibility and Billing Procedures Manual. Contractor shall base its fees upon the patient's ability to pay for such services. Contractor shall determine the patient's ability to pay in accordance with the "Uniform Method of Determining Ability to Pay" (UMDAP) promulgated by the State of California Department of Mental Health. Contractor shall determine the appropriate UMDAP patient fees for its patients. In no event, however, shall the fees charged to patients (or to other third-party payers) pursuant to this Agreement exceed Contractor's estimated actual cost for such services. No patient shall be denied any services offered by Contractor under this Agreement because of inability to pay for such services.

R. QUICK REFERENCE

DIRECTORY

ACCESS AND CRISIS LINE (ACL)	(888) 724-7240
ACL FAX	(619) 641-6975
COUNTY OF SAN DIEGO MHP ADMINISTRATION	(619) 563-2700
Local Mental Health Director	(619) 563-2700
Medical Director	(619) 563-2700
Quality Management Unit – Program Manager	(619) 641-8802
Serious Incident Reporting Line	(619) 641-8800
QM FAX	(619) 236-1953
QM Email	QIMatters.hhsa@sdcounty.ca.gov
PIT Unit– Program Manager	(619) 584-5015
PIT Email	BHSQIPIT@sdcounty.ca.gov
MIS Unit– Program Manager	(619) 584-3004
MIS Help Desk:	(619) 584-5090
MIS Help Desk Email:	MHEHRSupport.HHSA@sdcounty.ca.gov
CalMHSA Help Desk:	833-686-6801
CalMHSA Help Desk Email:	calmhsa.sandiego@Buchanan-mail.onbmc.com
CalMHSA Access Issues:	SUDEHRSupport.HHSA@sdcounty.ca.gov
Contract Administration Unit Manager	(619) 563-2733
Claim Submission FAX	(619) 563-2730
MHP Compliance Hotline	(866) 549-0004
MAA Coordinator	(619) 563-2700
Mental Health Billing Unit	(619) 338-2612
FAX	(858) 467-9682
Email	mhbillingunit.hhsa@sdcounty.ca.gov
County Health Information Management Dept. (HIMD)	(619) 692-5700 Option #3 (Medical Record Requests)

OPTUM (ADMINISTRATIVE SERVICES ORGANIZATION)

Provider Line	(800) 798-2254 Option #7
Optum Administrative Services for MHP	(619) 641-6800
Admin FAX	(619) 641-6801
Optum Support Desk	(800) 834-3792
OPTUM Help Desk Email	SDHelpdesk@optum.com
Clinical-Access and Crisis Line	(619) 641-6802
TDD/TTY	(619) 641-6992

CLIENT ADVOCACY ORGANIZATIONS

Consumer Center for Health Education and Advocacy	(877) 734-3258

JFS Patient Advocacy Program	(800) 479-2233

AMERICAN SIGN LANGUAGE (ASL) INTERPRETER SERVICES

Deaf Community Services	(619)398-2441
Videophone	(619) 550-3436
Interpreter's Unlimited	(858) 451-7490

INTERNET RESOURCES

County of San Diego	www.sdcounty.ca.gov
Optum	www.optumsandiego.com
CalMHSA	https://2023.calmhsa.org/
CalMHSA Live Chat Support	https://2023.calmhsa.org/live-chat-support/
California Board of Behavioral Sciences	www.bbs.ca.gov
California Board of Psychology	www.psychology.ca.gov
CA Code of Regulations	www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx
California Department of Health Care Services	www.dhcs.ca.gov
California Medi-Cal Website	www.medi-cal.ca.gov
County Behavioral Health Directors Association of California	www.cbhda.org
California Welfare & Institutions Code	leginfo.legislature.ca.gov/faces/codes.xhtml
Center for Medicare and Medicaid Services	www.cms.hhs.gov
Community Health Improvement Partners	www.sdchip.org
Disability Benefits 101	https://www.db101.org/
211 San Diego (Social Services Database)	www.211sandiego.org
Intentional Caregiver Website	www.intentionalcaregiver.com
Psychiatric Rehabilitation Association	www.psychrehabassociation.org
Joint Commission on Accreditation of Healthcare Org.	www.jointcommission.org
National Institute of Mental Health (NIMH)	www.nimh.nih.gov
Office of Inspector General Exclusion List	www.oig.hhs.gov
GSA Excluded Parties Listing System (debarment)	www.gsa.gov
Social Security Online	www.socialsecurity.gov or www.ssa.gov
Ticket to Work Program	www.yourtickettowork.com
Voter Registration Services – Secretary of State	www.sos.ca.gov/elections/elections_vr.htm Or (800) 345-VOTE