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

Organizational Provider Operations Handbook Adult/Older Adult Services

[Appendix to Mental Health Plan]

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ABBREVIATIONS REFERENCE GUIDE

ACL – Access and Crisis Line
AMHS – Adult Mental Health Services
A/OAMHS – Adult/Older Adult Mental Health Services
ASP – Augmented Services Program
ASW – Associate Social Worker (registered with the BBS)
BBS – Board of Behavioral Sciences
B&C – Board and Care
CA-QOL – California Quality of Life (client survey)
CMUMC – Case Management Utilization Management Committee
CCHEA – Consumer Center for Health Education and Advocacy
CCISC – Comprehensive, Continuous Integrated System of Care
CCR – California Code of Regulations
CCRT – Cultural Competence Resource Team
CFR – Code of Federal Regulations
CMHS – Children’s Mental Health Services
CMS – County Medical Services
COTR – Contracting Officer’s Technical Representative
DCS – Deaf Community Services
DHS – Department of Health Services (State of California)
DMH – Department of Mental Health (State of California)
DSM-IV-TR – Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
ECR – Error Correction Reports
EPU – Emergency Psychiatric Unit
FFP – Federal Financial Participation
FFS – Fee-For-Service

FTE – Full-Time Equivalent
HHSA – Health and Human Services Agency
HIPAA – Health Insurance Portability and Accountability Act
HMO – Health Maintenance Organization
ICM – Intensive Case Management
IMF – Intern Marriage and Family Therapist (registered with the BBS)
IMD – Institute of Mental Disease
LCSW – Licensed Clinical Social Worker
LPS – Lanterman-Petris-Short (Conservatorship)
McFloop – Multi-Use Complete Feedback Loop
MFT – Marriage and Family Therapist
MHP – Mental Health Plan
MHS – Mental Health Services
MHSIP – Mental Health Statistics Improvement Program
MIS – Management Information Systems
MSR – Monthly Status Report
NOA-A – Notice of Action – Assessment
NOA –B – Notice of Action
OIG – Office of Inspector General
OP - Outpatient
P&T – Pharmacy and Therapeutics Committee
PCR – Program Contract Representative (Program Monitor)
PSR – Psychosocial Rehabilitation
QI – Quality Improvement
QM – Quality Management
QRC – Quality Review Council
SMA – Statewide Maximum Allowances
SDCMHA – San Diego County Mental Health Administration
SDCPH – San Diego County Psychiatric Hospital
SF/LTC – Secure Facility/Long-Term Care
SNF/STP – Skilled Nursing Facility/Special Treatment Program
SOC – Systems of Care
TAR – Treatment Authorization Request
TBS – Therapeutic Behavioral Services
TBI – Traumatic Brain Injuries
UBH – United Behavioral Health
UMDAP – Uniform Method for Determining Ability to Pay
UR – Utilization Review
URC – Utilization Review Committee
USD – University of San Diego (Patient Advocacy Program)
W&IC – Welfare & Institutions Code (State of California)

A. SYSTEMS OF CARE (SOC)

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

The mission of the Health and Human Services Agency is: “Through partnerships, and emphasizing prevention, assure a healthier community and access to needed services, while promoting self-reliance and personal responsibility.” Mental Health Services adds to that mission: “To provide quality, cost-effective mental health treatment, care, and prevention services by dedicated and caring staff to people in the service population.”

Client Population Served by the Mental Health Plan (MHP)

Clients with serious mental illness who are:

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

Psychosocial Rehabilitation and Recovery

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

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

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

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

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

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

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

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

- San Diego Charter adoption and implementation
- COMPASS completion
- Action Plan development
- Program Policies:
 - Welcoming Policy/Statement
 - MHS Co-occurring Disorders Policy
 - Other
- Training and supervision of staff in Integrated Treatment Practice Model
- Integrated Screening
- Integrated Clinical Assessment
- Integrated Psychiatric Assessment
- Implementing Stage of Change Interventions

- Measure of client progress as evidence in the client plan and in progress notes (Outcomes: stage of change level, number of relapses, reduction of alcohol/drug use by type, number of months clean and sober, other)
- QI Baseline Monitoring Tool compliance

For additional information on the Dual Diagnosis initiative, please refer to the County of San Diego Health and Human Services Agency, Adult/Older Adult Mental Health, Children’s Mental Health Services, Alcohol and Drug Services Charter and Consensus Document for Co-occurring Psychiatric and Substance Abuse Disorders, March 2003; and the County of San Diego, Mental Health Services Policy and Procedures Specialty Mental Health Services for Clients with Co-occurring Substance Use Problems No. 01-06-117, February, 2004, and the HHSA, Dual Diagnosis Strategic Plan, 2002.

Services to Older Adults

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

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

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

Services to Youth in Transition

In recent years, the existence of a significant mental health service gap for youths 18-24 transitioning from the Children's Mental Health (CMH) System of Care to the Adult Mental Health (AMH) System of Care has been identified as a serious issue. To address this issue, the County of San Diego, HHSA MHS has implemented the Youth Transition Services Plan. This plan identifies transitional youths' needs and existent resources, addresses services gaps, and makes recommendations to the AMH and CMH Systems of Care. This transition plan is the blueprint for the improvement of youth transition services within the mental health system.

The mission of the Youth Transition Services Plan is for CMH and AMH Systems of Care to work in partnership with youths on developing and implementing services that are developmentally and culturally appropriate. To accomplish this mission, both systems are working to address the unique needs of youths and to integrate a seamless referral process. Two sets of policies have been developed to support the implementation of this process. The Youth Transition Self-Evaluation Policy defines the process for identifying the mental health needs of transitional age youths and ensuring that comprehensive services are available to youths transitioning from the CMH system to the AMH system. The Transition Age Youth Referral Policy initiates a process for the transition of clients whose needs present unusual challenges for our system.

Adult and children's mental health providers shall coordinate with each other and seek appropriate consultation to ensure that the unique needs of this population are met. An ongoing team shall work to address issues regarding services and coordinate the varied agencies that provide services for this population. This group recently developed the Transitional Youth Resource Directory to ensure that those working with this population have accurate information on available services for these youths.

For additional information on the Youth Transition Services Plan, please refer to the County of San Diego, HHSA MHS, Mental Health Youth Transition Services Plan, July 2000, Transitional Age Youth Referral Policy (No. 01-01-114) and Youth Transition Self-Evaluation Policy (No: 06-01-113).

Peer-Supported Recovery and Rehabilitation Services

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

Road to Recovery, which offer volunteers the opportunity to use their consumer experiences to help educate and support others.

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

Homeless Outreach Services

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

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

Homeless Funds

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

Emergency Shelter Beds

The homeless outreach services staff is the gatekeepers and manager of the utilization of short-term shelter beds located in all the regions, with the exception of the South region. The County's program monitor oversees the purchase orders and approves on a monthly basis the utilization of these beds. The following is a current list of shelters utilized by the homeless outreach staff:

Broadway Home
Center for Community Solutions
Chipper's Chalet
Char-Lou Manor
MPH Guest Home
North County Interfaith Council
Volunteers of America

Additional References:

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

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

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

B. COMPLIANCE AND CONFIDENTIALITY

The County of San Diego Health and Human Services Agency (HHS) is committed to maintaining a culture that promotes the prevention, detection and resolution of instances of conduct that do not conform to laws, rules, regulations, or County policies or procedures.

County Compliance Programs

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

For more information:

HHS Code of Conduct and Statement of Incompatible Activities:

http://hhsa_intranet.co.san-diego.ca.us/policy/mpp/m/m1_2.pdf

HHS Compliance Program:

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

Provider Compliance Programs

Each contractor is required to have an internal compliance program to ensure that all applicable Federal and State laws are followed. At all times during the term of the provider's contract, contractor shall maintain and operate a compliance program that meets the minimum requirements for program integrity as set forth in 42 CFR 438.608. Failure to establish and maintain a compliance program, as required by this section, shall be considered a material breach of the contract. In addition, organizational providers share some elements of the MHP's compliance program.

Elements of a Compliance Program

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

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

Code of Conduct Standards

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

Compliance Standards

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

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

MHP's Compliance Hotline

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

Documentation Requirements

All organizational providers are recipients of Federal funds and as such are required to prepare and maintain appropriate medical records on all clients receiving services in compliance with Title 9, Chapter 11 and 42 CFR guidelines. The provider is expected to meet all documentation requirements established by the MHP in the preparation of these medical records. This includes all providers of outpatient, case management, and crisis residential services. The MHP has the responsibility to prepare and maintain the Documentation and Uniform Clinical Record Manual (DUCRM), which outlines the MHP's requirements and standards in this area. Also contained within the DUCRM is the Documentation Requirements Grid. This grid lists detailed and specific documentation requirements for the most commonly used CPT and HCPCS codes of the MHP. The Quality Improvement Unit distributes copies of the MHP's most recent version of the DUCRM annually throughout the organizational provider system. A copy may also be obtained at anytime by contacting County Medical Records (619) 692-5700.

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

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

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

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

CONFIDENTIALITY

The maintenance of client confidentiality is of primary importance, not only to meet legal mandates, but also because of the fundamental trust inherent in the services provided through the MHP.

MHP Responsibilities

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

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

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

Provider Responsibilities

- Each provider will act in accordance with good judgment, clinical and ethical standards and State and Federal law to ensure that all written and verbal communication regarding each client's treatment and clinical history is kept strictly confidential.
- Every provider must have policies, procedures and systems in place to protect the confidentiality (or security) of health information and individual rights to privacy. Requirements include safeguards to prevent intentional or accidental misuse of protected health information and sanctions for employee violations of those requirements.
- Each provider must train all members of its workforce on the policies and procedures with respect to protected health information. The provider must document that the training on confidentiality has been provided. At a minimum, documentation of training shall consist of a signed acknowledgement by the member of the workforce specifying which training has been received and the date the training was taken. The provider must

retain the documentation of the training for six years. These training records will assist the provider in identifying where supplementary training needs to be conducted if there are changes in the privacy or security regulations.

- Every provider must have in place a Confidentiality Agreement for all workforce members. The Confidentiality Agreement should sufficiently identify the type of information to be protected, the workforce's/vendor's responsibility to protect it, and methods that must be used to protect it in order to assure confidentiality and to comply with Health Insurance Portability and Accountability Act (HIPAA) regulations. The Agreement must include a signed statement from the workforce member/vendor saying that he or she has received the information related to the maintenance, disclosure, or destruction of confidential information. This statement must be signed within a reasonable period of time after the person joins the provider's workforce. Additionally, providers must be able also to access documentation showing that all vendors and business partner personnel with access to protected information have also signed such agreements with their employers.
- Every provider must provide a written notice of information practices known as a "Privacy Notice" to all clients and must include:
 - Mandated reporting requirements when a client presents as an imminent danger to self or others;
 - Mandated reporting requirements concerning the abuse or neglect of children or older adults;
 - The review of records by third party payers for authorization or payment purposes;
 - All clients are to receive a "Program" Notice of Privacy Practices (NPP) when they first enroll for services;
 - Any client receiving services under the Mental Health Plan (e.g., Medi-Cal clients) are to receive a second "Mental Health Plan" NPP upon enrollment;
 - All Mental Health Plan clients are to receive a reminder NPP at least once every three years.
- Providers are encouraged to have adult clients read and sign a "Consent for Treatment Form."

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

Specific Procedures for Providers

Each provider and its agents, employees and representatives shall comply with all applicable provisions of the California Welfare and Institutions Code. Provider shall follow all pertinent Federal, State, and County regulations for safeguarding client medical records and

confidentiality. Before services commence, provider shall have in place County-approved policies and procedures for:

- Storage and maintenance of open and closed cases;
- Limiting access to medical records and any other client information among levels of staff;
- Assuring that the Adult Mental Health Services (AMHS) Documentation and Uniform Clinical Record Manual standards for the type of service provided are adhered to;
- Assuring that information in the medical record is organized, clear, complete and current.

Claiming and Reimbursement of Mental Health Services

When providing reimbursable mental health services, providers are required to utilize all available payor sources appropriate for reimbursement of services. Many clients have one or more insurance sources (e.g., Medicare, indemnity, PPO, HMOs, Medi-Cal) and it is the responsibility 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**. You may also obtain a copy of this manual by visiting the Technical Resource Library at www2.sdcountry.ca.gov/hhsa. Click on All Services A-Z, then Mental Health Services Act, and select Technical Resource Library from the drop down menu.

FALSE CLAIMS ACT

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

- Billing for services not rendered or goods not provided.
- Falsifying certificates of medical necessity and billing for services not medically necessary.
- Billing separately for services that should be a single service.

C. ACCESSING SERVICES

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

In accordance with Title 9, California Code of Regulations requirements, organizational providers and County-operated clinics must maintain logs of all persons requesting Specialty Mental Health Services. Required information includes the date of inquiry, client’s name, nature and degree of urgency of the request, and disposition of request. A sample copy of a Request for Services Log is located in *Appendix C*.

Emergency Psychiatric Condition

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

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

Urgent Psychiatric Condition

Title 9 defines an “Urgent Psychiatric Condition” as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition.

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

Routine Condition

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

QI Goal for Services: System wide average of nine (9) calendar days from initial contact to mental health assessment. This number is a system wide weighted average for all adult providers. Each year, providers are given a specific benchmark goal for wait times for their individual program based on past performance and QI goal for the current fiscal year. If you do not know your current benchmark, please contact the QI unit.

ACCESS AND CRISIS LINE: 1-800-479-3339

United Behavioral Health (UBH) operates the statewide San Diego County Access and Crisis Line (ACL) on behalf of the San Diego County Mental Health Plan (MHP). The ACL, which is staffed by licensed and master's level counselors, provides telephone crisis intervention, suicide prevention services, and mental health information and referral 24 hours a day, seven days a week. The ACL may be the client or the family's initial access point into the MHP for routine, urgent or emergency situations.

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

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

The ACL has Spanish-speaking counselors on staff. Other language needs are met through the Language Line, which provides telephonic interpreter services for approximately 140 languages at the point of an initial ACL screening. Persons who have hearing impairment may contact the ACL via the TTY line at (619) 641-6992.

Authorizations for Mental Health Plan Services Provided by the ACL

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

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

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

Referrals to the ACL

It is appropriate to refer individuals to the ACL for:

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

Providers should inform clients about the option of their directly using the Access and Crisis Line by calling 1-800-479-3339. Clients should be given clear directions on how to use the ACL.

Provider Interface with the ACL

- Use the ACL as an adjunct to provider services in emergencies and after hours. To provide the most effective emergency response and back-up to their own services, provider office voice mail messages should state, “If this is a mental health emergency or crisis, please contact the Access and Crisis Line at 1-800-479-3339.”
- If a client is high risk and may be calling the ACL for additional support, the client’s therapist or care coordinator may call (with client’s approval) the ACL in advance on behalf of the client. (Please obtain a signed Release of Information from the client). To facilitate the most effective ACL response to the high-risk client’s needs when he or she calls, please provide the ACL with all relevant clinical and demographic information.

Receiving Referrals from the ACL

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

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

Hours of Service Availability

In accordance with 42 CFR, providers serving Medi-Cal clients must ensure service availability by offering hours of operation that are no less than the hours of operation offered to commercial clients. If the provider serves only Medi-Cal clients, the hours of service availability must be the same for fee-for-service and managed care clients. Providers are also expected to ensure that hours of operation are convenient to the area's cultural and linguistic minorities.

The MHP QI Unit will monitor availability of service hours at the annual Site Review. Problems with availability will be monitored through examination of the provider's Internal Problem Resolution/Transfer Log and the Grievance/Appeals Logs of the MHP contracted advocacy organizations.

Available Language Assistance

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

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

Interpreters can be qualified staff members at the provider site. Consistent with the AMHS Cultural Competency Standards, contractors are encouraged to develop and maintain staff's language competency for threshold languages. If no qualified staff is available, with the approval of the program manager or designee, program staff can contact Interpreters Unlimited (for language interpreting) at (800) 726-9891 or Deaf Community Services (DCS) (for hearing impairment) at (619) 398-2488 to arrange for free language assistance. If for some reason DCS is unable to provide for sign language services, providers may call Network Interpreting as a back up only at (800) 284-1043. If there is a need to use Network Interpreting, providers should document why DCS was not utilized. As soon as the services have been rendered, the provider will fill out a Service Authorization Form (*See Appendix C*).

The completed form will be faxed to Interpreters Unlimited or Deaf Community Services or Network Interpreting (back up only). The interpreting services will then submit an invoice to the MHP.

To comply with State and federal regulations, providers must be able to provide information on Mental Health Plan (MHP) services to persons with visual or hearing impairment, or other

disabilities, making every effort to accommodate an individual's preferred method of communication.

Client Selection of a Provider

In accordance with 42 CFR and Title 9, providers are reminded that clients have the right to obtain a list of MHP providers, including information on their location, hours of service, type of services offered, and areas of cultural and linguistic competence. Information about organizational providers is posted on the *Network of Care* website (www.networkofcare.org), and in the *Organizational Provider Resource Manual*, which may be obtained through the Quality Improvement Unit by calling (619) 563-2776. Information on fee-for-service providers is available from UBH. When feasible, beneficiaries will be provided with the initial choice about the person who provides specialty mental health services, including the right to use culturally specific providers.

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

Clients Who Must Transition 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 to the AMHS system, and completion of internships and field placements. The transition is likely to be difficult and disruptive to clients. Good clinical practice indicates that the following should be implemented whenever possible:

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

ACCESSING SECURE FACILITY/LONG-TERM CARE (SF/LTC)

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.

Referral Process

United Behavioral Health (UBH), 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 United Behavioral Health (UBH) 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 and medical doctor [MD])
7. Hospital face sheet
8. Proof of current Medi-Cal coverage (an Automated Eligibility Verification System [AEVS] strip from the hospital business office) or alternative funding for all ancillary services
9. Current completed Mini Mental Status Exam
10. Current lab reports
11. Result of purified protein derivative (PPD) (tuberculosis [TB] test) or clean chest x-ray from current hospitalization
12. Recommendation and information from the case manager, if possible

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

The UBH 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 UBH 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 UBH LTC Medical Director or his/her designee may complete an independent on-site evaluation of the referred individual. The Secure Facility/Long-Term Care Placement Committee shall review the information when it is established that the referred individual meets the admittance requirements for SF/LTC.

Target Population

The persons served should have the potential to benefit functionally from psychiatric rehabilitation services and have the capacity to progress to a less restrictive level of care. The client must have an Axis I psychiatric diagnosis (as the primary diagnosis) and meet the Medical 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 conservator. The age range is from 18 through 64 years, although persons 65 and older may be admitted to treatment programs as an exception, if it is determined they can benefit from the program.

Eligibility Criteria for Admittance to SF/LTC

To County-Funded Secure Facilities/Long-Term Care

Individuals must meet all of the following criteria:

1. have met Title 9 medical necessity criteria for psychiatric inpatient services at time of referral.
2. be unable to be maintained at a less restrictive level of care.
3. have an adequately documented Axis I diagnosis of a serious, persistent, major, non-substance-abuse-related mental disorder as stated in Title 9. This diagnosis must not be primarily a manifestation of mental retardation or other developmental disorder. Clients may also have a concurrent diagnosis on Axis II or have a substance abuse diagnosis as a concurrent Axis I diagnosis. An Axis II diagnosis alone is not, however, sufficient to meet criteria.

4. have the potential to benefit from psychiatric rehabilitation services and potential to progress to a less restrictive level of care.
5. be gravely disabled as determined by a court's having established a temporary or permanent public or private San Diego County Lanterman-Petris-Short (LPS) Conservatorship. Grave disability is defined in the Welfare and Institutions Code 5008, Section (h)(1)(A)... "A condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic needs for food, clothing, or shelter."
6. be a resident of San Diego County who is both indigent and referred by the San Diego County Psychiatric Hospital or who has San Diego Medi-Cal as his primary insurance or alternative funding for all ancillary services.
7. not be entitled to comparable services through other systems (i.e., Veterans Administration [VA], Regional Center, private disability insurance, Forensic system, etc.).
8. be 18 to 64 years old, although persons 65 and older may be admitted, as an exception, if it is determined that they can benefit from the program.
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.
13. be an individual between the age of 18 and his/her 21st birthday and must also meet the following criterion:
 - a. have been offered or considered for services by Therapeutic Behavior Services. A certification form shall be completed.

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 13 criteria for admittance to County-funded secure facilities. In addition:

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

To a State Psychiatric Hospital

Individuals must meet all of the following criteria:

1. Individual must meet all of the criteria for admission to a Secure Facility/Long-Term Care, with the exception of #12 above.
2. Be a current or recurrent danger to self or others, which includes chronic or recurrent episodes of assaultive or suicidal behavior.
3. All admissions to State Hospitals shall be approved by the County Adult/Older Adult Mental Health Services Medical Director.
4. Individual shall be on San Diego County LPS Permanent Public Conservatorship.

Reviews of Determination Decisions

Situations may arise in which the referring agency does not agree with the decision regarding admittance. The attending M.D., the conservator/client or the referring agency may request a review of the decision by notifying the San Diego County Adult/Older Adult Mental Health Director in writing within three business days. A copy of the request shall also be sent to the UBH Long-Term Care Coordinator and the County Long-Term Care Manager. This request shall include submission of the following information:

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

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

Placement

For individuals who have been accepted into SF/LTC, the Secure Facility/Long-Term Care Placement Committee makes placement decisions.

Information about clients accepted for SF/LTC services is presented at a weekly Secure Facility/Long-Term Care Placement Committee meeting to determine optimal placement. 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. The UBH LTC Coordinator is responsible for notifying the referral agency as to the outcome after the placement decision. At times, placement in a County-funded, out-of-County located program may be appropriate. In these cases, the following criteria shall be met:

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

Placement in a State Hospital

When a client has been approved for admittance to a State Hospital by the San Diego County Adult/Older Adult Mental Health Services Medical Director, and 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 admittance to a State Hospital. Certification must be obtained from the appropriate Assistant Deputy Director that funds are available to support the placement. In addition, the County Case Manager/Conservatorship designee shall notify the facility and the UBH LTC Coordinator of the discharge and transportation date and time. The referring facility shall have the client and the client's belongings ready to be transported.

Services to Undocumented Clients

In accord with County and State policy, the Uniform Method of Determining Ability to Pay (UMDAP) does not require that a person have a specific period of residence in the county or state to qualify for services. Intent to reside in San Diego County is a necessary condition, and is established by the client's verbal declaration. This applies to foreign nationals, including undocumented immigrants. Without intent to reside in San Diego County, any client, regardless

of citizenship, must be billed at full cost. However, persons known to be undocumented immigrants are eligible only for emergency services, such as an acute care hospital or the EPU.

D. PROVIDING SPECIALTY MENTAL HEALTH SERVICES

Coordination of Care: Creating a Seamless System of Care

Coordination of care among inpatient and outpatient service providers is essential for a mental health system to work efficiently. As the client may move between different levels of care, it is vital that service providers communicate with each other to provide continuity of care for the client. This also supports the clients' efforts to return to, achieve and maintain the highest possible level of stability and independence. The MHP Systems of Care stipulates that the provider shall provide each client with a care coordinator as the "single point of accountability" for his or her rehabilitation and recovery planning, and service and resource coordination. The MHP monitors coordination of care.

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

72-Hour Post Discharge Coordination of Care

Clients who meet the criteria for needing "urgent" services shall be seen within 72 hours. All clients whether existing or newly referred to your program after being discharged from a crisis residential, psychiatric hospital facility, or locked/IMD placement meet the "urgent" criteria and shall be seen within 72 hours. The MHP requires that providers confirm that clients were referred to an outpatient program, psychiatrist, or other licensed mental health care provider, with a verified outpatient appointment within 72 hours. To assist with tracking of admissions for existing clients, providers are expected to check the morning reports that are generated each day from the InSyst MIS. Providers are expected to track client discharge referrals and follow-up appointments. A sample of a 72-Hour Post Discharge Log is located in *Appendix D*.

Monitoring Coordination of Care

Inpatient medical record reviews include retrospective review of documentation to confirm that clients were referred to an outpatient program, psychiatrist or other licensed mental health care provider upon discharge. Outpatient reviews include review of chart documentation and the 72-Hour Post Discharge Log to verify outpatient appointments within 72 hours of discharge.

Outpatient Services

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

- Calling the organizational provider or County-operated program directly
- Walking into an organizational provider or County-operated program directly
- Calling the Access and Crisis Line at 1-800-479-3339

When the provider conducts an assessment of a client who has called or walked into the program, that provider is responsible for entering administrative and clinical information into all the appropriate fields in the InSyst system. Providers must register clients, record episode and service activities, and update the Care Coordination field in InSyst. See the Management Information Systems section of this Handbook for a description of how the InSyst system supports these provider activities.

If the Access and Crisis Line refers a client to an organizational provider or to a County-operated facility, the ACL opens a record in eCura (a computerized client data system) for each client. If the client is new, he or she will be concurrently registered in InSyst. The provider's program staff is then responsible for recording all ongoing activity for that client into InSyst. This information includes, but is not limited to, episode and service activities, the name of the client's Care Coordinator, the Care Coordination Plan, and all client episode closings.

Medical Necessity for Outpatient Services

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

Note: Title 9 can be accessed through the state website at www.calregs.com. For a hard copy of Title 9, please call the State Office of Administrative Law at 916-323-6225.

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

1. The client must have a diagnosis included in the Diagnostic and Statistical Manual, Fourth Edition (DSM IV-TR) that is reimbursable for outpatient services as described in Title 9, Section 1830.205(1).
2. The client must have at least one of the following as a result of the mental disorder(s):
 - A significant impairment in an important area of life functioning; or
 - A probability of significant deterioration in an important area of life functioning.
3. All of the following:
 - The focus of proposed intervention is to address the significant impairment or probability of significant deterioration in an important area of life functioning;
 - The proposed intervention is expected to benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning; and
 - The condition would not be responsive to physical health care treatment.

SPECIFIC PROCEDURES AND CRITERIA FOR OUTPATIENT CARE

Clarification of Service Mix for Programs

On May 24, 2006, a special meeting was held with providers to discuss certain issues pertaining to Short-Doyle/Medi-Cal and other health coverage, including Medicare. Attendees were provided with clarification on what San Diego County Adult/Older Adult Mental Health System's expectations are for service mix of its organizational provider programs effective July 1, 2006. The following is the information that was presented:

- Case Management (CM) programs are only authorized to provide case management brokerage, individual and group rehabilitation, collateral, and occasional crisis intervention services.
 - Note that the evaluation completed when a client enters a case management program is designed to determine case management and rehabilitation needs and should be coded as a Rehab Evaluation.
- Assertive Community Treatment (ACT) programs are authorized to provide primarily case management brokerage and individual and group rehabilitation, collateral and occasional crisis intervention services.
 - ACT programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity, medication support services and some psychotherapy.
- Outpatient Biopsychosocial Rehabilitation Programs (OP/BPSR) are authorized to provide primarily individual and group rehabilitation, collateral, medication support, case management brokerage and occasional crisis intervention services.
 - OP/BPSR programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity and some psychotherapy.
- Crisis Residential Programs are authorized to provide medication support services, and crisis residential services bundled as a 24-hour service.

Clinical Assessment for Medical Necessity

At the time a client is admitted to a program, clinicians shall perform a face-to-face assessment to ensure that each new client meets medical necessity criteria for specialty mental health services. According to service mix outlined above, the clinician shall complete the appropriate assessment form as indicated in the AMHS' Uniform Clinical Record Manual and ensure that all relevant clinical information is obtained and documented.

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

Outpatient Providers

Within one month after the first planned visit, an Assessment and Client Plan shall be completed. If, after completing the assessment, the clinician determines that medical necessity criteria for

specialty mental health services are not met, the client will be issued an NOA-A (see more complete description of the process in the Beneficiary Rights and Issue Resolution chapter of this Handbook) and his/her beneficiary rights shall be explained.

Case Management

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

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

OUTPATIENT CASE MANAGEMENT PROGRAMS

Case Management Service Eligibility

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

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

- Has current LPS Conservatorship (may be a designated County Conservator or family member);
- Has been hospitalized or received involuntary psychiatric treatment within the past year;
- Is at high risk of admission to an inpatient mental health facility;
- Has a substantial need for supportive services (including care coordination and outreach mental health services) to maintain current level of functioning in the community, as evidenced by missed appointments, medication non-adherence, or inability to coordinate services from multiple agencies;
- Does not have a case manager from another program who is able to address mental health needs.

Clients receiving case management services are reviewed by the program's Utilization Review Committee (URC) to determine continuation of case management services and/or changes in the same level of case management.

Levels of Case Management

Three levels of case management services are available: Intensive, Traditional and Institutional.

- ***Intensive Case Management (ICM)*** programs provide a high level of mental health, rehabilitation and case management services, and have a staff to client ratio of approximately 1:10-15. Services, offered on a '24/7' basis, are delivered frequently and include a wide range of direct services. For example, ACT programs usually provide all medication management services to their clients.
- ***Traditional Case Management*** services provide a mix of mental health, rehabilitation and case management functions and have a staff-to-client ratio of approximately 1:35. Clients are evaluated in person at least monthly or by phone as clinically indicated, and it is expected that the case manager will have contact with significant others at least monthly. Services may be provided on a much more frequent basis, depending on client need.
- ***Institutional Case Management*** services are provided to clients who reside in the State Hospital, or in out-of-county or in-county Institutes of Mental Disease (IMD) or Skilled Nursing Facilities (SNF). Services consist primarily of linking, coordinating and monitoring functions and have a staff-to-client ratio of up to 1:100. Clients are contacted at least quarterly.

Referral Process for Case Management

Case management programs may receive referral information from any source. The program receiving the referral may determine that it is best able to serve the person, and will open the case. If the program receiving the referral determines the person might be better served through

another provider, contact is made with the other program and the referral is forwarded for review. Each program maintains a log of all referrals and referral dispositions.

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

Augmented Services Program

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

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

- Have a DSM-IV-TR Axis I or Axis II primary diagnosis of a serious mental disorder;
- Have an active case open to A/OAMHS case management program and have been evaluated by their care coordinator to be in need of ongoing case management services. The assigned case manager is the only person who can submit a request for ASP services;
- Reside in an ASP contracted facility;
- Score in the eligible range on the ASP scoring tool; and
- ASP funds must be available for the month(s) of service.

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

Inpatient Services for Medi-Cal Beneficiaries

Pre-Authorization Through UBH

Organizational Provider Operations Handbook

PROVIDING SPECIALTY MENTAL HEALTH SERVICES

Inpatient service providers must secure pre-authorization for all inpatient services for Adults/Older Adults through the UBH Provider Line, 1-800-798-2254, option #2, except:

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

Medical Necessity for Adult/Older Adult Inpatient Services

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

- The client must have a diagnosis included in the Diagnostic and Statistical Manual, Fourth Edition (DSM IV-TR) that is reimbursable for inpatient services as described in Title 9, Section 1830.205(1).

AND

Both of the following:

- The condition cannot be safely treated at a lower level of care;
 - Psychiatric inpatient hospital services are required as a result of a mental disorder and the associated impairments listed in 1 or 2 below:
 1. The symptoms or behaviors:
 - a. Represent a current danger to self or others, or significant property destruction;
 - b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter;
 - c. Present a severe risk to the beneficiary's physical health;
 - d. Represent a recent, significant deterioration in ability to function.
- OR
2. The symptoms or behaviors require one of the following:
 - a. Further psychiatric evaluation; or
 - b. Medication treatment; or
 - c. Other treatment that can reasonably be provided only if the patient is hospitalized.

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

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

Crisis Residential Services

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

Mental Health Services to Parolees

On a regular basis, individuals are discharged on parole from California State penal institutions (list of institutions located in *Appendix D*). 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:

1. Parolees who fall under the Forensic Conditional Release Program (CONREP) will be provided services in accordance with the current contract between the California Department of Mental Health and the County of San Diego.
2. 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. Parolees with Medi-Cal coverage can receive inpatient services at any County-contracted acute care hospital. Indigent parolees can receive inpatient services at the San Diego Psychiatric Hospital.
3. Parolees who are Medi-Cal beneficiaries and who meet specialty mental health medical necessity requirements, as specified in CCR, Title 9, Section 1830.205, will be provided appropriate Medi-Cal covered mental health services.
4. Parolees, whether or not they are Medi-Cal beneficiaries, who do not meet specialty mental health medical necessity requirements will be referred for services at the local Department of Corrections-established outpatient mental health clinic, which is designed to meet the unique treatment needs of parolees, or to another health care provider.
5. Parolees who are not Medi-Cal beneficiaries and who do meet specialty mental health medical necessity requirements will be informed of the availability of services at the local Department of Corrections-established outpatient mental health clinic, and may choose to receive services from either County Mental Health or from the local Department of Corrections outpatient mental health clinic.

6. The California Welfare & Institutions Code, Section 5813.5 (f), explicitly prohibits the use of Mental Health Services Act (Proposition 63) funds for services to parolees. Managers of County and contracted programs which receive MHSA funding, are, therefore, responsible for ensuring that no MHSA funds are utilized for services to parolees from State prisons.

Mental Health Services to Veterans

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

Referral Process for Providing Mental Health Services to Veterans

1. **Adult/Older Adult Mental Health Services:** Staff will ask client if he or she is receiving veterans' services benefits. If the client states he or she is receiving benefits or claims to have serviced in the military, the staff will be responsible for completing the following procedure:
 - a. The staff will complete "Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form" (*located in Appendix D*) that will contain all appropriate demographic information and required client signature.
 - b. The form shall be faxed to the Veterans Service Office for verification at (619) 232-3960, or other current fax number.
 - c. If an urgent response is required, the mental health provider shall note on the Request Form in the Comment Section and contact the office by telephone after faxing the Request Form. All individuals who present for emergency mental

- health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.
- d. If the client meets the eligibility criteria for seriously mentally ill persons and is receiving veteran benefits but needs mental health services not offered by the USDVA, the client can be offered mental health services.
 - e. If the client meets the eligibility criteria for seriously mentally ill persons and eligibility for veterans' services is pending, the client can be offered mental health services until the veterans services benefit determination is completed.
2. **Aging and Independence Services 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

Suspension of Utilization Review Requirement

A memorandum was issued on May 12, 2006 to all AOAMHS County-operated and contracted organizational providers regarding suspending the requirement that utilization review be conducted at all outpatient, case management, and crisis residential programs. Even though the AOAMHS is suspending the current structured utilization process, programs are still required to have a process in place to provide clinical review for the clients they serve. Programs, however, may now choose what type of clinical review they will perform. Programs may also decide to continue with the current utilization review process. Program who decide to choose a different clinical review format have until October 1, 2006 to identify and implement that process.

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

The Utilization Management for all service providers (outpatient, crisis residential, case management) includes procedures for establishing a Utilization Review Committee (URC),

standards for participation in the URC, logs for URC activities, and standards for authorization. Although there are slight variances in the utilization review process conducted by different service providers based on level of care, all programs participating in utilization review shall adhere to the following guidelines:

- Utilization review is a “not billable activity”
- URC logs are to be maintained at each program that record the results of the UR process
- URC logs are to be made available for review as needed by the MHP
- A clinician cannot participate in the authorization decisions regarding their own client
- Questions pertaining to the UR process should be directed to the Adult QI unit.

The Utilization Review procedures for Crisis Residential, Outpatient and Case Management programs are outlined below. All applicable forms and logs necessary to perform the Utilization Review process are located in *Appendix D*.

Utilization Review for Crisis Residential Programs

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

Utilization Review for Outpatient Programs

Each outpatient mental health program shall implement a utilization review (UR) process for all clients that are receiving “*meds plus*” services (mental health services other than medication only). For purposes of this UR process, these “*meds plus*” clients are individuals who have been receiving 6 months or more of planned therapeutic services and who also may be receiving medication support services. Each outpatient program may decide whether its UR process is conducted by a UR committee or a single clinician. For committee review, a minimum of 3 direct service or supervisory staff must participate and the chairperson must be either licensed or

registered/waivered. For single clinician review, the clinician must be licensed or registered/waivered. All “meds plus” clients receive their initial 6 months of planned therapeutic services without needing UR authorization. Subsequent reviews will occur at intervals of not more than 6 months based upon the UR’s authorization. UR may authorize continued “meds plus” service for up to an additional 6 months. There is no limit on number of sessions or modality of therapy (i.e. group or individual). A “Request for Utilization Review Outpatient Services” form (*located in Appendix D*) is completed by the clinician providing the individual’s treatment or the Care Coordinator no more than 30 days prior to the date of UR. The UR Clinician approving this form must be licensed or registered/waivered. After completion of the UR process, this form is filed in the client’s medical record in the “Plans” section in front of Client Plan(s). Additionally, “Outpatient Utilization Review Minutes” (*located in Appendix D*) will be maintained.

Utilization Review for Case Management Programs

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

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

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

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

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

E. INTERFACE WITH PHYSICAL HEALTH CARE

Coordination with Primary Care Physicians

The bio-psychosocial model for recovery, practiced by County Adult Mental Health Services, recognizes the totality of the person and the important role of physical well being for progress toward recovery. For this reason, organizational providers are highly encouraged to coordinate beneficiary care, as needed, with San Diego's Medi-Cal Primary Care Physicians. Over 50% of Medi-Cal beneficiaries are enrolled in one of the seven Health Maintenance Organizations (HMOs) that are part of Healthy San Diego. The remaining Medi-Cal beneficiaries receive their physical health care from fee-for-service physicians. Organizational providers and County-operated programs are required by the MHP to request a Release of Information (ROI) from the client during the first visit to facilitate coordination with the client's Primary Care Physician, ensuring that confidentiality is maintained in accordance with applicable State and federal laws and regulations. Located in *Appendix E*, are the Healthy San Diego Physical and Mental Health Coordination Guidelines, Coordination Form, and an Authorization for Release of Information Form, which providers may use to facilitate or enhance coordination of care with the client's Primary Care Physician.

Pharmacy and Lab Services

HMO Medi-Cal Beneficiaries

Each HMO has contracts with specific pharmacies and laboratories. Providers prescribing medication or lab tests need to be aware of which pharmacy or laboratory is associated with each client's HMO in order to refer the client to the appropriate pharmacy or lab. The client's HMO enrollment card may have a phone number that providers and clients can call in order to identify the contracted pharmacy or lab. Psychiatrists may order the following lab studies without obtaining authorization from the client's Primary Care Physician:

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

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

Primary Care Physician to determine which lab test(s) require authorization from the client's Primary Care Physician.

Medi-Cal Beneficiaries not Enrolled in an HMO

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

Non-Insured Realignment Funded Clients

Realignment-funded (non-insured) clients 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.

Physical Health Services While in a Psychiatric Hospital

HMO Medi-Cal Beneficiaries

The client's Healthy San Diego HMO is responsible for the initial health history and physical assessment required for admission to a psychiatric inpatient hospital. The client's HMO also is responsible for any additional or ongoing medically necessary physical health consultations and treatments. The HMO contracted provider must perform these services, unless the facility obtains prior authorization from the HMO to use another provider.

The MHP contracted psychiatrist is responsible for obtaining the psychiatric history upon admission and for ordering routine laboratory services tests. If the psychiatrist identifies a physical health problem, he or she contacts the client's HMO to request an evaluation of the problem. If the psychiatrist determines further laboratory or other ancillary services are needed, the contracted hospital must obtain the necessary authorizations from the client's HMO.

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

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

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

The ACL may refer realignment-funded clients to County Medical Services (CMS) for assessments and medical services. The telephone number for CMS is (858) 492-4444.

Transfers from Psychiatric Hospital to Medical Hospital

Psychiatric hospitals may transfer a client to a medical hospital to address a client's medical problems. The psychiatric hospital must consult with appropriate HMO staff to arrange such a

transfer for physical health treatment. It is the responsibility of the HMO to pay for transportation in such cases. The UBH Medical Director and the HMO Medical Director will resolve any disputes regarding transfers.

Medical Transportation

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

Home Health Care

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

Clinical Consultation and Training

Beneficiaries with less severe problems or who have been stabilized may be referred back to their Primary Care Physician for continuing treatment. To help support client's treatment by the Primary Care Physician, the MHP, as well as organizational providers and County-operated programs, should make clinical consultation, including consultation on medications, available to a beneficiary's Primary Care Physician. Clinical consultation, if requested, should also be made available for clients who are receiving treatment from a health care provider, in addition to receiving MHP services. These health care providers include Medi-Cal Managed Care Providers, Primary Care Providers not belonging to a Medi-Cal Managed Care Plan, to Federally Qualified Health Centers, Indian Health Centers or Rural Health Centers. As another means of supporting clients, Providers are encouraged to provide training to community partners, as requested, or as the need arises.

F. BENEFICIARY RIGHTS & ISSUE RESOLUTION

Client Rights and Protections Under Federal Code

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

- *Dignity, respect, and privacy.* Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- *Receive information on the managed care plan and available treatment options.* Each managed care enrollee is guaranteed the right to receive information on the managed care plan and its benefits, enrollee rights and protections, and emergency care, as well as available treatment options and alternatives. The information should be presented in a manner appropriate to the enrollee's condition and ability to understand.
- *Participate in decisions.* Each managed care enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- *Free from restraint or seclusion.* Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- *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, Part 164.
- *Free exercise of rights.* Each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the County MHP, its providers or the State agency treat the enrollee.

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

***Note:** New clients must receive a copy of the Guide to Medi-Cal Mental Health Services when they first obtain services from the provider and upon request, thereafter. (Handbooks are available in threshold languages of English, Spanish, and Vietnamese.) Additional copies may be obtained from the MHP Quality Improvement Unit at (619) 563-2776.*

Additional Client Rights

- **Provider Selection**

In accordance with 42 CFR 438.6 and Title 9, providers are reminded that clients have the right to obtain a list of MHP providers, including information on their location, type of services offered, and areas of cultural and linguistic competence. (See Accessing Services section in this Handbook for details.)

- **Second Opinion**

If the MHP or its designee determines that a client does not meet Title 9 Medical Necessity Criteria for inpatient or outpatient mental health services, a client may request a second opinion. A second opinion from a mental health clinician provides the client with an opportunity to receive additional input on his or her mental health care. As the MHP designee, UBH is responsible for informing the treating provider of the second opinion request and for arranging the second opinion with an MHP contracted individual provider.

The second opinion provider is required to obtain a release of information from the client in order to review the client's medical record and discuss the client's treatment. After the second opinion evaluation is completed, the second opinion provider forwards a report to the MHP Program Monitor 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 Log (See *Appendix F*). 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 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. AMHS Policy prohibits the expectation that the client use family or friends for interpreter services. However, if the client so chooses, this choice should be documented in the client record. For more complete information about linking

clients to free interpreter services, please see the Accessing Services section of this Handbook.

Providers must also be able to provide persons with visual or hearing impairment, or other disability, with information on Mental Health Plan Services, making every effort to accommodate individual's preferred method of communication, in accordance again with Title 9 and AMHS policy.

Advance Health Care Directive Information

Federal Medicaid regulations (42 CFR 422.128) require the MHP to ensure that all adult 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 new clients be given this information at their first face-to-face contact for services. An Advance Health Care Directive is defined in the 42 CFR, Chapter IV, Part 489.100 as "a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Generally, Advance Health Care Directives deal with how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for himself/herself.

In order to be in compliance with the Federal regulations (42 CFR, Chapter IV, Section 422-128), providers shall do the following for new clients:

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

The MHP is providing an informational brochure on Advance Directives, available in the threshold languages, which can be given out to new clients or members of the community who request it. Copies may be obtained through the MHP QI Unit by calling (619) 563-2776, or providers may duplicate their own copies. The MHP will also be responsible for notifying providers of any changes in State law regarding Advance Directives within 90 days of the law change.

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

Periodic Notice of Clients' Rights

In accordance with DMH regulations, written and oral information explaining the grievance/appeal process and the availability of a State Fair Hearing for Medi-Cal beneficiaries shall be provided to new clients upon first admission to Mental Health Services, along with the Guide to Medi-Cal Mental Health Services. The date of this activity shall be reflected on the Admission Checklist Form. Information on the Beneficiary Problem Resolution Process and State Fair Hearing Rights must be provided annually and documented in the medical record. It is strongly recommended that this information be tied to the anniversary date of admission for services.

BENEFICIARY PROBLEM RESOLUTION PROCESS

San Diego County Mental Health Services is strongly committed to honoring the rights of every consumer to have access to a fair, impartial, effective process through which the consumer can seek resolution of a problem encountered in accessing or receiving quality mental health services. All contracted providers are required to participate fully in the Beneficiary Problem Resolution Process (Grievance and Appeal Process), which is located in its entirety in *Appendix F*. Providers shall comply with all aspects of the Process, including the distribution and display of the appropriate beneficiary protection materials, including posters, brochures and grievance/appeal forms as described in the Process. When a provider is notified by the contracted advocacy organization, the Consumer Center for Health Education and Advocacy (CCHEA) or USD Patient Advocacy Program that a client has filed a grievance or appeal about that provider's program or staff, the provider shall cooperate with the investigation and resolution of the client's concerns in a timely manner as specified in the Process.

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

In accord with 42 CFR and Title 9, the County of San Diego Mental Health Beneficiary Problem Resolution Process has been streamlined, some terms redefined, and strict timelines added. An

opportunity for provider appeals has also been added, as well as a clinical review of grievances and appeals concerning clinical issues. The provider continues to play an important part in this process as follows:

Problem Resolution at Provider Sites

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

Providers shall inform all clients about their right to file a grievance with one of the MHP's contracted advocacy organizations if the client has an expression of dissatisfaction about any matter, is uncomfortable approaching program staff, or the dissatisfaction has not been successfully resolved at the program. Clients should feel equally welcomed to bring their concerns directly to the program's attention or to seek the assistance of one of the advocacy organizations.

At all times, Grievance and Appeal information must be readily available for clients to access without the need for request. Each provider site shall have posters, brochures, and grievance/appeal forms in threshold languages, and addressed envelopes available to clients. These materials shall be displayed in a prominent public place.

Grievance Process

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

A "grievance" has been defined as an expression of dissatisfaction about any matter other than an action. USD Patient Advocacy facilitates the grievance process for clients in inpatient and other 24-hour residential facilities. CCHEA facilitates the grievance process for outpatient and all other mental health services. These advocacy services will contact providers within three (3) days of receiving written permission from the client to represent him/her. Securing this permission can be difficult and time consuming. In order to be in compliance with the mandated federal timeline, providers shall work closely with the Advocacy organization to find a mutually agreeable solution to resolve the grievance quickly.

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

Appeal Process

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

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

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

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

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

Expedited Appeal Process

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

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

State Fair Hearings

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

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 Problem Resolution Process in *Appendix F* for details of this portion of the process.

Monitoring the Beneficiary Problem Resolution Process

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

CLIENT NOTIFICATION OF ACTION ON SERVICES (NOA PROCESS)

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

Notice of Action-Assessment (NOA-A)

All Adult/Older Adult outpatient programs (County and contract), case management, short term acute residential treatment (START) programs, and the San Diego County Psychiatric Hospital (SDCPH) shall follow procedures for issuing NOA-A forms and maintaining a Notice of Action Assessment Log for Medi-Cal beneficiaries. In accordance with Title 9, Section 1850.210, an NOA-A shall be issued when services are requested and medical necessity criteria are not met and therefore no services are appropriate in the mental health system. Issuing of an NOA-A begins the 90-day period that a beneficiary has to file for a State Fair Hearing.

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

- Reason for denial based on Title 9, California Code of Regulations
- Beneficiary's right to a second opinion
- The grievance/appeal process
- Right to a State Fair Hearing (once local process has been exhausted)
- Criteria for an expedited State Fair Hearing
- Explanation of the circumstances under which a specialty mental health service will be continued if a State Fair Hearing is requested

- Method by which a hearing may be obtained
- Beneficiary may be either self represented or represented by an authorized third party such as legal counsel, relative, friend or any other person.

The following procedures shall be followed by Adult/Older Adult County and Organizational providers when issuing an NOA-A:

1. The Notice of Action-Assessment (NOA-A) form shall be issued to a Medi-Cal beneficiary following a mental health screening and/or assessment (face to face or phone) when it is determined by the provider that the beneficiary does not meet medical necessity criteria, resulting in denial of all specialty mental health services.
 - a. If upon screening/assessment, the beneficiary is identified as currently receiving specialty mental health services, an NOA-A shall not be issued.
 - b. As part of the screening/assessment process, the beneficiary may be informed of the option to obtain care outside the Mental Health Plan. When a beneficiary verbalizes interest only in information gathering or in obtaining a referral outside of the Mental Health Plan (thus declining or modifying the original inquiry for specialty mental health services), no NOA-A needs to be issued. Services outside of the Mental Health Plan may not be reimbursable by Medi-Cal.
2. The NOA-A shall outline the action taken by the Mental Health Plan (MHP) or provider, reason for the action, beneficiary's rights, and citation of the specific regulations or MHP payment authorization procedures supporting the action.
3. In accordance with federal regulations, the NOA-A may be hand delivered on the date of the notice or deposited with the United States Postal Service in time for pick-up no later than three (3) working days of the decision by the provider.
4. All above cited programs shall maintain a Notice of Action Assessment Log on the program site.
5. The NOA-A Log shall document all NOA-As provided to Medi-Cal beneficiaries and their response to the NOA-A, if known.
6. The NOA-A Log shall contain the following information:
 - a. Date the NOA-A was issued
 - b. Beneficiary identification number, if known
 - c. Response, including requests and provisions for second opinions, initiation of grievance/appeal procedure, and/or request for State Fair Hearing, if known.
7. The original NOA-A Log will be maintained at the program site, with a copy of each NOA-A issued attached. When no NOA-As are issued in a given month, the Log shall reflect this information with a check in the appropriate box. The Month Status Report shall identify the number of NOA-As issued during the report period.
8. When an NOA-A is issued, a copy shall be forwarded to the County Adult Mental Health Quality Improvement Unit Administrative Analyst via confidential fax (619) 563-2795.

Notice of Action (NOA-B)

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

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

Note: A copy of the NOA-A, NOA-A Log, NOA-B and the NOA-Back forms are included in *Appendix F* and may be copied.

Additional Types of Notices of Action

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

1. A Notice of Action form will be sent to a client from an advocacy organization (CCHEA or USD Patient Advocacy) or the MHP, as appropriate, if a grievance, appeal, or expedited appeal is not completed in accordance with federal timelines. (NOA-E)
2. A Notice of Action form will be sent to a client from UBH if a Treatment Authorization Request (TAR) has been denied as a result of insufficient information submitted by the provider. (NOA-C)

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

G. QUALITY IMPROVEMENT PROGRAM

The MHP's philosophy is that high-quality mental health care is client centered, clinically effective, outcome driven, and culturally competent. The purpose of the MHP Quality Improvement Program is to ensure that all clients receive this type of mental health care. In order to achieve this goal, each provider 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, measuring clinical outcomes, medication monitoring and/or a formal Quality Improvement unit, which offers training and technical assistance to clinical staff. In addition, all provider programs are required to attend regular Program Manager meetings, quarterly Leadership Plus meetings, QI In-Service and documentation trainings, and other training. These meetings are essential to keep abreast of system changes and requirements.

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, Title 9, Chapter 11, of the California Code of Regulations;
- State Department of Mental Health (DMH) Letters and Notices;
- the MHP Managed Care contract with the State DMH; and
- the Annual State DMH Protocol

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

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

Through program monitoring, program strengths and deficiencies are identified; educational and other approaches are utilized to achieve positive change. To be maximally effective, the Quality Improvement Program must be a team effort. It requires the dedicated effort, responsibility, and involvement of clients, family members, clinicians, 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. AMHS QI administers two client surveys. The first of these surveys is the Mental Health Statistics Improvement Program (MHSIP), a county mandated survey. The second survey is the Mental Health Survey, which is mandated by the State.

MHSIP Survey – County AMHS Requirement

Surveys Due: *On client anniversary or discharge from program*

All qualifying County-operated and County-contracted adult mental health providers who have clients in the target population shall comply with the client satisfaction program. The target population for measuring client satisfaction is adults with serious mental illness ages of 18 to 59 who will receive mental health services for 60 days or longer. A tool that will be used for clients 60 years and older is currently under development. *Please note that clients receiving medication only are excluded from MHSIP reporting at this time.*

- Outpatient providers shall administer the MHSIP Survey to all eligible clients annually on the anniversary date of admission to program, and at the time of transfer or discharge from program.
- Crisis Residential providers shall administer the MHSIP Survey to all eligible clients at the time of transfer or discharge from program.
- Case Management providers shall administer an adapted version of the MHSIP that was designed for case management clients to all eligible clients annually on the anniversary of their admission to the program and at time of transfer or discharge from the program.

Since this is a service satisfaction survey, providers must ensure client confidentiality in order to encourage accurate, frank responses. Therefore, the treating clinician should not administer this survey. A staff person not involved in the direct care of the client should provide the client with the survey and confidential envelope to return the survey. For confidentiality, client names shall not be recorded on the instruments; only the client ID number shall be recorded. The date the survey was taken, and the name of the provider must also be indicated on each survey.

Clients should be instructed to seal their surveys in the provided envelope and place it in the locked orange collection box provided by the County. Every month, designated non-clinical staff at the clinic will open the box, retrieve the sealed envelopes, place them in a larger envelope and return the client-sealed envelopes to the AMHS QI Unit in any of the following ways: 1) Mail to: Adult Q.I., P.O. Box 85524, MS: P531-G, San Diego, CA 92186-5524; 2) Deliver to: Mental Health Administration, 3255 Camino Del Rio South, San Diego, CA 92108; 3) Bring to any meeting with AMHS QI staff. Surveys cannot be faxed to the AMHS.

The MHSIP is available in English, Spanish, Cambodian, Korean, Tagalog, Chinese, and Vietnamese. The provider shall be responsible for notifying the QI department of the survey

languages needed for their unique population blend. The AMHS QI Unit monitors the number of MHSIP Surveys returned by each program and distribute quarterly reports of MHSIP results to each provider. Programs shall be required to ensure that eligible clients are given an opportunity to complete the MHSIP regardless of language, literacy, sight, or other disabling barriers.

Mental Health Survey – State Requirement

Survey Period: Two week period in May and November as specified by the State DMH

The State DMH selects a two-week time period twice a year in which all Outpatient providers, including Case Management, are required to administer the Mental Health survey. This survey consists of two parts, a MHSIP section, and Quality of Life section. This survey should be administered to all clients receiving services during the two weeks, **including clients receiving medications only**. Providers will be notified by the MHP of the exact State selected time period; historically, survey periods have been in May and November. The survey returns are scanned in directly to the State, therefore original printed forms provided by the MHP must be used. Providers shall administer and collect this survey in the same manner as described above for the MHSIP surveys. However, because of the limited window for submitting this information to the State, providers are strongly requested to send in completed survey envelopes at the end of the first week and immediately at the end.

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

MONITORING THE SERVICE DELIVERY SYSTEM

Using the Uniform Medical Record

All programs are required to utilize the forms specified in the San Diego County Adult Mental Health Services Documentation and Uniform Clinical Record Manual, and any updated forms, which are issued on an interim basis. Programs may adapt forms for specific program needs with the consent of the Uniform Medical Record Committee, which is an ad hoc committee chaired by the Quality Improvement team. The 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.

Standards for “Late Entry” Documentation

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

- A “late entry” is defined as any documentation that is done on a calendar day other than the date the service was provided.

- When documenting a late entry in the client’s medical record, “late entry” should be written at the beginning of the note.
- Late entry notes should be filed in the medical record chronologically to when written, not filed by the date the service was provided.

Claiming for a Late Entry

- Late entries will be accepted for claiming purposes up to 14 days after the date of service.
- If a late entry has not been documented within 14 days from the date of service, the service must still be documented but may not be claimed. The late entry would be considered a non-billable service and would be entered into InSyst as such.
- A recoupment will be made for a late entry with a documentation date of over 14 days from the date of service if this late entry has been claimed and the claim is included within the audit period of a medical record review.

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

Programs will be monitored for compliance by AMHS Quality Management (QM) Program. Programs shall be required to submit and implement a Plan of Correction for issues/problems identified by the QM Program. The deadline for a Plan of Correction shall be established by the QM Program.

Plans of Correction

The QI Unit monitors organizational and County providers on a regular and annual basis to evaluate the provider’s performance in various delegated activities. Medical record reviews are conducted to ensure that MHP contract requirements are met pertaining to documentation standards. Site certification and recertification reviews are also conducted to ensure that all MHP onsite requirements are being adhered to by the provider. If the provider’s performance is found to be inadequate, or areas for improvement are identified, a request for Plan of Correction (POC) will be issued by the MHP to the provider. The provider will have 30 days, or another identified time frame, after receipt of the MHP’s written report of findings to complete and submit their POC to the QI Unit. The POC must describe the interventions or processes that the provider will implement to address items that have been identified out of compliance or that were identified as needing improvement. In some instances, the QI Unit will be making more specific process improvement recommendations to the provider that must be included in the POC. When appropriate, the POC must include all supporting documentation (i.e. copy of a policy and procedure that has been written, description of a system that program is implementing, copy of sign-in sheets from a training, etc.). Even when supporting documentation is not requested to be submitted with the POC, the program is still required to keep this documentation on-file at their program. The POC must also include identified timelines and/or dates as to when the out of compliance item or area needing improvement will be implemented or completed. Pursuant to the “Withholding of Payment” clause of the contract,

failure to respond adequately and in a timely manner to a request for a POC may result in withholding of payment on claims for non-compliance.

Upon receipt of a POC, the QI Unit will review what has been submitted to ensure that it adequately addresses the identified items. If the determination is made that the POC does not adequately address these items, the QI Unit will request that an addendum POC be submitted within a specified time frame.

Programs will be monitored for trends and patterns in their out of compliance items or areas needing improvement. Additional QI 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 adhering to standards. These determinations will be made under the direction of the QI Program Manager and may take place within 30 days, 60 days or some other identified time frame depending upon the severity of the noncompliance. For medical record reviews, these additional reviews will include the billing audit and will be subject to recoupment.

When a program's identified trends and patterns for out of compliance items or areas needing improvement are not responding to the program's written POC, QI may issue a POC to the program's Legal Entity. This POC to the Legal Entity will include a description of the noncompliance categories, history of program's POC actions, and statement of minor to no improvement having been made. QI may recommend identified interventions or process changes to be implemented. If a POC is issued to a Legal Entity, the following will also be notified: County Contracts Unit, County Executive Management, and County Regional Program Coordinator. Failure to respond adequately and in a timely manner to a request for a POC may result in a withholding of payment on the claims for non compliance and could result in putting the contract at risk.

Medical Record Reviews

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

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

- Admission Checklist
- Assessment/Appropriateness of Treatment
- Medical Necessity
- Clinical quality
- Client Treatment Plan and Client Involvement
- Compliance with Medi-Cal, State, Federal, and County Documentation Standards

- Billing Compliance
- Medication Treatment/Medical Care Coordination
- Administrative/Legal Compliance
- Care Coordination
- Discharge

Medi-Cal Recoupment and Appeals Process

It shall be the policy (Recoupment Based on Medical Record Review; No: 01-01-125) of County of San Diego Mental Health Services to disallow billing by Organizational, County, Individual and Group providers that do not meet the documentation standards set forth in the Uniform Clinical Record Manual and to recoup Federal Financial Participation (FFP) in accordance with the current *California State Department of Mental Health Reasons for Recoupment of Federal Financial Participation Dollars, Non-Hospital Services (see Appendix J)*.

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

- Medical Necessity
- Client Plan
- Progress Notes.

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

At the conclusion of each medical record review, the provider will receive a Medi-Cal Recoupment Summary listing all disallowed billings based on the DMH reasons for recoupment criteria. If the provider disagrees with a Medi-Cal recoupment, AMHS Quality Improvement has developed a 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision. Providers must submit their first or second level appeal in writing to the Quality Improvement Unit within required timelines. Located in *Appendix G* is the complete description of the step-by-step appeal process with timelines for first and second level appeals.

Actions Regarding Reasons for Recoupment

The MHP will perform all required service deletions at the time the results of the medical record review are considered final, i.e. after completion of the appeal process or provider's decision not to appeal. These specific service deletions are not to be done by the provider. There are, however, actions regarding the reasons for recoupment that the service provider is required to perform. On certain of the progress note reasons for recoupment, the provider must re-enter the service. Re-entry of the service deleted by the MHP will be re-entered as one of the following: billable service, non-billable service, or a "no show" when no service was provided. With the

exception of the “no show” service deletion, all other progress note service deletions are required by the MHP to be re-entered by the provider. Entry into InSyst for client “no shows” (InSyst code 299) is at the option of the service provider. This re-entry by the provider into InSyst may be performed at any time after the medical record review is considered final. Re-entry by the provider may occur even if the MHP has not yet performed the service deletion. Specific instructions on how each re-entry should be performed by the service provider are explained in the table “Actions Regarding Reasons for Recoupment” located in *Appendix G*.

Annual Site Reviews

The Quality Improvement Unit is also responsible for monitoring the health and safety of organizational provider sites. Providers must be in compliance with all Federal and State regulatory requirements and MHP contract requirements with DMH. Annual site reviews are conducted to ensure that providers comply with necessary licenses/certification requirements, maintain a safe facility, and store and dispense medications in compliance with all pertinent Federal and State standards. During the site review visit, a Quality Improvement Specialist may review:

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

Medication Monitoring

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

- Medication rationale and dosage consistent with community standards
- Appropriate labs prescribed
- Consideration of physical health conditions

- Effectiveness of medication(s) prescribed
- Adverse drug reactions and/or side effects
- Evidence of signed informed consent
- Client adherence with prescribed medication and usage
- Client medication education and his/her degree of knowledge regarding management of medications.

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

Contracted providers are required to perform the first-level screening of medication monitoring for their facility, using the Medication Monitoring Screening Tool. If a variance is found in medication practices, a Medication Monitoring Feedback Loop (McFloop) form is completed, given to the psychiatrist for action, and then returned to the Medication Monitoring Committee for approval. Results of medication monitoring activities are reported quarterly by the 15th of each month following the end of each quarter to the QI Unit on the Medication Monitoring Committee Minutes form. All completed McFloop forms shall be sent to the QI Unit within 30 days of the reporting deadline for each quarter. (*The Medication Monitoring Screening Tool, Committee Minutes form and McFloop form are located in Appendix G.*)

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

The QI Unit evaluates the reports from both the contractors and Chief of Pharmacy for trends, compiling a summary report submitted to the Quality Review Council (QRC) and County Pharmacy and Therapeutics Committee (P&T) quarterly. If a problematic trend is noted, the report is forwarded to the Medical Director for recommendations for remediation.

Medi-Cal Certification and Recertification

Contracted and County providers shall be familiar with the Short-Doyle/Medi-Cal delivery system and shall become Medi-Cal certified prior to commencing services and billing Medi-Cal. Providers who bill for Medi-Cal services will be recertified every three (3) years. The recertification 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 health and safety requirements
- Adherence to requirements for ensuring the confidentiality and safety of client records
- Medication service

ACCESSIBILITY OF SERVICES

The provider is responsible for preparing and maintaining appropriate records on all clients receiving services in compliance with CCR, Title 9, Chapter 11 and 42 CFR guidelines. This includes on site and secure maintenance of a written Request for Services Log (located in *Appendix C*). At a minimum, the log must contain the name of the individual, the date of the request, the nature of the request, and the initial disposition of the request. For outpatient services, AMHS requires providers to keep records of the urgency status of each request. It is strongly suggested that providers also keep records of the consumer's insurance coverage, and whether the client telephoned or walked in to request services.

The provider is expected to meet the MHP standards for access to emergent, urgent and routine mental health services to ensure that clients receive care in a timely manner. These access standards refer to the acceptable timelines for triage, intake, assessment, and clinical evaluation. The MHP will be monitoring compliance according to established industry standards and a mandate by the San Diego County Board of Supervisors (see Section C for a review of these standards).

Guidelines for Orientation Groups

Orientation groups were implemented in some outpatient programs in San Diego County in order to improve access to care, educate clients about services and provide services more efficiently. While orientation groups may aid programs in meeting these objectives, it is critical that program staff understands that the use of Orientation Groups may not create a barrier to accessing services.

For many clients seeking mental health services, attendance at an Orientation Group may create a barrier to access due to perceptions of stigma, fear of groups, increased symptoms, cultural considerations, and privacy and confidentiality reasons. To ensure that Orientation Groups are meeting standards set by the MHP and not creating an unintentional barrier to accessing mental health services, programs must ensure that Orientation Groups are adhering to the following standards:

1. New clients who are being discharged from a hospital or crisis residential facility shall not be required to attend an orientation group prior to receiving a mental health and/or psychiatric assessment.
2. A mental health professional must be substantially involved in the Orientation Group and be available to assess clients attending the group.
3. Clients who choose not to or are unable to attend an Orientation Group must be given alternative ways to receive the information shared in this meeting.

4. Medi-Cal beneficiaries may not be denied a mental health assessment based on attendance or non-attendance at an Orientation Group. (Clients with Medi-Cal have a right to an assessment, and denial of an assessment would be basis for a client to file for a State Fair Hearing.)
5. Orientation groups may not be counted in the calculation of Wait Time for a mental health assessment. If a program is unable to meet their Wait Time goal, the Program Manager should contact their designated Regional Program Coordinator or QI to ask for assistance.

It is the responsibility of each Program Manager to train appropriate staff on all standards regarding the use of Orientation Groups.

Wait Times

Report Due: *Every Monday*

Another measure of system efficiency is the amount of time clients have to wait to receive services. County-operated and designated contracted providers of outpatient assessments and medication evaluations shall report Wait Times information each week to AMHS. Data shall include the previous week's (Monday through Sunday) information on client access (waiting time) for urgent services and routine initial mental health and psychiatric assessments. For technical support and questions on the Wait Times Program, contact Paul Ellingsen in the QI Unit at 619-563-2785 or by email at paul.ellingsen@sdcounty.ca.gov.

The Wait Time (for both Mental Health and Psychiatric Assessments) is defined as the time between the initial contact from a new client requesting services until the first *available* appointment. Orientation Groups cannot be considered as a Mental Health Assessment, nor can Wait Times for mental health or psychiatric assessments be calculated using attendance at Orientation Groups as a starting point.

Wait Time benchmarks have been established for each outpatient program based on historical data. Wait Times are monitored by AMHS, and any program that consistently exceeds its Wait Time benchmark will be required to submit a quality improvement plan.

Wait Times for Emergency and Urgent Services:

- Any client who needs emergency service shall have his/her needs addressed within one hour.
- Any client who meets the criteria for needing "urgent" services shall be seen within 72 hours. Any client being discharged from a crisis residential, psychiatric hospital facility, or locked/IMD placement or who calls for services and is screened as needing services urgently meets the "urgent" criteria and shall be seen with 72 hours. All urgent services must be tracked on the Request for Services Log.

The procedure for reporting the Wait Times data shall be as follows:

1. AMHS will provide a Request for Services Log for use by all outpatient facilities.
2. Outpatient facilities shall completely and accurately fill in the logs.
3. Each Monday the completed logs shall be emailed to the AMHS Performance Outcomes Unit (Ellen.Heigert@sdcounty.ca.gov) or faxed to (619) 563-2799.

The Performance Outcomes Unit will calculate and report the following to each provider on a quarterly basis.

1. The average wait time in calendar days between the initial client contact and the first available appointment for a Mental Health Assessment.
2. The average wait time in calendar days between the initial client contact and the first available appointment for a Psychiatric Assessment.

CLIENT AND PERFORMANCE OUTCOMES

The MHP has developed clinical performance indicators and related outcome standards for organizational providers. The County initially approved these standards and indicators in November 1997 (*FY 1997-98 Outcome Standards*). In addition to client satisfaction and accessibility standards for many programs, there are outcome standards and indicators relating to re-admission rates, or improvement in functioning as assessed by the Global Assessment of Functioning (GAF) scale score. Please refer to the *FY 1997-98 Outcome Standards* to review those that apply to your particular program.

Some data is obtained via the InSyst system. Other data is manually collected by providers and submitted in the Monthly Status Report. The data is useful in determining trends and patterns in service provision and demand, as well as identifying opportunities for improvement.

Monthly Status Report (MSR)

Report Due: No later than the 15th calendar day of each month for the preceding month

Providers are required to submit a monthly status report which gives the MHP vital information about provider services. All sections of the report not specifically marked “Children” must be completed. The report has been revised to include sections for reporting client outcomes and possible participation in Medicare Part D. Additionally, instead of twice yearly reports on staffing for cultural competence, the new form includes a place to report monthly on staffing and training. This report form is updated periodically in accordance with changing State, Federal and County regulations. A current sample of the MSR form is included in *Appendix G*.

Client Outcomes

Report Due: Included as part of the Monthly Status Report due the 15th calendar day of each month for the preceding month

In conjunction with new State and Federal mandates to show program effectiveness and client progress in rehabilitation and recovery, the MHP is extending the Client Outcomes tracking to all programs. In determining what indicators to select as part of the performance measurement system, San Diego County A/OAMH used the following criteria: meaningfulness, applicability, availability, compatibility with California programs and priorities, and ease of use.

The client outcomes indicators determined by the MHP are:

- Improvement in or stabilization of mental health status—measured using the Mental Health Recovery Treatment Stages (MHRTS) tool which assesses a client’s progress in the stages of recovery.
- Improvement or stabilization of community functioning—measured by the Mental Health Statistics Improvement Program (MHSIP) questions 20-26 which gathers data on client functioning within the community.
- Improvement or stabilization in a person’s stage of substance abuse treatment—measured using the Substance Abuse Treatment Scale-Revised (SATS-R) which assesses a client’s stage of substance abuse treatment.
- Improvement or maintenance in residential status—measured by the Residential Status Key and Log which assesses and tracks changes in a person’s residential status.
- Improvement in Employment/Educational status—measured by the Employment/Education Status Key and Log which assesses and tracks changes in a person’s employment/education status.

Participating programs shall report their outcomes data on the *Monthly Status Report* according to defined timelines. The Program Monitor will review the results, check for adherence to the outcome standard, and identify if a plan of correction is needed. The QI unit will track trends for the data provided on the MSR. The specific outcomes procedures by level of care, the outcomes tools, and reporting requirements can be obtained by contacting your Program Monitor and requesting a copy of the *Client Outcomes Manual*.

Mental Health Services Act (MHSA) Outcomes

Under the MHSA in San Diego, approximately 30 new programs are being started while others are expanding. As the MHSA is implemented across the State, new requirements for outcome reporting are anticipated to document how these funds are changing the lives of mental health clients. Providers receiving MHSA funding will be responsible for complying with any new requirements for additional outcome data. Currently, programs that have entered into Full Service Partnerships under the MHSA are required to participate in a direct State data collection program which tracks initial specialized client assessments, ongoing key incident tracking, and quarterly assessments.

Performance Improvement Projects (PIPs)

The State has mandated that each county be engaged in one administrative and one clinical performance improvement project each year in order to improve processes and outcomes of care. A PIP is a comprehensive, long-term study which includes a commitment to improving quality through problem identification, evaluating interventions and making adjustments as necessary. It may provide support/evidence for implementing protocols for “Best Practices”. Progress on each PIP is evaluated annually by the External Quality Review Organization (EQRO), an independent State contracted organization.

San Diego County presently has two active PIP projects.

1. Treating Clients with Co-occurring Disorders
2. Improving Latino Access to Care

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 (Unusual Occurrences)

All providers are required to report unusual occurrences or “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 AMHS Quality Improvement Unit who will review, investigate as necessary, and monitor trends. The provider shall also be responsible for reporting serious incidents to the appropriate authorities.

Serious incidents are categorized as follows, resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring medical attention:

- Adverse drug reaction
 - Suicide attempt
 - Medication error
 - Injurious assault on a client occurring on the program’s premises
 - Injurious assault by a client occurring on the program’s premises
- or
- Use of physical restraints (excluding SDCPH/EPU)
 - Felony arrests or convictions (excluding SDCPH/EPU)
 - Death of client (includes death by suicide), excluding natural causes
 - Serious physical injury resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties
 - Sexual assault on a client

NOTE!
Suicide attempts and adverse drug reactions need only be reported if the attempt or the reaction requires medical attention.

- Other

Serious incidents shall be classified into two levels with Level One being most severe and Level Two less severe. A Level One incident must include at least one of the following:

- The event is associated with a significant adverse deviation from the usual process for providing mental health care.
- The event has results in a death or serious physical injury on the program's premises.
- The event has the potential for significant adverse media involvement.

For a Level One incident, the provider shall telephonically notify the County Quality Improvement Unit within four (4) hours from the time of the incident, or awareness thereof. The provider shall also complete a Serious Incident Report (see *Appendix G*) and fax it to the QI Unit within 72 hours.

For a Level Two incident, the provider shall telephonically notify the County QI Unit within 24 hours and fax a Serious Incident Report to the QI Unit within 72 hours.

Within 30 days of submitting a Serious Incident Report, the provider shall submit a Serious Incident Report of Findings (see Serious Incident Review Summary Form in *Appendix G*) by mail or fax, summarizing the findings, identifying interventions, outcomes, and/or other improvements implemented as a result of the incident.

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

The AMHS QI Unit will monitor trends of Serious Incident Reports and report to the QRC and Mental Health Administration Executive Team periodically and as required resolving any problematic issues.

QUALITY REVIEW COUNCIL (QRC)

The Quality Review Council (QRC) is a collaborative group that is chaired by the MHP Clinical Director and consists of MHP stakeholders including clients and family members, County and contracted providers, associations and advocacy groups representing the mental health community, and hospital providers. The QRC meets regularly to review, discuss and make recommendations regarding quality improvement issues that affect the delivery of services through the MHP. Participation in the QRC is encouraged. If you would like to participate in the QRC, please contact the QI unit at (619) 563-2771.

H. CULTURAL COMPETENCE

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 demographic dynamics combined with the recognition that culture is a key factor in service delivery pose an ongoing challenge for the MHP and its contracted mental health care providers. The 2000 United States Census reports that racially and ethnically diverse groups comprised 25% of the total population, with continued growth expected. The demographics for San Diego County reveal magnification of that trend. According to the San Diego Association of Governments (SANDAG) growth forecast, ethnically diverse populations will increase from 40% of the population of San Diego County in 2000 to 51% in the year 2020.

As the diversity of the population continues to increase, the 2003 –2004 Cultural Competence Plan San Diego County Mental Health noted an increase in the number of Medi-Cal mental health clients from various minority populations, but found minority populations under-represented among total mental health clients. For example, as of 2002, 26% of the County population was Hispanic, but only 12% of the mental health clients are from this ethnic group and only approximately 13% of direct service providers. A disparity was also found between the number of minority clients participating in the Medi-Cal program and the number of clinicians available with self-assessed proficiency in needed cultural specialties.

The Cultural Competence Plan reports that in addition to changing demographics related to ethnicity and race, age demographics are changing in the county and will affect service demands. The child population is the most rapidly increasing portion of the population. The number of older adults living in San Diego is also growing, with 18% of the target population being 56 plus years of age.

Cultural Competence Plan

To address these issues in the 2003-2004 Cultural Competence Plan, the MHP set the following objectives to improve cultural competence in the provision of mental health services:

- 1) Conduct an ongoing evaluation of the level of cultural competence of the mental health system, to be based on an analysis of gaps in services that are identified by comparing the target population to provider staffing
- 2) Investigate possible methods to mitigate identified service gaps
- 3) Enhance cultural competence training system-wide

Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

- 4) Evaluate the need for linguistically competent services through monitoring usage of interpreter services
- 5) Evaluate system capability for providing linguistically competent services through monitoring organizational providers and FFS capacities, compared to both threshold and non-threshold language needs
- 6) Study and address access to care issues for underserved populations.

Current Standards and Requirements

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization 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.

Clinical Practice Standards:

The Culturally Competent Clinical Practice Standards currently utilized by SDCMHS were originally written in 1998. These standards have now been revised by the Cultural Competence Resource Team (CCRT) in order to ensure that the Clinical Practice Standards would: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels.

The revised standards are as follows:

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

help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.

- 9) Cultural factors are integrated into the clinical interview and assessment.
- 10) Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.
- 11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.
- 12) Psychiatrists consider the role of cultural factors (ethnopsychopharmacology) in providing medication services.
- 13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.
- 14) Staffs actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

Staffing Requirements:

To support the cultural competence standards, providers are required to take the following steps:

1. Develop policies and procedures that support culturally competent services and provide training to staff.
2. Include questions regarding experience in working with ethnic/minority clients, and/or culture communities in job applications for direct service or interpreting positions.
3. Require that at a minimum, all provider staff, including support staff dealing 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, review of published articles, web training, viewed videos, or attended a conference can count the amount of time devoted to cultural competence enhancement.
4. Train direct services staff on MHP Cultural Competence Clinical Practice Standards and establish a process for monitoring adherence to the standards.
5. Establish a method or process for ensuring that staffs that indicate they are bi/multi-lingual have the language capability to appropriately communicate ideas, concerns, and rationales.
6. Establish a method or process for ensuring that staffs that indicate they are bi/multi-cultural have knowledge of culturally appropriate evaluation, diagnosis, treatment, referral resources, and familiarity with culturally variant beliefs regarding mental illness.

Cultural/Ethnicity 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.

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 language assistance services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. The offer of interpreter services and the client's response must be documented.

Progress notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the beneficiary, consumers must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers.

Some county and contracted programs are Mandated Key Points of Contact. As a Mandated Key Point of Contact, the program must have staff or interpretation available to clients during regular operating hours that are linguistically proficient in the mandated threshold languages. The Access and Crisis Line, the EPU, and the Center for Community Health Education and Advocacy are Mandated Key Points of Entry for all four threshold languages. In addition the following clinics are also designated as Mandated Key Points of Entry for the languages listed:

- Spanish
 - EPU
 - All Outpatient and Case Management programs
- Vietnamese
 - UPAC
- Tagalog
 - UPAC
- Arabic
 - East County Mental Health

All other County and Contracted providers must at a minimum be able to link clients with appropriate services that meet the clients language needs whether the language is a threshold language or not.

Facility Requirements:

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.

Additional Program Requirements

Programs will also be required to do the following:

- 1) Develop and implement a Cultural Competence Plan for each provider site/program.
 - If providers have already developed a plan, they may continue to use their current plan to meet this requirement.
 - Plans will be due to County QI and Program Monitor by July 1, 2007.
 - Progress on plans made throughout the year may be noted in the MSR under QI activities.
 - County can provide technical assistance for Cultural Competence Plan development.
- 2) 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 must be documented. *(County will work with CCRT on the development of a standard process that may be used to meet this requirement with client input.)*
- 3) 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, assess community needs and what efforts the program is making to meet those needs. Topics that must be covered in the survey or focus group are:
 - Regarding Language:
 - Offers of providers who speak the client's language, or interpreter services
 - Linguistic proficiency of staff providing services or of interpreter if one is used
 - Staff's ability to clearly communicate ideas, concerns, and rationales in client's preferred language
 - Availability of written materials, including alternate formats in client's preferred language
 - Regarding Cultural/Ethnicity:
 - Direct services staff's knowledge of culturally appropriate evaluation, diagnosis, and treatment
 - Direct services staff's knowledge of culturally appropriate referral resources
 - Direct services staff's familiarity with variant beliefs regarding mental illness
 - Appropriateness of clinic environment
 - Results shall include outcomes, findings, and plans for interventions as needed.

- The County can provide technical assistance with developing survey/focus group questions.
- 4) Conduct a survey or focus group at least once and periodically if needed in the community to assess broader cultural competence issues that may be creating barriers to services.
- The County can provide technical assistance with developing survey/focus group questions.

Programs should send their cultural competence plans/reports to the QI Unit, County of San Diego, P.O. Box 85524, San Diego, CA. 92186-5524, Mail Stop: P531G.

Monitoring Cultural Competence

The MHP QI Unit is responsible for monitoring compliance with cultural competence standards as outlined in the County's Cultural Competence Plan and with State and Federal requirements. The QI Unit utilizes both the medical record review and site review process to monitor providers regarding cultural competence. To assist in the assessment of the cultural competence of staff system-wide, providers are asked to report the cultural and linguistic background of all staff members twice a year, including experience and training with any diverse population so that QI may compare the availability of staff to target population. In addition, the MHP may choose to periodically administer a Cultural Competence Survey.

I. MANAGEMENT INFORMATION SYSTEM

InSyst ®

The San Diego County Mental Health Plan (MHP) uses the InSyst system to register clients into the mental health system and to record each client's episode of service activities. The InSyst system also tracks Short-Doyle/Medi-Cal and third-party billing. The MHP contracts with the UBH MIS Department to support and maintain the InSyst system.

Using the InSyst system, organizational providers enter the data for client registration, episode and service activity on line. InSyst performs various validations to assist with accurate data entry: for example, InSyst will show a provider if a client being registered is already open in that provider's program, and will indicate whether a particular staff member is qualified to bill for a specific service. InSyst can provide the following client tracking and billing information to authorized users 24 hours a day, seven days a week:

- On-line Client Locator
- Instant Client Status Information
- Medi-Cal Eligibility Inquiry
- Client Registration
- Service History Inquiry
- Utilization Review
- "Significant Other" Tracking
- Financial Information and UMDAP (Uniform Method for Determining Ability to Pay) Tracking

The InSyst system supports on-line financial assessments. It will perform Medi-Cal, Medicare, third party insurance, and client billing functions, as well as electronic payment processing and many accounts receivable tasks.

The InSyst system resides on a VAX 7820, which is housed in a secure computer room at the office of the County's Information Services vendor, the Pennant Alliance.

Provider Support through UBH Customer Service (Help Desk) for InSyst

MHP Organizational Providers can obtain support for InSyst through the UBH MIS Customer Service Desk (Help Desk). The Help Desk can assist a provider with technical support or special requests and may be contacted as follows:

Phone: (619) 641-6928

Fax: (619) 641-6975

Emails: helpdesk@sdubh.com

All requests received by the UBH MIS Help Desk are logged and a Technical Support Specialist will be assigned to follow up on each provider request.

Help Desk support is available as follows:

During Business Hours

Normal business hours: Monday through Friday, from 8:00 a.m. to 5:00 p.m. (Holiday coverage is detailed below.)

Staff is available to handle problems, which include:

- Password expired; cannot log on to system
- Printer won't print a face sheet or a report
- Cannot obtain reports
- Need to use a different printer
- Creation of new user accounts
- Training issues and questions

After-Hours Support

UBH provides after-hours technical support for InSyst users. UBH MIS staff is available through a voice messaging pager system, which allows a caller to leave a detailed message for the support center. The pager system is operational on the following schedule

Monday through Friday: 6:30 a.m.- 8:00 a.m. and 5:00 p.m.- 9:00 p.m.
Saturday and Sunday: 9:30 a.m.- 5:00 p.m.

The customer service pager number is: (619) 893-4839

Some examples of support calls that may be handled after hours are:

- Can log on to network, but cannot log on to DOC or InSyst.
- When dialing the County modem, there is no response or the modem disconnects immediately.
- Logged in, but InSyst seems frozen. No data can be entered.
- Program errors in Service Entry screen or other data entry areas.

Emergency-Only Support

In some rare instances, providers may have serious problems with InSyst after hours, revealing an emergency situation, which affects all users. (Individuals or organizations experiencing a problem unique to their site must seek assistance from their technical support department, since UBH cannot support any non-UBH equipment.) Such emergencies may include:

- InSyst application failure – application is not available or system error messages indicate a fatal error
- Operating system failure (generally identified by Pennant Alliance staff)
- VAX system hard disk failure; need to restore from backup (generally identified by Pennant Alliance staff)
- Journaling files or database files are corrupt (generally requested by Information Services and Pennant Alliance staff)

In such an emergency, contact the Customer Service through its pager number (619) 893-4839.

Holiday Support

Provider support is available through the pager system for emergency problems which occur on the following holidays which will be observed by UBH in 2004: New Year's Day; day after New Years Day; Martin Luther King, Jr. Day; Memorial Day; Independence Day; Labor Day; Thanksgiving Day; and the day after Thanksgiving; Christmas Day; day after Christmas.

Connecting to the System

Most County-operated facilities have a direct connection to the VAX via the County's INET. Several larger contractors have dedicated data lines that support continuous connection to the VAX. However, most MHP organizational provider contractors connect to the VAX and log on to InSyst via dial-up modem connections or Remote Access Server (RAS) connections. The County's information services vendor, the Pennant Alliance, has established both telephone and access code numbers for this purpose.

Note: New providers should contact the UBH MIS Help Desk at (619) 641-6928 to determine their best dial-in solution and to establish the appropriate access codes.

System Training

Training is available for providers who use the InSyst system. InSyst data entry and look-up training is offered monthly and reports training or special module training is also available. For training inquiries, please contact UBH MIS at the above numbers. Users may also access: <http://www.ubhpublicsector.com/sandiego/sdmishelp.htm> to see the latest training schedule.

Note: Users must apply for or have an InSyst user account to attend InSyst basic training.

System Authorization

The County's Health and Human Services Agency (HHS) Information Technology System Security Department coordinates access to the agency's computer systems. Since the InSyst system is the County's mental health database and resides on a County computer network operated by the County, the System Security Department must authorize all requests for user access. Providers who need access to InSyst must complete the following forms to establish a User Account:

- Computer Services Registration Form (for Pennant Alliance/County)
- Remote Access Form—for modem users only (for Pennant Alliance/County)
- Confidentiality Policy (included in County Summary of Policies)
- InSyst User Authorization Form (for UBH)

The forms are processed by Pennant Alliance in coordination with the County's Internal Security to set up the VAX user account and AS5200 (Secured Modem) user account. Pennant Alliance or Internal Security notifies UBH who then creates a user account for the new agency within InSyst. Pennant or Internal Security then calls the provider and informs them that the account has been set up and presents the provider with their user name(s) and password(s). Forms can be obtained by contacting the UBH MIS Help Desk at (619) 641-6928, and completed forms can be mailed or faxed to UBH for processing at the following address:

UBH MIS
3111 Camino Del Rio North, Suite 500
San Diego CA 92108
Fax (619) 641-6975

Users are given general lookup privileges for client, episode, and service information. However, data entry and update privileges for specific reporting units must be authorized by the user's program director.

Clinical Staff Profiles

Each person whose services or MAA Activities are recorded through InSyst must have a Staff Identification Number. This number is tied to a profile specifying the training and duties of the staff person to whom it belongs. The information is used in determining whether a given activity may be billed if provided by that staff member, e.g., certain procedure codes may be used only by physicians, some only by psychologists and interns, others by all licensed and waived staff, and others by all staff. As a consequence, it is essential to update the profile when a staff member's status changes, for example when a waived intern becomes actually licensed. Requests by Staff Identification Numbers are made to UBH by the organizational provider program employing the individual, and UBH will seek approval of the application from the Program Monitor.

NOTE !

For system security, providers must notify UBH when staff with access to InSyst move, change jobs, or are terminated.

Security and Confidentiality

The County's mental health database must be protected from unauthorized use. Providers must ensure that only users with "need to know," who have signed confidentiality statements, are permitted to use the database. Sharing of passwords or allowing unauthorized individuals access into the system is strictly prohibited. All terminals and computer screens must be protected from the view of unauthorized persons. Reports with confidential client information are required to be stored in a secure place and properly destroyed when no longer needed.

In order to preserve the integrity of InSyst, providers must notify UBH Help Desk (619-641-6928) when a person with InSyst access moves, is terminated, or changes jobs. The InSyst User Authorization Form and the Computer Services Registration Form must be faxed to the UBH Help Desk (619) 641-6975 with the "Terminate" box checked off. UBH will then remove the person's InSyst access and add the replacement's name. UBH will also notify Pennant Alliance to have them 'disuser' the accounts.

User Manual and Reports Manual

Every program using the InSyst system is expected to maintain updated copies of the UBH InSyst User Manual and the UBH InSyst Reports Manual. These manuals were given to all contracted organizational providers and County-operated facilities during system implementation. New programs coming online, or existing programs with a need for new manuals, may request them by calling (619) 641-6928.

The appendices to the User Manual contain important information related to data codes allowed by the system. These appendices are updated from time to time and are available to providers at the UBH Website: <http://www.ubhpublicsector.com/sandiego/sdmishelp.htm>. Managers must ensure that the updated appendices are inserted in the User Manual and that staff is informed about the changes.

Providers are also encouraged to utilize the Organizational Provider Financial Eligibility and Billing Procedures Manual that is provided by AMHS. This manual is available by calling the Administrative Support Unit at (619) 563-2788.

InSyst Reports

A number of reports may be generated directly from the InSyst Reports Menu and printed at local or remote printers. Most reports may be requested directly from the system by authorized system users, while other InSyst reports are generated by UBH MIS personnel and distributed to the programs on a monthly schedule. Some of the most frequently used InSyst reports available to programs are listed below. Please note that some reports require a significant block of time to run, which can slow system performance if run during the business day; these reports should be run after hours, as noted in the "When Run" column.

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Report Number	Report Name	When Run	Notes
PSP100	Primary Staff Caseload Report	After Hours	See InSyst Reports Manual. Some users prefer the less detailed MHS802 report.
PSP101	Service Detail Report	After Hours	See InSyst Reports Manual. This is the standard Service Detail Report. This report sorts by staff and includes demographic and diagnostic information. Many users prefer the less detailed MHS801 report.
PSP102	Daily Service Audit Report	Any Time	See InSyst Reports Manual.
PSP104	Indirect Services	Any Time	See InSyst Reports Manual. Use this report to monitor Medi-Cal Administrative Activities (MAA).
PSP117	Provider Staff Activity Analysis Report	After Hours	See InSyst Reports Manual.
PSP118	Client Episode History Report	Any Time	See InSyst Reports Manual.
PSP119	Absence of Service Report	After Hours	See InSyst Reports Manual.
PSP121	Program Caseload Report	Any Time	See InSyst Reports Manual.
PSP123	24-Hour Daily Attendance Log	Any Time	See InSyst Reports Manual.
PSP131	Reporting Unit Service Summary Report	After Hours	See InSyst Reports Manual.
PSP138	Service Entry Performance	After Hours	See InSyst Reports Manual.
MHS140	Client Information Face Sheet	Any Time	See InSyst Reports Manual.
PSP186	Missing Social Security Number	Any Time	See InSyst Reports Manual.

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MANAGEMENT INFORMATION SYSTEM

Report Number	Report Name	When Run	Notes
MHS164	Liability Due Report	After Hours Monthly	See InSyst Reports Manual. This report is distributed by MIS and is directed to go to the program's default printer.
	Unbilled Medicaid Services	After Hours Monthly	See InSyst Reports Manual. Day Programs may use this report to see unauthorized services. This report is distributed by MIS and is directed to go to the program's default printer.
	Accounts Needed	After Hours Weekly	See InSyst Reports Manual. This report is distributed by MIS and is directed to go to the program's default printer.
	Staff Caseload Summary Statistics	After Hours Monthly	See InSyst Reports Manual. MIS submits this report on a monthly schedule.
PSP280	Physician Caseload Report	Any Time	See InSyst Reports Manual.
PSP577	Insurance Approval Report	After Hours Monthly	This report is distributed by MIS and is directed to go to the program's default printer. The report helps staff identify insurance policies that need attention in InSyst.
MHS800	Episode Face Sheet	Any Time	This face sheet shows the detail of a client's episode.
MHS801	Service Detail Report	After Hours	This report is sorted by client and has less demographic and diagnostic data than the PSP101.

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MANAGEMENT INFORMATION SYSTEM

Report Number	Report Name	When Run	Notes
MHS802	Primary Staff Caseload Report	After Hours	This report shows less detail than the PSP100.
MHS804	Staff Service Detail Report	Any Time	Use this report to review the activity of one staff at a time. To review the activities of the entire staff, use the MHS801 or PSP101.
MHS807	Admits & Discharges Report	Any Time	Users may run this report to show admissions and discharges at their program during a given period of time.
	Program Caseload Report for CSI Required Data	After Hours	Users may run this report to review caseload for CSI required data elements. The report is used as a tickler to remind program staff to update required data in InSyst.
MHS831	Service Summary Report	After Hours	This report is similar to the PSP131 but includes a column for total time in minutes. This report also calculates group size, including the number of staff assigned to the group, to determine total hours for group procedure codes.
	Annual Review Report	After Hours	This report is submitted by MIS and directed to the program's default printer. The report is used as a tickler to remind program staff to update required data in InSyst.

Note: If you do not see one of these reports on your Reports Menu and you wish to receive it, please call the UBH MIS Help Desk at (619) 641-6928.

NOTE: Failure to receive an InSyst report (including client Face Sheets), password resets, training questions or scheduling are not considered an emergency and will be handled the next business day.

Other Reports

UBH produces many other reports that are made available to programs via the Internet. Some of these reports include:

- Report 4a – Medi-Cal Claims Summary Report

- Report PSP354 – Units of Service Report
- Report PSP356 – Cost Report (Medi-Cal Units Report)
- Report MIS-6 – Admissions, Discharges and Census Report
- Provider Tracking Report

Users may visit the web site at:

<http://www.ubhpublicsector.com/sandiego/sdprovreports/sdoprpts.htm>

Note: A username and password is required to download the reports from the website. Users may contact (619) 641-6928 to obtain a password and directions.

New Reports

County Mental Health and UBH are also introducing new reports to assist programs with monitoring their Medi-Cal services and data entry performance. While these reports are introduced, the format and distribution method may vary. Some of the reports intended for contractors may be saved on compact disc and made available via the Contracts office. For example, this year, UBH prepared new Detail Direct Service Reports for contractors. These reports were saved as Excel spreadsheets with multiple tabs. The tabs include:

- The "Posted but No Medi-Cal" has services that are completely posted, but the services did not bill Medi-Cal. This tab would include non-billable services, but would also include Medi-Cal billable services that did not bill to Medi-Cal, usually because there is no eligibility in the system.
- The "Posted Medi-Cal" tab has all services that billed to Medi-Cal or to a payor mix including Medi-Cal.
- The "Services Stuck in Posting" tab include services that are "stuck" in posting because the system is waiting for further action. For example, "Insurance Policy not currently ready" indicates that a Medicare or Insurance policy is on hold and the user must determine if policy is viable and insert three X's in the insurance policy screen. Once corrected, these services can move to the next stage in the posting and claiming process.
- The "All Other Services" tab will include all other services, i.e., services that are newly entered and have not yet posted (the system has a seven (7) day window before services post).

Another new report that is being introduced this year is the Medi-Cal Denials Report. This detailed report shows the services that were claimed to the State Medi-Cal program but were denied and not paid.

J. PROVIDER CONTRACTING

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

All non-County-operated organizational providers must contract with the County of San Diego in order to receive reimbursement for Specialty Mental Health Services. Please read your contract carefully. It contains:

- General terms applicable to all contracts;
- Special terms specific to a particular contract;
- A description of work or services to be performed;
- Budget schedules; and
- Statutes and/or regulations particular to the Medi-Cal managed mental health care programs, as well as programs supported by other funds.

All contracted providers will be expected to adhere to these requirements. Please contact the Mental Health Services Contract Administration Unit at (619) 563-2733 if you have any questions regarding your contract.

Program Monitoring

Each provider will have assigned to their contract a County Program Contract Representative (PCR) also called Program Monitor, 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 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.

Contractor Orientation

Providers receiving a new contract are required to attend a contractor orientation meeting, which will be held within 45 days of contract execution. Contractor will designate a contact person to coordinate attendance of necessary contractor staff at the orientation.

Notification in Writing of Status Changes

Contractors are required to notify the Mental Health Contract Administration Unit in writing if any of the following changes occur:

- Change in office address, phone number or fax;

NOTE!

Please read your contract carefully and keep it in a place where you can refer to it easily.

If you have any questions regarding your contract, please contact the Mental Health Services Contract Administration Unit at (619) 563-2733.

- Addition or deletion of a program site;
- Change of tax ID number or check payable name; or
- Additions or deletions from your roster of Medi-Cal billing personnel.

Site Visits

The County MHP will conduct an annual site visit to all organizational providers. The County MHP includes MHS Program Chief/Designee, MHS CAU, MHS Quality Improvement (QI) Unit, and the Health and Human Services Agency (HHSA) Contract Support. The site visit may include, but is not limited to, a review of:

- Compliance with contractual statement of work
- Client medical records (where applicable)
- Building and safety issues
- Staff turnover rates
- Insurance, licensure and certification documentation
- Request for Services and Problem Resolution/Provider Transfer Request Logs
- Fiscal and accounting policies and procedures
- Compliance with standard terms and conditions.

Information from the site visit will be included in the contract monitoring process. Please see the Quality Improvement Program section of this Handbook for a more detailed discussion of Medi-Cal provider site visits.

Status Reports

Contracted providers are required to submit a completed Monthly Status Report (MSR) within 15 calendar days after the end of the report month. The MSR may require the submission of additional forms, such as the Problem Resolution/Provider Transfer Request Log. Twice yearly, in July and December, Contractors are required to submit a Cultural Competency Report (CCR) as part of the monthly report. For those months, the MSR is not complete without a completed CCR.

Plans of Correction (POC)

A Plan of Correction is a tool identifying deficiencies in complying with contractual obligations and required corrective actions within a specified timeframe. A POC may result from site visits or information derived from reports. Contractors are required to respond to the POC specifying course of actions initiated/implemented to comply within the specified timeframe.

Contract Issue Resolution

Issues, problems or questions about your contract should be addressed to:

Contracting Officer's Technical Representative (COTR)
Mental Health Services
Contract Administration Unit (P531K)
P O Box 85524
San Diego, CA 92186-5524

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 the Mental Health Services Disaster Response Plan. Response may include staff being deployed to provide services in the community, out of county under mutual aid Contracts, in shelters and/or other designated areas.
- Contractor shall provide CHMS 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 receive Disaster Orientation Training by the County in 2007. The identified staff will be added to the Disaster roster maintained by the County for possible deployment in critical incidents.

Contractor shall advise COTR of subsequent year training needs to maintain 25% trained direct service staff in the event of staff turnover.

CLAIMS AND BILLING FOR CONTRACT PROVIDERS

Contractor Payments

Contractors will be paid in arrears. After the month for which service has been given, the MHS CAU will process claims (invoices) in accordance with the contract terms.

Budgets, Cost Reports and Supplemental Data Sheets and Claims (Invoices)

- Budgets, cost reports, supplemental data sheets, and claims (invoices) must comply with the established procedures in the State of California, Department of Mental Health, Cost Reporting/Data Collection Manual, dated July 1989.
- Quarterly Cost Reports are due by October 31, January 31, April 30.
- Year-end Cost report is due by August 31.

Submitting Claims (Invoices) for Services

Please submit all claims (invoices) for payment to:

Mental Health Services
Contract Administration Unit (P531-K)
P O Box 85524
San Diego, CA 92186-5524
Fax: (619) 563-2730, Attn: Lead Fiscal Analyst

Overpayment

In the event of overpayments, excess funds must be returned or offset against future claim payments.

Certification on Disbarment or Exclusion

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

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

To verify through the Internet if someone is on the OIG Exclusion list or the GSA debarment list, go to:

<http://www.oig.hs.gov/fraud/exclusions/listofexcluded.html>

<http://epls.arnet.gov/epls/servlet/EPLSSearchMain/1>

To view the list of what will get someone placed on the OIG list, go to:

<http://oig.hhs.gov/fraud/exclusions/exclusionauthorities.html>

Please remember the following:

- Providers must retain the records verifying that these required monthly checks have been performed and the names of the employees checked.
- Any employees who appear on either the OIG or GSA lists are prohibited from working in any County funded program

- Providers are encouraged to consult with their compliance office or legal counsel should any of their employees appear on either of the exclusion lists.

SHORT-DOYLE MEDI-CAL

Per Cost Reporting/Data Collection Manual, the “policy of the State Agency is that reimbursement for Short-Doyle Medi-Cal services shall be limited to the lowest of published charges, Statewide Maximum Allowances (SMA), negotiated rates or actual costs if the provider does not contract on a negotiated rate basis.”

I. *Definitions*

Actual Cost is reasonable and allowable cost based on year-end cost reports and Medicare principles of reimbursement per 42 CFR, Part 413 and HCFA Publication 15-1.

Federal Financial Participation per Title 9 CCR, Chapter 11 means the federal matching funds available for services provided to Medi-Cal beneficiaries under the Medi-Cal program.

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

Provider means the legal entity providing Short-Doyle Medi-Cal Services.

Published Charge or Published Rate is a

“term used in CFR Title 42 to define provider cost reimbursement mechanisms from third party sources. This generally means that customary charges throughout the year should be as close to actual (cost) as possible to avoid a lesser of costs or charges audit exception circumstance.”

Published rates for services provided by organizational providers must be updated at the beginning of each fiscal year to ensure the County’s information system, InSyst, has the accurate information, as well as ensuring no potential loss of Medi-Cal revenue. The published rate for a specific service should at a minimum reflect the total cost for providing that service to ensure no loss of Medi-Cal revenue. Published rates are to be submitted to MHS CAU no later than June 14 of each year.

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

II. *Medi-Cal Revenue*

InSyst will bill Medi-Cal for covered services provided to Medi-Cal beneficiaries by Short-Doyle/Medi-Cal certified programs. For services that do not clear the billing edits, the State will issue Medi-Cal Error Correction Reports (ECRs) to the MHP's agent, United Behavioral Health (UBH). UBH will mail the ECRs to the appropriate providers. Providers need to make the necessary corrections to the ECRs and resubmit them to UBH within 10 business days at the following address:

UBH Financial Management Unit
3111 Camino Del Rio North, Suite 500
San Diego, CA 92108

III. *Medi-Cal Disallowance/Recoupment of Federal Financial Participation (FFP) Dollars*

It shall be the policy (Recoupment Based on Medical Record Review; No: 01-01-125) of County of San Diego Mental Health Services to disallow billing by Organizational, Individual and Group providers that does not meet the documentation standards set forth in the Uniform Clinical Record Manual and to recoup Federal Financial Participation (FFP) in accordance with the current California State Department of Mental Health Reasons for Recoupment of Federal Financial Participation Dollars (*see Appendix J*).

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

- Medical Necessity
- Client Plan
- Progress Notes.

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

The federal share of the Medi-Cal claims for the above circumstances will be deducted from your contract payment.

In accordance with State guidelines, these disallowances may be subject to future change.

IV. *Billing Disallowances – Provider Self Report*

The policy of San Diego County Mental Health Administration (SDCMHA) is to recoup Federal Financial Participation (FFP) and Early Periodic Screening and Diagnostic Treatment (EPSDT) dollars by disallowing billing which has been identified and reported to the SDCMHA by the Contracted Organizational Providers and County Owned and Operated Clinics in accordance

with documentation standards as set forth in the current California State Department of Mental Health “Reasons for Recoupment of Federal Financial Participation Dollars.”

Below are the procedures to be followed for Self Reporting of Billing Disallowances to ensure consistent procedures are used when the information is reported to Mental Health Administration by providers.

Provider

1. Providers are required to conduct an internal review of medical records on a regular basis in order to ensure that the documentation meets all County, State and Federal standards and the billing is substantiated.
2. If the review of a Medi-Cal client’s chart results in a finding that the clinical documentation does not meet the documentation standards as set forth in the current California State Department of Mental Health, Reason for “Recoupment of Federal Financial Participation Dollars (FFP),” the provider shall be responsible for addressing the issue by filing a Self Reported Disallowance Claim Form (located in *Appendix J*) with San Diego County Mental Health (SDCMH) Administration.
3. To file a Self Reporting of Billing Disallowances with SDCMH, Providers shall fill out the provider self report billing disallowance form (located in *Appendix J*) and e-mail the form to Khris.gimeno@sdcounty.ca.gov and indicate if they would like to receive verification that the claims were disallowed.
4. The services noted on the form shall be entered into the State Disallowed Claims System (DCS). If the services are found, the system will disallow. Services that are not found in the DCS will be noted on the Provider Self-Report Billing Disallowance form and communicated to the provider for follow-up and resolution.
5. For items that are not found in the DCS: Providers shall review their Provider Self-Report Billing Disallowance form for errors and re-send a corrected form if errors are identified.
 - Items that have not yet billed to Medi-Cal will not be listed in the DCS.
 - Items that have been billed to Medi-Cal which had errors as noted on the Error Correction Report (ECR) will not be listed in the DCS.
6. For services that were disallowed, the DCS automatically creates an invoice report containing the amount of SC/MC, FFP and EPSDT dollars that will be recouped. As noted above, any provider who would like verification that the claims were disallowed shall indicate in the e-mail to Khris.gimeno@sdcounty.ca.gov.
7. To correctly complete the Provider Self-Report Billing Disallowance form, providers must note on the form under the column labeled Service Deletion2 whether the services noted as billing disallowances need to be deleted in InSyst. To determine which services should be noted as a service deletion, see the attachment titled Provider Actions for Billing Disallowances and Service Deletions. Service deletions will be forwarded to UBH to be entered into InSyst. Please note: Providers are responsible for re-entering corrected billing or entering non-billable service for services that are identified as service deletion or billing disallowance.

8. In order to remove billing from EPSDT review, providers must send the Self-Report form two days prior to the last day noted in the DMH notice for the time period that is being reviewed. Items sent after the deadline will not be removed from the EPSDT review and will be subject to recoupment.

Financial Management Unit

1. Upon receipt of the Provider Self-Report Billing Disallowance form, FMU staff will access the Disallow Claim System (DCS) on ITWS and enter the disallowances.
2. After all of the disallowance data has been entered, FMU staff will:
 - a. Notify UBH to perform service deletions from InSyst for the Disallowed Claims.
 - b. Email the Disallowed Claims Report to the QI Supervisor and CAU Staff indicating the disallowances made in the DCS on ITWS.
 - c. Discrepancies will be noted on the Provider Self-Report Billing Disallowance form and returned to the provider for follow-up and resolution.
3. The DCS automatically creates an Invoice Report containing the amount of SC/MC, HFP, and EPSDT dollars that will be recouped. The Invoice Report is e-mailed by ITWS to the staff listed on the DCS e-mail distribution list. The distribution list can be updated at any time through the utilities function of the DCS. Those on the distribution list will assure that the invoice is emailed to HHSA fiscal and CAU staff.
4. When the disallowance module was set up, MHS elected to have the Recoupment of disallowed services deducted from future claims rather than payment by check. This can be modified through the utilities function of the DCS.
5. Staff will retain the Disallowed Claims Report, corresponding Invoice Report, and Provider Self-Report Billing Disallowance form.

Administrative Service Organization

Upon receipt of report from FMU staff, ASO staff will;

1. Perform service deletions from InSyst according to their policy and procedure.
2. Send confirmation to ASU staff of the date the services were deleted from InSyst.
3. If discrepancies are noted on the "Service Deletion and State Disallow Claim System Request Form", ASO will communicate the discrepancy to FMU staff for follow-up and resolution.

HHSA Fiscal

1. Fiscal receives and retains the Invoice Report for documentation of the future claim offset.
2. When Remittance Advices are received from the State and indicate a reduction due to the recoupment of Disallowed Claims, Fiscal will match the recoupment amount to the

Invoice Report. If there is a discrepancy or if Fiscal does not have a corresponding Invoice Report, they will contact the FMU who will be accountable for researching and resolving the issue.

Contracts Administration Unit

1. Contracts Administration Unit (CAU) staff will generate the “Provider Disallowance Payment Reduction Worksheet” upon receipt of the Disallowed Claims Report and corresponding Invoice Report.
2. CAU staff prepares a Recoupment Notice and cover letter and sends them to the contractor.
3. The contractor may elect to repay the Recoupment via check or an offset from future payments.
 - a. If the contractor pays by check, the check is received by CAU staff and forwarded to Financial Management staff for deposit. The payment is logged in the contract file along with a copy of the payment.
 - b. If no check is received by CAU within 15 business days from the date of the letter to the Provider, the recoupment amount is deducted from the next scheduled provider payment.
4. CAU staff ensures that all disallowances are included in the calculation of the year-end provider payment settlement and contractor Short-Doyle/Medi-Cal Cost Report by comparing it to the PSP356 Report.

NOTE: Only the amounts listed on the Invoice Reports are recouped from the providers.
5. CAU staff provides the reconciliation to HHSA Fiscal staff for backup to the County’s Short-Doyle/Medi-Cal Cost Report.

Quality Improvement

Upon receipt of the Disallowed Claims Report the QI Supervisor will forward the report to Performance Outcomes to staff to track by program and for systemwide information.

Billing Inquiries

Questions regarding claims (invoices) for payment should be directed in writing to:

Mental Health Services
Contract Administration Unit (P531-K)
P O Box 85524
San Diego, CA 92186-5524
Attn: Lead Fiscal Analyst

Questions can also be addressed by calling the Lead Fiscal Analyst at (619) 563-2722.

MEDI-CAL BILLING MONITORING PLAN: COUNTY OPERATED PROGRAMS

The purpose of this monitoring plan is to ensure accurate and appropriate claiming for Medi-Cal reimbursable services and to implement a process of monitoring by the Mental Health Plan of all San Diego County operated mental health services. Noted processes may change with the implementation of the new Mental Health Management Information system (Anasazi).

A. County Operated Mental Health Services

The County Operated Mental Health Services program manager is responsible for ensuring that policies and procedures are clear and upheld and that monitoring may include, but is not limited to, the following:

- Identify staff that are Medicare-eligible providers and ensure that these identified staff obtains necessary certification as Medicare Providers.
- Medicare/Medi-Cal (Medi-Medi) insured clients shall be identified at the time of enrollment for program services. Medi-Medi insured clients shall be provided and/or referred to Medicare-approved providers for Medicare-approved services.
- Reimbursable Mental Health Services shall be claimed in a timely and accurate manner with Medicare and/or Other Health Coverage (OHC) billed first as the primary payor.

B. HHSA Mental Health Billing Unit

The HHSA Mental Health Billing Unit will monitor the Error Correction Report (ECR) and Assignment of Benefits (AOB) process for County programs.

- Error Correction Report (ECR) for County programs is received by the HHSA Mental Health Billing Unit. ECR identifies errors on claims submitted to Medi-Cal (e.g. the client having Other Health Coverage (OHC), wrong DOB, and no eligibility on file, etc). A copy of the corrected ECR report is sent to the County programs to identify the corrective actions for those errors received. Programs have 10 days to review the ECR report and/or explain future actions/follow up on the ECR summary form. Programs shall return the ECR summary form within 10 days to the ASO. The program manager should indicate on the ECR correction summary form how the error(s) occurred, how error(s) will be corrected, and what corrective action measures are in place to avoid future errors. The HHSA Mental Health Billing Unit is responsible for editing the ECR and updating the system with the necessary corrections; otherwise, the program is responsible for follow-up with the corrective action indicated on the ECR summary form. The HHSA Mental Health Billing Unit identifies the corrections made on the ECR report in green ink and submits it to the State. The HHSA Mental Health Billing Unit will monitor the provider for timely

return of the ECR correction form, and if necessary, send a letter to each provider who is out of compliance and notify the Program Monitor.

- Assignments of Benefits (AOB) - It is the programs responsibility to get a signed AOB form from the client so that the OHC/Medicare can be billed prior to billing Medi-Cal. Every month, programs will receive a report from of all clients who have outstanding AOBs.

Note: Error Correction Report (ECR) will be changing to Void and Replace when State has implemented this new process.

C. County Program Monitor and/or their Designee

The Program Monitor and/or their designee will monitor the County operated programs through the following:

- Provider Tracking Reports which include:
 - Deletion requests
 - ECR completion
 - Aged Accounts Receivable Report (Insurance Receivable detail 120+ Days) (MHS116)
 - Liability Due Report (MHS164) (UMDAPS)
 - Summary Provider Tracking Report
- Approving Budgets
- Review Cost Reports (Function provided by Contract Support Services)
- Review Staffing
- Review Monthly Status Reports

Programs with reports that are found to be out of compliance or have an unusual variance/trend will be contacted by the Program Monitor to identify areas of concerns. Program Monitor will assign corrective action which may include progressive interventions up to and including a verbal notification of deficiency and required remediation, increased monitoring, technical assistance, and/or issuing a written Notice of Corrective Action.

Note: May change when system moves to Anasazi.

D. Quality Improvement Unit

The Quality Improvement Unit is responsible for monitoring compliance and standards through:

- Site Reviews including Policy and Procedure Reviews. Programs should have policies and procedures in place dealing with the following:
 - Policies and Procedures for scheduling Medi-Care services
 - Policies and Procedures for referring to Fee for Service Providers

- Policies and Procedures for reimbursement of mental health services from primary and secondary health insurance payor sources
- Medical Record Reviews to monitor compliance in the following areas:
 - Short-Doyle/Medi-Cal documentation and coding requirements are being met
 - Mental Health Services are provided for clients according to covered health insurance benefits
 - Qualified staff are providing eligible Medicare approved mental health services (This standard will be added to the billing section of the 08/09 Adult/Older Adult Organizational Provider Medical Record Review Tool).
- Monitoring Tools:
 - Organizational Provider Site Review Tool
 - Organizational Provider Medical Record Review Tool
 - Focused Medical Record Reviews as necessary

For programs that are found to be out of compliance, the QI Unit will verbally notify the Program Monitor to identify areas of concerns. Program Monitor will assign corrective action which may include progressive interventions up to and including a verbal notification of deficiency and required remediation, increased monitoring, technical assistance, and/or issuing a written Notice of Corrective Action.

Note: May change when system moves to Anasazi.

E. Behavioral Health Services Financial Management Unit

Explanation of Benefits (EOB) monitoring consists of:

- Select a random date to review EOBs
- Quarterly, the Financial analyst will select the MHS 172 Report (A signed certification of payments received or denied from OHC and Medicare) from HHSA Mental Health Billing Unit.
- A random selection of names that show OHC and Medicare payments and denials is made from this report. The individual who signed the certification for the programs is then contacted and a copy of the EOB is requested.
- The contacted individual is given 10 business days to provide a copy of the requested EOB via fax.
- If a program has not provided the information within the 10 business days, an email request is sent to the program's COTR requesting that he/she contact the program to provide the requested information.
- The EOBs are reviewed and compared to the MHS 172 report.
- A Summary Report of EOB Program Compliance is generated by the financial analyst within 30 days from the date the EOBs were reviewed and forwarded to the COTRs and HHSA Mental Health Billing Unit.

- Programs that did not provide an EOB or that are not in compliance with the standard billing practices for OHC and Medicare will be contacted by the COTR. Appropriate action will be assigned to the program by the COTR which may include progressive interventions up to and including a verbal notification of deficiency and required remediation, increased monitoring, technical assistance, and/or issuing a written Notice of Corrective Action for Non-Compliance.
- Monthly, the ASO generates an ECR Trend Report that identifies each provider's dollar error rate and the specific number and type of errors that were made. The trend report is reviewed by the fiscal analyst and made available to the COTRs on the S-drive. The COTR is alerted to any provider showing an error rate over 2% for 3 consecutive months.

Note: May change when system moves to Anasazi.

F. Behavioral Health Services Contract Support Services

The financial analysts in Behavioral Health Services Contract Support Services (BHS CSS) review cost reports which include any reporting of third party revenue. Cost adjustments are made for each contract on a monthly basis. The legal entity receives a written notification of any cost adjustments that apply to a specific contract. BHS CSS will inform the Program Monitor of any cost adjustments to a specific contract and any potential issues as a result of the cost adjustment.

G. Administrative Services Organization

The ASO is responsible for providing the following monitoring reports to County operated programs:

- Provider Tracking Report
- Aged Accounts Receivable Report (MHS116)
- Liability Due Report (MHS164) (UMDAPS)
- Monthly, the ASO generates an ECR Trend Report that identifies each provider's dollar error rate and the specific number and type of errors that were made.

Note: Report numbers may change when system moves to Anasazi.

MEDI-CAL BILLING MONITORING PLAN: CONTRACTED ORGANIZATIONAL PROVIDERS

The purpose of this monitoring plan is to ensure accurate and appropriate claiming for Medi-Cal reimbursable services and to implement a process of monitoring by the Mental Health Plan of all Contracted Organizational Providers of mental health services. Noted processes may change with the implementation of the new Mental Health Management Information system (Anasazi).

A. Contracted Organizational Providers

The Contracted Organizational Providers are responsible for development and implementation of internal program policies, procedures, and monitoring systems which may include but are not limited to the following:

- Identify staff that are Medicare-eligible providers and ensure that these identified staff obtains necessary certification as Medicare Providers.
- Medicare/Medi-Cal (Medi-Medi) insured clients and other healthcare insured clients shall be identified at the time of enrollment for program services. Medi-Medi insured clients shall be provided and/or referred to Medicare-approved providers for Medicare-approved services.
- Reimbursable Mental Health Services shall be claimed in a timely and accurate manner with Medicare and/or Other Health Coverage (OHC) billed first as the primary payor.
- Assignments of Benefits (AOB) - It is the program's responsibility to get a signed AOB form from the client so that the OHC/Medicare can be billed prior to billing Medi-Cal. Every month, programs receive a list (PSP577) from the ASO, via the Portal, of all clients who have outstanding AOBs.
- Program Manager or Designee is responsible for monitoring the Aged Accounts Receivable Report monthly posting and making an appropriate posting into InSyst.
- Program managers must monitor the Error Correction Report (ECR) which is sent to the programs to identify errors that were made on claims submitted to Medi-Cal. (e.g. the client having Other Health Coverage (OHC), wrong DOB, no eligibility on file, etc). This report is sent directly to programs from the HHSA Mental Health Billing Unit. Programs have 10 days to correct the errors on the ECR report in green ink and/or explain future actions/follow up on the ECR summary form. Both the ECR report and summary form shall be returned HHSA Mental Health Billing Unit within 10 days. The program manager needs to indicate on the ECR correction summary form how the errors have been corrected and what corrective action measures are put in place to avoid the errors from happening in the future.

B. HHSA Mental Health Billing Unit

HHSA Mental Health Billing Unit will review, monitor, and batch Error Correction Reports (ECR) from Contract Programs. ECR report will be replaced by Void and Replace System upon implementation in InSyst or Anasazi. The HHSA Mental Health Billing Unit will monitor the provider for timely return of ECRs, and if necessary, send a letter to each provider who is out of compliance and notify the COTR.

C. Contracting Officers Technical Representatives (COTR) and/or their Designees

COTRs and/or their designees will monitor the Contracted Organizational Providers through the following:

- Provider Tracking Reports which include:
 - Deletion requests
 - ECR completion
 - Aged Accounts Receivable Report (Insurance Receivable detail 120+ Days) (MHS116)
 - Liability Due Report (MHS164) (UMDAPS)
 - Summary Provider Tracking Report
- Approving Budgets
- Review Cost Reports (Function provided by Contract Support Services)
- Review Staffing
- Review Monthly Status Reports

Programs with reports that are found to be out of compliance or have an unusual variance/trend will be contacted by the COTR to identify areas of concerns. Appropriate action will be assigned to the program by the COTR which may include progressive interventions up to and including a verbal notification of deficiency and required remediation, increased monitoring, technical assistance, and/or issuing a written Notice of Corrective Action for Non-Compliance.

Note: May change when system moves to Anasazi.

D. Quality Improvement Unit

The Quality Improvement Unit is responsible for monitoring compliance and standards through:

- Site Reviews in which programs should have policies and procedures such as:
 - Policies and Procedures for scheduling Medicare Services
 - Policies and Procedures for scheduling Fee for Service Providers
 - Policies and Procedures for reimbursement of mental health services from primary and secondary health insurance payor sources

- Medical Record Reviews to monitor compliance for:
 - Short-Doyle/Medi-Cal documentation and coding requirements
 - Mental Health Services provided for clients according to covered health insurance benefits
 - Qualified staff providing eligible Medicare approved mental health services. (This standard will be added to the Billing section of the 08-09 Adult/Older Adult Organizational Provider Medical Record Review Tool).
- Monitoring Tools:
 - Organizational Provider Site Review Tool
 - Organizational Provider Medical Record Review Tool
 - Focused Medical Record Reviews as necessary

For programs that are found to be out of compliance, the QI Unit will verbally notify the COTR to identify areas of concerns. Appropriate action will be assigned to the program by the COTR which may include progressive interventions up to and including a verbal notification of deficiency and required remediation, increased monitoring, technical assistance, and/or issuing a written Notice of Corrective Action for Non-Compliance.

Note: May change when system moves to Anasazi.

E. Behavioral Health Services Financial Management Unit

Monitoring of Explanation of Benefits (EOB) will be completed by the Behavioral Health Services Financial Management Unit. EOB monitoring consists of the following steps:

- Select a random date to review EOBs
- Quarterly, the Financial analyst will select the MHS 172 Report (A signed certification of payments received or denied from OHC and Medicare) from the HHS Mental Health Billing Unit.
- A random selection of names that show OHC and Medicare payments and denials is made from this report. The individual who signed the certification for the program is then contacted and a copy of the EOB is requested.
- The contacted individual is given 10 business days to provide a copy of the requested EOB via fax.
- If a program has not provided the information within the 10 business days, an e-mail is sent to the program's COTR requesting that he/she contact the program to provide the requested information.
- The EOBs are reviewed and compared to the MHS172 report.
- A Summary Report of EOB Program Compliance is generated by the Financial analyst within 30 days from the date the EOBs were reviewed and forwarded to the COTRs
- Programs that did not provide an EOB or that are not in compliance with the standard billing practices for OHC and Medicare will be contacted by the COTR. Appropriate

action will be assigned to the program by the COTR which may include progressive interventions up to and including a verbal notification of deficiency and required remediation, increased monitoring, technical assistance, and/or issuing a written Notice of Corrective Action for Non-Compliance.

- Monthly, the ASO generates an ECR Trend Report that identifies each provider's dollar error rate and the specific number and type of errors that were made. The trend report is reviewed by the Financial Analyst and made available to the COTRs on the S-drive. The COTR is alerted to any provider showing an error rate over 2% for 3 consecutive months.

Other monitoring:

- Financial analyst will review each contractor at least once a year, or more often if indicated, using the Aged Accounts Receivable Report (MHS116) to insure appropriate Medicare claiming and posting to InSyst. The COTR is alerted if programs are not claiming Medicare appropriately.

Note: May change when system moves to Anasazi.

F. Behavioral Health Services Contract Support Services

The financial analysts in Behavioral Health Services Contract Support Services review cost reports which include any reporting of third party revenue. Cost adjustments are made for each contract on a monthly basis. The legal entity receives a written notification of any cost adjustments that apply to a specific contract. The COTR is notified by BHS CSS of any cost adjustments to a specific contract and any potential issues arising as a result of the cost adjustment.

Note: May change when system moves to Anasazi.

G. Administrative Services Organization – ASO

The ASO is responsible for providing the following monitoring reports to Contracted Organizational Providers:

- Provider Tracking Report
- Aged Accounts Receivable Report (MHS116)
- Liability Due Report (MHS164) (UMDAPS)
- Monthly, the ASO generates an ECR Trend Report that identifies each provider's dollar error rate and the specific number and type of errors that were made.

Note: Report numbers will change when system moves to Anasazi.

K. PROVIDER ISSUE RESOLUTION

The MHP recognizes that at times providers may disagree with the MHP over an administrative or fiscal issue and will be happy to work with them to solve the problem. There is both an informal and formal Provider Problem Resolution Process for providers who have concerns or complaints about the MHP.

Informal Process

Providers are encouraged to communicate any concerns or complaints to the Program Monitor or designee. The Program Monitor or designee shall respond in an objective and timely manner, attempting through direct contact with the provider to resolve the issue. When issues are not resolved to the provider's satisfaction informally, a formal process is available. A copy of complaint materials will be sent to the County Mental Health QI Unit.

If the provider is not satisfied with the result or the informal process or any time, the formal process below is available:

Formal Provider Problem Resolution Process

1. Providers shall submit in writing any unresolved concerns or complaints to the MHS Contracts Manager or designee, using the Formal Complaint by Provider form (located in *Appendix K*).
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 or designee shall have 60 calendar days from the receipt of the written complaint to inform the provider in writing of the decision, using the Formal Response to Complaint form (see *Appendix K*).
5. The written response from the Contracts Manager or designee shall include a statement of the reason(s) for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.
6. Formal Provider Problem Resolution documentation is to be directed to:

Mental Health Services Contracts Manager
P O Box 85524
San Diego, CA 92186-5524
Mail Stop: P531-K

7. A copy of all complaint materials shall be sent to the County Mental Health QI Unit.

Formal Provider Appeal Process

1. Provider may submit an appeal within 30 calendar days of written decision to the Formal Complaint.
2. An appeal from an adult services provider shall be submitted in writing, using the Formal Appeal by Provider form (see *Appendix K*), to the Assistant Deputy Director (ADD) for AMHS. Formal Provider Appeals from CMHS shall be submitted in writing to the Assistant Deputy Director of CHMS.
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 form (see *Appendix K*).
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's Mental Health Services
P.O. Box 85524
San Diego, CA 92186-5524
Mail Stop: P531-C

7. A copy of all appeals materials should be sent to the County Mental Health QI Unit:

Quality Improvement Unit

P.O. Box 85524
San Diego, CA 92186-5524
Fax: (619) 584-5018
Mail Stop: P531-Q (Children)
Mail Stop: P531-G (Adults)

Complaints and Appeals for Denial of Authorization or Payment for Services

Providers have the right to access the provider appeal process at any time before, during or after the provider problem resolution process has begun when the complaint concerns a denied or modified request for MHP authorization or a problem with processing of a payment.

Providers appealing a denial of authorization or payment must submit a written complaint within 90 days of the receipt of the denial to their County Regional Coordinator/Program Monitor. The written complaint should include the client name, InSyst #, date of authorization/payment denial and/or dates of all service(s), along with any specific information relevant to the complaint. (See

Authorization of Reimbursement for Services section of this Handbook for more information on denials.)

All such complaints will be logged and a response will be issued within 30 days about action or denial. At any time within 90 days of the original attempt to resolve the issue informally, providers may appeal any decision made by the Regional Coordinator by submitting an appeal to the County Mental Health Director or his designee. The appeal should include the client name, InSyst #, date of authorization/payment denial and/or dates of all service(s), along with a copy of the Regional Coordinator's letter of response. The County Mental Health Director or his designee will have 30 days to make a final decision on the appeal and respond back in writing to the provider.

Contract Administration and Fiscal Issues with MHP Contracts

Please see the Provider Contracting section of this Handbook.

L. PRACTICE GUIDELINES

Practice guidelines refer to methods and standards for providing clinical services to clients. They are based on clinical consensus and research findings as to the most effective best practices and evidence-based practices available. Because they reflect current interpretations of best practices, the guidelines may change as new information and/or technology becomes available. Special efforts must be given in respect to the unique values, culture, spiritual beliefs, lifestyles and personal experience in the provision of mental health services to individual consumers.

Treatment of Co-Occurring Substance Abuse and Mental Health Disorders

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. For adults with serious mental illness who meet eligibility criteria, integrated treatment of a co-occurring substance use disorder and the mental health diagnosis is nationally recognized as evidenced based practice. Please implement the following when serving an adult client that meets the criteria for co-occurring disorders:

- Document on the Admission Checklist that the client and/or family was given a copy of your program's Welcoming Statement, if any.
- Include substance use and abuse issues in your initial screening or assessment, including the MHS-912 form as well as additional screening tools that may be adopted or required.
- For adult clients who meet the DSM-IV-TR diagnostic criteria for both a mental health and substance use disorder, the primary diagnosis shall be the covered mental health diagnosis that is the focus of treatment. This does not imply that the substance use issue is less important than or attributed to the mental health disorder.
- For adult clients who do not meet the specialty mental health medical necessity criteria, but do have an identified substance use issue, the provider will make appropriate services referrals and document actions taken.
- Substance use or abuse, including in a caretaker should be coded under the Axis IV (Psychosocial and Environmental Problems) classification and also coded in the InSyst database under the *Other Factors* code.
- In general, treatment services and documentation shall focus on the primary mental health diagnosis and the identified functional impairment(s). For adult clients, the co-occurring substance use issue may be integrated into treatment interventions in terms of how it impacts the functional impairment related to the mental health diagnosis. All prepaid treatment interventions shall focus on the mental health diagnosis.
- Documentation of treatment services and interventions must meet the federal and CCR Title 9 requirements if mental health services are to be claimed to Medi-Cal. If the substance use is in a collateral person, the progress note must focus on the impact of the substance use on the identified client.

- It is not appropriate to exclude a client from services solely because of the presence of a substance use disorder or a current state of intoxication. This decision should be made based on the client's accessibility for treatment, as well as client and provider safety concerns.

For more information, please reference HHSA's MHS Policy and Procedure: Specialty Mental Health Services for Clients with Co-occurring Substance Use Problems No: 01-01-117. This resource is available by contacting your Program Monitor.

Dual Diagnosis Capable Programs

Certain programs within the AMHS system will seek certification as Dual Diagnosis Capable or Dual Diagnosis Enhanced. These certifications refer to program and staff competence with clients with co-occurring disorders. In general, Dual Diagnosis Capable programs will welcome clients with both types of diagnosis, make an assessment that accounts for both disorders, and may provide treatment for the substance use within the context of the mental health treatment. Enhanced programs will be able to provide comprehensive, integrated treatment for both disorders. Following are the characteristics of Dual Diagnosis Capable Mental Health Programs when fully developed:

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

For participating programs in FY 04-05, the following describes criteria for these characteristics in AMHS programs. These criteria will become more demanding as the system develops its capability.

- The program's Administrator has signed the CCISC Charter
- The program has self-surveyed by annual use of the COMPASS survey
- The program has developed an action plan after completing the COMPASS, which incorporates:
 - ✓ Screening
 - ✓ Assessment
 - ✓ Treatment Plan
 - ✓ Progress Notes

- ✓ Discharge summary
- ✓ Medication planning when appropriate
- ✓ Referrals
- The program has identified leads responsible for implementation of Dual Diagnosis Capability
- The program's CADRE staff are available for trainings
- Each clinician has completed the CODECAT
- The program has developed Mission and/or Welcoming Statements that reflect dual diagnosis capability
- The program has a Policy and Procedure to support Mission and Welcoming statements, including visible materials such as posters and referral brochures
- The program routinely reports dual diagnosis clients in InSyst in the diagnosis, where appropriate, and in the Other Factor codes.

Drug Formulary for HHS Mental Health Services

All contracted provider programs and physicians shall adopt the Medi-Cal Formulary as the San Diego County Mental Health Services (MHS) formulary. All clients, regardless of funding, must receive appropriate and adequate levels of care at all MHS programs. This includes the medications prescribed. The guidelines below allow for clinical and cost effectiveness.

The criteria for choosing a specific medication to prescribe shall be:

1. The likelihood of efficacy, based on clinical experience and evidence-based practice
2. Client preference
3. The likelihood of adequate compliance with the medication regime
4. 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.

San Diego Medication Algorithm Program (San D/MAP) – For Designated Programs Only

The San Diego Medication Algorithm Program (San D/MAP) is a disease management program for the medication management portion of care for individuals with severe and persistent mental disorders. San D/MAP is San Diego County Mental Health Service's adaptation of the Texas Medication Algorithm Program (TMAP). Although TMAP has identified algorithms for most major diagnostic categories at this time San D/MAP has been implemented for treatment of clients with a diagnosis of Schizophrenia.

The San D/MAP program consists of:

- a. Pharmacotherapy algorithms
- b. Care coordination
- c. Client/family education
- d. Uniform documentation of client outcomes
- e. Use of specifically designed San D/MAP forms
- f. Quality management program.

Designated San D/MAP Programs

The full San D/MAP program (items a through f above) has been implemented for treatment of clients with a diagnosis of Schizophrenia at the Central and North Central Mental Health Centers. The East County, North Coastal, and North Inland Mental Health Centers utilize only the San D/MAP forms. In addition to the San D/MAP forms, North Coastal Mental Health Center has implemented the client/family education portion.

Pharmacotherapy Algorithms

The San D/MAP pharmacotherapy algorithm is administered according to the "TIMA Procedural Manual" as published on the following website: <http://www.mhmr.state.tx.us>. The treatment algorithms are not just general recommendations for medication treatment, but provide systematic guidance for use of a chosen medication regimen in individual clients. This includes such factors as initial medication(s), initial dosage, dosage changes, methods to assess, response to treatment, frequency of assessment and re-evaluation, and minimum and maximum treatment periods in order to assess the adequacy of therapeutic response.

Care Coordination

San D/MAP places great emphasis on care coordination. Each client enrolled in San D/MAP is assigned both a physician and care coordinator. The care coordinator serves as the main point of contact for the client as currently organized. Care coordinators must have one of more of the following clinical licenses: RN, LCSW or MFT.

The care coordinator job description is as follows:

- Coordinate and monitor client and clinician adherence to San D/MAP protocol using “San D/MAP Client Checklist.” Assist the psychiatrist in the proper implementation of treatment algorithms by prompting the psychiatrist and providing feedback regarding adherence with the algorithm.
- Assist in the clinical procedures, administration of research instruments, and collection of data. Specific duties include:

At Psychiatric Evaluation:

- Administer the Clinician Symptom Rating Scale
- Assist the client in completing the Client Self Report
- Administer or assure other clinician gains vital signs
- Complete Section A of the Medication Management form

At each subsequent visit with the psychiatrist:

- Administer the Clinician Symptom Rating Scale
 - Assist the client in completing the Client Self Report
 - Administer or assure other clinician gains vital signs
 - Complete Section A of the Medication Management form
- Build an alliance with the psychiatrist to assist the client in full participation in the algorithm. This entails:
 - Assisting the psychiatrist and client with scheduling appointments.
 - Traveling to the client’s/family home, if necessary, to perform patient follow up, if necessary.
 - Utilizing the San D/MAP Client Checklist for tracking.
 - Learning to complete the Clinician Symptom Rating Scale.
 - Functioning as clinical liaison and point of contact for the client.
 - Establishing liaison with families and other collaterals, as necessary, to enhance client adherence with treatment.
 - Build an alliance with the client to foster full participation in the algorithm by:
 - Implementing procedures for increasing the likelihood that patients attend appointments as scheduled (e.g., a postcard and/or telephone call to remind the patient of his/her

- appointment prior to the visit; stressing with the patient and family at the initial visit the importance of keeping appointments).
- Specifying and implementing a procedure for following up with patients who do not show for scheduled appointments (e.g., asking clerical staff to telephone the patient the day he missed an appointment; contact other persons who may be able to help locate the patient so that a new appointment can be scheduled).
 - Providing referral and linkage of clients to their respective caseworkers or case managers when they have issues unrelated to medication treatment.
 - Conducting individual and group patient and family education, with the assistance of trained mental health clients, physicians, and other content experts, as needed.
- Monitor all aspects of the client's care, including tracking clients who may be hospitalized during treatment by obtaining the Morning Report and following up with staff in other facilities.
 - Participate in QI activities relating to full participation in the algorithm. This may include:
 - Extracting and documenting client medical record information, as needed, for quality improvement.
 - Assisting in evaluation of adherence with algorithms.
 - Participate in other activities, as necessary, for the successful implementation of treatment algorithms.

Client/Family Education Program

Client and family education and involvement with treatment are essential to achieving successful outcomes. Therefore, as an integral element of San D/MAP, there is a requirement that designated programs facilitate a Road Map to Recovery client/family education/program. A complete description of the San D/MAP requirement for an effective client and family education program can be found in the San D/MAP Road Map to Recovery (R2R) Handbook. The R2R Handbook is available by contacting MH Administration by calling (619) 563-2771.

Uniform Documentation of Client Outcomes

Designated San D/Map providers are required to document client outcomes using the selected outcomes tools. The designated tools are the Client Self Report and Clinician Symptom Rating Scales. Copies of these tools are located in the Appendix. Information on the Client Self-Report tool is provided to clients in the R2R program. Training on the use of the Clinician Symptom Rating Scales is available in the TIMA manual, on pages 55-65. In addition, there are training videos that are available by from MH Administration by calling (619) 563-2771.

San D/MAP Forms

All designated programs shall utilize required standard forms for San D/MAP. Copies of standard forms can be found in the Uniform Clinical Record Manual.

Quality Management Program

The purpose of a San D/MAP Quality Management Plan is to establish guidelines for monitoring the San D/MAP program to ensure the delivery of safe, effective, efficient, timely, equitable, and client centered specialty mental health services for San D/MAP participants.

The expected elements of a San D/MAP Quality Management Plan are:

- Guidelines for the roles and responsibilities for monitoring
- Regular/periodic chart reviews utilizing San D/MAP Review tool, including, but not limited to, Peer Review
- Process for analysis of results of chart reviews
- Tracking and trending of outcomes
- Identifying areas of concern and recommending action plans.

M. STAFF QUALIFICATIONS

Each provider is responsible for ensuring that all staff meets the requirements of federal, State, and County regulations regarding licensure, training, clinician/client ratios and staff qualifications for providing direct client care and billing for treatment services. Documentation of staff qualifications shall be kept on file at the program site. Provider shall adhere to staff qualification standards and must obtain approval from their Program Monitor or designee for any exceptions.

Provider shall comply with the licensing requirements of the California Welfare and Institutions Code Section 5751.2. Provider shall have on file a copy of all staff licenses and ASW/IMF certificates of registration with the Board of Behavioral Sciences. For staff positions requiring licensure, all licenses and registrations must be kept current and be in active status in good standing with the Board of Behavioral Sciences.

Staffing

Commensurate with scope of practice, mental health and rehabilitation services may be provided by any of the following staff:

- Physician
- Licensed/Registered/Waivered Psychologist
- Licensed/Registered/Waivered Clinical Social Worker
- Licensed/Registered/Waivered Marriage and Family Therapist
- Registered Nurse
- Licensed Vocational Nurse
- Psychiatric Technician
- Mental Health Rehabilitation Specialist (*see definition below*)
- Staff with a bachelor's degree in a mental health related field (see supervision and co-signature requirements)
- Staff with two years of full-time equivalent experience (paid or unpaid) in delivering mental health services (see supervision and co-signature requirements)
- Staff without bachelor's degree in a mental health field or two years of experience (see supervision and co-signature requirements)

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

- ***Mental Health Rehabilitation Specialist (MHRS).*** A mental health rehabilitation specialist is an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education

may be substituted for the experience requirement on a year-for-year basis. Up to two years of post associate arts clinical experience may be substituted for the required educational experience (as defined in Title 9) in addition to the requirement of four years of experience in a mental health setting.

Professional Licensing Waiver Guidelines

The Welfare and Institutions Code Section 5751.2(a) states that “persons employed or under contract to provide mental health services shall be subject to all applicable requirements of law regarding professional licensure, and no person shall be employed in local mental health programs and provide services for which a license is required, unless the person possesses a valid license.” Some categories of persons employed as psychologists, clinical social workers, marriage, family and child counselors, however, may be exempt from the requirement of subsection (a) for a time-limited period. The general guidelines for the professional waiver process are as follows:

- 1) W&IC Section 5751.2 refers to psychologists, social workers and marriage family therapists providing mental health services in local mental health programs. Mental health services are defined as those services that can only be performed by a licensed professional or by one who is obtaining qualifying experience under the supervision of a licensed professional.
- 2) W&IC Section 5751.2 refers to those persons employed in local mental health programs or under contract to provide those services. This means all individual, group and organizational provider staff, both County and contract.
- 3) Each psychologist candidate must obtain a waiver, even though he/she is registered with the Board of Psychology. Each LCSW and MFT candidate is to remain registered with her/his licensing board until such time the candidate is licensed. The candidate must remain registered, even though he/she is no longer accumulating qualifying hours. No waiver is needed, nor can one be obtained; the only exception pertains to license-ready candidates recruited from out of state—consult the Code for details.
- 4) Each license-ready psychologist, LCSW or MFT recruited from out of state must obtain a waiver.
- 5) A waiver candidate must be obtaining post-graduate experience. Therefore, a graduate student cannot receive a waiver.
- 6) A waiver granted in one county is valid for any program in any county in the State of California for the life of the waiver.

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- 7) The waiver period commences the date of employment in a local mental health program (County or contract) anywhere in the State of California in a position that requires a license or whenever the applicant is gaining qualifying clinical experience.
- 8) A volunteer may gain waiver status if the County provides evidence that this applicant is “employed” or under “contract” to provide mental health services. This evidence shall take the form of written confirmation from the County Mental Health Director or designee.
- 9) All applicants will receive the maximum waiver period, unless requested differently by the County; five years for the standard psychologist waiver and three years for the license-ready psychologist, LCSW, and MFT candidates recruited from outside the state.
- 10) There are no provisions for waiver extensions beyond the maximum waiver periods.
- 11) All waiver requests are to be submitted by the MHP and signed by the local mental health director or the director’s designee.
- 12) All items on the waiver request form must be completed to the best of the applicant’s and provider’s knowledge.
- 13) Use the “Mental Health Professional Licensing Waiver Request” form (and instruction sheet) included in *Appendix M*.

Documentation and Co-Signature Requirements

AMHS staff that provide mental health services are required to adhere to certain documentation and co-signature requirements. For the most current information on co-signature requirements, please refer to the Adult Documentation and Uniform Clinical Record and Manual. This manual will instruct staff on form completion timeframes, licensure and co-signature requirements, and staff qualifications necessary for completion and documentation of certain forms.

In general, staff that hold the license of an M.D., R.N., Ph.D., LCSW, or MFT do not require a co-signature on any documentation in the medical record. In addition, the same holds true for staff that are registered associates or interns (ASW or IMF) with the Board of Behavioral Sciences (CA) or waived according to State guidelines. These above referenced staff may also provide the co-signature that is required for other staff. Staff that does not meet the minimum qualifications of an MHS shall have adequate clinical supervision and co-signatures from a licensed/registered/waivered staff.

In the Documentation and Uniform Clinical Record Manual, there are specific forms for Mental Health Assessments, Client Plan, and Discharge Summary that require the signature of a licensed/registered/waivered staff member. If the staff completing the form is not licensed/registered/waivered, then a co-signature by a licensed/registered/waivered staff is

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required. These forms have specific time requirements which affect compliance with regulations and recoupment of FFP dollars. In order to be in compliance and not risk recoupment of FFP dollars, all required co-signatures must be signed within the required time frame. Following is a brief summary chart, which indicates in general, documentation and co-signature requirements. For additional questions, please contact your Adult QI Specialist.

STAFF DISCIPLINE	CO-SIGNATURE REQUIREMENTS (From Documentation and Uniform Clinical Record Manual)			
YES = REQUIRES A CO-SIGNATURE NO = NO CO-SIGNATURE REQUIRED	Initial Assessment, Mental Health Assessment Update, and Expedited Assessment	Client Plan	Discharge Summary	Progress Notes
M.D.	NO	NO	NO	NO
R.N.	NO	NO	NO	NO
LICENSED/REGISTERED/WAIVERED PH.D, LCSW, MFT	NO	NO	NO	NO
LICENSED VOCATIONAL NURSE	YES	YES	YES	NO
PSYCHIATRIC TECHNICIAN	YES	YES	YES	NO
MENTAL HEALTH REHAB SPECIALIST (MHRS)	YES	YES	YES	NO
STAFF NOT MEETING THE MINIMUM QUALIFICATIONS FOR AN MHRS	YES	YES	YES	YES

Staff Supervision Requirements

- Programs must provide supervision in amount and type that is adequate to insure client safety, maximize gains in functioning, and meet the standards of the professions of those staff employed in the program.
- Programs who employ waived/registered staff receiving supervision for licensure must offer experience and supervision that meet the requirements of the licensing board to which the person is registered.
- 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.

Staffing Requirements

- All providers shall have staff in numbers and training adequate to meet the needs of the program's target population.

STAFF QUALIFICATIONS AND SUPERVISION

- Psychiatry time: Outpatient programs must also have psychiatry time sufficient to allow the psychiatrist's participation in treatment reviews, especially where medications may be discussed, plus adequate time per month for new client assessments and medication followed up.
- For programs certified to provide Medi-Cal/Short Doyle mental health services, the Head of Service (Program Manager) providing clinical direction must be licensed. If the Program Manager is not licensed, there must be a Clinical Lead who can provide clinical supervision and perform certain tasks, such as diagnosing, that are within the scope of practice of licensed and waived persons.

Use of Volunteers and Interns

- Provider shall utilize family and community members as volunteers in as many aspects of the programming as possible, including teaching a special skill and providing one-on-one assistance to clients. Particular emphasis shall be made to recruit volunteers from diverse communities within program region.
- Provider shall have policies and procedures surrounding both the use of volunteers and the use of employees who are also clients.
- Licensed staff shall supervise volunteers, students, interns, mental health clients and unlicensed staff involved in direct client care.

N. DATA REQUIREMENTS

Data Collection and Retention

Contractor shall maintain daily records of services provided, including dates of service, times of service, total time of service, types of services provided, persons served, and progress of clients in meeting the objectives of the case plan. Records shall be kept up to date and data shall be entered into the AMHS MIS (InSyst) within one business day of service delivery.

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* is provided by AMHS for providers as a guide for determining financial eligibility, billing and collection procedures. This handbook includes the following procedure categories:

- Using the InSyst System
- Registering a new client
- Episode opening/closing and recording services
- Determining financial eligibility
- Claims, billing, and posting procedures
- Training and technical assistance.

This handbook is not intended to replace the InSyst Users Manual or intended to be a comprehensive “Insurance and Medicare Billing” guide. It is meant to augment existing resource materials.

Medi-Cal Administrative Activities (MAA)

Federal and State regulations (Welfare and Institutions Code, Section 14132.47, Medi-Cal Administrative Activities) permit counties to earn federal Medi-Cal reimbursement for activities that are necessary for the proper and efficient administration of a State’s Medicaid (Medi-Cal) plan. These MAA activities are focused on assisting individuals to access the Medi-Cal Program and the services it covers through such functions as Medi-Cal and mental health outreach, facilitating Medi-Cal eligibility determinations, MAA coordination and claims activities and other designated activities.

Organizational providers may be permitted to provide and claim for MAA services. The MHP requires that each organizational provider have an approved MAA Claiming Plan prior to claiming MAA services, and that each provider comply with all applicable State and federal regulations. MAA activities in mental health are governed by a set of procedures, which are

described in detail in the *MAA Instruction Manual* developed by the State Department of Mental Health.

To assist providers, AMHS offers technical assistance and training on MAA through the MAA Coordinator. The MAA Coordinator can provide assistance with claiming and procedural questions or provide a MAA training to staff.

Included in *Appendix N* 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.

Additional Outcome Measures

Additional data may be required in your specific contract. This may involve additional tools for specific parts of the system. Your contract may also require manual collection of certain outcomes from charts, such as number of hospitalizations, readmissions, arrests, or changes in level of placement/living situation. The data collected should be submitted on your MSR or as directed by your Program Monitor or AMHS QI unit.

O. TRAINING/TECHNICAL ASSISTANCE

The Quality Improvement Unit provides training and technical assistance on topics related to the provision of services in the Adult/Older Adult Systems of Care.

Training and information is disseminated through:

- Documentation and Uniform Clinical Record Manual Training
- QI In-Service Trainings
- QI Matters Newsletter
- Organizational Provider Operations Handbook
- Regular Provider Meetings.

For information on upcoming trainings or in-services, or if you require technical assistance, please contact the:

Quality Improvement Unit
P.O. Box 85524
San Diego, CA 92186-5524
MS: P531-G

Other Training

The HHSA Training and Development department publishes a monthly calendar of clinical trainings that are available to organizational contracted providers. Please note there may be a fee for these trainings. Please contact your organization's training liaison directly for information on training, registration, and fees.

P. AB 2726 SERVICES FOR ADULTS 18-22

This section provides the treatment and documentation protocol for adult mental health programs that will begin treating or are currently treating adult clients (between 18-22) who are currently receiving mental health services through AB2726 and are transitioning from the children's mental health system via a referral from the current children's mental health provider to the new adult mental health provider.

Assembly Bill 2726

AB 2726 (Assembly Bill 2726; also known as AB3632) is a program designed to provide educational mental health services to special education students who need the services to benefit from their education. These services are listed on the students' Individualized Education Plan (IEP) and can be provided for adult clients between 18 and 22 years of age who are still participating in a high school program. The students must have a mental health issue that affects their educational performance, or impedes them from benefiting from educational services, and who do not respond to counseling provided by the school. The educational mental health services are identified on the student's Individualized Education Plan (IEP). The major service delivery models used are Outpatient Therapy, Day Treatment and Residential Care. The County of San Diego's Special Education Services (SES) program provides assessment, re-assessment and case management services for these identified clients. The SES program provides regionalized services and has Central and North County office locations.

Referrals to the County of San Diego's SES program can be from school staff or parents. Once a referral is received, an SES case manager is assigned to complete a multi-faceted assessment, within mandated timelines, to determine eligibility for AB2726 services. If the case manager recommends outpatient therapy through AB2726, the services are added to the student's IEP. A Mental Health Treatment Plan is completed and the referral is forwarded to an outpatient provider. The SES case manager then closes the case in their program, and the outpatient clinician provides the special education services, as per the IEP and the Mental Health Treatment Plan.

Although the majority of AB2726 clients are children and adolescents served in the Children's Mental Health System, there are adult AB2726 clients that are between the ages of 18 and 22 years of age, who are still participating in a high school program, that are served in the Adult Mental Health System. Providers must follow the specified regulations for all AB2726 clients as outlined below.

Outpatient Standards for Adult AB2726 Clients

Outpatient service requirements for standards of practice with regard to provider/school interactions on behalf of Adult AB2726 students have been established and are to be documented in the medical record as follows:

- Timeline for Intake within 7-10 calendar days
- Upon receipt of assignment the clinician shall contact the school contact person
- A face-to-face contact between the therapist and school person (teacher or other designated contact person) within the first 60 (sixty) days of treatment
- A minimum of monthly contact with the school contact thereafter to include discussion regarding medication effectiveness as well as academic status and behavioral management
- A home visit by the therapist during the course of treatment. Exception shall include justification in the medical record as to why a home visit is not clinically indicated. (*Justification for exception of the home visit for existing clients who have been in treatment a year or more may be the length of time they have been in treatment already and the move toward termination*).
- Attendance of therapist, or knowledgeable representative from the mental health program, at IEP meetings when a major educational placement change may occur, annual review and at the end of treatment.
- Quarterly Progress Mental Health IEP Reports shall be submitted to the client/parent and the teachers—(refer to Mental Health IEP Reporting section below)
- Comply with timelines for Requests for Information and Records. Under the Individuals with Disabilities Education Act, pupil records are subject to the federal FERPA and state pupil records provisions, including state rules on providing copies to parents. All AB2726 parent/client requests for pupil records are to be completed and delivered to the parent/client within 5 (five) calendar days. Any request for release of pupil records must be accompanied by a signed authorization for release of those records.

Mental Health IEP Reporting

- The outpatient clinician shall contact the student's teacher monthly to discuss progress and concerns. This contact shall be recorded in the client's medical record.

- The outpatient clinician shall submit the “Quarterly Progress Mental Health IEP Report” (instruction sheet and form located in *Appendix P*) to the client and school contacts on a quarterly basis. This report shall document the student’s progress on the Mental Health IEP goals addressed through outpatient services. A copy of this report shall be maintained in the client’s medical record.
- The outpatient clinician shall coordinate the AB 2726 outpatient mental health services with all other counseling services the student is receiving that are documented on the IEP. Evidence of such service coordination shall be documented in the client’s medical record.
- The outpatient clinician shall update the “Mental Health Treatment Plan” (instruction sheet and Plan located in *Appendix P*) at the Benchmark/Short Term Objective time frames listed on the form. Clinician shall complete an updated “Mental Health Treatment Plan” every six months, and request an IEP meeting for IEP team to review and accept updated plan.

Note: to reconvene an IEP meeting, the outpatient provider completes the “Need for IEP Review” form (instruction sheet and form located in *Appendix P*) and forwards it to the school contact. Please note that the Clinician needs all signed, updated IEP’s to maintain in client’s medical record.

Medication Monitoring for AB 2726 Clients

Medication evaluation and/or medication management services are provided under the required provisions of the AB 2726 program and are at no cost to the client/parent (Section 60020, Education Code; Section 7587, Government Code). The medication itself is not a benefit covered by the AB 2726 program nor does the County incur this service or cost.

The following are some general guidelines to assist clients and families in obtaining assistance with medication and laboratory costs:

IF CLIENT HAS MEDI-CAL

Program psychiatrist can write a prescription and have the client fill it at a Medi-Cal participating pharmacy, as is the current procedure.

IF CLIENT HAS HEALTHY FAMILIES

Program staff, clinician, or psychiatrist should work with the client’s physician to see if they will provide medication if provided with a consultation or psychiatric evaluation by the program psychiatrist. Providers should be aware that Healthy Families may refer the student back to County Mental Health for an assessment. If this occurs and the client is diagnosed with a Severe

Emotional Disturbance (SED), then the program would be responsible for medication under the Healthy Families carve-out.

IF CLIENT/FAMILY HAS PRIVATE INSURANCE

Refer to services covered by family's private insurance plan.

(Parents/Clients with private insurance coverage will be helped by the passage of The Mental Health Parity Law (AB 88) two years ago. AB 88 requires most California health care plans to cover the diagnosis and medically necessary treatment of serious mental illness and emotional disturbances of a child on terms equal to their health plan medical coverage.)

IF CLIENT'S/FAMILY'S PRIVATE INSURANCE HAS NO MENTAL HEALTH BENEFIT

Program should verify with insurance plan if mental health is a covered benefit due to the Mental Health Parity Law (AB88). Mental health program psychiatrists may be able to provide sample medications or work with the client's physician to see if they will provide medication if provided with a consultation or psychiatric evaluation by the program psychiatrist.

IF CLIENT IS INDIGENT

Every effort must be made to link the family to other resources in the community.

Program psychiatrists may be able to provide sample medications or work with the client's physician to see if they will provide medication if provided with a consultation or psychiatric evaluation by the program psychiatrist.

Program can provide financial screening to determine the annual client liability for mental health services using the "Uniform Method for Determining Ability to Pay" (UMDAP) method. Following the financial screening, the Program Manager must approve all clients who will be receiving medication through the program.

Discharge for Adult AB2726 Clients

1. Discharge may occur when a student is ready to leave the outpatient program because:
 - a. they have met their mental health IEP goals
 - b. a change in the mental health level of care is needed
 - c. the client is refusing services

Note: Any and all changes must be reviewed by the IEP team members, which include at a minimum, the outpatient clinician, the district of residence, and the client. Some changes in the level of care may require a request for reassessment through the IEP process.

2. The program will coordinate discharge planning with the school district liaison(s) before providing any specific information to the client.

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AB 2726 SERVICES FOR ADULTS BETWEEN 18-22

3. Discharge recommendations regarding level of care will be developed in accordance with AB2726 guidelines and may require a request for reassessment through the IEP process.
4. Discharge summaries shall clearly address student progress on IEP goals and other treatment issues.
5. When a student is transferring from one outpatient program to another, the student may not be discharged from the sending program until he/she has been admitted to the new program. The outpatient clinician shall make certain that there is connection to the new program. This includes ensuring outpatient mental health services on the IEP are changed from the sending school district to the receiving school district.
6. Programs shall not discharge a student without requesting an IEP review. Stay put orders apply in cases of Due Process.
7. Notify the regional Mental Health Special Education services program manager in writing when there are critical problems related to IEP (e.g. client fails to start treatment).
8. Regional Mental Health Special Education Services program managers:

North Coastal/Poway

Program Manager
340 Rancheros Dr., Suite 298
San Marcos, CA 92069
(Tel.) 760-752-4900
(Fax) 760-752-4924

North Inland/East Region

Program Manager
3692 Midway Drive
San Diego, CA 92110
(Tel.) 619-758-6240
(Fax) 619-758-6250

South/Central Region

Program Manager
3320 Kemper St., Suite 104
San Diego, CA 92110
(Tel.) 619-758-6205
(Fax) 619-758-6209

Administration

3320 Kemper Street, Suite 206
San Diego, CA 92110
(Tel.) 619-758-6227
(Fax) 619-758-6255

Q. QUICK REFERENCE

PHONE DIRECTORY

ACCESS AND CRISIS LINE

1-800-479-3339

COUNTY OF SAN DIEGO MHP ADMINISTRATION

(619) 563-2700

Local Mental Health Director

(619) 563-2700

Medical Director

(619) 563-2700

Director, Adult Quality Improvement Unit

(619) 563-2754

Program Manager, Adult Quality Improvement Unit

(619) 563-2747

Serious Incident FAX

(619) 563-2795

Adult Service Intake/Triage Log FAX

(619) 563-2799

Contract Administration Unit Manager

(619) 563-2733

Claim Submission FAX

(619) 563-2730

MHP Compliance Hotline

(866) 549-0004

MAA Coordinator

(619) 563-2700

UNITED BEHAVIORAL HEALTH, SAN DIEGO

Provider Line

1-800-798-2254

UBH Administrative Services for MHP

(619) 641-6800

Director, Compliance and Provider Services

(619) 641-6806

MIS Help Desk

(619) 641-6928

MIS FAX

(619) 641-6975

Clinical

(619) 641-6802

Provider Services & Quality Improvement

(619) 641-6979

CLIENT ADVOCACY ORGANIZATIONS

Consumer Center for Health Education and Advocacy

1-877-734-3258

USD Patient Advocacy Program

1-800-479-2233

WORLD WIDE WEB RESOURCES

County of San Diego

www.sdcounty.ca.gov

United Behavioral Health (UBH)

www.ubhpublicsector.com

California Board of Behavioral Sciences

www.bbs.ca.gov

California Board of Psychology

www.psychboard.ca.gov

California Code of Regulations

www.calregs.com

California Department of Mental Health

www.dmh.ca.gov

California Medi-Cal Website

www.medi-cal.ca.gov

California Mental Health Directors Association

www.cmhda.org

California Welfare & Institutions Code

www.leginfo.ca.gov/calaw.html

Center for Medicare and Medicaid Services

www.cms.hhs.gov

Community Health Improvement Partners

www.sdchip.org

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QUICK REFERENCE

Disability Benefits 101	www.disabilitybenefits101.org
Inform San Diego (Social Services Database)	www.informsandiego.com
Intentional Care Website	www.intentionalcare.org
International Association of Psychosocial Rehabilitation Services (IAPSRs)	www.iapsrs.org
Joint Commission on Accreditation of Healthcare Organizations	www.jcaho.org
National Institute of Mental Health (NIMH)	www.nimh.nih.gov
Network of Care	www.networkofcare.org
Office of Inspector General Exclusion List	www.oig.hhs.gov
GSA Excluded Parties Listing System (debarment)	http://epls.arnet.gov
Social Security Online	www.socialsecurity.gov or www.ssa.gov
Ticket to Work Program	www.yourtickettowork.com

R. MENTAL HEALTH SERVICES ACT - MHSA

After California voters passed Proposition 63 in November 2004, the Mental Health Services Act (MHSA), became effective January 1, 2005. The purpose of the act was to expand mental health service funding to create a comprehensive community based mental health system for persons of all ages with serious and persistent mental health problems. The MHP has completed its initial extensive community program planning process and has secured a state approved Community Services and Supports Plan. The next phases of enactment of the MHSA will include funding for prevention/early intervention, innovations, capital facilities and technology, and education and training.

MHSA System Transformation

Under the MHSA, community based services and treatment options in San Diego County are to be improved, expanded, and transformed by:

1. Increasing Client and Family Participation
2. Serving More Clients
3. Improving Outcomes for Clients
4. Decreasing Stigmatization
5. Minimizing Barriers to Services
6. Increasing Planning and Use of Data
7. Increasing Prevention Programming
8. Including Primary Care in the Continuum of Care
9. Using of Proven, Innovative, Values-Driven and Evidence-Based Programs

As a result of expanded funding, the MHSA will hold 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 the start-up of MHSA services. Contractors receiving MHSA funding will be responsible for complying with any new MHSA requirements.

MHSA Full Service Partnerships

A number of providers will be participating in MHSA Full Service Partnerships, which both provide mental health services to clients and link them with a variety of community supports, designed to increase self sufficiency and stability. These providers are required to participate in a State data collection program which tracks initial, specialized client assessments, ongoing key incident tracking and quarterly assessments. The State has set timeframes for provisions of each type of data.

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MENTAL HEALTH SERVICES ACT - MHSA

For current information on MHSA, visit www.sandiego.networkofcare.org/mh. For current State level and general MHSA information, visit www.dmh.cahwnet.gov/MHSA or call (800) 972-6472.