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.

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

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

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

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

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

- Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the beneficiary meets access criteria for SMHS. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS. MHPs must not deny or disallow reimbursement for SMHS provided during the assessment process described above if the assessment determines that the beneficiary does **not** meet criteria for SMHS or meets the criteria for NSMHS.
- MHPs, DMC and DMC-ODS programs and providers may use the following options during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established:

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

Co-occurring Substance Use Disorder

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

Concurrent NSMHS and SMHS

- Beneficiaries may concurrently receive NSMHS via FFS or MCP provider and SMHS via a MHP provider when the services are clinically appropriate, coordinated and not duplicative. When a beneficiary meets criteria for both NSMHS and SMHS, the beneficiary should receive services based on individual clinical need and established therapeutic relationships. MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary based on the beneficiary also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Likewise, MCPs must not deny or disallow reimbursement for NSMHS provided to a beneficiary based on the beneficiary also meeting SMHS criteria and/or receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be

coordinated between MCPs and MHPs to ensure beneficiary choice. MHPs must coordinate with MCPs to facilitate care transitions and guide referrals for beneficiaries receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the beneficiary. Such decisions should be made via a patient-centered shared decision-making process.

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

Access to Services Journal

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. The Access to Services Journal is available and completed through the electronic health record (EHR). Should access to the EHR be unavailable, the form can also be located on the Optum Website (www.optumsandiego.com). The instructions for how and when to complete, the Access to Services Journal is located on the Optum website (www.optumsandiego.com) under the Training Tab under County Staff & Providers.

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

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 services.

Access Standard: Face-to-face clinical contact with client within one (1) hour of 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. The County further refers to Urgent as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention

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

Routine Condition

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

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

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

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

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

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

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

MHP Services Authorization Requirement Provided by Optum

- Outpatient mental health services for children, adolescents and adults delivered to

beneficiaries through the Fee-for-Service (FFS) Provider Network. This is a network of contracted licensed mental health professionals.

- Acute Inpatient Mental Health Services
- Crisis Residential Treatment Services
- Adult Residential Treatment Services
- Intensive Home-Based Services
- Child/Adolescent Day Treatment Program Services
- Therapeutic Behavioral Services
- Therapeutic Foster Care

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

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

Referrals to the ACL

It is appropriate to refer individuals to the ACL for:

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

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

Provider Interface with the ACL

- Use the ACL as an adjunct to provider services in emergencies and after hours. To provide the most effective emergency response and back-up to their own services, provider office voice mail messages should state, "If this is a mental health emergency or crisis, please contact the Access and Crisis Line at 1-888-724-7240."

- If a client is high risk and may be calling the ACL for additional support, the client's therapist or care coordinator may call (with client's approval) the ACL in advance on behalf of the client. (Please obtain a signed Release of Information from the client). To facilitate the most effective ACL response to the high-risk client's needs when he or she calls, please provide the ACL with all relevant clinical and demographic information.

Receiving Referrals from the ACL

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

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

Hours of Service Availability

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

Language Assistance

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

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

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

If program staff are not available to meet the language needs of a client, County contracted providers must have processes in place to be able to provide outside interpreter services as needed. County operated programs can contact Hanna Interpreting Services, LLC (for language

interpreting) at (619) 741-0000 or Interpreters Unlimited (for hearing impairment) at (800) 726-9891 to arrange for language assistance. To request interpreter services, County operated programs shall create an online account with Hanna Interpreting Services, LLC through their Language Services Online Portal Registration.

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

Provider Selection, Terminations, Incentives

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

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

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

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

The MHP does not currently offer any physician incentive plans.

Requests for Continuity of Care

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

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

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

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

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

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

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

A beneficiary or provider may make available information to the MHP that provides verification

of their pre-existing relationship with a provider.

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

Timeline Requirements

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

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

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

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

A continuity of care request is considered complete when:

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

Requirements Following Completion of Continuity of Care Request

If the provider meets all the required conditions and the beneficiary's request is granted, the MHP must allow the beneficiary to have access to that provider for a period of up to 12-months, depending on the needs of the beneficiary and the agreement made between the MHP and the out-of-network provider. When the continuity of care agreement has been established, the MHP

must work with the provider to establish a Client Plan and transition plan for the beneficiary. Upon approval of a continuity of care request, the MHP must notify the beneficiary and/or the beneficiary's authorized representative, in writing, of the following:

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

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

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

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

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

Repeated Requests for Continuity of Care

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

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

Beneficiary and Provider Outreach and Education

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

Reporting Requirements

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

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

Continuity of Care Requests Processed by ASO

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

Clients Who Must Transfer to a New Provider

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

- The client and caregiver should be informed of the impending change as soon as it is clinically indicated and possible, but at least 14 days prior to the final visit with the first provider.
- The client and caregiver should be informed of the client's right to request a new provider.

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

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

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

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

Urgent Psychiatric Condition

Title 9 defines an "Urgent Psychiatric Condition" as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition. The County further refers to Urgent as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention.

Access Standard: Face-to-face clinical contact for urgent services shall be within (48) hours of initial client referral.

Exodus and Jane Westin – Full Time Access

- Individuals who walk in and who are not currently receiving services will be triaged/screened. If they are not deemed in need of urgent services, they may be referred to a primary care provider with known capacity, the closest outpatient mental health provider, or a fee for service provider, via the Access and Crisis Line phone number (client should mention that your program referred them to ACL). The client's choice prevails as per DHCS regulations.

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

- Clients who walk in after missing an appointment with their provider will be triaged/screened. If they are not deemed in need of urgent services, they may be referred to their own mental health provider, fee for service provider, or primary care provider. If they are requesting medication, the client may be advised/assisted to call their pharmacist to contact their prescribing physician for a refill.
- Clients with urgent mental health needs and/or urgent medication needs shall be triaged/screened and offered appropriate services, regardless of where the client may be receiving mental health services. If a walk-in clinic staff treats a client open to another program due to urgent service needs, the assigned program should be notified within 24 hours, or the next business day, for follow-up services.

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

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

Outpatient Clinics with Walk-In Urgent Components

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

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

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

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

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

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

Access to Electronic Health Record (EHR):

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

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

All programs:

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

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

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

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

- HIPAA Privacy Rule Sec. 164.506 states that a covered entity may use or disclose protected health information for treatment. This would apply in the case of a clinical referral source (another clinic, case management, hospital, IMD, etc.) inquiring whether a referred client appeared for their intake process.

Priority List

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

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

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

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

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

ASSISTED OUTPATIENT TREATMENT/LAURA'S LAW

Laura's Law/Assisted Outpatient Treatment authorizes court-ordered outpatient treatment pursuant to Welfare and Institutions Code (WIC) Sections 5345-5349.5 for individuals who have a history of untreated mental illness and meet all nine of the following criteria stipulated in the Code:

1. The person is at least 18 years of age.
2. The person is mentally ill as defined in WIC 5600.3

3. The person is clinically determined to be unlikely to survive safely in the community without supervision.
4. The person has a history of treatment non-compliance as evidenced by one of the following:
    - Two occurrences of hospitalizations, or mental health treatment in prison or jail within the last 36 months **OR**
    - One occurrence of serious and violent behavior (including threats) within the last 48 months.

5. The person has been offered treatment (including services described in WIC Section 5348) and continues to fail to engage in treatment.
6. The person has a condition that is substantially deteriorating.
7. Assisted Outpatient Treatment must be the least restrictive placement to ensure the person's recovery and stability.
8. The treatment is needed to prevent a relapse or deterioration that would likely result in grave disability or serious harm to self or others as defined in WIC Sections 5150 *et seq*.
9. The person is expected to benefit from AOT.

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

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

1) In the event that the referred individual is not engaged in IHOT services, a clinical determination will be made to refer the individual for an assisted outpatient examination. Following the assisted outpatient examination, the individual will be provided with the opportunity to voluntarily enter the assisted outpatient treatment program. If the individual refuses to enter the assisted outpatient treatment program voluntarily, and the individual continues to meet all nine (9) criteria as stated in Laura's Law, a request for an assisted outpatient treatment examination is made through the BHS Director or his designee. Upon receiving the request, the BHS Director or his designee must conduct an investigation into the appropriateness of the filing of the petition.

2) The petition with an affidavit from the designated IHOT licensed mental health clinician (LMHC) shall state that s/he has personally evaluated the person within 10 days prior to

the submission of the petition; the person meets all 9 criteria; the LMHC recommends AOT and is willing and able to testify at the hearing on the petition,
OR
The licensed mental health clinician has made within 10 days of filing the petition appropriate attempts to elicit the cooperation of the person but has not been successful in persuading the person to submit for the AOT examination and is willing and able to testify at the hearing on the petition.

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

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

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

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

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

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

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

Locked/secure facilities service those residents of San Diego County who experience serious psychiatric disabilities and require a secure, safe, and structured environment; these residents are not entitled to services through other systems, either public or private. SF/LTC Facilities funded

by the County of San Diego include Institutes of Mental Disease, additional funds for a County SNF Patch, and State Hospitals.

Referral Process

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

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

2. Court Investigative Report for San Diego County LPS Conservatorship

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

4. Current Physical and Medical History

5. Current medications

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

7. Hospital face sheet

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

9. Current completed Mini-Cog Exam

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

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

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

13. Signed payee form

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

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

Target Population

The persons served should have the potential to benefit functionally from psychiatric rehabilitation services and have the capacity to progress to a less restrictive level of care. The client must have a Title 9, ICD 10 psychiatric diagnosis (as the primary diagnosis) and meet the Medi-Cal criteria for psychiatric inpatient services at the time of application. The person will have been certified as gravely disabled, despite active acute care interventions and will have a temporary or permanent Lanterman-Petris-Short (LPS) Conservator. For an IMD, the age range is 18 years to 64 years old

Eligibility Criteria for Admittance to SF/LTC

To County-Funded Secure Facilities/Long-Term Care

Individuals must meet all the following criteria:

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

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

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

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

5. Be gravely disabled as determined by a court's having established a temporary or permanent public or private San Diego County Lanterman-Petris-Short (LPS) Conservatorship. Grave disability is defined in the Welfare and Institutions Code 5008, Section (h) (1) (A)… "A

condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic needs for food, clothing, or shelter."

6. A current resident in the State of California with Medi-Cal eligibility for the County of San Diego.

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

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

10. Have current tuberculosis (TB) clearance.

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

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

To San Diego County Funded SNF Patch Facilities

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

To Vista Knoll

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

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

To a State Psychiatric Hospital

Individuals must meet all the following criteria:

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

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

3. Admissions to state hospitals shall be approved by the County LTC Coordinator.

4. Individual shall be on LPS Permanent Conservatorship. The Lanterman-Petris-Short (LPS) Conservator must authorize A/OAMHS to provide case management services to monitor the individual's placement and progress.

Reviews of Determination Decisions

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

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

2. Supportive documentation, as relevant.

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

Placement

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

In some cases, the most appropriate placement may not be clear. In these situations, more information may be requested from the referring agency or the case manager. In some cases, an on-site evaluation of the referred individual may be appropriate. Optum LTC Coordinator is responsible for notifying the referral agency as to the outcome after the placement decision. At

times, placement in a County-funded, out-of-County located program may be appropriate. In these cases, the following criteria shall be met:

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

MHP and MCP Responsibility to Provide Services for Eating Disorders

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

1. MCPs are responsible for the physical health components of eating disorder treatment and NSMHS, and MHPs are responsible for the SMHS components of eating disorder treatment.
2. MHPs must provide or arrange and pay for, medically necessary psychiatric inpatient hospitalization and outpatient SMHS.
3. MCPs must provide inpatient hospitalization for beneficiaries with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization.
4. MCPs must cover and pay for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations.
5. For partial hospitalization and residential eating disorder programs, MHPs are responsible for the medically necessary SMHS components, and MCPs are responsible for the medically necessary physical health components.
6. DHCS does not require a specific funding split for MHPs and MCPs to share the cost of services provided in partial hospitalization and residential eating disorder programs. DHCS recommends that both parties mutually agree upon an arrangement to cover the cost of these medically necessary services.

Placement in a State Hospital

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

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

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

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

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

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

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

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

TRANSITIONAL AGE YOUTH (TAY) REFERRAL PROCESS

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

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

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

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

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

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

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

    a. Clubhouses which are informal centers with employment and education supports and socialization opportunities with a focus on wellbeing

b. Outpatient clinics which provide individual and group therapy and medication support services
c. Case Management services which provide assistance with linkage to services and community supports as well as psychosocial intervention and resource management to assist individuals to obtain optimum independence.
d. Full-Service Partnership programs which provide intensive services that comprehensively address client and family needs and "do whatever it takes" to meet those needs
e. Residential programs, which are 24/7, structured treatment programs that may provide individual, group, family therapy and other treatment modalities as appropriate.
f. Crisis Residential programs which are an alternative to acute hospitalization for persons in crisis of such magnitude so as not to be manageable on an outpatient basis.
g. Inpatient services which are for mental health emergencies that require a hospital setting.
h. Non-residential alcohol and other drug (SUD) treatment and recovery programs which provide process, educational and curriculum groups to assist individuals in recovering from substance abuse disorders on an outpatient basis. Programs may also provide specialized services for special populations including criminal justice populations (on a referral basis).
i. Residential SUD programs which provide 24/7 structured treatment and recovery services for individuals requiring a higher level of care.
j. Residential detoxification programs which provide 24/7 SUD detoxification and pre-treatment and referral services.
k. Non-residential and residential women's programs, which provide gender-specific, trauma-informed SUD treatment and recovery services, designed for adult women over the age of eighteen (18), including pregnant, parenting women, and their dependent minor children from birth through and including age seventeen (17).
l. Drug Court programs, which provide non-residential alcohol and other drug (SUD) treatment and testing program services to serve non-violent adult male and female offenders who have been referred to Adult Drug Court.
m. Driving under the Influence (DUI) programs which provide state licensed and mandated education and counseling programs for offenders arrested and convicted of Wet Reckless or first or multiple offense DUI. Programs are funded entirely by participant fees; SUD is responsible for local administration and monitoring.
n. Special population programs which provide SUD
o. Treatment and recovery services to traditionally harder to reach populations, such as Gay, Lesbian, Bi-sexual, and Transgender (GLBT), serial inebriates and HIV positive adults.

Identify the System Target Population

1. CYFBHS provides services to youth up to a youth's 21 birthday who are seriously emotionally disturbed. Services are provided to clients with co-occurring mental health and substance use, Medi-Cal eligible clients that meet medical necessity, as well as Indigent, and/or low income/underinsured individuals. All specialty mental health providers will evaluate and assess the treatment needs of the client. This process will encourage and involve the active participation of the client's significant others such as: the parent/caregiver, for children and youth, family members, friends and/or advocates selected by the adult client. Orientation and

education of significant others includes discussion of what services are available, treatment goals, role of the provider, and expectations of the client and provider. It also includes legal limits around confidentiality. Seriously emotionally disturbed children or adolescents means minors under the age of 21 who have a mental disorder as identified in the ICD-10, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

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

   i) The child is at risk of removal from home or has already been removed from the home.
   ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

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

     1. For youth who meet criteria for medically necessary services, they are eligible for 14/19 sessions (within a 12-month period), to include:
        - Two Assessment Session
        - 12 Treatment Sessions
        - An emphasis on group and family treatment. (If solely providing group or family sessions, youth is eligible for 19 sessions)

     2. For youth who meet Utilization Management (UM) criteria and require additional services, up to 14/19 additional sessions may be granted in alignment with the Organizational Provider Operations Handbook (OPOH) UM process.

     3. If a youth needs services beyond the potentially available 38 sessions and they continue to meet UM criteria, a specific request may be submitted to the COR for review and potential approval, per the OPOH UM process.

In the SUD Adolescent programs, the target population is defined as adolescents aged twelve (12) through seventeen (17) years of age with substance use problems. Adolescents learn how to socialize, grow, and recover in a safe and supportive, youth-focused, alcohol and drug free environment.

2. In the A/OABHS, the target population is defined as individuals with a serious psychiatric illness that threatens personal or community safety or that places the individual at significant risk of grave disability due to functional impairment. In addition, the system of care serves people with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and / or who require unusually complex medication regimens. Required psychosocial services may include illness

management, or skill development to sustain housing, social, vocational, and educational goals. In the Adult SUD programs, the target population is defined as individuals in need of SUD treatment and recovery services. The goal of alcohol and other drug treatment and recovery services is to assist individuals to become and remain free of alcohol and other drug problems, which lead to improved individual and family capability, overall functioning, decrease the incidence of crime, and support the person's ability to become self-sufficient through employment. Additionally, Regional Recovery Centers and select residential programs serve a target population of PROs (Post Release Offenders) and Probationers who are referred for services and are assigned to high-risk caseloads and supervision by the Probation Department.

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

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

Coordinate Care Between Sectors:

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

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

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

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

Coordinate Care When Making Referrals:

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

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

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

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

Procedures to follow if unsuccessful routine referral is below:

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

    - Referral Form/Cover Letter
    - 650 Children's Mental Health Assessment and most recent update
    - Current Title 9 Diagnosis
    - Youth Transition Evaluation
    - Mental Status conducted by psychiatrist within the last 45 days
    - Physical Health Information
    - Medication Sheet
    - Service Plan and other plans, e.g., Flexible Service Plan, Therapeutic Behavioral Services (TBS) Plan
    - Psychological Testing done within past year (if available)
    - Individual Education Plan and Individual Transition Plan
    - Assessment of financial needs (may need referral to apply for Supplemental Security Income (SSI) six months prior to 18th birthday if applicable)
    - Any self-evaluations recently given to youth.

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

3. The MHPC will review the packet to determine medical necessity according to Title 9 and the Service Eligibility Policy for the Adult/Older Adult System of Care.

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

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

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

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

7. Team will review youth defined needs and options and create a transition plan, complete a Transition Age Youth Referral form, including all signatures. The Care Coordinator will include a copy of a Transition Age Youth Referral Plan in the medical record. The plan shall identify the individual that will follow up with the transition plan. Should the youth decide this plan is not acceptable, an alternative shall be identified, and same procedure followed.

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

Organizational Provider Outpatient Services or County Operated Services

If a client first accesses services by calling or walking into an organizational provider site or a county-operated program, the client can be seen and assessed, and the organizational provider authorizes services based on medical necessity and/or the SED criteria as outlined in California Welfare & Institutions Code Section 5600.3. (See Systems of Care section of this handbook for

elaboration of the content of this code.) See Authorization/Reimbursement Section of this handbook for a description of organizational provider and county-operated program responsibility for registration of clients.

Day Intensive and Day Rehabilitative Services (CYFS)

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

Prior authorization is required for all day services. Clients referred to day services shall begin treatment services within contract guidelines. Prior to admission of the client, day programs shall comply with authorization procedures for day services as set forth in the DHCS Informational Notice No.: 19-026. An Administrative Services Organization (ASO) provides authorization for all day services. Optum acts as the ASO. Reauthorization is required every three months for day intensive services and every six months for day rehabilitative services. Copies of Optum's current Specialty Mental Health Services ISR forms are available at https://www.optumsandiego.com

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

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

Service Priority for Outpatient Assessment Services – CYFS

High

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

Routine

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

Ongoing Services

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

THERAPEUTIC BEHAVIORAL SERVICES (TBS)

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

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

Utilization Review

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

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

DUAL DIAGNOSIS CAPABLE PROGRAMS

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

MENTAL HEALTH SERVICES FOR INDIAN ENROLLEES

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

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

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

RESIDENCY

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