B. Providing Specialty Mental Health Services

Adult/ Older Adult Specialty Mental Health Services

Adult/Older Adult services include:

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

b. Outpatient clinics provide individual and group therapy and medication support services.

c. Case Management services which assist 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 member and family needs and “do whatever it takes” to meet those needs.

e. Residential programs, which are twenty-four/ seven (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 requiring a hospital setting.

h. Treatment and recovery services to traditionally harder to reach populations, such as Lesbian, Gay, Bi-sexual, and Transgender (LGBT), serial inebriates and HIV positive adults.

Case Management and Assertive Community Treatment

Optum San Diego serves as the Single Point of Access (SPOA) for Assertive Community Treatment (ACT) and Strength Based Case Management (SBCM) referrals. Optum provides a standard routing system for receipt and processing of referrals to most appropriate program based on the information provided on the referral and additional collateral information available. Optum will collaborate with the case management programs throughout the referral process. Anyone can refer to the SPOA for ACT and SBCM, the individual being referred must agree to the referral and services

provided. The SPOA may determine that ACT or SBCM is not the appropriate level of care, at which time the person will be referred to another service, such as an Outpatient Clinic. The ACT or SBCM program receiving the referral will complete an assessment to determine if their level of care is best able to serve the person and will open the case. If the program receiving the referral assesses the person and determines the person might be better served through another provider, contact is made with the other program, the person is informed, and the referral may be forwarded for review.

For more information, regarding the SPOA for ACT and SBCM go to the website below: Single Point of Access-ACT & Strength Based Case Management. More information on ACT and SBCM can be found at the links below: Assertive Community Treatment Services & Case Management

Descriptions for these programs are as follows:

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

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

Strength-Based Case Management: Services are delivered through BHS contracted service. Programs assist members with severe mental illness who may have a co-occurring disorder and may be justice-involved to access needed mental health, medical, educational, social, prevocational, vocational, housing supports and rehabilitative or other community services. The SBCM model emphasis is on the structure of the program, supervision, and clinical services. The goal of SBCM is to help improve the member's mental health and quality of life for the member to live in the least restrictive environment. SBCM services provide a mix of mental health, rehabilitation and case management functions and have a staff-to-member ratio of approximately 1:25.

Members are typically evaluated in person at a minimum of once (1x) a month. Services may be provided on a much more frequent basis, depending on member clinical need. It is also expected that the case manager will have contact with significant others as clinically appropriate.

Services provided include, but are not limited to:

- Medication management (coordinated outside the program in the FFS sector)

- Case Management
- Rehabilitation and recovery services
- Care Coordination between needed services
- Co-occurring services linkages
- Access and linkage to Supportive Housing
- referral and linkage to needed services
- monitoring services delivery to ensure member access to services and the services delivery system
- monitoring of the member's progress
- plan development.
- Access to Supportive employment/vocational and educational services

Assessment/ Eligibility Criteria: Individual must meet two (2) or more criteria:

1. A face-to-face meeting is necessary to determine the presence of a severe psychiatric disability and need for Strength Based Case Management (SBCM) services per LOCUS (Level 3 – High Intensity Community Based Services)

2. Has current LPS Conservatorship (may be a designated County Conservator or family member (Private Conservator)

3. Is not homeless but may be at-risk of homelessness

4. Minimum one hospitalization in the past year, OR multiple ER utilizations, PERT interventions, jail mental health service and/or long-term care hospitalization.

5. Has major impairments in life functioning

6. Is not connected to outpatient treatment

7. Is experiencing an acute psychiatric episode that might require SBCM level services

8. Is at high risk of admission to an inpatient mental health facility

9. 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

10. Does not have a case manager from another program who is able to address mental health needs.

Discharge Criteria: A LOCUS is completed every six (6) months to assist in determining if member is ready for lower level of care. Members receiving Strength-Based Case

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

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

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

Services provided include, but are not limited to:

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

Assessment/ Eligibility Criteria: Eligibility criteria are the same as the criteria for SBCM with the following additional factors: Homelessness or at risk of homelessness and a level of acuity and need for intensive ACT services per LOCUS assessment (Level 4 Medically Monitored Non-Residential Services)

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

Evaluation: Members are typically evaluated in person at a minimum of four (4) times per week to meet the member's clinical needs and meet a high ACT fidelity rating. ACT

programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity, medication support services and some psychotherapy. Clinical Assessment for Criteria to Access Specialty Mental Health Services Delivery System

Discharge Criteria: Same as SBCM

Providing SBCM/ACT Services to LPS Conservatees

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

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

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

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

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

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

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

6. Upon request, provide case information to the Public Conservator's Office regarding grave disability, including information on the following:

- Clinical presentation (psychiatric/medical, functional ability, etc.)
- High-risk behaviors
- Activities of daily living
- Current medications and adherence
- Placement history
- Strengths and goals

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

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

9. During the course of LPS Conservatorship proceedings, including, but not limited to reestablishments, rehearings, or jury trials, it is possible the Public Conservator's Office may not be available to evaluate and provide testimony on select contested matters. In such situations, the treating Psychiatrist or licensed Psychologist for the Conservatee may be asked to testify as an expert in the contested matter. If the current treating Psychiatrist or licensed Psychologist for the Conservatee is affiliated with the case management program, the Office of the Public Conservator may ask the doctor to provide testimony as an expert at the hearing. In the absence of a testifying expert, the conservatorship may be terminated.

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

11. Notify the Public Conservator's Office within twenty-four (24) hours when any of) the following situations occur for a conservatee:

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

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

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

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

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

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

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

- <u>ACT:</u> Within forty-eight (48) hours of the program formally opening the case, consistent with the OPOH standard for face-to-face visits for those deemed urgent and recently discharged from acute care.

- SBCM: Within ten (10) business days of the program formally opening the case, unless deemed urgent and recently discharged from acute care, which would then require the urgent visit within forty-eight (48) hours

- <u>Institutional-In County:</u> Within thirty (3) days of the program formally opening the case or expedited in response to clinical need, on a case-by-case basis.

- Institutional-Out of County: Within ninety (90) days of the program formally opening the case or expedited in response to clinical need, on a case-by-case basis.

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

If discharge is imminent (planned in less than ten (10) business days) when the case is opened to County Institutional Case Management services, no face-to-face contact must be made unless the member is requesting such contact, or it is otherwise clinically indicated. Telephone contacts may be made as needed to facilitate discharge planning or other clinical needs during the time the patient remains in acute care.

If discharge is not imminent at the time the case is opened to County Institutional Case Management services, the case manager must plan to meet with the patient in the acute care setting within ten (10) business days of case opening, with the exception of patients in jail settings.

For conservatees in jail settings (where discharge is not imminent at the time Permanent Conservatorship is established), face-to-face contact must be made within 30 days of opening case to County Institutional Case Management to accommodate clearances needed and access to incarcerated individuals.

When a Private Conservator is appointed and requests the assistance of County operated Case Management Services, initial face-to-face contacts will follow the same periods as when the Public Conservator is appointed.
On-Going Face-to-Face Visits: Frequency of visitation will be conducted according to either Strength-Based Case Management (SBCM) or Assertive Community Treatment (ACT) program as follows:

- SBCM: Members are typically seen in person at a minimum of once a month. Services may be provided on a much more frequent basis, depending on the member's clinical need. It is also expected that the case manager will have contact with significant others as clinically appropriate. Members who are conservatees are required to be seen, at minimum, within thirty (30) calendar days from the date of the previous visit.

- ACT: Members are typically evaluated in person at a minimum of four (4) times per week in order to meet the member's clinical needs and meet a high ACT fidelity

rating. It is also expected that the case manager will have contact with significant others as clinically appropriate.

- Institutional-In County: Routine visits occur every ninety (90) days. Frequency increases based on clinical need on a case-by-case basis.

- Institutional-Out of County: visits to occur every ninety (90) days. Telehealth contacts occur monthly in between face-to-face visits. Frequency of visits may be adjusted based on clinical need on a case-by-case basis, as approved by Public Conservator's Office COR or designee.

Augmented Services Program

Designated case management providers may refer to Augmented Services Program (ASP). The goal of the Augmented Services Program is to enhance and improve member 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 member strengths, symptom management, and member self-sufficiency. Priority for ASP services is given to those members 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 member must:

1. Have a primary diagnosis of a serious mental disorder,

2. Have an active case open to A/OAMHS case management program and have been evaluated by their care coordinator to need ongoing case management services. The assigned case manager is the only person who can submit a request for ASP services,

3. Reside in an ASP contracted facility,

4. Score of sixty (60) and above on the ASP scoring tool – if below a score of sixty (60) will need Behavioral Health Program Coordinator (BHPC) approval; and

5. ASP funds must be available for the month(s) of service

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

Housing Quality Checklist

The purpose of the Housing Checklist is to ensure participants who are receiving ACT or SBCM services and housing are connected to safe and quality housing placements. The checklist is an evaluation tool that ensures all housing is equally assessed using the same standards. Service providers are required to confirm that the housing under consideration meets all required elements of providing safe, decent, and sanitary housing for the initial and ongoing occupancy of enrolled participants. If the placement process indicates the presence of any health and safety issues, the home/unit should be removed from consideration and member should not be placed in the home/unit. Documentation in MSR or QSRs shall report any of the housing sites that have been removed. Permanent Housing funded by a local or Federal Housing Authority are exempt and not required to be inspected. The Housing Quality Checklist is located on the Optum San Diego Website > MH *Resources* Tab.

Utilization Review for ACT/FSP/Case Management Programs

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

The URC shall consist of a minimum of three (3) staff persons. The chair of the URC shall be a licensed/registered/waivered mental health clinician. Additional members shall be two (2) or more staff who provides direct services or clinical oversight. A clinician shall not participate in the authorization decisions of the member. The QA unit may identify cases for review.

Initially, all members who have been receiving services for more than two (2) 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 member, the case manager will complete the *Adult Outpatient Utilization Management Form* verifying that the member meets criteria for access to SMHS and the services must be medically necessary. This will summarize necessary information in order to assist with the URC review.

Case managers will prepare cases for URC review by the first of the month of their annual review when the admission date to the current program was two or more years ago. The Program Manager/Supervisor will develop a list of members due for review each month and will notify the case manager and the URC of the cases to be reviewed. The URC will notify the program and case managers of the date and time of the URC and have the charts gathered accordingly.

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

Recovery Markers Questionnaire (RMQ)
Illness Management and Recovery (IMR)
Milestones of Recovery Scale (MORS)

Members with a MORS rating of one (1) to five (5) will be qualified to receive ongoing services at the County or Contracted outpatient clinic. The MORS rating shall be kept in the member's record. Time spent with the member completing outcome measures may be claimed as part of another direct member service when the information obtained from the outcome measure is used for UM/UR review. Documentation shall demonstrate how the information was used for furthering the clinical assessment or for planning, guiding, or developing treatment.

Children and Youth Specialty Mental Health Services

All authorization requirements in this section must be completed for all members even if the services will be funded by a source other than Medi-Cal, including Behavioral Health Services Act (BHSA), formerly MHSA. Department of Health Care Services (DHCS) BHIN 22-016 outlines authorization requirements for Specialty Mental health Services (SMHS). It emphasizes that all medically necessary covered SMHS must be sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished (42 CFR). The information notice specifies that for outpatient services prior authorization is required for Intensive Home-Based Services, Day Treatment Intensive, Day Rehabilitation, Therapeutic Behavioral Services, and Therapeutic Foster Care. Prior authorization may not be required for Crisis Intervention, Crisis Stabilization, Metal Health Services, Targeted Case Management, Intensive Care Coordination, or Medication Support Services.

The Children, Youth and Families Behavioral Health 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 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 several specialized programs that focus on specific populations.

c. Full-Service Partnerships are outpatient programs which provide intensive services that comprehensively address member 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.

    i. 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.

    ii. 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 requiring 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 members 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.

Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Brochure

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

Therapeutic Behavioral Services (TBS)

Prior authorization through Optum is required preceding the provision of Therapeutic Behavioral Services (TBS). Members are referred to New Alternatives, Inc. (NA), who is the point of contact for TBS. The referring party may include COSD SOC, Child & Family Wellbeing (CFWB), and Probation Department.

The referring party will complete and return an authorization request form and to the Administrative Services Organization (ASO) who provides authorization for TBS. Optum acts as the ASO. Prior authorization must be submitted prior to the opening of the assignment or the provision of services. All prior authorizations are sent via FAX to Optum secure fax (866) 220-4495. The required authorization request forms are located on the Optum Website > *MH Resources* tab.

Authorization requests are screened and assessed for eligibility criteria according to California Department of Mental Health guidelines provided in DMH Letter 99-03 and DMH Notice 08-38. Optum will send authorization response to the referring party within five (5) business days of receipt of request. The provider assigned to the member/family will conduct an assessment to ensure the member meets the class, service, and other TBS criteria prior to services being delivered. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

Authorization management for extended Therapeutic Behavioral Services is retained by the BHP. If a member requires more than twenty-five (25) hours of coaching per week of TBS, the Contractor shall contact COR for approval. But if member requires more than four (4) months of services, provider will use internal/tracking request system that does not require COR approval. Authorization for services for San Diego members placed out of county are referred to the COR for authorization for TBS services.

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

1. Placing agency from the county of origin may instruct legal guardians to contact San Diego Administrative Services Organization (ASO), at 1-888-724-7240 for services referrals. The ASO makes a referral to a Fee-For-Service (FFS) or an organizational provider.

2. The program providing the services will submit the Service Authorization Request (SAR*)* to the county of origin for authorization and signature.

3. For outpatient services, if county of origin SAR authorization is delayed, services may be provided when the reason for delay is administrative in nature and not a clinical denial.

4. If requested by the placing agency of the county of origin, the program will inform them of the services being provided, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.

5. Services shall be entered into the EHR by the MIS.

6. The County of San Diego will submit the claim for services directly to the State Department of Health Care Services via the MIS.

7. SPA shall submit the notification SAR and the DSR to Optum.

8. STRTPs shall contact the COR for written prior authorization for admission to mental health treatment services and confirm that out-of-county youth has a San Diego connection/caregiver to whom they will be discharging to.

9. STRTPs shall submit the completed SAR to the county of jurisdiction and forward a copy of the SAR and DSR to Optum with a written COR approval to serve youth under County contract due to discharge to San Diego residence.

10. STRTPs shall complete an AB1299 STRTP Admission Report submitted to the COR and BHS CCR team by the 15th day of the following month and clearly indicate that the AB1299 STRTP Admission Report is being utilized to provide information about an out of county KinGAP or AAP youth under a COR written authorization.

There are, in essence, two types of OOC Medi-Cal members:

1. OOC members who fall under the aid codes AAP or KinGAP. For those members the program shall submit a SAR to the Behavioral Health Plan (BHP) from the

County of Jurisdiction. The members are subject to our local UM process and the services are entered into our EHR.

2. OOC members who do not fall under one of those codes need to have their Medi-Cal shifted to San Diego in order for programs to serve them. Programs need to get written authorization from COR to serve those children prior to Medi-Cal shifting to San Diego. When authorization is granted prior to the Medi-Cal shift it is with the expectation that the program is actively and promptly collaborating with the guardian to have Medi-Cal shift to San Diego. No need to complete a SAR; follow local UM process.

All BHS CYF contracted programs are to ensure that the "County of Responsibility" code is accurate and up to date for each youth admitted to the program to also track all youth's Medi-Cal County of origin.

Outpatient Time Based Utilization Management

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

Members who meet the access criteria for specialty mental health services shall be eligible for up to six (6) months of treatment sessions. This will apply to Medi-Cal members and other eligible members outlined in this handbook. Additional treatment time may be authorized as clinically indicated. Utilization Management shall be completed at the program level by a licensed clinician.

School Interface

Aligned with AB114, students with behavioral health needs are assessed through the school system and when appropriate are offered related services through the school district so they can benefit from their education. Students receiving services through the school may also access Children, Youth & Families services through the County system when they meet access criteria for specialty mental health services.

Children, Youth & Families standard of practice is to offer a full range of services which may include medication services as well as services which are educationally related and therefore coordination of care with the school continues to be critical. Through contracts with Community Based Organizations, School ink services are offered on identified school campuses. Information about School ink can be accessed through the HHSA-BHS webpage.

Day Intensive and Day Rehabilitative Services

Day services are offered in school/community settings and as enhanced treatment services in residential facilities for the most severely emotionally disturbed children and youth who meet criteria for access to SMHS and the services must be medically necessary. Referral and admission to all day services may come from Juvenile Probation, Child and Family Wellbeing 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. Members referred to day services shall begin treatment services within contract guidelines. Prior to admission of the member, 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 (3) months** for day intensive services and **every six (6) months** for day rehabilitative services. Copies of Optum's current *Prior Authorization Day Services Request* (DSR) as well as the *Ancillary Specialty Mental Health Services Request* are located on the Optum Website > *UCRM* tab.

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

Utilization Review for Day Treatment Intensive and Day Rehabilitation Services

Utilization review of day treatment intensive and day rehabilitation services for Medi-Cal members is delegated to Optum and managed on a ninety (90) day cycle for STRTPs, twelve (12) weeks for IOP & and four (4) weeks for PHP.

The Day Service Request for STRTP, IOP, and PHP essentially states that the member cannot be served at a lower level of care and that a recommendation for intensive services has been made. If access or service necessity criteria are not met, the Medi-Cal member will be issued an NOABD (which must also be documented in the NOABD log) and the member rights shall be explained. In the event that the provider has received a denial of authorization from Optum, a NOABD shall be issued by Optum. Programs are responsible to check monthly all Medi-Cal and UMDAP members for eligibility and update the MIS as appropriate. Authorizations should be filed in the medical record in the Plans section or be accessible upon request. Without authorization approval services may not be billable. Questions regarding the DSR process may be directed to Optum at (800) 798-2254 option #4.
Prior to obtaining authorization to receive services within the program, each member must have:

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

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

Ancillary Services

An Ancillary Service Request Form must be submitted if a member is going to receive Outpatient services in addition to the Day Intensive services. This form is located on the Optum Website > *UCRM* tab. If Day Service and Outpatient Services are provided by the same program, the Ancillary Services Request section in the DSR form will be completed as part of the prior authorization. If Outpatient services are provided by another program, an Ancillary Services Request form must be completed by the OP provider and sent to IOP for submission to Optum. When the DSR Ancillary information is done incorrectly, Optum will send the DSR to the Day program with whom the outpatient program is coordinating.

Pathways to Well-Being and Continuum of Care Reform

Pathways to Well-Being (PWB) was prompted by the Katie A. class action lawsuit, filed in 2002 against the County of Los Angeles and the State of California by a group of foster youth and their advocates. The lawsuit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. PWB was implemented in March 2013 in the County of San Diego as a joint partnership between Behavioral Health Services (BHS) and Child and Family Well-Being (CFWB), in collaboration with Probation and Youth/Family Support Partners. The County of San Diego is dedicated to collaborative efforts geared toward providing safety, permanency, and well-being for youth identified

as having complex or severe behavioral health needs and to establish long term permanency within a home-like setting.

PWB includes services that are needs driven, strengths-based, youth and family focused, individualized, culturally competent, trauma informed, and are delivered in a well-coordinated, comprehensive, community-based approach with a central element of engagement and participation of the youth and family. PWB services are available to youth across the System of Care, including Transitional Age Youth (TAY) who are involved in County of San Diego Behavioral Health Services.

California's Continuum of Care Reform

California's Continuum of Care Reform (CCR), initiated across California on January 1, 2017, builds on the efforts made through the Katie A. class action suit. CCR is mandated through AB403 (2015) and AB1997 (2016) and integrates the positive practices identified through the implementation of PWB. CCR strives to help all children live with permanent, nurturing and committed families, and to reduce the time children spend living in congregate care.

CCR adheres to fundamental principles including youth and family receiving collaborative and comprehensive support through teaming and youth not having to change placement to get services and support. CFWB and Probation have mandated timelines for CCR, Child and Family Team (CFT) meetings that include specific case decision making situations such as:

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

BHS PWB and CCR Program staff are available to provide outreach assistance to BHS providers in all aspects of PWB and CCR implementation. This includes assisting providers with utilizing ICC and IHBS in accordance with the DHCS Medi-Cal Manual, as

well as technical assistance for STRTPs and group home providers who are transitioning to a STRTP. The PWB and CCR Program teams work collaboratively and in partnership with BHS providers, CFWB, Probation, and Youth/Family Support Partners. Program staff can be reached through the BHS Pathways to Well-Being Website.

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

Per BHIN 21-058, BHP's must make individualized determinations for each child/youth's need for ICC, IHBS or TFC upon intake and at each assessment interval. Having an open child welfare services case is not required for a child or youth to receive ICC, IHBS or TFC. BHP's are obligated to provide ICC, IHBS, and TFC to all children and youth under the age of twenty- one (21) eligible for full scope Medi-Cal and who meet access criteria for these services.

The BHP cannot develop or utilize a screening or assessment tool or policy that narrows the eligibility for ICC, IHBS or TFC *beyond being medically necessary.* Providers should be considering ICC and IHBS services for all youth as part of the assessment process and indicate as such in their documentation at intake and re-assessment. Members identified as meeting criteria for these services will be indicated as a "Special Population" in the EHR.

CFT Meetings

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

For children or youth who are receiving ICC, IHBS, or TFC, a CFT meeting must occur as needed, but at least every ninety (90) days.

More information regarding the CFT meeting can be found in the The Medi-Cal Manual for ICC, IHBS, and TFC Services.

The CFT is comprised of the following members :

- Child/youth/TAY (Mandatory)
- Family/caregiver (Mandatory)

- CWS social worker (Mandatory)
- BHS provider (Mandatory)
- Probation (Mandatory when youth is a ward of the court)
- Tribal Members (When applicable)
- Court Appointed Special Advocate (CASA) (Mandatory when assigned by a judge)
- Natural supports
- Education and Other Formal Supports

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

CFT Meeting Facilitation Program

All mental health treatment programs (other than those with a written COR-approved exception) that serve youth and families who are participating in CFT meetings, are required to utilize the CFT Meeting Facilitation Program. The CFT Meeting Facilitation Program is responsible for scheduling, organizing, and facilitating CFT meetings for children/youth up to twenty- one (21) years of age, within the BHS Children, Youth and Families system of care who are receiving Intensive Care Coordination (ICC) and are either required to have CFT meetings due to Pathways to Well-Being criteria, or would benefit from a CFT meeting due to multi-system involvement.

The program also serves Child and Family Well-Being and Probation involved youth while closely collaborating and coordinating with all pertinent people in the youth and family's life including CFWB workers, Probation Officers, BHS providers, educational supports, other identified formal supports, and natural supports. Providers will initiate the CFT meeting process by completing the *Child and Family Team Meeting Referral Form* and faxing to the CFT Meeting Facilitation Program.

Please note that if a member is **not** involved with CFWB, the program does **not** have to utilize a facilitation Fred Finch for CFT meetings. In these cases, the CFT meetings can be self-facilitated by the provider within regular timelines.

Special Populations Selection

DHCS no longer requires the identification of class or subclass when determining eligibility for ICC/IHBS services, however, counties are recommended to continue tracking of those youth who would have been subclass to facilitate data collection and reporting of all services provided. BHPs must continue to ensure appropriate claiming of

ICC, IHBS, and TFC services. BHPs are obligated to provide ICC and IHBS through the EPSDT benefit to all children and youth under the age of twenty- one (21) who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for these services. All youth under age twenty- one (21) and eligible for full scope Medi-Cal must be assessed for criteria to receive ICC/IHBS services Neither membership in the *Katie A.* class nor subclass is a prerequisite to consideration for receipt of ICC and IHBS, and therefore a child does not need to have an open child welfare services case to be considered for receipt of these services. All children and youth should be screened for ICC and IHBS services as part of the Assessment process, and these services should be provided to youth when medically necessary.

Documenting and Billing for CFT Meetings in SmartCare

When ICC/IHBS services are assessed to be medically necessary, these youth should be entered into the appropriate *Special Populations* category in SmartCare – this will link the appropriate modifier (HK) for billing and tracking purposes when providing these services. Special populations “ICC/IHBS” is used for any youth receiving ICC/IHBS services. Special populations “Katie A ICC/IHBS” is used for any youth that would have been considered “subclass” under previous PWB criteria. **Resource**: How To Identify a Client as Katie-A or Other Special Population

Providers should utilize **Procedure Code: CFT/MDT** when documenting a CFT meeting. Each treatment team member that plans to bill for their time spent discussing the member with other treatment team members must create their own service note. Additional guidance: Document Treatment Team Meetings - 2023 CalMHSA

Resource: Medi-Cal Manual for ICC, IHBS and TFC for Medi-Cal Beneficiaries

ICC & IHBS Services

Intensive Care Coordination

The BHP is obligated to provide ICC to all children and youth under the age of twenty- one (21) eligible for full scope Medi-Cal and who meet access criteria for these specialty mental health services. ICC is provided through collaboration between the members of a CFT. **A Child and Family Team must be identified to provide ICC.** ICC requires active, integrated, and collaborative participation by the provider and at least one member of the CFT. ICC is a service that is used for the identification and coordination of ancillary supports and systems which promote safety, permanency, and well-being. ICC services are offered to members with significant and complex functional impairment and/or whose treatment requires cross-agency collaboration.

BHS providers comply with both the California Department of Health Care Services (DHCS) The Medi-Cal Manual for ICC, IHBS, and TFC Services, in adherence to

considerations for when to provide ICC, Intensive Home-Based Services, and Therapeutic Foster Care (TFC) services for Medi-Cal Beneficiaries.

Intensive Home-Based Services

Intensive Home-Based Services (IHBS) are individualized, strength-based interventions designed to correct or ameliorate mental health conditions that interfere with a child or youth's functioning and are aimed at helping the child or youth build skills necessary for successful functioning in the home and community, and improving the child's or youth's family's ability to help the child or youth successfully function in the home and community. IHBS services are provided according to an individualized treatment plan developed in accordance with the ICPM by the Child and Family Team (CFT) in coordination with the family's overall service plan.

They may include but are not limited to assessment, plan development, therapy, rehabilitation, and coordination of care services. IHBS is provided to beneficiaries under twenty- one (21) who are eligible for full-scope Medi-Cal services and who meet access criteria for specialty mental health services. Prior authorization is required to access IHBS services. IHBS Prior Authorization Request form process is the following: BHS Mental Health Organizational Treatment Provider submits the IHBS Prior Authorization Request Form to Optum via FAX (866) 220-4495 or electronically via the IHBS Prior Authorization Request Web-Based form

Optum reviews and provides authorization determination within five (5) business days of receipt. Authorization is forwarded to the requesting provider to be filed in the member's hybrid medical record. Optum issues a NOABD to provider and Medi-Cal member if IHBS request is denied, modified, reduced, terminated, or suspended. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable. The required authorization request forms are located on the Optum Website>*UCRM* tab.

A Child and Family Team must be identified to provide IHBS. IHBS are individualized, strength-based interventions that assist the member in building skills necessary for successful functioning in the home and community. IHBS is offered to members with significant and complex functional impairment. These services are primarily delivered in the home, school, or community and outside an office setting. There are situations where ICC or IHBS are a lock out, including youth currently incarcerated and when the service is provided during day treatment hours, which is inclusive of these services.

Short-Term Residential Therapeutic Programs (STRTPs)

California's Continuum of Care Reform (CCR), AB403 (2015) and AB1997 (2016), requires that Residential Care Level (RCL) group homes who serve foster youth and/or non-minor dependents (NMD) transition to licensure as an STRTP. The legislation ensures that youth with the most acute mental health treatment needs receive specialized, trauma informed, and intensive treatment focused on stabilization to allow for a successful transition to a family setting.

The Quality Management Unit will monitor Day Treatment Programs in accordance with state standards. For more information, see links: Day Treatment Intensive and Day Rehabilitation Service Components - Attachment A DMH Information Notice NO. 02-06 . Monitoring includes but it not limited to: the annual collection of schedules, program descriptions and group descriptions for pre-approval programs must submit any changes to the schedule, or group descriptions for review and pre-approval. STRTPs are required to comply with the program, documentation and staffing requirements outlined in the most current Interim STRTP Regulations provided in BHIN No: 20-005.

IPC and CFT Meeting

Prior to placement in an STRTP, all children and youth shall participate in a **Child and Family Team meeting** and be evaluated by the **Interagency Placement Committee (IPC)** to ensure that the youth's needs cannot be met in a less restrictive environment and that they meet the criteria listed in All County Letter No. 17-22 , including that the child/youth:

1. Does not meet criteria for inpatient care and has been assessed as requiring the level of services provided by an STRTP in order to maintain their safety and well-being AND one of the following:

    i) Meet **access criteria** for Medi-Cal Specialty Mental Health Services,

    ii) is assessed as **seriously emotionally disturbed**, or

    iii) is assessed as **requiring the level of services** provided by the STRTP in order to meet their behavioral or therapeutic needs, or

    iv) meets criteria for **emergency placement** prior to determination by the IPC.

The IPC consists of representatives from Child and Family Well-Being (CFWB), Probation, and Behavioral Health Services as well as representatives from Public Health, and Educational sectors. Interagency Placement Committee meetings are held

weekly by both Probation and CFWB. For children 6-12 years old, placement in an STRTP shall not exceed six (6) months. For children aged 13 and up, placed under supervision of CFWB, the placement shall not exceed 6 months. For children aged 13 and up, placed under supervision of Probation, the placement in an STRTP shall not exceed twelve (12) months.

Family First Prevention and Services Act

On February 9, 2018, the Bipartisan Budget Act of 2018, which includes the Family First Prevention and Services Act (FFPSA), was signed into law. FFPSA is designed to enhance support services for families to help children remain at home and reduce the use of unnecessary congregate care placements by increasing options for prevention services, increasing oversight and requirements for placement, and enhancing the requirements for congregate care placements.

As outlined in BHIN NO. 21-060, a Qualified Individual (QI) shall conduct an independent assessment and determination regarding the needs of a child prior to placement in a Short-Term Therapeutic Residential Program (STRTP) or in an out-of-state residential facility. The Qualified Individual shall include engagement with the child and family team members and, in the case of an Indigenous child, the Indigenous child's tribe, in conducting the assessment. The QI shall conduct the independent assessment and determination prior to placement in a STRTP. In the case of emergency placement, the QI shall conduct the independent assessment and determination within thirty (30) days of the start of the placement.

Per FFPSA, Short-Term Residential Therapeutic Programs (STRTPs) aftercare component will routinely extend for at least six (6) months post discharge and will include a connection to wraparound services as the youth transitions out of the STRTP. The goal of the aftercare component is to support youth in the transition from congregate care to a family-based setting. STRTPs are responsible for discharge planning and ensuring family-based aftercare supports are in place for at least six (6) months.

STRTPs have authorization to make direct referrals to BHS contracted wraparound programs and shall routinely discuss the implementation of wraparound services in the Child and Family Team (CFT) meeting during the transition period from the STRTP to aftercare to ensure the team is a part of the recommendation. Wraparound providers can begin providing services up to three months prior to a youth's planned discharge from the STRTP in order to prepare for the transition to a family-based placement.

Program Procedure for Medi-Cal Eligible Children in Foster Care under AB1299

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

(For foster children whose care is presumptively transferred to San Diego)

1. Placing agency from the county of original jurisdiction may instruct legal guardians to contact San Diego Administrative Services Organization (ASO), at 1-888-724-7240 for services referrals. The ASO makes a referral to a Fee-For-Service (FFS) or an organizational provider.

2. The placing agency informs Optum of the presumptive transfer.

3. If requested by the placing agency of the county of original jurisdiction, the program will inform them of the services being provided, in accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) and Medi-Cal confidentiality requirements.

4. Services shall be entered into the EHR by the MIS.

5. The County of San Diego will submit the claim for services directly to the State Department of Health Care Services via the MIS.

6. STRTPs who provide day services shall submit DSR to Optum.

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

Therapeutic Foster Care

The Therapeutic Foster Care (TFC) service model allows for the provision of short-term, intensive, highly coordinated, trauma-informed and individualized Specialty Mental Health Service (SMHS) activities to children and youth up to twenty-one (21) years of age who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC service model is intended for children and youth who require intensive, individualized, and frequent mental health support in a family environment. The TFC service model allows for the provision of certain SMHS services available under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit as a home-based alternative to high level care in institutional

settings such as group homes and, in the future, as an alternative to Short-term Residential Therapeutic Programs (STRTPs).

The TFC home also may serve as a step down from STRTPs. The TFC service model components consist of plan development, rehabilitation, and coordination of care. The SMHS service activities provided through the TFC service model are ancillary to other SMHS that the child or youth receives. Children and youth receiving SMHS service activities through the TFC service model must receive Intensive Care Coordination (ICC) and other medically necessary SMHS, as set forth in the care plan.

Prior authorization through Optum is required preceding the provision of TFC services. An authorization request form shall be completed and returned to the Administrative Services Organization (ASO) who provides authorization for TFC. Optum acts as the ASO. Authorization requests are screened and assessed by Optum for eligibility criteria. Optum will send authorization determination to the requestor within five (5) business days or receipt of request. Prior authorization must be submitted prior to the opening of the assignment or the provision of services. The Optum Provider Line for authorization requests is 1-800-798-2254. The required authorization request forms are located on the Optum Website> *MH Resources*.

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

The TFC program is responsible for the oversight of the interventions provided by the TFC parent and for ensuring that the TFC parent follows the care plan. The TFC parent serves as a key participant in the therapeutic treatment process of the child or youth. The TFC parent provides trauma-informed interventions daily, up to seven (7) days a week, including weekends, at any time of the day, as medically necessary for the child or youth. The TFC program is responsible for ensuring the TFC parent receive competency-based trainings both initially and ongoing, as outlined in DHCS Medi-Cal Manual. The TFC program conducts an annual parent evaluation to determine if any additional training or needs must be addressed.

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

The SMHS provided through the TFC service model assists the child or youth in achieving care plan goals and objectives; improving functioning and well-being; and helps the child or youth to remain in a family-like home in a community setting; thereby avoiding residential, inpatient, or institutional care. As a member of the CFT, the TFC parent participates in planning, monitoring, and reviewing the child/youth's progress in TFC and informing the team of any changes in the child's needs during CFT meetings.

Bulletins: PWB Bulletins are used to inform and provide procedures. Bulletins are located on the BHS Pathways to Well-Being Website

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

Forms: Member related forms specific to Pathways to Well-Being which must be completed include the following below. Forms referenced below are located on the BHS Pathways to Well-Being website under the Tools and Forms tabs. The page includes general information, required forms, training, schedules, and contact information for BHS Pathways to Well-Being staff.

Form	Details
Child and Family Meeting Facilitation Program Child and Family Team Referral	Completed any time there is an identified need for a CFT meeting for a youth in a mental health treatment program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Child and Family Team Meeting Summary and Action Plan	Initiated by CFT Meeting Facilitation Program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Child and Family Team Meeting Confidentiality Agreement	Initiated by CFT Meeting Facilitation Program unless provider has an exception to facilitate their program CFT meetings, approved by COR.
Pathways to Well-Being BHS/CFWB Information Exchange Form	Provider completes and submits form to CFWB (see secure region fax numbers on form) initially within thirty (30) days of determining eligibility and for any update (upon significant change or revision to either a care plan or problem list).

Resources:

- DHCS Medi-Cal Manual Third Edition (2018):
- DHCS Integrated Core Practice Model Guide (2018):

Peer Support Services

Peer Support Specialist (PSS) refers to certified Peer Support Specialist who is providing services in the behavioral health field using their "lived experience" to establish mutuality and build resiliency and recovery. Peer support services are recovery-oriented and resiliency-focused services for those managing behavioral health challenges as well as the parents, family members, and caregivers that support them. Peer Support Services may be delivered and claimed as a standalone service or provided in conjunction with other SMHS services and in numerous environments including: inpatient facilities, residential services, outpatient clinics, case management programs and clubhouses.

Following federal approval, DHCS added Medi-Cal Peer Support Specialists as a unique provider type within specific reimbursable services. Peer Support services may be provided face-to-face, by telephone or telehealth and may be provided anywhere in the community. Peer Support Certification is required, with training to align with County designated certification process. Peer Support Services require a care plan and must be recommended by physician or other Licensed Mental Health Professional within their scope of practice and as medically necessary.

Peer-led interventions provide an additional tool to assist members in developing self-awareness and self-mastery skills. Examples of peer led interventions include but are not limited to Wellness Recovery Action Plan® and Whole Health Action Plan (WHAM). These services are designed to assist members in managing day-to-day activities at home and in the community. Designated staff with an understanding of the peer experience may also facilitate the structured interventions.

Crisis Stabilization Services

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

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

Assessment/ Eligibility Criteria: Member must present with a mental health crisis for a condition that requires a timelier response than a regularly scheduled visit and must meet access criteria - services must be medically necessary

Services provided include, but are not limited to:

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

Discharge Criteria: Discharge occurs when members no longer meet criteria for danger to others, danger to self and grave disability and crisis stabilization services are no longer medically necessary. It must be ensured that the member can be discharged safely to a lower level of care in addition to being connected to outpatient services and provided with referrals.

Crisis Residential Services

The BHP, through its contracted provider, operates Crisis Residential Services, which are considered a “step down” or diversion from inpatient services. Crisis residential services are provided to both Medi-Cal and non-Medi-Cal members who meet access criteria and admission criteria. Referrals for services can be made directly to the Crisis Residential intake staff but do require initial authorization from Optum. Optum will then reauthorize medically necessary services, as appropriate, concurrently with the member’s stay based on the continued need for services. More information about the locations and services provided by the Crisis Residential Programs may be obtained from the contractor’s website, Community Research Foundation. The Optum Provider Line for authorization is 1-800-798-2254.

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

Medication Only Services

The BHP has delegated the responsibility to outpatient County operated programs and contracted providers to assure proper enrollment, services and monitoring of

children and youth who are receiving only medication support and have no therapist or case manager involved.

Children and adolescents, as a result of their rapid development, should receive a thorough assessment as a part of any clinical service, and for most, services should include a full spectrum of treatment services, including psychotherapy, designed to reduce or ameliorate symptoms and functional impairment. However, a small number of youths may have chronic conditions for which periodic breaks in treatment are appropriate. For those that require ongoing medication treatment even during such a hiatus, outpatient providers shall leave the assignment open with the psychiatrist designated as the primary server.

Such cases are not subject to utilization management but are subject to medication monitoring and additional peer review if the situation is unusually prolonged. Children and adolescents who have completed an assignment of psychotherapy and been retained as a medication only members must have rapid access to a resumption of therapy if a need should arise.

Procedure for Medication Only Members:

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

When the child or adolescent has a therapist in a different organizational provider program, that program shall be contacted as to why the needed medications are not being provided by the assigned therapist's program. If the child's therapist is a fee-for-service provider, the child's legal representative shall be provided with the number to the Access and Crisis Line for assignment to a fee-for-service psychiatrist.

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

Criteria for requiring such support shall include:

1. The member has been stabilized on a medication regime for a minimum of three (3) months under the care of the provider's staff psychiatrist

2. In the opinion of the prescribing psychiatrist, the child or adolescent would experience an exacerbation of symptoms or impairment if removed from the medication,

3. The child's primary care physician is unable or unwilling to continue the medication, even with consultation from the program psychiatrist,

4. The continuation of medication support is desired by the member and caregiver; and

5. For School Based members, clinician shall have the outpatient services removed from the student's Individual Education Program (IEP).

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

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

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

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

2. Whether the child's age, health status, and emotional functioning continue to support the need for ongoing medication treatment.

3. Whether a return to active psychotherapy is indicated.

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

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

Intensive Services

- Day Rehabilitation - a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries. Program design promotes a therapeutic milieu which is a therapeutic program with specified service components and specific activities performed by identified staff. The milieu includes staff and activities that teach, model, and reinforce constructive interactions, includes peer and staff feedback to members on strategies for symptom reduction, increased adaptive behavior, and stress reduction, and includes member involvement and behavior management interventions.

  The program must operate for more than four (4) continuous hours for a full-day program and a minimum of three (3) continuous hours for a half-day program. The therapeutic milieu must be made available for at least a weekly average of three (3) hours per day for full-day programs and an average of two (2) hours per day for half-day programs. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation, and coordination of care.

- Day Intensive - a structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the member in a community setting, with service available at least three (3) hours for half-day programs, four (4) hours for full-day programs and less than twenty-four (24) hours each day the program is open. Service activities may include, but are not limited to: assessment, plan development, therapy, rehabilitation and coordination of care.

  The therapeutic milieu must be made available for at least a weekly average of three (3) hours per day for full-day programs and an average of two (2) hours per day for half-day programs. The milieu includes staff and activities that teach, model, and reinforce constructive interactions, includes peer and staff feedback to members on strategies for symptom reduction, increased adaptive behavior, and stress reduction, and includes member involvement and behavior management interventions.

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

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

- Intensive Outpatient Program (IOP) - IOP offers outpatient specialty mental health services to children and youth up to age twenty-one (21) who would benefit from time limited programming in an intensive outpatient setting. Average length of stay for services is typically six to eight (6-8) weeks with a cohort of similar ages and presenting problems. Program services are typically offered three (3) to five (5) times a week after school hours where youth attend Day Intensive Half (DIH) programming consisting of an evidenced based approach to addresses specific treatment issues. Additionally, the local model offers weekly caregiver groups and multi-family group once a month. The design calls for a full range of ancillary Outpatient Specialty Mental Health Services (SMHS) inclusive of medication monitoring which is offered outside of the Day Treatment program hours.

  Referrals to IOP typically come through an outpatient service provider and/or emergency screening/crisis stabilization unit when it is determined that intensive services are needed or as a step-down service from an acute setting. A prior authorization is required for Medi-Cal beneficiaries receiving DIH.

- Partial Hospitalization Program (PHP) - PHP offers outpatient specialty mental health services to children and youth up to age twenty-one (21) who would benefit from time limited intensive programming. Average length of stay is typically two to four (2-4) weeks with a cohort of similar age youth and presenting problems. Program services are typically offered Monday through Friday. Throughout the day, youth attend an all-inclusive Day Intensive Full (DIF) program with individual, group, and family treatment sessions utilizing an evidenced based approach, as well as educational instruction. Medication Services are available as ancillary.

  Referrals to PHP typically come from the emergency screening/crisis stabilization unit to prevent an escaladed need for inpatient psychiatric care, from intensive hospital teams as a step down from an acute setting and/or from an Intensive Outpatient Program who determine a higher level of care is needed. A prior authorization is required for Medi-Cal beneficiaries receiving DIF.

Children in foster care, Aid to Adoptive Parents (AAP), and Kinship Guardianship Assistance Payment Program (KinGAP), when placed outside their country of origin, have

had difficulty receiving timely access to specialty mental health services. Assembly Bill (AB) 1299 and Senate Bill (SB) 785 intend to improve the timely access to services.

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