C. Practice Guidelines

Practice guidelines refer to methods and standards for providing clinical services to members. The BHP applies guidelines that comply with 42 C.F.R. 438.236(b) and Cal. Code Regs Welfare and Institutions Code 14184.402. They are based on clinical consensus and research findings as to best practices and evidence-based practices available. Because they reflect current best practices, the guidelines may change as new information and/or technology becomes available.

As these changes occur, the BHP is responsible for disseminating the guidelines to Providers, as well as ensuring that changes being made are done so with consideration to the needs of the consumers. Special efforts must be given in respect to the unique values, culture, spiritual beliefs, lifestyles and personal experience in the provision of mental health services to individual consumers. The BHP and providers have created the *Clinical Standards Committee* as a means for collaboration within the BHP and Contracted Providers. Providers shall comply with standards that may be adopted by the Mental Health Clinical Standards Committee. This Committee sets standards of care for Behavioral Health within the county, develops system-wide guidelines, and includes representatives from County and Contract programs.

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 member's service needs. According to 42 CRF, members 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 members 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 members 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 Behavioral Health Plan (BHP) 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 member, County contracted providers must have processes in place to be able to provide outside interpreter services as needed. County operated programs can contact Interpreters Unlimited at (800) 726-9891 to arrange for language assistance via ASL, written and/or oral interpreter services. Detailed instructions can be found on the reference sheet posted on the County of San Diego's Department of Purchasing and Contracting website and San Diego's Insite- Purchasing & Contracting > Language website.

Member Deaths

All member deaths must be reported promptly and in accordance with County requirements. Notify both the HIMS department and the County MEDS Coordinator when a member passes.

1. Submit a BHS 025 Form with date of member death in the comments

2. Send an email to 37Crdnt.HHSA@sdcounty.ca.gov including:

   i. Member Name
   ii. Social Security Number
   iii. Date of Birth
   iv. Date of Death

Retain a copy of the sent email(s) as documentation of compliance. Death reporting is monitored by QA as part of the Medi-Cal recertification process. The program should ensure all documentation is entered within the EHR prior to emailing these departments

Please reference the Optum Website > *Incident Reporting tab* to determine if the member death also requires a Critical Incident Report (CIR).

Admission Policies, Procedures and Protocols

Programs shall develop and maintain written program admission policies, procedures and protocols. The policies, procedures and protocols shall be developed to ensure services to the target population and shall comply with the non-discrimination and related clauses in Article 8, Compliance with Laws and Regulations, of the Service Template. Programs shall implement non-discriminatory admission policies, ensuring that members are admitted to treatment regardless of anticipated treatment outcome that are in line with harm reduction principles. Policies shall also comply with the entry criteria and priority as defined by the contracts.

In the occasion that providers should exclude members from their program (example: member become violent), providers are to use case managers to do a warm hand-off to appropriate services. Medi-Cal members are entitled to receive Medi-Cal services. Providers should consult with their legal entity when excluding Medi-Cal members from receiving services as this does not align with the SOW and OPOH requirements. Legal entities may discuss with CORs.

Continued Care Criteria

After the admission criteria for a given level of care have been met, it is appropriate to retain the member at the present level of care if:

- The member is making progress but has not yet achieved the goals articulated in the individualized treatment plan or making progress on identified problems on problem list.

- The member continues to work toward treatment goals or problems

- The member is not yet making progress but has the capacity to address his or her problems.

- The member is actively working on the goals articulated in the individualized treatment plan or working on identified problems on problem list.

- New problems have been identified that are appropriately treated at the present level of care. The current level of care is the least intensive at which the member's new problems can be addressed effectively.

Coordinating & Transitioning Care

Coordination of care between service providers is essential for a member's continuity of care and a mental health system to work efficiently. As a member may move between different levels of care, it is vital that service providers complete a **warm hand off** with each other to provide continuity of care for the member.

This is accomplished in the following manner: *Providers shall develop discharge planning to support individuals transitioning between the same or a different level of care, including those outside the BHS system of care.*

This includes but is not limited to the referring provider contacting and developing collaborative communication with *one individual staff member* responsible for intake at the receiving provider, transportation to the receiving provider, and participation in appointment fulfillment or confirmation/documentation of receiving provider achieving a face-to face linkage.

This includes completion of the Transition of Care Tool for Medi-Cal Mental Health Services when transitioning members between SMHS services with the BHP to a lower level of care for Non-SMHS with the MCP . This tool is located on the Optum Website> *UCRM* tab. See also: Transition of Care Tool Explanation Sheet

This also supports the member's efforts to return to, achieve and maintain the highest possible level of stability and independence. The BHP Systems of Care stipulates that the provider shall assign each member a care coordinator as the "single point of accountability" for his or her rehabilitation and recovery planning, through service and resource coordination. The BHP monitors coordination of care.

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

Members diagnosed with a primary or co-occurring opioid and/or alcohol use disorder should be offered a referral for an assessment for Medication Assisted Treatment (MAT). Although it is outside the scope of practice for a non-prescribing staff to make specific medication recommendations, staff can recommend a referral for MAT at the intake appointment and at other points in the treatment process, as clinically indicated.

Staff are encouraged to use motivational interviewing to help members who would benefit from medication treatment to consider this option. Members with an opioid and/or stimulant use disorder should be referred or linked to naloxone treatment to prevent overdose risk.

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

Transition of Care Tool

The Transition of Care Tool is designed to leverage existing clinical information to document a member's mental health needs and facilitate a referral for a transition of care to, or addition of services from the members' MCP or BHP, as needed. The Transition of Care Tool documents the member's information and referring provider information. Members may be transitioned to their MCP or BHP for all, or a subset of, their mental health services based on their needs. The Transition of Care Tool is designed to be used for both adults and youth alike. The Transition of Care Tool provides information from the entity making the referral to the receiving delivery system to begin the transition of the members' care. Referring entities may provide additional documentation, such as medical history reviews, care plans, and medication lists, as attachments to the Transition of Care Tool.

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

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

- Services requested and receiving plan contact information.

The Transition of Care Tool for Medi-Cal Mental Health Services is intended to ensure that members who are receiving mental health services from one delivery system receive timely and coordinated care when either:

- Their existing mental health services need to be transitioned to the another delivery system (example: from BHP specialty mental health services to MCP non-specialty mental health services or DMC/DMC-ODS substance use services); or

- Services need to be added to their existing mental health treatment from the other delivery system consistent with the *No Wrong Door* policies regarding concurrent treatment set forth in W&I section 14184.402(f) and described in BHIN 22-011 and APL 22-005 and continuity of care requirements described in MH SUD IN 18-059 and APL18-008, or subsequent updates. The Transition of Care Tool documents member needs for a transition of care referral or a service referral to the MCP or BHP.

The Transition of Care Tool and the Transition of Care Tool Explanation Sheet are both located on Optum Website > *UCRM* tab.

Please note completion of the Transition of Care Tool is not considered an assessment. The Transition of Care Tool **does not** replace:

- BHP P&Ps that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals.

- BHP protocols that address clinically appropriate, timely, and equitable access to care.

- BHP clinical assessments, level of care determinations, and service recommendations.

- BHP requirements to provide EPSDT services.

Administering the Transition of Care Tool

BHPs are required to use the Transition of Care Tool to facilitate transitions of care to MCPs for all members, including adults (aged 21 and older) and youth (under age 21), when their service needs change. The determination to transition services to and/or add services from the MCP delivery system must be made by a clinician via a patient-centered shared decision-making process in alignment with BHP protocols.

Once a clinician has made the determination to transition care or refer for additional services, the Transition of Care Tool may be filled out by a clinician or a non-clinician. Clinicians are the provider types listed on Supplemental 3 to Attachment 3.1.A, pages 2m-2p in the California Medicaid State Plan as providers of Rehabilitative Mental Health Services. Non-clinicians may include administrative staff, peer support staff or other professionals who do not meet the definition of clinician. Beneficiaries shall be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice. The Transition of Care Tool may be completed in a variety of ways, including in person, by telephone, or by video conference.

The Transition of Care Tool is to be completed in the EHR. A downtime PDF document is located on the Optum Website. If the downtime TOC Tool is completed, providers are to scan document into the EHR. Additional information may be enclosed with the Transition of Care Tool and may include documentation such as medical history reviews, care plans, and medication lists.

Following Administration of the Transition of Care Tool

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

Members Who Must Transfer to a New Provider

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

The member and caregiver should be informed of the impending change as soon as it is clinically indicated and possible, but at least fourteen (14) days prior to the final visit with the first provider. The member and caregiver should be informed of the member's right to request a new provider. The member 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 member 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 member will continue in the same program) should be written and incorporated into the chart. Final outcome tools should be administered if the member will go to another provider program. A written plan for emergency services should be developed with the member and caregiver, to include the ACL, the new program, and informal supports.

Post Discharge Coordination of Care

New members discharged from a twenty- four (24)-hour facility (acute psychiatric hospital or crisis house) shall be assessed by program within seventy-two (72) hours. Current members discharged from an acute care twenty-four (24) hour facility (hospital or crisis house) must receive a high-risk assessment within a clinically appropriate timeframe and thereafter anytime a member presents with risk factors. The County of San Diego is defining a "clinically appropriate timeframe" as between seventy- two (72) hours and five (5) days post discharge. If the risk assessment cannot be completed for any reason within timeframes the documentation must at minimum document attempted efforts to complete the risk assessment and/or reasons why it was not completed on time.

If the referral is deemed urgent, member shall be seen within forty-eight (48) hours of contact with program. A need for urgent services is defined in 8 HSC §1367.03(e)(7); 28 CCR §1300.67.2.2 (b)(21) health care provided to a member when the member's condition is such that the member faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function.

The County further refers to Urgent as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention. Compliance to this standard is monitored through the Quality Assurance Program Review process.

Transitional Age Youth (TAY) Transition Process

Youth receiving behavioral health services in the Children, Youth and Families Behavioral Health System of Care may require system coordination to successfully transition to the Adult/Older Adult Behavioral Health System of Care when they reach the ages of eighteen to twenty- one (18-21).

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 CFWB & Probation as applicable, to strategize about planned services as some youth may be best served by continued services in Children, Youth and Families BHS and for others a referral to the Adult /Older Adult BHS may be indicated. 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 Children, Youth and Families BHS and the Adult/ Older Adult BHS in terms of consent to treat and expectations of support systems.

The following considerations should be taken if the youth is also involved with the following sectors:

- Child and Family Wellbeing Services: In an effort to coordinate care with CFWB, 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 https://www.fosteringchangeforchildren.org/.

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

- 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.

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. 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 a routine referral is unsuccessful:

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

    - Referral Form/Cover Letter
    - Children's Behavioral Health Assessment and most recent update
    - The Mental Health Diagnosis
    - Youth Transition Evaluation
    - Mental Status conducted by psychiatrist within the last forty- five (45) days
    - Physical Health Information
    - Medication Sheet
    - Care 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 Behavioral Health Program Coordinator (BHPC) of Adult Behavioral Health Services in the region where the youth resides. The BHPC offices are located at 3255 Camino del Rio South, San Diego, CA 92108. The BHPC will review the packet to determine if access criteria are met for SMHS and the Service Eligibility Policy for the Adult/Older Adult System of Care.

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

4. If a transition plan is agreed upon, the member's Children, Youth and Families BHS Case Manager or Care Coordinator will attempt to link the member with the appropriate service. If the linkage is not successful, the BHPC shall coordinate an initial meeting with a multidisciplinary support team within two (2) 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
    - Children, Youth and Families BHS Case Manager and /or Therapist
    - Current Psychiatrist
    - Children, Youth and Families BHS Contracting Officer's Representative (CORS), or designee
    - Adult/Older Adult BHS COR if applicable, or designee
    - Probation Officer (if applicable)
    - CFWB Social Worker (if applicable)
    - Education/Vocational Specialist

5. 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.

Requests for Continuity of Care

Effective July 1, 2018, Title 42 of the Code of Federal Regulations, part 438.62 requires the State (and BHP) to have in effect a transition of care policy to ensure continued access to services during a member'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 member, 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 members who meet access criteria for SMHS have the right to request continuity of care. Members with pre-existing provider relationships who make a continuity of care request to the county BHP must be given the option to continue treatment for up to twelve (12) months with an out-of-network Medi-Cal provider or a terminated network provider (i.e., an employee of the BHP 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 BHP.
- 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 BHP to another county BHP due to a change in the member's county of residence.
- Transitioning from an MCP to an BHP; or,
- Transitioning from Medi-Cal FFS to the BHP.

A member, the member's authorized representatives, or the member's provider may make a direct request to an BHP 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. BHPs must provide reasonable assistance to members in completing requests for continuity of care, including oral interpretation and auxiliary aids and services.

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 Behavioral Health Plan (BHP). Providers shall notify all beneficiaries with existing non-BHP providers that continuity of care requests are available as the member transfers care over to the BHP. Providers are expected to assist members and work directly with Optum to ensure a smooth transfer of care. To begin the process, instruct the member to call the Access and Crisis Line and initiate the Continuity of Care request.

Timeline Requirements

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

- Thirty (30) calendar days from the date the BHP received the request.

- Fifteen (15) calendar days if the member's condition requires more immediate attention, such as upcoming appointments or other pressing care needs: or,

- Three (3) calendar days if there is a risk of harm to the member.

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

- The provider meets the continuity of care requirements.

- Services were provided after a referral was made to the BHP (this includes self-referrals made by the member); and,

- The member is determined to meet criteria for access to SMHS.

A continuity of care request is considered complete when:

- The BHP informs the member and/or the member's authorized representative, that the request has been approved; or,

- The BHP and the out-of-network provider are unable to agree to a rate and the BHP notifies the member and/or the member's authorized representative that the request is denied; or,

- The BHP has documented quality of care issues with the provider and the BHP notifies the member and/or the member's authorized representative that the request is denied; or,

The BHP makes a good faith effort to contact the provider, and the provider is non-responsive for thirty (30) calendar days and the BHP notifies the member and/or the member's authorized representative that the request is denied.

Member and Provider Outreach and Education

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

Validating Pre-existing Provider Relationships

An existing relationship with a provider may be established if the member has seen the out-of-network provider at least once during the twelve (12) months prior to the following:

- The member establishing residence in the county.
- Upon referral by another BHP or MCP; and/or,
- The BHP determining the member meets criteria for access to SMHS.
- A member or provider may make available information to the BHP 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 BHP 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 member.

Continuity of Care Reporting Requirements

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

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

Requirements Following Completion of Continuity of Care Request

If the provider meets all the required conditions and the member's request is granted, the BHP must allow the member to have access to that provider for a period of up to twelve (12) months, depending on the needs of the member and the agreement made between the BHP and the out-of-network provider. When the continuity of care agreement has been established, the BHP must work with the provider to establish a Care Plan and transition plan for the member.

Upon approval of a continuity of care request, the BHP must notify the member and/or the member's authorized representative, in writing, of the following:

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

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

- The BHPs denial of the member'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 BHP.
- The member's right to file an appeal based on the adverse benefit determination; and,
- The BHPs member handbook and provider directory.

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

The BHP must notify the member, and/or the member's authorized representative, thirty (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 member 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 member's continuity of care period ends, the member must choose a mental health provider in the BHPs network for SMHS. If the member later transitions to

a MCP or Medi-Cal FFS for non-specialty mental health services, and subsequently transitions back to the BHP for SMHS, the twelve (12) month continuity of care period may start over one time.

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

Discharge Criteria

It may be appropriate to transfer or discharge the member from the present level of care if the following criteria are met:

- The member has achieved the goals articulated in their individualized treatment plan or resolved problems identified on the problem list, thus resolving the need(s) that justified admission to the current level of care.

- The member has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan or problem list. Treatment at another level of care or type of service therefore is indicated

- The member has demonstrated a lack of capacity to resolve their problem(s). Treatment at another level of care or type of service therefore is indicated;

- The member has experienced an intensification of their problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

Providers should clearly document and communicate the member's readiness for discharge or need for transfer to another level of care. If the criteria apply to the existing or new problem(s), the member should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.

Provider Termination of Services

Providers shall make a good effort to give written notice of a termination of a contracted provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Providers shall report to the QA Unit and COR upon receiving any changes affecting the Provider Directory. The BHP shall update the paper Provider Directory monthly. The BHP shall update the electronic

provider directory no later than thirty (30) days after receiving updated provider information. The BHP does not currently offer any physician incentive plans.

Monitoring Psychotropic Medications

The following recommendations are not intended to interfere with or replace clinical judgment of the clinician when assessing members on psychotropic medications. Rather, they are intended to provide guidelines and to assist clinicians with decisions in providing high quality care, ensuring that members receive the intended benefit of the medications, and to minimize unwanted side effects from the medications.

Informed Consent

Per BHS Notice on 09/12/2023, California Senate Bill (SB) 184 updated and superseded state regulations (Cal. Code Regs. Tit. 9, § 852) that required mental health facilities to obtain patient signatures to demonstrate informed consent for antipsychotic medications delivered in specified community mental health settings. (Reference: WIC § 5325.3).

Instead, facilities must maintain written consent records that contain **both** of the following:

1. A notation that information about informed consent to antipsychotic medications has been discussed with the member;

and

2. A notation that the member understands the nature and effects of antipsychotic medications, and consents to the administration of those medications.

The minimum requirement going forward is to include the above notations within the medical record progress note(s) when prescribing, adding or adjusting antipsychotic or psychotropic medications. Providers may choose to continue using the *Informed Consent for Psychotropic Medications* form to document that they have reviewed consent and the nature and effects of antipsychotic or psychotropic medications however, use of this form is not monitored as part of the medical record review and member signature is not a requirement. SB184 does not supersede JV-220 requirements for dependent youth or youth in an out-of-home placement.

Antipsychotic Medications

Typical Antipsychotics: also know known as First Generation Antipsychotics: such as chlorpromazine (Thorazine), fluphenazine (Prolixin), haloperidol (Haldol), perphenazine (Trilafon), prochlorperazine (Compazine), thiothixene (Navane), thioridazine (Mellaril), and trifluoperazine (Stelazine).

Atypical Antipsychotics: also known as Second Generation Antipsychotics: aripiprazole (Abilify), asenapine (Saphris), clozapine (Clozaril), iloperidone (Fanapt), lurasidone (Latuda), olanzapine (Zyprexa), paliperidone (Invega), quetiapine (Seroquel), risperidone (Risperdal), ziprasidone (Geodon) and any derivatives of these medications (i.e. long acting injectable formulations, extended release formulation, etc.)

Drug Formulary for HHSA Mental Health Services

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

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

- The likelihood of efficacy, based on clinical experience and evidence-based practice
- Member preference
- The likelihood of adequate compliance with the medication regime
- Minimal risks from medication side-effects and drug interactions

If two (2) or more medications are equal in their satisfaction of the four (4) criteria, choose the medication available to the member and/or the system at the lowest cost. Programs shall provide information to all appropriate staff as to the typical cost for all drugs listed on the Medi-Cal Formulary, at least annually.

For all initial prescriptions, consideration should be given to prescribing generic medication rather than brand name medication unless there is superior efficacy for the brand name medication, or the side-effect profile favors the brand name medication. Providers shall follow the requirements for preparing a Treatment Authorization Request (TAR) as stated in the Medi-Cal Drug Formulary. County-operated programs shall send TARs to the County Pharmacy for any non-formulary medication Contractor operated programs shall develop an internal review and approval process for dispensing non-formulary medication for both Medi-Cal and non-Medi-Cal eligible members. There shall be an appeal process for TARs that are not accepted.

Clinical Advisory for Monitoring Antipsychotic Medications

- Ordering labs and monitoring should be tailored to each member. Members may require more or less monitoring than these recommendations.

- All antipsychotic medications carry a Black box warning for increased risk of mortality for older adult members with dementia-related psychosis.

- Geriatric members may require more frequent monitoring due to changes in metabolism and renal function.

- Obtain baseline assessment for Tardive Dyskinesia and Abnormal Involuntary Movement Scale prior to initiate of antipsychotic and every six (6) months.

- Atypical antipsychotics are associated with abnormal blood work such as elevated serum glucose and lipid levels, and increased prolactin levels. They are also associated with weight gain, increased risk of type 2 diabetes, diabetic ketoacidosis, and cardiovascular side effects.

- Avoid using ziprasidone (Geodon), haloperidol (Haldol), thioridazine (Mellaril), and chlorpromazine (Thorazine) in members with known history of QT_c prolongation, recent Acute Myocardial Infarction, uncompensated heart failure, taking other medications with prolong QT, and alcoholic members on diuretics or having diarrhea which may alter electrolytes.

- All members should be assessed for cardiovascular disease before initiating antipsychotic therapy.

- Refer to Clozapine REMS Program for monitoring Clozaril.

- An initial comprehensive baseline assessment should include a thorough personal and family medical history, including risk factors for diabetes, vital signs, weight, body mass index, waist circumference, metabolic laboratory analysis such as fasting glucose, and lipid profile.

- Fasting blood glucose is preferred, but HbA_{1c} is acceptable if fasting glucose test is not feasible.

- Neutropenia uncommonly occurs in members taking antipsychotic medications. It is recommended to obtain baseline Complete Blood Count and annually.

- Members with a history of a clinically significant low white blood cell count (WBC) or a drug-induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and discontinuation of

medication should be considered at the first sign of a clinically significant decline in WBC in the absence of other causative factors (package insert).

Naloxone for Risk of Overdose

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

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

Psychotropic Medication in Youth

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

In 2018, Department of Health Care Services published "*California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care*. These guidelines target youth involved in county child welfare and probation agencies and is specific to those children and youth who are placed in foster care. Prescribers should be familiar with the linked document as this shall serve as the guideline for provision of care locally.

The *California Guidelines* document also includes reference to the Los Angeles "*Department of Mental Health Parameters 3.8 For Use of Psychotropic Medication in Children and Adolescents*" (Rev. 03.15.2023) DHCS has recognized this living document as the guideline for provision of psychotropic medication. County of San Diego prescribers should be familiar with this linked document as this shall serve as the guideline for provision of care locally.

Foster Care is defined as twenty-four (24) hour substitute care for children placed away from their parents or guardians and for whom the State and/or county agency has placement care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, childcare institutions, and pre-adoptive homes. County of San Diego prescribers should be familiar with the CA Guidelines as they shall serve as the guideline for provision of care locally to all youth.

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

Monitoring Controlled Substance Prescriptions

For the past number of years, abuse of prescription drugs has become increasingly prevalent. In September 2016, Senate Bill 482 pertaining to controlled substances and the CURES database was enacted. As of July 1, 2021, this law requires a health care practitioner to consult the CURES database to review a member's-controlled substance history before prescribing a Schedule II, III or IV controlled substance for the first time to that patient and at least once every six (6) months thereafter, if the prescribed controlled substance remains part of the member's treatment, with specified exemptions. Additionally, this law requires reporting the dispensing of Schedule V drugs. This requirement applies to pharmacists and prescribers who dispense controlled substances.

Starting January 1, 2021, the dispensing of a controlled substance must be reported to the Controlled Substance Utilization Review and Evaluation System (CURES) within one working day after the medication is released to the patient or the member's representative. (Previously, the deadline to report was seven days after dispensing.) The County of San Diego expects prescribers to document monitoring efforts consistent with this law.

Telehealth Services

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

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

1. The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment, and that the member has

a right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit

2. The member has provided verbal or written consent, at least once prior to initiating applicable health care services via telehealth, and it has been documented in the medical record

3. An explanation that the use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time by the Medi-Cal member without it affecting their ability to access covered Medi-Cal services in the future,

4. The member has been provided with an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted

5. The presence of a health care provider is not required at the originating site unless determined medically necessary by the provider at the distant site

6. An explanation of the potential limitations and risks related to receiving services through telehealth as compared to an in-person visit to the extent that any limitations or risks are identified by the provider

7. The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components associated with the covered service; and

8. The services provided via telehealth meet all laws regarding confidentiality of health care information and a member's right to the member's own medical information.

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

Videoconferencing Guidelines for Telehealth

Telehealth services are designed to assure timely access of routine and urgent mental health and psychiatric services to reduce emergency and acute hospital inpatient services Specialty Mental Health Provider; hereafter referred to as "telehealth provider" will perform various specialty mental health services via tele-video linkage when an on-site mental health provider is unavailable; primarily due to illness or other scheduled absences or vacancies; or other special needs as arranged.

The site where the telehealth provider is located who will provide the mental health service will be termed “distant” site and the site where the mental health services are being received by the member will be termed the “originating” site. This practice also extends mental health services to members in remote areas of the county.

The standards of telehealth practice will be the same as for on-site mental health services as described in the California “*Telehealth Law of 2012*”. County contracted organizational providers connecting to their own network must follow the guidelines below in order to deliver secure telehealth services.

1. Use a secure, trusted platform for videoconferencing.

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

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

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

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

6. It is recommended to use a broadband internet connection that, at minimum, has a transmission speed of at least 5 MB upload/download to avoid pixilation, frequent buffering, and other video and audio difficulties associated with slow and

insufficient transmission. Higher speeds might be required for newer technologies that use HD capabilities.

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

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

NOABD Log

The BHP programs shall have a written policy and procedure addressing the collecting, storing, filing, and mailing of Notice of Adverse Benefit Determinations. It is recommended that programs maintain all Notice of Adverse Benefit Determinations in a confidential location at the program site for no less than ten (10) years after discharge for adults. For minors, records are to be kept until they have reached the age of eighteen (18), plus seven (7) years.

- All BHP programs shall maintain on site a monthly NOABD Log.
- Programs shall include the following in their NOABD Logs:
    - Date NOABD was issued.
    - Member identification number/medical record number
    - Mode of NOABD Delivery
    - Member response, requests, provisions for second opinions, initiation of grievance/appeal procedure, and/or request for a State Fair Hearing if known.
        - Logs to contain copies of each NOABD and "Your Rights" forms attached.
        - Logs to contain documentation of inability to contact the member, if applicable.
        - Log to reflect "NO NOABD ISSUED" if none are issued within a month.
        - NOABD Logs must be available for review at COR or QA request.

- Monthly logs are to be submitted to QA on a quarterly basis. Dates for submission are as follows:

    - Quarter One: October 15th
    - Quarter Two: January 15th
    - Quarter Three: April 15th
    - Quarter Four: July 15th

QA has developed an Excel NOABD Log that programs can use to track monthly NOABD's. If programs choose to create their own log, it must contain all the same elements listed above. All NOABD's will be stored in the Logbook, therefore not being stored in the member's individual chart.

Program Advisory Group (PAG)

Contract provider shall conduct a PAG a minimum of two (2) times per year to advise Contractor on program design, practice, and polices. The PAG membership shall consist of at least six (6) members, at least fifty percent (50%) of whom shall be the member's or families served by the program and shall reflect the ages and cultures of the member population. Meeting minutes and action items based on PAG input shall be reported to the Contracting Officer's Representative (COR) or designee in the program status report.

Missed Appointment and Follow Up Standard

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

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

For current members: When a member (and/or caregiver, if applicable) is scheduled for an appointment and does not show up or call to reschedule (defined as a "No Show"). The member shall be contacted within one (1) business day by clinical staff. If the member has been identified as being at an elevated risk, the member (or caregiver, if applicable) will be contacted by clinical staff the same day as the missed appointment.

For members who are at an elevated risk and are unable to be reached on the same day, the program needs to document next steps, which may include consultation with a supervisor, contacting the member's emergency contact, or initiating a welfare check.

Additionally, the policy shall outline how the program will continue to follow up with the member (or caregiver, if applicable) to re-engage them in services, and should include specific timeframes and specific types of contact (e.g., phone calls, letters). Staff should continue to monitor the members' whereabouts and admittance to different levels of care throughout the County (e.g., hospital, PERT or jail admissions). All providers shall have policies and procedures in place regarding the monitoring of missed appointments for members (and/or caregivers, if applicable).

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

Utilization Management

The BHP has delegated responsibility to outpatient County operated and contracted organizational providers to perform utilization management for specialty mental health services, outpatient services, medication services, and case management services. Authorization decisions are based on the access criteria delineated in Welfare and Institutions Code section 14184.402. The BHP monitors the utilization management activities of County-operated and contracted organizational providers to ensure compliance with all applicable State and federal regulations. Each delegated entity shall be accountable to the Behavioral Health Services Division Director and shall follow the Utilization Management processes established for children's mental health programs.

The UM process is in addition to Department of Health Care Services (DHCS) Information Notice No. 22-016 dated 04.15.22, which outlines that for outpatient services prior authorization is required for Intensive Home-Based Services, Day Treatment Intensive, Day Rehabilitation, Therapeutic Behavioral Services, and Therapeutic Foster Care. If the member is concurrently provided day and outpatient services, then ancillary authorization must occur through day program and Optum as the day services cycle supersedes outpatient UM. In these cases, the outpatient program must also complete a UM in accordance with the procedure described in Children, Youth & Families Outpatient Level of Care. Medication only members
are not included in the Utilization Management process as they are subject to medication monitoring.

The Utilization Management for all service providers (outpatient, crisis residential, case management) includes procedures for establishing a Utilization Review Committee (URC), standards for participation in the URC, logs for URC activities, and standards for authorization. Although there are slight variances in the utilization review process

conducted by different service providers based on level of care, all programs participating in utilization review shall adhere to the following guidelines:

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

Utilization Review Committee (URC)

Members who approach six (6) months of treatment and appear to require additional services shall be evaluated for continuation of care. The Utilization Management Committee operates at the program level and must include at least one (1) licensed clinician and may not include the requesting clinician.

The Utilization Management Committee bases its decisions on whether access criteria is still present and works with the treating clinician to ensure that the proposed services are medically necessary and likely to promote meeting the member’s treatment goals or resolving areas noted on the *Client Clinical Problem List*.

To assist in its determination, the Utilization Management Committee receives a UM Request form and a new Care Plan/Client Clinical Problem List to cover the interval for which authorization is requested. Secondary UM review at six (6) months of treatment is reserved for members who demonstrate ongoing need and require additional services. Secondary and subsequent UM review is also conducted by the program level Utilization Management Committee.

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

- Review quarterly a minimum of five (5) members.
- A review of services, treatment plan, and the Utilization Management Form shall be completed in order to support determination and document the results of the Utilization Review Committee.

- Member service review shall be performed through SmartCare. [Note that members who have not received services for six (6) months or longer should be considered for discharge.]

- Utilization Management Form shall be reviewed by program manager or designee within five (5) business days.

- Program manager or designee shall be licensed.

- Program manager or designee may agree with primary provider or may recommend a different level of service.

- Final determination shall be made after agreement by program manager or designee and primary provider.

- The Utilization Management Form shall be kept in the medical record.

- At the time of your Quality Assurance Program Review, QA Specialists will review Utilization Management Forms in addition to programs quarterly URC process.

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

Utilization Review for Crisis Residential Programs

Each crisis residential program meets the utilization management requirement through the service authorization process conducted by the County's Administrative Services Organization (ASO), Optum. Referrals to crisis residential level of care can be made directly to the intake staff but do require initial authorization from Optum. Crisis residential intake staff shall submit the initial authorization request, documenting access criteria for crisis residential level of care, to Optum for review. Optum will review the initial authorization request form to identify if crisis residential services are medically necessary and respond to the provider with a final determination.

For continued stay services, the crisis residential program shall submit requests for concurrent authorization review based on the member's need. Optum will then reauthorize, as appropriate, concurrently with the member's stay based on the continued need for services.

Crisis residential programs invite members to attend their treatment team meeting when continuation of care is being discussed. Should members decline to attend the treatment meeting, staff will have input from the member prior to the meeting and will meet with the member again following the meeting to review the request for concurrent

authorization determination. The treatment team meeting will be documented and submitted to Optum along with the request for concurrent authorization. The authorization determination shall be maintained in the member's hybrid chart.

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

Utilization Review for Outpatient Programs

Beginning July 1, 2010, the BHP implemented a policy change affecting the Adult/Older Adult Behavioral Health Services utilization review process. The purpose of this new policy is to reinforce a change of the primary focus of current County Mental Health-funded (A/OA MHS) outpatient clinic practices to recovery-oriented brief treatment and establish the requirement for implementing the Utilization Management process.

In connection with this policy, members who still require services but who are stabilized and able to function safely without formal County Behavioral Health outpatient services will be referred to a primary care setting or other community resources for services. It is the expectation of Adult / Older Adult Behavioral Health Services that most members shall receive brief treatment services that focus on the most critical issues identified by the clinician and member and that services will conclude when members are stabilized. For detailed information and requirements regarding Utilization Management for outpatient programs see the Optum Website> *UCRM* tab for the UM forms and Explanation Sheets.

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

The following member MUST be reviewed via UM:

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

The following members MAY be reviewed via UM:

- Members with unchanged MORS rating
- Members who have been enrolled in program services for two (2) years or longer
- Treatment Team recommendation
- URC may review members that meet the above criterion in order to determine appropriateness for ongoing services or transition to a lower level of care.

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

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

Initial Eligibility for Services

Initial Eligibility for Urgent and Routine Services will be based on meeting the criteria for: W&I Code 14148.402 Access Criteria. The Adult/ Older Adult BHS Target Population-Individuals we serve include:

- 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.
- People with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and/or who require unusually complex medication regimens. Required psychosocial services may include illness management; or skill development to sustain housing social, vocational, and educational goals.

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

Eligibility for Ongoing County or Contracted Program Outpatient Services

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

1. Continued Mental Health Access Criteria, with proposed intervention/s significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning.
2. Meet Target Population Criteria

3. MORS- rating guideline of five (5) or less

OR

An approved Utilization Management Form documenting justification for on-going services for members with MORS scores of six (6) through eight (8) which includes at least one continuing current Risk Factor related to their primary diagnosis:

1. Member has been in Long-Term Care, had a psychiatric hospitalization, or was in a Crisis Residential facility in the last year.

2. Member has been a danger to self or to others in the last six months.

3. Member's impairment is so substantial and persistent that current living situation is in jeopardy or the member is currently homeless.

4. Member's behavior interferes with member's ability to get care elsewhere.

5. Member's psychiatric medication regimen is very complex

6. Member is actively using substances.

Integration with Physical Health Care

Coordination of care between physical and behavioral health providers is necessary to optimize the overall health of a member. All providers are expected to coordinate mental health care with a member's Primary Care Physician (PCP) and should have a policy and procedure in place regarding this coordination of services. Almost all Medi-Cal beneficiaries are enrolled in one of the Medi-Cal Managed Care Plans (MCPs) that are part of Healthy San Diego (HSD).

To find a list of included MCPs go to the *Healthy San Diego* website. The "Healthy San Diego Medi-Cal Managed Care Plan Contact Card" is a helpful tool to use for coordination of care and is located on the Optum Website

Contracted providers are required by the BHP to complete the *Coordination with Primary Care Physicians and Behavioral Health Services* form with the member to facilitate coordination with the member's PCP. For members that do not have a primary care physician, provider shall connect them to a primary care facility. The Coordination with PCP form should be introduced at intake and completed no later than thirty (30) days upon opening the member to program services. Users of the form shall check the appropriate box at the top of the form noting the nature of the referral. Requesting member /guardian authorization to exchange information with primary care physicians is

mandatory. Please see the *Coordination with PCP Explanation Sheet* on the Optum Website> *UCRM* tab for more information.

Clinical Consultation with Primary Care

Beneficiaries with less severe problems or who have been stabilized shall be referred back to their Primary Care Physician for continuing treatment. To help support treatment by the Primary Care Physician, the BHP as well as organizational providers and County operated programs shall make clinical consultation and training, including consultation and training on medications, available to a member's health care provider for beneficiaries whose mental illness is not being treated by the BHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving specialty mental health services from the BHP. Efforts shall be made to provide consultation and training to Medi-Cal Managed Care Providers, Primary Care Providers who do not belong to a Medi-Cal Managed Care Plan and to Federally Qualified Health Centers, Indian Health Centers, or Rural Health Centers.

Pharmacy and Lab Services

Each MCP has contracts with specific pharmacies and laboratories. Providers prescribing medication or lab tests need to be aware of which pharmacy or laboratory is associated with each member's MCP to refer the member to the appropriate pharmacy or lab. HSD website lists all the contracted pharmacy or lab services for each Medi-Cal MCP. Additionally, the member's MCP enrollment card has a phone number that providers and members can call to identify the contracted pharmacy or lab. Providers must use the health plans contacted lab vendor.

Psychiatrists may order the following lab studies without obtaining authorization from the member's Primary Care Physician: CBC and Liver function study: Electrolytes, BUN or Creatinine, Thyroid panel, Valproic acid, Carbamazapine, Tricyclic blood levels, Lithium level.

All other lab studies require authorization from the member's Primary Care Physician. It is recommended that each provider contact the member's MCP Member Services Department or Primary Care Physician to determine which lab test(s) require authorization from the member's Primary Care Physician.

Enhanced Care Management (ECM)

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit available to eligible members with complex needs often engaged with several systems of care. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental, and dental care, and social services. While this benefit is provided by the

member's Managed Care Plan (MCP) – it may include engagement and collaboration with our BHP system of care providers to refer members and coordinate care. BHP providers should be familiar with the basics of ECM and the Populations of Focus (described below) that are eligible for this benefit and make the appropriate referral to the member's Managed Care Plan for ECM services, when appropriate.

Enhanced Care Management is available to specific groups (aka "Populations of Focus"):

- Adults and families experiencing homelessness
- Adults, youth and children at risk for avoidable hospital or emergency department care
- Adults, youth and children with serious mental health and/or substance use disorder needs
- Adults living in the community and at risk for long-term care institutionalization.
- Adults transitioning back to the community from a residential nursing facility
- Children and youth enrolled in California's Children's Services (CCS) or CCS Whole Child Model with additional needs beyond their CCS condition(s).
- Children and youth involved in child welfare (foster care)
- Adults and youth transitioning back to the community after incarceration
- Pregnant and post-partum individuals, birth equity population of focus

For additional information and definitions, please see: ECM Policy Guide Updated August 2024.pdf (ca.gov)

Managed Care Plan (MCP) Enhanced Care Management (ECM) Referral Forms / Contacts

Providers should utilize the below links for ECM referrals and contacts – all referrals should be directed to the MCP using the below forms/email contacts:

Medi-Cal Managed Care Plan	Referral Form	Email Address
Blue Shield Promise	ECM Referral Form (blueshieldca.com)	Email: ECM@blueshieldca.com
Community Health Group	ECM Referral Form (chgsd.com)	Email: ecm-cs@chgsd.com

Kaiser	ECM Referral Form (kaiserpermanente.org)	Email: RegCareCoordCaseMgmt@KP.org
Molina	ECM Referral Form (molinahealthcare.com)	Email: MHC_ECM@Molinahealthcare.com

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

Non-Medi-Cal Beneficiaries

Non-Medi-Cal beneficiaries who meet financial eligibility requirements being seen at County operated clinics may have their prescriptions filled at little or no cost at a county mental health clinic, or the Health and Human Services Agency Pharmacy at the Health Services Complex (3851 Rosecrans Street, San Diego, California, 92110). Contracted providers shall provide medications to non-Medi-Cal members who meet financial eligibility requirements. Contractor shall comply with the Medi-Cal Drug Formulary for Mental Health Services. Providers shall make every effort to enroll members in low cost or free medication programs available through pharmaceutical companies or obtain free samples to offset the cost of medication.

Physical Health Services in a Psychiatric Hospital

Healthy San Diego Recipients

The member's HSD Medi-Cal MCP is responsible for the initial health history and physical assessment required for admission to a psychiatric inpatient hospital. The member's MCP also is responsible for any additional or ongoing medically necessary physical health consultations and treatments. The health plans do not require prior authorization for the initial health history and physical assessment. All other physical health services provided while a member is in a psychiatric hospital require authorization from the health plan.

The BHP contracted psychiatrist is responsible for obtaining the psychiatric history upon admission and for ordering routine laboratory services tests. If the psychiatrist identifies a physical health problem, he or she contacts the member's MCP to request an evaluation of the problem. If the psychiatrist determines further laboratory or other ancillary services are needed, the contracted hospital must obtain the necessary authorizations from the member's MCP. For those Medi-Cal eligible members who are not members of a HSD Medi-Cal MCP, physical health services provided in a psychiatric hospital are reimbursed by Medi-Cal.

Transfers from Psychiatric Hospital to Medical Hospital

Psychiatric hospitals may transfer a member to a medical hospital to address a member's medical problems. Except in an emergency, the psychiatric hospital must consult appropriate MCP staff to arrange such a transfer for physical health treatment. It is the responsibility of the MCP to pay for transportation in such cases. The Optum Health Medical Director or Liaison and the MCP Medical Director or Liaison will resolve any disputes regarding transfers.

Medical Transportation

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

Home Health Care

Beneficiaries who are members of one of the HSD Medi-Cal MCPs must request in-home physical health services from their Primary Care Physician. The MCP will cover at the Medi-Cal rate home health agency services prescribed by a Plan provider when medically necessary to meet the needs of homebound members in accordance with its Medi-Cal contract with the State DHCS. The BHP will pay for services solely related to the included mental health diagnoses. The MCP Case Manager and the Primary Care Physician coordinate on-going in-home treatment. The MCP is responsible for lab fees resulting from in-home mental health services provided to Medi-Cal members of the MCP.