**COUNTY OF SAN LUIS OBISPO**
**HEALTH AGENCY**
**BEHAVIORAL HEALTH DEPARTMENT**
**POLICIES AND PROCEDURES**

# Section 1

# Program Mission and Goals

# 1.00 Program Mission, Goals, and Priorities

## I. PURPOSE

To clarify the Mental Health Plan's (MHP) mission, goals, and priorities

## II. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) will enable persons experiencing severe and disabling mental illnesses and children with serious emotional disturbances to access services and programs that assist them to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive settings. SLOBHD will operate systems of care that focus resources (programs, staff, and funding) on providing efficient and effective care to identified target populations in a client-centered, strength-based, and culturally-competent manner.

## III. REFERENCE

- Welfare and Institutions Code §§ 5600 – 5772
- SLOBHD Policy & Procedures:
  - 2.00 *Culturally Competent, Multi-lingual Services*
  - 3.00 *Access to Services*
  - 3.23 *Availability, Timeliness, Network Adequacy, and Array of Services*
- SLOBHD Implementation Plan

## IV. GENERAL PRINCIPLES

A. SLOBHD will identify and serve individuals with serious mental illness and severe emotional disturbance, particularly those who:
   1. Have significant functional impairments that result in the need for public assistance
   2. Are involved with multiple community agencies or services
   3. Have multiple and/or co-occurring disorders
   4. Are homeless or at risk of homelessness
   5. Are involved in the legal system
   6. Are veterans
   7. Are at risk of requiring a high level of care

B. SLOBHD's Systems of Care will provide integrated, coordinated services in collaboration with other community resources and community agencies

C. SLOBHD will, to the extent resources are available, make a full array of services available to all individuals in all areas of SLO County

D. SLOBHD will assertively reach out to and engage homeless and hard-to reach individuals with mental illnesses

E. SLOBHD will ensure that its providers deliver services in a cultural competent manner

F. SLOBHD will encourage services and programs that involve community support, peer-driven services, wellness activities, and other sustainable interventions that reduce dependence on county-operated systems

G. SLOBHD will strive to operate efficiently by providing services of a type, intensity, level, and duration to help individuals achieve a constructive and satisfying lifestyle of the individual's choosing in a least restrictive manner

H. SLOBHD will allocate funding to provide services to individuals who require acute care services without regard to age or Institute of Mental Disease (IMD) exclusions

I. SLOBHD will account for expenditures and maintain funding for youth and adult programs as required by law

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 12/27/2017 | all | Formatting |
| 09/11/2018 | all | Reformatted & Updated language and references |
| Prior Approval dates: | | |
| 02/27/2009, 10/12/2012 | | |

| *Signature on file* | | *10/10/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# Section 2

# Culturally Competent Services

# 2.00 Culturally Competent, Multi-lingual Services

## I. PURPOSE

To describe the way we provide multilingual and culturally appropriate services to the diverse populations in the County, as detailed in the Cultural Competence Plan

## II. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) continues to develop a system of care that serves an increasing, changing, and diverse population in the County. SLOBHD will follow the guidelines in the Cultural Competence Plan to become a more culturally competent organization and to ensure that each person receives Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS) that are culturally and linguistically appropriate.

SLOBHD will value diversity, reduce disparities, and will not discriminate against or deny admission or services to any person based on age, ethnicity, marital status, medical condition, national origin, physical or mental disability, pregnancy, race, religion, sex, sexual orientation, gender expression or identity, socio-economic status, literacy level, or any other legally protected status.

## III. REFERENCE

- Code of Federal Regulations, Title 45, Part 80
- Code of Federal Regulations, Title 42, §438.6(f)(1), §438.10, §438.100, §438.206
- Welfare & Institutions Code §14727(d), §5600.2(g)
- California Code of Regulations, Title 9, §1810.410
- California Code of Regulations, Title 9, §3200.100, §3200.210, §3320
- Mental Health Plan Contract with DHCS
- Drug Medi-Cal Organized Delivery System contract with DHCS
- SLOBHD Cultural Competence Plan and Updates
- SLO Health Agency Non-discrimination and Language Access Plan

## IV. PROCEDURE

A. Language Needs/Informing:

1. Upon initial contact to request services, individuals are informed in a language they understand that they have a right to free language assistance. An offer of free interpretation services is documented on the BH Service Request form and on the Demographic form.

2. Informing materials, including the Beneficiary Handbook, Notice of Privacy Practices, Consent for Treatment and other relevant documents are available in English and Spanish (SLOBHD's threshold language). Large print (72-point font) and audio CD versions of the Beneficiary Handbook are also available. See Policy 4.20, Information Process for Beneficiaries, for more detail.
3. When SLOBHD staff translate written materials into Spanish, every effort is made to provide review by two bilingual staff members to ensure that the translation is clear and culturally appropriate. See the SLO Health Agency Non-discrimination and Language Access Plan for additional detail.

B. Language Capacity:

1. SLOBHD is committed to the recruitment, hiring, and retention of a multicultural workforce from, or experienced with, identified unserved and underserved populations so that beneficiaries are provided with culture-specific and linguistically appropriate services. Our goal is to provide services by, in order of preference:
   - Bilingual/bicultural providers
   - Bilingual providers
   - Bilingual/bicultural interpreters
   - Language Line Solutions
2. SLOBHD will make key hiring and contracting decisions to grow our language capacity in all geographic regions of SLO County.
3. Particular emphasis will be placed on making sure that key points of contact, such as Central Access and SLOBHD afterhours 24/7 Access Line contractor employ staff who are bilingual (English and Spanish).
4. Language Line Solutions will be used to ensure oral interpretation capacity in Spanish if a more preferred option is not available.
5. Language Line Solutions will be used to accommodate consumers who speak non-threshold languages. Information and training in the use of the Language Line Solutions will be provided for all staff.
6. A specialized MHSA program, (Servicios Sicologicos Para Latinos: A Latino Outreach Program (LOP)) will offer culturally appropriate psychotherapy services to monolingual, low-income Spanish speakers and their bilingual children. LOP staff will be bilingual/bicultural.
7. Each clinic site will have the capacity to provide services in Spanish using bilingual staff.
8. Additionally, SLOBHD contracts with a community agency, Center for Family Strengthening, to provide in-person translation by "Promotores". Promotores are bilingual/bicultural community members who have received training to provide interpretation services.
9. SLOBHD will maintain an open purchase order with Independent Living Resource Center for the provision of American Sign Language (ASL) services.

C. Translation and interpretation services will be provided in a confidential manner.

D. Family members will not be relied on as interpreters due to the extreme difficulty this often creates in treatment and familial relationships. However, upon documented request of the beneficiary, a family member may provide interpretation after the beneficiary is informed of the availability of free interpreter services. Minor children will not be used as interpreters except in emergencies; justification for such action must be well documented in the record.
E. Bilingual Certification: Bilingual Certification Committee or designee will evaluate language competence. The committee will determine whether oral and/or written language skills are adequate for the staff member's role. See the SLO Health Agency Non-discrimination and Language Access Plan for additional detail
F. In addition to ethnic and language considerations, SLOBHD will expand capacity and expertise in serving other underserved populations, including, but not limited to, the LGBTQ community, hard to reach veterans, homeless residents, transitional aged youth, and children aged zero to five (0-5).
G. Cultural Competence Committee and Cultural Competence Training:
    1. The Cultural Competence Committee will meet regularly to address issues related to reducing disparities and increasing staff awareness and competence.
    2. Cultural Competence Training will include the following:
        a. Mandatory annual e Learning cultural competence training
        b. Periodic live cultural competence trainings
        c. A Cultural Competence newsletter, which will be published periodically to highlight key issues affecting beneficiaries in SLO County
H. When culturally appropriate services are unavailable at the clinic site, or upon request of the beneficiary, referrals for such services will be made within the community.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 10/1/2015 | All | Reformatted and expanded |
| 3/15/2018 | All | Added references to the SLO Health Agency Non-discrimination and Language Access Plan |
| 09/22/2018 | All | Reformatted and updated language |
| 8/21/2020 | All | Updated language and procedures |
| Prior Approval dates: | | |
| 02/27/2009 | | |

| *E-Signature on file* | | *08/21/2020* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 2.01 SLOHA NONDISCRIMINATION AND LANGUAGE ACCESS PLAN

## I. PURPOSE

- To ensure compliance with regulations regarding non-discrimination
- To ensure compliance with regulations regarding access to healthcare programs and activities for persons with limited English proficiency
- To articulate standards for interpretation and translation
- To identify standards for certifying and compensating qualified bilingual staff.

## II. SCOPE

Applies to all County of San Luis Obispo Health Agency programs, staff, and contractors

## III. POLICY

Consistent with State and Federal Regulations, the County of San Luis Obispo Health Agency (SLO HA) shall not discriminate in the provision of services based on race, color, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sex, sexual orientation, or religion in any health programs or activities and shall take reasonable steps to provide meaningful access to each individual with limited English proficiency.

In addition, the Health Agency's Behavioral Health and Public Health clinics do not discriminate in the provision of clinical services to an individual based on the individual's inability to pay or whether payment for clinical services would be made under Medicare, Medi-Cal (CenCal, Medicaid), or Children's Health Insurance Program (CHIP).

All Health Agency All Health Agency clinic sites must prominently display notices to patients stating that no one will be denied access to eligible services due to inability to pay, and that there is a discounted/sliding fee schedule available based on family size and income. See Appendix A: Non-Discrimination Notice to Patients. These notices must be posted in highly visible common areas on-site, on Health Agency web pages about clinic services, and on social media platforms, which are specifically for clinical services.

## IV. DEFINITIONS

- **"Limited English Proficient Person (LEP)"** means "…an individual whose primary language for communication is not English and who has a limited ability to read, write, speak or understand English." (45 CFR § 92.4)
- **"Qualified interpreter"** means one who, via a remote interpreting service or in person,
  1) Adheres to generally accepted interpreter ethics principles, including client confidentiality.

2) Has demonstrated proficiency in speaking and understanding both spoken English and [the relevant] spoken language; and
3) Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology. (45 CFR § 92.201(d)(1))

- **"Qualified bilingual/multilingual staff"** means a member of the SLO HA's workforce who is designated to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the SLO HA that he or she:
  1) Is proficient in speaking and understanding both spoken English and another spoken language, including any necessary specialized vocabulary, terminology and phraseology, and
  2) Is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages. (45 CFR § 92.201(e))
- **"Qualified translator"** means a person who:
  1) Adheres to generally accepted translator ethics principles, including client confidentiality.
  2) Has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and
  3) Is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology. (45 CFR § 92.201(d)(2)).
- **Culturally and Linguistically Appropriate Services (CLAS)** means a set of recognized standards which aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

## V. PROCEDURE

A. Notice to public of non-discrimination and free language access (section 1557 of the Affordable Care Act)

1. POSTED NOTICE: SLO HA shall conspicuously post written notice in all clinics serving clients of its nondiscrimination and language access policy. The notice shall be written in the top 15 languages spoken by individuals with limited English proficiency in California and shall contain, at minimum, the following information:

   a. Statement of nondiscrimination on the basis of race, color, national origin, sex, age, or disability in health programs and activities.
   b. Availability of free, qualified interpreters and information in alternate formats.
   c. Availability of free language assistance services, including translated documents and oral interpretation.
   d. How to obtain the aids and services described above.

e. Contact information for the employee responsible for coordinating compliance
f. Availability of the grievance procedure and how to file a grievance
g. How to file a discrimination complaint with Office of Civil Rights (OCR)

2. Notice in publications: SLO HA shall place the above-described notice in significant publications and shall place a modified notice in and small publications.

B. Availability of free oral interpretation in both threshold and non-threshold languages

1. SLO HA shall make reasonable efforts to recruit, and train qualified bilingual staff as direct service providers.
2. When a qualified bilingual staff member is not available as a service provider, SLO HA shall arrange free interpretation services from a qualified interpreter.
3. In providing interpretation services, staff shall NOT:
   a. Require an individual with limited English proficiency to provide his or her own interpreter
   b. Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except:
      i. In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or
      ii. Where the individual with limited English proficiency has first been informed of the availability of free interpreter services and specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.
   c. Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available.
   d. Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.
4. If a family member or minor interprets for a client in a situation described above, staff shall clearly document the reasons for this decision in the client's record.

C. Availability of translated material

1. SLO HA shall make significant publications and forms used by consumers available in English and Spanish (the threshold languages for San Luis Obispo County) and in alternative formats.
2. Translated material shall be completed by a qualified translator, as defined in Federal law and as determined by the Bilingual Certification Committee.
3. SLO HA shall ensure the accuracy of translated materials in terms of both language and culture by review of translated materials by multiple qualified translators and/or field testing.

D. Identification and compensation of qualified bilingual staff

1. SLO HA shall establish a Bilingual Certification Committee to implement a standard process for identifying and compensating qualified bilingual staff.
2. The Bilingual Certification Committee shall verify that each staff member who receives a bilingual compensation differential meets the Federal definition of "qualified bilingual staff" by conducting an oral interview to assess fluency, ability to communicate in a culturally appropriate manner, and knowledge of specialized vocabulary and terminology relevant to the staff member's role.
3. The Bilingual Certification Committee shall recommend compensation at one of two differential levels, based on staff role and expectation for using the non-English language.
    a. High differential shall be approved when bilingual skills are a primary element of the staff member's job and are used as a regular and routine part of the job. Operationally, the high differential means that the staff member is regularly called upon to use the non-English language at least 50% of a normal workweek.
    b. Low differential shall be approved when non-English language skills are used on a frequent but intermittent basis i.e., when the staff member is regularly called upon to use the non-English language less than 50% of a normal workweek.

E. Grievance Procedure

1. SLOHA shall establish a grievance process for addressing complaints about discrimination or language access.
2. Under SLO HA, the Behavioral Health Department shall designate the Patient's Rights Advocate as the Grievance Coordinator.
3. Contact information for the Patient's Rights Advocate shall be publicly posted in English and Spanish.
4. Grievances may be submitted orally or in writing and shall be investigated and resolved in a timely manner, normally within 60 calendar days.
5. The Patient's Rights Advocate shall notify the individual submitting the grievance in writing when resolution cannot be completed within 60 days.

## **VI.** APPLICABLE STANDARDS/REGULATIONS

- Code of Federal Regulations (CFR), Title 45, Subtitle A Subchapter A, Part 92
- Patient Protection and Affordable Care Act, §1557 (42 USC. §18116)
- US Code 42, § 2000d (Title VI, Civil Rights Act of 1964)
- CFR Title 42, Chapter IV, Subchapter C, Part 438
- CFR Title 28, Chapter I, Part 35, Subpart E
- California Code of Regulations (CCR), Title 9, Chapter 11, § 1810.410

## **VII.** RESOURCES

- https://www.hhs.gov/civil-rights/for-individuals/language-assistance/index.html
- Implementing CLAS standards: https://www.thinkculturalhealth.hhs.gov/

I. REVISION HISTORY

| Effective/Revision Date: | Sections Revised | Status: Initial/ Revised/Archived Description of Revisions |
|---|---|---|
| 08/04/2020 | Entire Policy | Initial Release |
| 09/21/2022 | Entire Policy | Added HSRA language |
| Prior Approval dates: | | |
| | | |

| | | |
|---|---|---|
| *E-Signature on file* | | 9/21/2022 |
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# Section 3

# Managed Care -- Access and Authorization

# 3.00 Access to Services

## I. PURPOSE

To clarify the County of San Luis Obispo Behavioral Health Department's (SLOBHD) access procedures.

## II. POLICY

SLOBHD will deliver medically necessary Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services in an amount, duration, and scope sufficient to achieve symptom reduction or improvement in functioning to eligible Medi-Cal beneficiaries (herein "member"). SLOBHD will provide access to services in a timely manner, based on the urgency of the member's need for services, and will issue a Notice of Adverse Benefit Determination (NOABD) in any instance when a member's access does not meet SLOBHD's standard.

SLOBHD will maintain a written/electronic log of all initial requests for behavioral health services and will monitor timeliness of access as part of a continuous quality improvement effort.

Consumers without Medi-Cal will receive services based on medical necessity to the extent resources are available.

## III. REFERENCE

- MHSUDS Information Notice 21-075
- California Code of Regulations, Title 9, §1810.405, §1810.410
- California Code of Regulations, Title 9, §§ 10280-10415
- Code of Federal Regulations, Title 42, Part 2 §§ 2.1-2.67
- DMC-ODS Contract with DHCS (Intergovernmental Agreement)
- MHP Contract with DHCS, Exhibit A, Attachment 1
- DMC-ODS Waiver Intergovernmental Agreement
- Standard Terms and Conditions, 89-119 and 265-282
- Welfare & Institutions Code § 5600.2

  Related Guidance:
- MHP Documentation Guidelines
- DMC-ODS Documentation Guidelines
- 3.25 Network Adequacy, Access Timeliness, and Array of Services
- 5.00 Outpatient Mental Health Assessment
- 3.21 Authorization, Documentation, Billing Process for Out of Plan Services

- 3.11 MHET Crisis Assessment of Youth
- 3.30 Notices of Adverse Benefit Determination
- 2.00 Culturally Competent, Multilingual Services
- 3.01 Services for Hearing and Vision Impaired Consumers

IV. PROCEDURE

A. Statewide, toll-free 24/7 Central Access Line

1. The Central Access Line will provide beneficiaries with information about:
    a. How to access behavioral health services, including how to receive an assessment or screening to determine if access criteria are met
    b. How to get treatment for an urgent behavioral health condition
    c. How to access the beneficiary problem resolution and fair hearing processes
2. The Central Access Line will have language capability in all languages spoken by beneficiaries in the county. This will be accomplished by:
    a. Prioritizing placement of bilingual (Spanish/English speaking) staff at this key point of contact
    b. Contract with Language Line Services for threshold and non-threshold language interpretation services
    c. Use of California Relay System
3. The Central Access Line will have live person answering capability 24/7, 365 days per year by utilizing SLOBHD Managed Care program staff and afterhours contracted personnel.

B. Service Request:

1. Initial requests for behavioral health services are documented and logged on a SmartCare Inquiry document.
2. An Inquiry document must be completed when a beneficiary who is not open to Behavioral Health requests behavioral health services:
    a. Telephone call made during regular business hours to the Behavioral Health Central Access Line
    b. Telephone requests for routine services which are received afterhours will be forwarded to Central Access staff for follow up the next business day
    c. Managed Care staff will use the Central Access Line Script when answering the Access Line (see Appendix A)
    d. Referrals for follow-up care from any treating provider including but not limited to: psychiatric health facility (PHF) or psychiatric inpatient hospital, crisis stabilization unit, emergency department, County jail, mobile crisis team (MCT) or mental health evaluation team (MHET), and Managed Care Plan staff or providers.
    e. In person at an outpatient clinic or program site

f. In writing to any outpatient clinic or program site or to the Behavioral Health department's website.

3. An Inquiry document must contain the following:
    a. Name of the beneficiary. If a caller declines to state a name, the caller is identified as John or Jane Doe
    b. Date the request is received
    c. Urgency level of the request (See Policy 3.25)
    d. Any language or cultural services preferences of the beneficiary
    e. Initial disposition of the request

C. Services provided during the assessment period:
    1. Services that may be provided during the assessment period include clinically appropriate and covered behavioral health prevention, screening, assessment, treatment, and recovery services
    2. Services provided during the assessment process are covered by Medi-Cal, even if the access determination is that the member does not meet access criteria for SMH or DMC-ODS services.
    3. DMC-ODS requires that access criteria be established within 30 days of the member's initial service, or within 60 days if the member is under the age of 21 or if the member is experiencing homelessness. If a member withdraws from the assessment process prior to its completion and later returns, the 30-day or 60-day assessment time period starts over.

D. DMC-ODS Walk-In Screening
    1. It is best practice and the standard for SLOBHD that the screening be conducted face-to-face, however, screenings can be completed by telehealth or telephone in necessary circumstances. Screening is typically one session but can take place over two contacts and is the first billable service.
    2. If the screening is completed by a Specialist (registered for certified Counselor), then a Licensed Practitioner of the Healing Arts (LPHA) shall evaluate that assessment with the Specialist and the LPHA shall render the initial diagnosis. Consultation between the LPHA and the Specialist can be conducted in person, by telehealth, or by telephone and must be documented in the client's record.
    3. The purpose of the Screening session is for the admitting staff to gather information about the member's basic needs, current substance use and substance use history, mental health status, and any past or immediate risk factors such as suicidality, homelessness, and emergency physical health needs.
    4. The outcome of the screening will be documented, and next steps include:
        a. Provide referrals and recommendations.
        b. Schedule Assessment when access criteria is met and a full assessment is warranted.
        c. Schedule member for stabilization services (Case Management Group) or assign client to treatment groups/treatment program if immediate placement in treatment is indicated.

d. Schedule client for an appointment for Medication for Addiction Treatment (MAT) services if requested or indicated (see current MAT Policy and Procedures for additional guidance).

E. SLOBHD must provide authorization for DMC-ODS residential and inpatient services (excluding withdrawal management services) within 24 hours of the prior authorization request being submitted by a provider.

F. Emergency inpatient psychiatric services and outpatient behavioral health services do not require prior authorization.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 4/29/2014 | 1,a and c, 2 | Post-PHF MD apt scheduled at intake |
| 4/10/2015 | 1, c and d | Including urgent referrals from jail. |
| 11/1/2015 | A 1 & 2, B 1& 2 Appendix A | Added detail regarding Service Requests, Jail/Forensic referrals, and script for answering the Central Access Line. |
| 03/09/2018 | Procedure | BH access integration, NOABD, and timeliness updates |
| 8/20/2023 | Procedure | Update to be consistent with procedures in our new EHR |
| 05/13/2024 | Procedure | Updates made to procedure to align with current guidance. |
| Prior Approval dates: | | |
| 02/27/2009, 08/08/2011, 1/20/2012 | | |

| | | |
|---|---|---|
| *Signature on file* | | *09/10/2024* |
| Approved by: | Star Graber, PhD, LMFT, Behavioral Health Administrator | Date |

APPENDIX A

## SCRIPTED RESPONSES FOR CENTRAL ACCESS LINE CALLS:

**Behavioral Health Central Access this is (state your name), how may I help you?**

*Depending on the caller's response, use the following scripts:*

1. **If a caller is requesting a Mental Health Assessment:**

   "I can help you with that; I just have a few questions to ask you so I can connect you with a therapist."

   - Complete a Service Request/Caller Information Sheet

   "I can give this information to a clinician who will call you back shortly, or would you prefer to speak with someone immediately?"

2. **If a caller is requesting information about County Behavioral Health Services:**

   "We offer outpatient behavioral health services for adults, adolescents, and children. I can help you access services now, or I can give you information about how to access services in the future."

   "You may access outpatient services in any of the following ways":

   a. Call the County Behavioral Health Central Access line at 1-800-838-1381, Monday through Friday, 8 AM to 5 PM.
   b. Visit your local clinic:

| Clinic | Location |
|---|---|
| South County Adult Mental Health clinic | 1350 E. Grand Ave Arroyo Grande |
| South County Youth Mental Health clinic | 354 S. Halcyon Arroyo Grande |
| Grover Beach Drug and Alcohol clinic | 1523 Longbranch Ave Grover Beach |
| SLO Adult Mental Health clinic | 2178 Johnson Ave SLO |
| SLO Youth Services Mental Health clinic | 1989 Vicente Dr. SLO |
| SLO Drug and Alcohol clinic | 2180 Johnson Ave SLO |
| Atascadero Drug and Alcohol clinic | 3556 El Camino Real Atascadero |
| North County Adult and Youth Mental Health clinic | 5575 Hospital Dr. Atascadero |
| Paso Robles Drug and Alcohol clinic | 805 4th Street, Paso Robles |

   c. Visit our website at: www.slocounty.ca.gov/health

3. **If a caller is calling with a complaint or grievance:**
   **"**You can speak with the Patient's Rights Advocate, Leah DeRose, about a complaint, grievance, appeal or State fair hearing. A Beneficiary Handbook is available in English, Spanish and alternative formats to help Medi-Cal beneficiaries learn more about behavioral health services, how to resolve problems with providers, and beneficiary rights. You can pick up a Beneficiary Handbook in the lobby of any Behavioral Health Clinic or ask us to mail a copy to you. Her number is 781-4738 would you like me to connect you?"

4. **If the caller is from a psychiatric hospital regarding the admission of a San Luis Obispo County Medi-Cal beneficiary:**

   "I can connect you to the voicemail instructions for notification of admission and billing information. Emergency admissions do not require pre-authorization." (Connect caller to x4706)

5. **If the caller is in need of urgent outpatient behavioral health services:**

   "Are you in need of immediate services due to urgent needs?"

   - If the caller responds "Yes":

   "I can help connect you to a clinician right away. Could I please have your name and number in case we get disconnected?"

   - Check whether client has received services in the past and is in Anasazi.
   - Confirm or attempt to learn client's DOB and address.
   - Connect client to the clinician covering crisis calls.

   "I will connect you to a clinician now, please stay on the line."

   - If the caller responds "No":

   - Complete a Service Request/Caller Information Sheet

   "I can give this information to a clinician who will call you back shortly, or would you prefer to speak with someone immediately?"

# 3.01 Services for Clients with Impaired Hearing and Vision

I. PURPOSE

To ensure provision of interpreters, telecommunication devices, and other forms of aid for clients with impaired hearing and vision where necessary to provide Behavioral Health Services.

II. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) will provide interpreters, telecommunication devices, and other forms of aid for clients with impaired hearing and/or vision when necessary to allow each client equal opportunity to benefit from treatment services. Aid provided will include access to the necessary forms, flyers, literature and handbooks, Beneficiary's rights, and treatment services in a manner that allows effective communication. When utilized, interpreters will sign an Oath of Confidentiality prior to providing services.

III. Reference

- The Americans with Disabilities Act (ADA) of 1990
- County of San Luis Obispo Health Agency Non-discrimination and Language Access Plan

IV. PROCEDURE

A. Hearing Impairment Accommodations

1. SLOBHD will utilize California Relay Service (CRS) to accommodate TTY callers

    a. When a call comes through a Behavioral Health clinic front desk or the Central Access 24-hour line, the Administrative Assistant will telephone the CRS at (800) 735-2922

    b. The CRS will facilitate the telephone call between SLOBHD and the client using TTY

2. SLOBHD will provide clients with in-person American Sign Language (ASL) or Tactile Interpreting upon request

    c. SLOBHD staff will contact the Independent Living Resource Center (ILRC) at (805) 925-0015, during regular business hours. Staff will identify himself/herself as a SLOBHD employee and will request an interpreter for the dates, times, type, and location where the services are needed

d. SLOBHD staff will submit l requests for an ASL interpreter at least 72 hours prior to the client's appointment, if possible

e. ILRC will provide the requested service and will submit a claim to SLOBHD Fiscal Department for payment

B. Vision Impairment Accommodations

1. SLOBHD will post a sign in 72-point font in both English and Spanish at all sites in plain view, informing the clients of their right to information provided in alternative formats

1. CD recordings of the Beneficiary Handbook and related literature are available in English and Spanish

2. Upon client request, SLOBHD staff will assist with completion of necessary paperwork. Assistance may include, but is not limited to reading information to the client, completing forms in an interactive verbal manner, etc.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 03/01/2015 | 1, c and d | Changed "MRT" to "AA"; reformatted. |
| 03/09/2018 | Procedure | Simplified procedure, any staff may call ILRC |
| Prior Approval dates: | | |
| 02/27/2009 | | |

| *Signature on file* | | *03/15/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# TTY/TDD/CRS USING THE CALIFORNIA RELAY SYSTEM

Voice Relay allows standard phone users to communicate with individuals who are deaf, hard of hearing, deaf-blind or have difficulty speaking and who may use a TTY, or other assistive telecommunications devices. A Communications Assistant (CA) facilitates the call by relaying messages between the individuals, according to their communication needs.

## Making a Call

- Dial 1-800-735-2922
- The CA will answer with his/her identification number and ask for the number you wish to call.
- Provide the area code and telephone number you wish to call, along with any special instructions.
- All messages are relayed word for word.

The person you are calling may also be made aware of any audible background noises or conversations occurring near you.

- The CA will facilitate the conversation through a turn taking process. When it is your turn, speak directly and clearly to the person you are calling and say *GA* or *Go Ahead* when you are ready for a response. The other party will begin their message and when you hear the words *GA* or *Go Ahead,* it is your turn to speak again.
- To end your call, say *GA to SK* or simply say *Goodbye.*

## Receiving a Relay Call

- When you pick up the phone and hear *This is the Relay Service,* someone who may be deaf, deaf-blind, hard of hearing or have difficulty speaking is on the line.
- The CA will give his/her identification number and ask if you have received a relay call before. If necessary, the CA will explain the process before connecting the call.
- The conversation will proceed in the same manner as when making a relay call; say *Go Ahead* or *GA* to indicate you are done speaking and say *GA to SK* to end the conversation.

## Tips for Voice Relay Users

- Provide the CA with as much information as possible before your call begins, such as the name of the person you are calling, so that the CA may ask for him/her when the call is answered.
- You may request a male or female CA – and depending on availability, your request will be honored.
- Once you are connected to the person you are calling, speak slower than usual and wait a few moments for a response as there may be a slight delay.
- If you have a series of questions, it is helpful to ask them one at a time, allowing the person you are calling to respond to each question individually. This will reduce any confusion or misunderstandings.
- There is no time limit on calls, and you may make as many consecutive calls as you wish.

## Helping Clients Access TTY Equipment

- The California Telecommunications Access Program provides TTY equipment for free or at a low cost.
- California Telecommunications Access Program: 1-800-806-1191.

# 3.02 Service Request

## I. PURPOSE

To ensure that all initial requests for services are documented on a Service Request in Anasazi.

## II. POLICY

The County of San Luis Obispo Behavioral Health Department maintains an electronic log of consumer requests for outpatient mental health services. All initial requests for services are documented on a Service Request in Anasazi.

## III. Reference(s)

- CCR Title 9, Chapter 11 section 1810.405 (f)
- Policy 3.0 Access to Services
- Policy 3.20 Authorization of Services and Medical Necessity

## IV. PROCEDURE

A. A Service Request must be completed when a consumer who is not open to Mental Health requests outpatient mental health services by any of the following means:

- Telephone call made during regular business hours to the Mental Health toll free access number (800-838-1381).
- Referral for follow-up care from any psychiatric health facility or psychiatric inpatient hospital staff.
- In person at an outpatient clinic or program site.
- Referral through interagency teams or other programs (e.g., Services Affirming Family Empowerment (SAFE), Family Resource Center (FRC), Forensic Re-entry Service (FRS), Educationally Related Mental Health Services (ERMHS) referrals from school districts, etc.), Mental Health Homeless Full Service Partnership (FSP).
- In writing to any outpatient clinic or program site or to the MHP's website.

B. Documentation in a Service Request must contain the following:

- Name of the consumer. If a caller declines to state a name, the caller is identified as Anonymous.
- Date of the request
- Urgency level of the request (Routine, Urgent, Crisis)
- Any language or cultural services preferences of the consumer
- Initial disposition of the request

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 06/01/2015 | Section 1 | Added purpose |
| 12/27/2017 | Entire Policy | Formatting |
| Prior Approval dates: | | |
| 03/30/2009, 04/30/2010, 09/21/2012 | | |

| *Signature on file* | | *06/01/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 3.04 Documentation Requirements

## I. PURPOSE

To describe guidelines and requirements that streamline clinical documentation requirements for all Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services.

## II. POLICY

The chart documentation requirements for all SMHS and DMC-ODS services are as established in the procedure below. Deviations from compliance with documentation standards outlined below will require corrective action plans. Recoupment shall be focused on fraud, waste, and abuse. DHCS removed client plan requirements from SMHS and treatment plan requirements from DMC-ODS, with the exception of continued requirements specifically noted in Attachment 1 and replaced them with these new behavioral health documentation requirements, including problem list and progress notes requirements. The specific forms utilized for the assessment domains, problem list, or progress notes are up to the county's discretion. Services shall be provided in the least restrictive setting and shall be consistent with the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency.

## III. REFERENCE(S)

- Behavioral Health Information Notices: 22-019 & 21-075
- Health & Safety Code 123100
- CFR 42 § 455.2
- W&I Code, Section 14107.11 (d)
- CCR Title 9 § 1840.344

## IV. PROCEDURE

A. Standardized Assessment Requirements
   1. SMHS
      a. The MHP requires providers to use the uniform assessment domains as identified below. For beneficiaries under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the assessment domain requirements.
      b. The time period for providers to complete an initial assessment and subsequent assessments for SMHS are up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice.

c. Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether Non-Specialty Mental Health Services (NSMHS) or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS.
d. The assessment shall include a typed or legibly printed name and signature of the service provider and date of signature.
e. The assessment shall include the provider's determination of medical necessity and recommendation for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.
f. The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a provider, operating in his/her scope of practice under California State law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional as defined in the State Plan.
g. The MHP may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals.

2. DMC-ODS
   a. Counties shall require providers to use the American Society of Addiction Medicine (ASAM) Criteria assessment for DMC and DMCODS beneficiaries.
   b. The assessment shall include a typed or legibly printed name and signature of the service provider and date of signature.
   c. The assessment shall include the provider's determination of medical necessity and recommendation for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.
   d. Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a diagnosis for Substance-Related and Addictive Disorders from the current Diagnostic and Statistical Manual (DSM) is established, or up to 60 days if the beneficiary is under age 21, or if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment.
   e. If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day or 60-day time period starts over. Assessments shall be updated as clinically appropriate when the beneficiary's condition changes.

B. SMHS Assessment Domain Requirements

The SMHS assessment shall include the following seven required domains. Providers shall document the domains in the SMHS assessment in the beneficiary's medical record. Providers shall complete the assessment within a reasonable time and in accordance with generally accepted standards of practice.

- Domain 1:
  - Presenting Problem(s)
  - Current Mental Status
  - History of Presenting Problem(s)
  - Beneficiary-Identified Impairment(s)
- Domain 2:
  - Trauma
- Domain 3:
  - Behavioral Health History
  - Comorbidity
- Domain 4:
  - Medical History
  - Current Medications
  - Comorbidity with Behavioral Health
- Domain 5:
  - Social and Life Circumstances
  - Culture/Religion/Spirituality
- Domain 6:
  - Strengths, Risk Behaviors, and Safety Factors
- Domain 7:
  - Clinical Summary and Recommendations
  - Diagnostic Impression
  - Medical Necessity Determination/Level of Care/Access Criteria

C. SMHS and DMC-ODS Problem List

1. The provider(s) responsible for the beneficiary's care shall create and maintain a problem list.
2. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.
3. A problem identified during a service encounter may be addressed by the service provider during that service encounter, and subsequently added to the problem list.
4. The problem list shall be updated on an ongoing basis to reflect the current presentation of the beneficiary.
5. The problem list shall include, but is not limited to, the following:
   - Diagnoses identified by a provider acting within their scope of practice, if any.
     - Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
   - Problems identified by a provider acting within their scope of practice, if any.
   - Problems or illnesses identified by the beneficiary and/or significant support

person, if any.
- The name and title of the provider who identified, added, or removed the problem, and the date the problem was identified/added or removed.

6. Providers shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.
7. DHCS does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

D. SMHS and DMC-ODS Progress Notes
1. Providers shall create progress notes for the provision of all SMHS DMC-ODS services. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.
2. Progress notes shall include:
    - The type of service rendered.
    - A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).
    - The date that the service was provided to the beneficiary.
    - Duration of the service, including travel and documentation time.
    - Location of the beneficiary at the time of receiving the service.
    - A typed or legibly printed name and signature of the service provider and date of signature.
    - ICD 10 code.
    - Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code as consistent with current guidance.
    - Next steps including, but not limited to, planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.
3. Providers shall complete progress notes within 3 business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.
4. Providers shall complete a daily progress note for services that are billed on a daily basis, such as residential and day treatment services (including therapeutic foster care, day treatment intensive, and day rehabilitation). Weekly summaries are no longer required for day rehabilitation and day treatment intensive.
5. When a group service is rendered, a list of participants is required to be documented and maintained by the Plan or provider. Should more than one provider render a group service, one progress note may be completed for a group session and signed by one provider. While one progress note with one provider signature is acceptable for a group activity where multiple providers are involved, the progress note shall clearly document the specific involvement and the specific amount of time of involvement of each provider of the group activity, including documentation time. All

other progress note requirements listed above shall also be met.

E. Treatment and Care Planning Requirements
DHCS removed client plan requirements from SMHS and treatment plan requirements from DMC-ODS, with the exception of the continued requirements specifically noted in Attachment 1. Several of these care plan requirements remain in effect due to applicable federal regulations or guidance.

1. Targeted Case Management
Targeted case management services within SMHS additionally require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment. The TCM care plan:
    - Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the beneficiary;
    - Includes activities such as ensuring the active participation of the beneficiary, and working with the beneficiary (or the beneficiary's authorized health care decision maker) and others to develop those goals;
    - Identifies a course of action to respond to the assessed needs of the beneficiary; and
    - Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.

    These required elements shall be provided in a narrative format in the beneficiary's progress notes.
2. Peer Support Services
Peer support services must be based on an approved plan of care. The plan of care shall be documented within the progress notes in the beneficiary's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.
3. Additional Treatment and Care Plan Requirements
Requirements for treatment and care planning for additional service types are found in Attachment 1.

F. Telehealth Consent
If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to confirm consent for the telehealth or telephone service, in writing or verbally, at least once prior to initiating applicable health care services via telehealth to a Medi-Cal beneficiary: an explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit; an explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future; an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider. The provider must document in the medical record the provision of this

information and the client's verbal or written acknowledgment that the information was received.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 02/06/2023 | All | Adopted |
| | | |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *02/23/2023* |
|---|---|---|
| Approved by: | Anne Robin, LCSW Behavioral Health Administrator | Date |

# 3.05 Adult and Youth Screening and Transition of Care Tools

## I. PURPOSE

To provide guidance to the County of San Luis Obispo Behavioral Health Department (SLOBHD) Mental Health Plan (MHP) on utilizing standardized, statewide Adult and Youth Screening and Transition of Care Tools to guide referrals of Adult and Youth beneficiaries to the appropriate Medi-Cal mental health delivery system and ensure that beneficiaries requiring transition between delivery systems receive timely, coordinated care.

## II. POLICY

Effective January 1, 2023, SLOBHD MHP shall implement the Screening and Transition of Care Tools for Medi-Cal Mental Health Services.

**Adult and Youth Screening Tools for Medi-Cal Mental Health Services:**

The Adult and Youth Screening Tools for Medi-Cal Mental Health Services shall be used when a beneficiary, or a person on behalf of a beneficiary under age 21, who is not currently receiving mental health services, contacts the MHP seeking mental health services. The tools are to be used to guide a referral by the MHP to the appropriate Medi-Cal mental health delivery system (i.e., Managed Care Plan (MCP) or MHP). The Adult Screening Tool shall be used for beneficiaries age 21 and older. The Youth Screening Tool shall be used for beneficiaries under age 21. The Adult and Youth Screening Tools identify initial indicators of beneficiary needs in order to make a determination for referral to either the beneficiary's MCP (CenCal) for a clinical assessment and medically necessary non-specialty mental health services (NSMHS) or to the beneficiary's MHP for a clinical assessment and medically necessary specialty mental health services (SMHS).

The Adult and Youth Screening Tools are not required to be used when beneficiaries contact mental health providers directly to seek mental health services. MHPs must allow contracted mental health providers who are contacted directly by beneficiaries seeking mental health services to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy & Procedure (P&P) 3.03.

The Adult and Youth Screening Tools do not replace:

1. SLOBHD P&Ps that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals.
2. SLOBHD protocols that address clinically appropriate, timely, and equitable access to care.
3. MHP clinical assessments, level of care determinations, and service recommendations.
4. MHP requirements to provide early and periodic screening, diagnostic, and treatment services (EPSDT) services.

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

Description of the Adult and Youth Screening Tools:

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

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

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

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

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

1. Safety: information about whether the beneficiary needs immediate attention and the reason(s) a beneficiary is seeking services.
2. System Involvement: information about whether the beneficiary is currently receiving treatment and if they have been involved in foster care, child welfare services, or the juvenile justice system.

3. Life Circumstances: information about challenges the beneficiary may be experiencing related to family support, school, work, relationships, housing, or other life circumstances.
4. Risk: information about suicidality, self-harm, harm to others, and hospitalizations.

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

- Questions related to SMHS access criteria, including those related to involvement in foster care or child welfare services, involvement in the juvenile justice system, and experience with homelessness. If a beneficiary under the age of 21, or the person on their behalf, responds affirmatively to the questions related to SMHS access criteria, they shall be referred to the MHP for an assessment and medically necessary services.
- A question related to substance use. If a beneficiary under the age of 21, or the person on their behalf, responds affirmatively to the question related to substance use, they shall be offered a referral to the SLOBHD for SUD assessment. The beneficiary may decline this referral without impact to their mental health delivery system referral.
- A question related to connection to primary care. If a beneficiary under the age of 21, or the person on their behalf, indicates that there is a gap in connection to primary care, they shall be offered linkage to CenCal for a primary care visit.

Based on responses to the screening tool questions, the Adult Screening Tool and the Youth Screening Tool each include a scoring methodology to determine whether the beneficiary must be referred to CenCal or to the MHP for clinical assessment and medically necessary services. Detailed instructions for appropriate application of the scoring methodology are provided in the tools. MHPs shall use the scoring methodology and follow the referral determination generated by the score. For all referrals, the beneficiary shall be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice.

**Transition of Care Tool for Medi-Cal Mental Health Services:**

The Transition of Care Tool for Medi-Cal Mental Health Services is intended to ensure that beneficiaries who are receiving mental health services from one delivery system receive timely and coordinated care when either: (1) their existing services need to be transitioned to the other delivery system; or (2) services need to be added to their existing mental health treatment from the other delivery system consistent with the No Wrong Door for Mental Health Services Policy & Procedure 3.03. The Transition of Care Tool documents beneficiary needs for a transition of care referral or a service referral to CenCal or the MHP.

The Transition of Care Tool does not replace:

1. SLOBHD P&Ps that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals.
2. SLOBHD protocols that address clinically appropriate, timely, and equitable access to care.
3. MHP clinical assessments, level of care determinations, and service recommendations.

4. MHP requirements to provide EPSDT services.

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

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

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

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

III. Reference(s)

- Welfare & Institutions Code section 14184.402
- BHIN 20-070, 21-023, 21-073, & 22-011,
- California Code of Regulations Title 9, Chapter 11 section 1810.410

IV. PROCEDURE

A. Administering Adult and Youth Screening Tools
   1. MHPs are required to administer the Adult Screening Tool for all beneficiaries age 21 and older, who are not currently receiving mental health services, when they contact the MHP to seek mental health services.
   2. MHPs are required to administer the Youth Screening Tool for all beneficiaries under age 21, who are not currently receiving mental health services, when they, or a person on their behalf, contact the MHP to seek mental health services.
   3. The Adult and Youth Screening Tools are not required or intended for use with beneficiaries who are currently receiving mental health services.
   4. The Adult and Youth Screening Tools are not required to be used when beneficiaries contact mental health providers directly to seek mental health services. MHPs must allow contracted mental health providers who are contacted directly by beneficiaries seeking mental health services to begin the assessment process and provide services during the assessment period without using the Screening Tools,

consistent with the No Wrong Door for Mental Health Services P&P 3.03.

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

B. Following Administration of the Adult and Youth Screening Tools
   1. After administration of the Adult or Youth Screening Tool, a beneficiary's score is generated. Based on their screening score, the beneficiary shall be referred to the appropriate Medi-Cal mental health delivery system (i.e., either CenCal or the MHP) for a clinical assessment.
   2. If a beneficiary is referred to an MHP based on the score generated by CenCal's administration of the Adult or Youth Screening Tool, the MHP must offer and provide a timely clinical assessment to the beneficiary without requiring an additional screening.
   3. If a beneficiary shall be referred by the MHP to CenCal based on the score generated by the MHP's administration of the Adult or Youth Screening Tool, MHPs shall coordinate beneficiary referrals with CenCal.
   4. Referral coordination shall include sharing the completed Adult or Youth Screening Tool and following up to ensure a timely clinical assessment has been made available to the beneficiary. Beneficiaries shall be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice.
   5. The Adult and Youth Screening Tools shall not replace MHPs' protocols for emergencies or urgent and emergent crisis referrals. For instance, if a beneficiary is in crisis or experiencing a psychiatric emergency, the MHP's emergency and crisis protocols shall be followed.

C. Administering the Transition of Care Tool
   1. MHPs are required to use the Transition of Care Tool to facilitate transitions of care to CenCal for all beneficiaries, including adults age 21 and older and youth under age 21, when their service needs change.
   2. The determination to transition services to and/or add services from the CenCal delivery system must be made by a MHP licensed mental health professional (LMHP) via a patient-centered shared decision-making process.

3. Once a LMHP has made the determination to transition care or refer for services, the Transition of Care Tool may be filled out by a LMHP or a non-LMHP.
4. Beneficiaries shall be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice.
5. The Transition of Care Tool may be completed in a variety of ways, including in person, by telephone, or by video conference.
6. Additional information enclosed with the Transition of Care Tool may include documentation such as medical history reviews, care plans, and medication lists.
7. Please refer to the Transition of Care Tool for further instructions on how to complete the tool.

D. Following Administration of the Transition of Care Tool
1. After the Transition of Care Tool is completed, the beneficiary shall be referred to CenCal.
2. MHPs shall coordinate beneficiary care services with CenCal to facilitate care transitions or addition of services, including ensuring that the referral process has been completed, the beneficiary has been connected with a provider in the new system, the new provider accepts the care of the beneficiary, and medically necessary services have been made available to the beneficiary.
3. All appropriate consents shall be obtained in accordance with accepted standards of clinical practice.

E. Forms/Attachments
- The Adult Screening Tool for Medi-Cal Mental Health Services: https://www.dhcs.ca.gov/Documents/DHCS-8765-A.pdf
- The Youth Screening Tool for Medi-Cal Mental Health Services: https://www.dhcs.ca.gov/Documents/DHCS-8765-C.pdf
- The Transition of Care Tool for Med-Cal Mental Health Services: https://www.dhcs.ca.gov/Documents/DHCS-8765-B.pdf

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 02/22/2023 | All | Adopted |
| | | |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *02/23/2023* |
|---|---|---|
| Approved by: | Behavioral Health Administrator | Date |

# 3.06 No Wrong Door for Mental Health Services

## I. PURPOSE

To provide the County of San Luis Obispo Behavioral Health Department (SLOBHD) Mental Health Plan (MHP) guidance and clarification regarding the No Wrong Door for Mental Health Services Policy. This policy ensures that Medi-Cal beneficiaries receive timely mental health services without delay regardless of the delivery system where they seek care, and that. beneficiaries are able to maintain treatment relationships with trusted providers without interruption.

## II. POLICY

The SLOBHD MHP will provide or arrange for clinically appropriate, covered specialty mental health services (SMHS) to include prevention, screening, assessment, and treatment services. The services are covered and reimbursable even when:

1. Services are provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether non-specialty mental health services (NSMHS) or SMHS access criteria are met.
2. The beneficiary has a co-occurring mental health condition and substance use disorder (SUD); or
3. NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

## III. Reference(s)

- Welfare & Institutions Code section 14184.402
- BHIN 21-073 & 22-011

## IV. PROCEDURE

A. SMHS Provided During the Assessment Period Prior to Determination of a Diagnosis or Prior to Determination of Whether SMHS Access Criteria Are Met
   1. Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the beneficiary meets access criteria for SMHS.
   2. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS.
   3. MHPs must not deny or disallow reimbursement for SMHS provided during the assessment process described above if the assessment determines that the beneficiary does **not** meet criteria for SMHS or meets the criteria for NSMHS.
   4. Likewise, Managed Care Plans (MCPs) must not disallow reimbursement for NSMHS services provided during the assessment process if the assessment determines that the beneficiary does **not** meet criteria for NSMHS or meets the criteria for SMHS.

5. MHPs may use the following diagnostic options during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established:
   a. ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by **all** providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).
   b. ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

B. Co-occurring Substance Use Disorder
   1. Clinically appropriate and covered SMHS delivered by MHP providers are covered Medi-Cal services whether or not the beneficiary has a co-occurring SUD.
   2. MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary who meets SMHS criteria on the basis of the beneficiary having a co-occurring SUD, when all other Medi-Cal and service requirements are met.
   3. Clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by Drug Medi-Cal Organized Delivery System (DMC-ODS) providers are covered by DMC-ODS counties, whether or not the beneficiary has a co-occurring mental health condition.
   4. Clinically appropriate and covered NSMHS delivered by MCP providers are covered whether or not the beneficiary has a cooccurring SUD.
   5. Clinically appropriate and covered SUD services delivered by MCP providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment; MAT) are covered by MCPs whether or not the member has a co-occurring mental health condition.

C. Concurrent NSMHS and SMHS
   1. Beneficiaries may concurrently receive NSMHS delivered by a MCP provider and SMHS delivered by a MHP provider when the services are clinically appropriate, coordinated and not duplicative.
   2. When a beneficiary meets criteria for both NSMHS and SMHS, the beneficiary should receive services based on individual clinical need and established therapeutic relationships.
   3. MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary on the basis of the beneficiary also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.
   4. MCPs must not deny or disallow reimbursement for NSMHS provided to a beneficiary on the basis of the beneficiary also meeting SMHS criteria and/or receiving SMHS, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.
   5. Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between MCPs and MHPs to ensure beneficiary choice.

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

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 02/22/2023 | All | Adopted |
| | | |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *02/23/2023* |
|---|---|---|
| Approved by: | Anne Robin, LCSW Behavioral Health Administrator | Date |

# 3.11 Mental Health Evaluation Team Crisis Assessment of Youth

I. PURPOSE

- To provide direction for crisis assessment of minors under the age of 18
- To provide a face-to-face therapeutic response to a youth in crisis and reduce immediate risk of danger to youth or others

II. REFERENCE

Welfare & Institutions Code (W&I Code) §5585

III. POLICY

Upon referral, the County of San Luis Obispo Behavioral Health Department contracted Mental Health Evaluation Team (MHET) will provide a face to face evaluation to a minor under the age of 18 who is in crisis to determine if the minor is in imminent danger to self or others, or gravely disabled and thus in need of immediate involuntary hospitalization under Welfare & Institutions Code §5585.

IV. PROCEDURE

1. When notified that a minor needs field crisis evaluation, MHET staff will:

    a. Conduct a face-to-face assessment
    b. Document specific behavior(s) and relevant environmental circumstances to help determine whether probable cause exists to detain the minor pursuant to WIC 5585
    c. Consult with a on call psychiatrist before leaving the site of the crisis
    d. Document the outcome of the psychiatric consultation

2. Without first consulting with the on call psychiatrist, MHET staff must <u>not</u>:

    a. Make a final determination (in the field or by phone) that "acting out" is a purely behavioral issue as opposed to a symptom of a mental health disorder that could result in an involuntary hold
    b. Leave a minor in the minor's residence

3. In all cases, the final decision to detain or release the minor rests with the psychiatrist, even when MHET staff writes the hold.

4. When the on call psychiatrist determines that W&I Code 5585 criteria are met, MHET staff will:
   a. Transport the minor to a local Emergency Department for medical clearance, if directed by the psychiatrist.
   b. Arrange for an appropriate out-of-county psychiatric facility in coordination with the PHF staff or transport the minor to the PHF for admission, evaluation and treatment.
   c. Family members may follow, but must not be transported to the PHF by MHET staff

5. When the on call psychiatrist determines that W&I Code 5585 criteria are not met, MHET staff will:

   a. Provide the minor and parent/legally responsible person with a referral for outpatient mental health or other appropriate services and with the 24/7 Mental Health crisis line (800-838-1381).
   b. Arrange for next day follow up with the minor and parent/legally responsible person

## V. DOCUMENT HISTORY

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| 06/08/2017 | Purpose<br>Policy<br>Procedure<br>Entire Policy | Added second line<br>Revised paragraph<br>Added 4b and removed 6 a & b<br>Formatting |
| 07/01/2016 | All | Reformatted, minor revision to language, add MHET |
| Prior Approval dates: | | |
| 4/30/2009 | | |

| | |
|---|---|
| *Signature on file* | *08/29/2017* |
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator |

# 3.19 Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022-2026

## I. PURPOSE

To provide DMC-ODS program requirements pursuant to California Advancing & Innovating Medi-Cal (CalAIM), effective January 2022 through December 2026, which replaces the Section 1115 Standard Terms and Conditions used to describe the DMC-ODS program for the years 2015-2021. In accordance with W&I § 14184.102(d), until county contract amendments are executed, DMC-ODS counties shall adhere to the terms in the Behavioral Health Information Notice, BHIN 23-001, where current contracts are silent or in conflict with the terms of BHIN 21-075. The information below reflects policy improvements under CalAIM.

## II. POLICY

A. The County of San Luis Obispo Behavioral Health Department (SLOBHD) shall ensure that all required services covered under the DMC-ODS are available and accessible to beneficiaries of the DMC-ODS in accordance with the applicable state and federal time and distance standards for network providers.
B. Access to medically necessary services, including all Food and Drug Administration (FDA)-approved medications for Opioid Use Disorder, cannot be denied for beneficiaries meeting criteria for DMC-ODS services and beneficiaries shall not be placed on wait lists.
C. DMC-ODS services shall be provided with reasonable promptness in accordance with federal Medicaid requirements and as specified in the DMC-ODS County Intergovernmental Agreement.
D. If the DMC-ODS network is unable to provide medically necessary covered services, the DMC-ODS county must adequately and in a timely manner cover these services out-of-network for as long as the DMC-ODS County's network is unable to provide them.
E. County shall provide prior authorization for residential and inpatient services--excluding Withdrawal Management (WM) Services--within 24 hours of the prior authorization request being submitted by the provider.
F. County may not impose prior authorization or centralized DMC-ODS County-administered full American Society of Addiction Medicine (ASAM) assessment requirements prior to the provision of nonresidential or non-inpatient assessment and treatment services, including WM Services.
G. Medications for Addiction Treatment/Medication Assisted Treatment (MAT): County must demonstrate they either directly offer or have an effective referral process to MAT services for beneficiaries with SUD diagnoses treatable with MAT. Additionally, under the “alternative sites” option, County may cover drug products costs for MAT when the medications are purchased and administered or dispensed in a non-clinical setting.
    1. All medications and biological products utilized to treat SUDs, including long- acting injectables, continue to be available through the medical pharmacy benefit without prior authorization, and can be delivered to provider offices by pharmacies.

2. Beneficiaries needing or utilizing MAT must be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in a program.
3. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a beneficiary who declines counseling services.
4. If the DMC-ODS provider is not capable of continuing to treat the beneficiary, the provider must assist the beneficiary in choosing another MAT provider, ensure continuity of care, and facilitate a warm handoff to support ongoing engagement.

H. DMC-ODS for beneficiaries in the criminal justice system:
1. County should recognize and educate staff and collaborate with Parole and Probation partners.
2. Parole and Probation is not a barrier to DMC-ODS treatment.
3. Beneficiaries may receive recovery services immediately after incarceration regardless of whether they received SUD treatment during incarceration.

I. Covered DMC-ODS Services
1. DMC-ODS services are provided by Drug Medi-Cal (DMC)-certified providers and are based on medical necessity.
2. DMC-ODS services must be recommended by Licensed Practitioners of the Healing Arts (LPHAs), within the scope of their practice.
3. DMC-ODS services include the following comprehensive continuum of outpatient, residential, and inpatient evidence-based SUD services:
   a. Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5)
   b. Outpatient Treatment Services (ASAM Level 1)
   c. Intensive Outpatient Treatment Services (ASAM Level 2.1)
   d. Partial Hospitalization Services (ASAM Level 2.5)
   e. Residential Treatment and Inpatient Services (ASAM Levels 3.1 – 4.0)
   f. Narcotic Treatment Program
   g. Withdrawal Management Services (ASAM Levels 1-WM, 2-WM, 3.2-WM, 3.7-WM, and 4-WM)
   h. Medication for Addiction Treatment (also known as Medication Assisted Treatment – MAT)
   i. Peer Support Specialist Services (effective July 2022)
   j. Recovery Services
   k. Care Coordination
   l. Clinician Consultation (not a direct service to the beneficiary)
   m. Indian Health Care Providers – there are no Indian Health Care Providers within the San Luis Obispo County service area or within range to be considered to meet time or distance standards.

J. Practice Requirements
1. DMC-ODS Counties shall ensure that providers implement at least two of the following evidenced-based treatment practices (EBPs) based on the timeline established in the DMC-ODS County implementation plan. The two EBPs are per provider, per service modality. The evidenced-based practices are:

a. Motivational Interviewing – A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on beneficiaries' past successes.
b. Cognitive-Behavioral Therapy – Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
c. Relapse Prevention – A behavioral self-control program that teaches individuals with SUD how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial SUD treatment.
d. Trauma-Informed Treatment – Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice, and control.
e. Psycho-Education – Psycho-educational groups are designed to educate beneficiaries about substance abuse and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.
f. DMC-ODS Counties shall ensure providers have implemented EBPs and are delivering the practices to fidelity.

K. All facilities delivering Residential Treatment services under DMC-ODS must also be designated as capable of delivering care consistent with the ASAM Criteria.
L. Department of Health Care Services (DHCS) Level of Care Designation or ASAM Level of Care Certification.
   1. All Residential Treatment facilities under DMC-ODS require a DHCS Level of Care (LOC) designation and/or at least one residential ASAM Certification.
      a. DHCS Level 3.1 – Clinically Managed Low-Intensity Residential Services
      b. DHCS Level 3.2 – Clinically Managed Residential WM
      c. DHCS Level 3.3 – Clinically Managed Population-Specific High-Intensity Residential Services
      d. DHCS Level 3.5 – Clinically Managed High-Intensity Residential Services
M. DMC-ODS Provider Qualifications
   1. County shall ensure that all covered services are provided by Drug Medi-Cal (DMC) certified providers.
   2. County shall ensure that DMC-certified providers meet the following requirements:
      a. Be licensed, registered, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations.
      b. Abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by DHCS.
      c. Providers shall sign an agreement with the DMC-ODS county or counties prior to rendering DMC-ODS services.

N. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
   1. In accordance with the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate under Section 1905(r) of the Social Security Act10, County shall ensure that all beneficiaries under age 21 receive all applicable SUD services needed to correct or ameliorate health conditions that are coverable under Section 1905(a) of the Social Security Act. Nothing in the DMC-ODS limits or modifies the scope of the EPSDT mandate. DMC-ODS Counties are responsible for the provision of SUD services pursuant to the EPSDT mandate.

III. Reference(s)

- Behavioral Health Information Notices: 21-075, 21-00, & 21-041
- 42 CFR §438.68; §438.206(b)(4)
- W&I Code Sections: 14197; 14059.5(a); 14184.402
- California Health and Safety Code Section 11834.015
- Social Security Act §1905
- DHCS All-Plan Letter 1801

IV. PROCEDURE

A. Initial Assessment
   1. Medi-Cal beneficiaries whose county of responsibility is a DMC-ODS county are able to receive covered and clinically appropriate DMC-ODS services consistent with the following assessment, access, and level of care determination criteria.
   2. Initial assessment for all levels of care, except for residential treatment services and narcotic treatment programs.
      a. Initial assessment may be conducted:
         i. Face-to-face
         ii. Telephone (synchronous audio-only)
         iii. Telehealth (synchronous audio and video)
         iv. In the community or home
   3. Initial assessment completed by:
      a. An LPHA
      b. A registered/certified alcohol and other drug counselor
         i. When an assessment is completed by a registered/certified counselor, an LPHA should evaluate the assessment in consultation with the registered/certified counselor who completed it.
         ii. Consultation between LPHA and registered/certified counselor may be performed.
            a. In-person
            b. Via telephone (synchronous audio-only)
            c. Via telehealth (synchronous audio and video)
         iii. Documentation of the initial assessment shall reflect consultation between LPHA and registered/certified counselor.

iv. Initial diagnosis shall be determined and documented by an LPHA.

4. Residential treatment services
   a. Prior authorization for residential and inpatient services (excluding WM services) is required within 24 hours of the prior authorization request being submitted by the provider.
   b. County shall review the Diagnostic and Statistical Manual (DSM) and ASAM Criteria to ensure that the beneficiary meets the requirements for the service.
5. Initial assessment for Narcotic Treatment Programs (NTPs)
   a. History and physical exams conducted by an LPHA at admission, pursuant to state and federal regulations, qualifies for the determination of medical necessity.
6. Timeliness and covered services during the initial assessment
   a. Beneficiaries aged 21 years and older.
      i. The initial assessment shall be completed within 30 calendar days following the first visit with an LPHA or registered/certified counselor.
      ii. Covered and clinically appropriate services may be provided during the 30-day initial assessment period.
   b. Beneficiaries under 21 years of age
      i. The initial assessment shall be completed within 60 calendar days following the first visit with an LPHA or registered/certified counselor.
      ii. Covered and clinically appropriate services may be provided during the 60-day initial assessment period.
   c. Adult beneficiaries experiencing homelessness:
      i. The initial assessment shall be completed within 60 calendar days following the first visit with an LPHA or registered/certified counselor.
      ii. The practitioner shall document that the beneficiary is experiencing homelessness and requires additional time to complete the initial assessment.
   d. Timeliness when a beneficiary withdraws from treatment prior to completion of assessment:
      i. When a beneficiary withdraws from treatment prior to completion of the assessment or establishing a diagnosis, and later returns to care, the 30-day or 60-day assessment period starts over.
7. Diagnosis During Initial Assessment (except for residential treatment services)
   a. Diagnostic determination shall be made by an LPHA.
   b. Covered and clinically appropriate services may be delivered following the first visit with an LPHA or registered/certified counselor.
   c. Covered and clinically appropriate services may be delivered before a DSM diagnosis for Substance-Related and Addictive Disorders is established. A provisional diagnosis may be used prior to establishing diagnosis.
      i. Medically necessary services may be provided for:
         a. up to 30 days for beneficiaries 21 years of age and older

b. up to 60 days for beneficiaries under the age of 21 or for beneficiaries experiencing homelessness.

d. Provisional diagnosis
   i. Provisional diagnoses are used prior to the determination of a diagnosis or in cases where suspected SUD has not yet been diagnosed.
      a. An LPHA may document and categorize a suspected SUD under "Other Specified" and "Unspecified" disorder or "factors influencing health status and contact with health services" (Z-codes).
      b. Diagnoses shall be updated by an LPHA when a beneficiary's condition changes to accurately reflect the beneficiary's needs.

B. Access Criteria AFTER Initial Assessment
   1. Beneficiaries 21 years and older
      a. A service is considered "medically necessary" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
      b. At least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.
      OR
      c. At least one diagnosis from the DSM for Substance- Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.
   2. Beneficiaries under the age of 21
      a. Receive covered and "medically necessary" services. Services are considered "medically necessary" if the service is necessary to correct or ameliorate screened health conditions (pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) under the federal statutes and regulations).
      b. Services need not be curative or completely restorative to ameliorate a substance use condition, including substance misuse and substance use disorders (SUDs). Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

C. Diagnosis AFTER Initial Assessment
   1. All diagnostic determinations shall be made by an LPHA.
   2. Covered and clinically appropriate services may be delivered following the first visit with an LPHA or registered/certified counselor.
   3. Covered and clinically appropriate services may be delivered whether or not a DSM diagnosis for Substance-Related and Addictive Disorders is established.
   4. A provisional diagnosis may be used prior to establishing diagnosis. Medically necessary services may be provided for:
      a. up to 30 days for beneficiaries 21 years of age or older

b. up to 60 days for beneficiaries under the age of 21, or for beneficiaries experiencing homelessness.

5. Provisional diagnosis
   a. An LPHA may document and categorize a suspected SUD under "Other Specified" and "Unspecified" disorder or "factors influencing health status and contact with health services" (Z-codes).
   b. Provisional diagnosis shall be updated by an LPHA to accurately reflect beneficiary needs.

D. Additional Clarification
   1. Services for covered services are reimbursable even when:
      a. Services are provided prior to determination of a diagnosis or prior to determination of whether access criteria are met, as described above.
      b. The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or
      c. The beneficiary has a co-occurring mental health disorder.
         i. Clinically appropriate and covered DMC services delivered by DMC providers are covered and reimbursable whether or not the beneficiary has a co-occurring mental health disorder.
         ii. The county shall not disallow reimbursement for clinically appropriate and covered DMC-ODS services provided during the assessment process if the assessment determines that the beneficiary does not meet the DMC-ODS Access Criteria for Beneficiaries After Assessment.
         iii. The county shall not disallow reimbursement for clinically appropriate and covered SUD prevention, screening, assessment, and treatment services due to lack of inclusion in an individual treatment plan, or lack of client signature on the treatment plan.

E. Level of Care Determination
   1. Practitioners shall use the ASAM Criteria to determine the appropriate level of SUD treatment service.
      a. For beneficiaries aged 21 year and over
         i. A full assessment using the ASAM Criteria shall be completed within 30 calendar days of the beneficiary's first visit with an LPHA or registered/certified counselor.
      b. For beneficiaries under the age of 21 or for adult beneficiaries experiencing homelessness
         i. A full assessment using the ASMA Criteria shall be completed within 60 calendar days of the beneficiary's first visit with an LPHA or a registered/certified counselor.
   2. Placement and level of care determination shall be in the least restrictive level of care that is clinically appropriate to treat the beneficiary's condition.
   3. A full ASAM assessment shall be repeated when a beneficiary's condition changes.
   4. An ASAM completed by a contracted provider may be utilized by County outpatient treatment staff if the ASAM completed by the contractor has been

signed by a LPHA and treatment staff have reviewed the ASAM and agree with the recommendations.

F. Additional Clarification
   1. Timeliness - If a beneficiary withdraws from treatment prior to completing the ASAM assessment and later returns, the time period starts over as noted above.
   2. Clinically necessary services are permissible prior to completion of a full ASAM assessment.
   3. An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services. Please note that no preliminary level of care recommendation or screening tool is a substitute for a comprehensive ASAM Criteria assessment.

G. Covered Services - Covered services are based on recommendations by an LPHA, within their scope of practice. Services shall be provided by DMC-certified practitioners. Services shall be "medically necessary".
   1. ASAM Level 0.5 - Screening, Brief Intervention, Referral to Treatment and Early Intervention Services
      a. Early intervention services are covered for beneficiaries under the age of 21. Any beneficiary under age 21 who is screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the beneficiary under age 21 is not participating in the full array of outpatient treatment services.
      b. An SUD diagnosis is not required for early intervention services.
      c. A full assessment utilizing the ASAM Criteria is not required for a beneficiary under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used.
         i. If the beneficiary under 21 meets diagnostic criteria for SUD, a full ASAM assessment shall be performed, and the beneficiary shall receive a referral to the appropriate level of care indicated by the assessment.
      d. Services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone. Nothing in this section limits or modifies the scope of the EPSDT mandate.
      e. Additional clarification:
         i. SBIRT is not a DMC-ODS benefit. Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT), commonly known as Brief Intervention, and Referral and Treatment (SBIRT) is not a DMC-ODS benefit. This is a benefit in the managed care delivery system for beneficiaries aged 11 years and older.
         ii. An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services. Please note that

no preliminary level of care recommendation or screening tool is a substitute for a comprehensive ASAM Criteria assessment.

2. ASAM Level 1 - Outpatient Treatment Services (often referred to as Outpatient Drug Free)
    a. Outpatient treatment services include the following:
        i. Assessment
        ii. Care Coordination
        iii. Counseling (individual and group)
        iv. Family Therapy
        v. Medication Services
        vi. MAT for Opioid Use Disorder (OUD)
        vii. MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
        viii. Patient Education
        ix. Recovery Services
        x. SUD Crisis Intervention Services
    b. Service hours:
        i. Beneficiaries aged 21 years and older – up to 9 hours a week
        ii. Beneficiary under the age of 21 – up to 6 hours a week
        iii. Services may exceed the maximum based on individual medical necessity.
    c. Services may be provided in person, by telehealth, or by telephone.
    d. Medication Assisted Treatment (MAT)
        i. County is required to either offer medications for addiction treatment directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving outpatient treatment services if not provided on-site (providing a beneficiary the contact information for a treatment program is insufficient).
        ii. County shall monitor the referral process or provision of MAT services.
3. ASAM Level 2.1 – Intensive Outpatient Treatment Services
    a. Intensive Outpatient Services are provided in a structured programming environment.
    b. Intensive outpatient treatment services include the following:
        i. Assessment
        ii. Care Coordination
        iii. Counseling (individual and group)
        iv. Family Therapy
        v. Medication Services
        vi. MAT for Opioid Use Disorder (OUD)
        vii. MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
        viii. Patient Education
        ix. Recovery Services
        x. SUD Crisis Intervention Services

c. Service hours:
    i. Beneficiaries aged 21 years and older - Minimum of 9 hours with maximum of 19 hours a week.
    ii. Beneficiary under the age of 21 - Minimum of 6 hours with maximum of 19 hours a week
d. Services may exceed the maximum based on individual medical necessity.
e. Services may be provided in person, by telehealth, or by telephone.
f. Medication Assisted Treatment (MAT)
    i. Provider is required to either offer medications for addiction treatment directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving outpatient treatment services if not provided on-site. Effective referral mechanism is defined as facilitating access to MAT off-site for beneficiaries if not provided on-site). Providing a beneficiary, the contact information for a treatment program is considered insufficient.
    ii. County shall monitor the referral process or provision of MAT services.

4. ASAM Level 2.5 - Partial Hospitalization Services (Optional DMC-ODS level)
    a. Partial Hospitalization Services are provided in a clinically intensive programming environment designed to address the treatment needs of beneficiaries with severe SUD requiring more intensive treatment services than can be provided at lower levels of care. Partial Hospitalization Services typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs that warrant daily monitoring or management, but that can be appropriately addressed in a structured outpatient setting.
    b. Service components include the following:
        i. Assessment
        ii. Care Coordination
        iii. Counseling (individual and group)
        iv. Family Therapy
        v. Medication Services
        vi. MAT for opioid use disorder (OUD)
        vii. MAT for alcohol use disorder (AUD) and other non-opioid SUDs
        viii. Patient Education
        ix. Recovery Services
        x. SUD Crisis Intervention Services
    c. Requires 20 or more hours of weekly intensive programming.
    d. Services may be provided in person, by synchronous telehealth, or by telephone.
    e. Medication Assisted Treatment (MAT)

i. Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (providing a beneficiary the contact information for a treatment program is insufficient).
ii. County shall monitor the referral process or provision of MAT services.

H. ASAM Levels 3.1, 3.3, & 3.5 - Residential Treatment (this section supersedes MHSUDS IN 16-042)
   1. Residential Treatment Services are provided in a short-term residential program through one of the following levels:
      a. Level 3.1 - Clinically Managed Low-Intensity Residential Services
      b. Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services
      c. Level 3.5 - Clinically Managed High Intensity Residential Services
   2. Service components:
      a. Assessment
      b. Care Coordination
      c. Counseling (individual and group)
      d. Family Therapy
      e. Medication Services
      f. MAT for OUD
      g. MAT for AUD and other non-opioid SUDs
      h. Patient Education
      i. Recovery Services
      j. SUD Crisis Intervention Services
   3. Services shall address functional deficits documented in the ASAM Criteria
      a. Services aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems.
   4. A beneficiary shall live on the premises and be considered a “short-term resident” of the residential facility where the beneficiary receives services under this DMC-ODS level of care.
   5. Services may be provided in facilities of any size.
   6. Services are driven by the beneficiary’s care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting.
   7. Residential treatment services for adults under these levels are provided by DMC-certified providers who must be licensed and enrolled in accordance with all applicable state and federal laws and regulations. This includes residential facilities licensed by DHCS, residential facilities licensed by the Department of Social Services, Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health or freestanding Acute Psychiatric Hospitals (FAPHs) licensed by Department of Public Health (DPH).
   8. Residential providers licensed by a state agency other than DHCS must be DMC-Certified.

9. DHCS Level of Care designation and/or ASAM Level of Care Certification:
    a. All facilities delivering Residential Treatment services under DMC-ODS must also be designated as capable of delivering care consistent with the ASAM Criteria.
    b. Designation is required for facilities offering ASAM levels 3.1, 3.3, 3.5.
    c. All counties with residential facilities offering levels 3.1., 3.3, and 3.5, licensed by a state agency other than DHCS, shall have an ASAM Level of Care Certification for each of the levels of care provided at the facility under the DMCS-ODS program by January 1, 2024.
10. Services may be provided in person, by telehealth, or by telephone.
    a. Most services shall be in person.
    b. Telehealth and telephone services shall be used to supplement, not replace, the in-person services and in-person treatment milieu.
11. Medication Assisted Treatment (MAT)
    a. Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (providing a beneficiary the contact information for a treatment program is insufficient).
12. County shall monitor the referral process or provision of MAT services.
13. Length of Stay
    a. The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard "cap" on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Beneficiaries shall be transitioned to appropriate levels of care as medically necessary.
    b. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

I. ASAM Levels 3.7 Medically Monitored Inpatient Services & 4.0 - Medically Managed Intensive Inpatient Services (this section supersedes MHSUDS IN 16-042)
    1. County may voluntarily cover and receive reimbursement through DMC-ODS program for inpatient ASAM Levels 3.7 and 4.0 delivered in general acute care hospitals, Freestanding Acute Psychiatric Hospitals (FAPHs) or Chemical Dependency Recovery Hospitals (CDRHs). Regardless of whether County covers these levels of care, the County must have a clearly defined referral mechanism and care coordination for these levels of care. Additional information can be found on the DHCS All-Plan Letter 18-001 which clarifies coverages of voluntary inpatient detoxification through the Medi-Cal Fee-for-Service program.
    2. Service components:
        a. Assessment
        b. Care Coordination
        c. Counseling (individual and group)
        d. Family Therapy
        e. Medication Services
        f. MAT for OUD
        g. MAT for AUD and other non-opioid SUDs

h. Patient Education
i. Recovery Services
j. SUD Crisis Intervention Services

3. Services shall address functional deficits documented in the ASAM Criteria
   a. Services aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems.
4. A beneficiary shall live on the premises and considered a "short-term resident" of the inpatient facility where the beneficiary receives services under this DMC-ODS level of care.
   a. Treatment services under these levels are provided by DMC-certified providers who must be licensed and enrolled in accordance with all applicable state and federal laws and regulations. This includes residential facilities licensed by DHCS, residential facilities licensed by the DHCS, residential facilities licensed by the Department of Social Services, Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health or freestanding Acute Psychiatric Hospitals (FAPHs) licensed by Department of Public Health (DPH).
5. Services may be provided in person, by telehealth, or by telephone.
   a. Most services shall be in person.
   b. Telehealth and telephone services shall be used to supplement, not replace, the in-person services and in-person treatment milieu.
6. Medication Assisted Treatment (MAT)
   a. Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (providing a beneficiary the contact information for a treatment program is insufficient).
   b. County shall monitor the referral process or provision of MAT services.
7. Services are driven by the beneficiary's care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting.
8. Length of Stay
   a. The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard "cap" on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Beneficiaries shall be transitioned to appropriate levels of care as medically necessary.
   b. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

J. Narcotic Treatment Program (this section supersedes MHSUDS IN 16-048)
1. Narcotic Treatment Program (NTP), also described in the ASAM Criteria as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to beneficiaries covered under the DMC-ODS formulary. NTPs shall comply with all federal and

state NTP licensing requirements. If the NTP cannot comply with all federal and state NTP requirements, then the NTP must assist the beneficiary in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. NTP services are provided in DHCS-licensed NTP facilities pursuant to the California Code of Regulations, title 9, Chapter 4, and Title 42 of the Code of Federal Regulations (CFR).

2. NTPs are required to administer, dispense, or prescribe medications to beneficiaries covered under the DMC-ODS formulary including:
    i. Methadone
    ii. Buprenorphine (transmucosal and long-acting injectable)
    iii. Naltrexone (oral and long-acting injectable)
    iv. Disulfiram
    v. Naloxone
    vi. If the NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP must prescribe the medication for dispensing at a pharmacy or refer the beneficiary to a provider capable of dispensing the medication.
    vii. Service components:
        i. Assessment
        ii. Care Coordination
        iii. Counseling (individual and group)
            a. The NTP shall offer the beneficiary a minimum of fifty (50) minutes of counseling services per calendar month.
            b. Counseling services may be provided in-person, by telehealth, or by telephone.
        iv. Family Therapy
        v. Medical Psychotherapy
        vi. Medication Services
        vii. MAT for OUD
        viii. MAT for AUD and other non-opioid SUDs
        ix. Patient Education
        x. Recovery Services
        xi. SUD Crisis Intervention Services
        xii. Medical evaluation for methadone treatment
            a. Medical history
            b. Laboratory tests
            c. Physical exam
            d. Medical evaluation must be conducted in-person.

K. Withdrawal Management (WM) Services
1. WM services are provided as a part of a continuum of care to beneficiaries experiencing withdrawal in the following outpatient, residential, and inpatient settings. The beneficiary shall be monitored during the detoxification process. Services are urgent and provided on a short-term basis.

2. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing WM. Service activities focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where beneficiary can receive comprehensive treatment services.
    a. Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision).
    b. Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting).
    c. Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting).
        i. This is considered a residential level of care and therefore requires the facility to be designated as capable of delivering care consistent with ASAM Criteria.
        ii. A DHCS level of care designation and/or an ASAM Level of Care Certification is required.
    d. Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits).
    e. Level 4.0-WM: Medically managed intensive inpatient withdrawal management (Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability).
3. Service components for outpatient, residential, and inpatient settings:
    a. Assessment
    b. Care Coordination
    c. Medication Services
    d. MAT for OUD
    e. MAT for AUD and other non-opioid SUDs
    f. Observation
    g. Recovery Services
4. Care transitions to facilitate additional services or transition to a comprehensive treatment program.
    a. WM services are urgent and provided on a short-term basis.
    b. Practitioner shall conduct a full ASAM Criteria assessment, brief screening, or other tools to support referral to additional services as appropriate.
    c. When a client is referred to an emergency department (ED) for detoxification services, staff will complete a Detoxification Referral Form (see Attachment A) and give the form to the client to give to the medical providers when they arrive at the ED.

If a full ASAM Criteria assessment was not completed as part of the withdrawal management service episode, the receiving program shall adhere to the initial assessment timeliness requirement.

5. WM services may be provided in an outpatient, residential, or inpatient setting.
6. Medication Assisted Treatment (MAT) Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (providing a beneficiary the contact information for a treatment program is insufficient).

L. Medications for Addiction Treatment (also known as Medication-Assisted Treatment or MAT)
   1. Medications for addiction treatment include all medications and biological products Food and Drug Administration (FDA) approved to treat Alcohol Use Disorder (AUD), Opioid Use Disorder (OUD), and any SUD.
      a. Methadone
      b. Buprenorphine (transmucosal and long-acting injectable)
      c. Naltrexone (oral and long-acting injectable)
      d. Disulfiram
      e. Naloxone
   2. Service components:
      a. Assessment
      b. Care Coordination
      c. Counseling (individual and group)
      d. Family Therapy
      e. Medication Services
      f. Patient Education
      g. Recovery Services
      h. SUD Crisis Intervention Services
      i. Withdrawal Management Services
   3. MAT may be provided in clinical or non-clinical settings.
   4. MAT may be delivered as a standalone service.
   5. Additional clarification on MAT
      a. DMC -ODS counties shall ensure all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanism to the most clinically appropriate MAT service for the beneficiary with SUD diagnoses that are treatable with medication or biological products.
         i. Effective referral mechanism is defined as facilitating access to MAT off-site for beneficiaries if not provided on-site.
         ii. Providing a beneficiary, the contact information for a treatment program is not considered sufficient.
         iii. An appropriate facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary shall be made whether or not the provider seeks reimbursement through DMC-ODS.
         iv. Counties shall monitor the referral process or provision of MAT services.

b. The required MAT medications were expanded to include all medications and biological products Food and Drug Administration (FDA)-approved to treat substance use disorders.
c. DMC-ODS counties have the option to cover drug product costs for MAT when the medications are purchased and administered or dispensed outside of the pharmacy or NTP benefit.
    i. This means county pays for cost for MAT medications purchased by providers and administered or dispensed on site or in the community and billed to the county DMC-ODS plan.
    ii. If the DMC-ODS county elects the above option could reimburse providers for the medications, such as naloxone, trans-mucosal buprenorphine, and/or long-acting injectable medications (such as buprenorphine or naltrexone), administered in DMC facilities and non-clinical or community settings.
d. DMC-ODS counties who do not choose to cover the drug product costs for MAT outside of the pharmacy or NTP benefit, DMC-ODS counties are still required to cover the drug product costs for MAT services even when provided by DMC-ODS providers in non-clinical settings and when provided as a stand-alone service.
e. All medications and biological produces utilized to treat SUDs, including long-acting injectables, continue to be available through the Medi-Cal pharmacy benefit without prior authorization and can be delivered to provider offices by pharmacies.
f. Beneficiaries needing or using MAT must be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in the program.
g. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a beneficiary who declines counseling services.
h. For beneficiaries with a lack of connection to psychosocial services, more rigorous attempts at engagement in care may be indicated, such as using different evidence-based practices, different modalities (e.g., telehealth), different staff, and/or different services (e.g., peer support services).
i. If the DMC-ODS provider is not capable of continuing to treat the beneficiary, the DMC-ODS provider must assist the member in choosing another MAT provider, support continuity of care and facilitate a warm hand-off to ensure engagement.

M. Peer Support Services (this section of the information notice supersedes MHSUDS IN 17-008) Implemented as a County Option Effective July 1, 2022
    1. Services are provided by Certified Peer Support Specialists
        1. A Peer Support Specialist is an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification.
        2. A Peer Support Specialist must meet all other applicable California state requirements, including ongoing education requirements.

3. Peer Support Specialists must provide services under the direction of a Behavioral Health Professional. “Under the direction of" means that the individual directing service is acting as a clinical team leader, providing direct or functional supervision of service delivery, or review, approval and signing of client plans. An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the service provided. Services are provided under the direction of a physician; a licensed or waivered psychologist; a licensed, waivered or registered social worker; a licensed, waivered or registered marriage and family therapist; a licensed, waivered or registered professional clinical counselor, or a registered nurse (including a certified nurse specialist, or a nurse practitioner).
    i. Behavioral Health Professionals must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of DMC-ODS or Specialty Mental Health Services.
    ii. Peer Support Specialists may be supervised by a Peer Support Specialist Supervisor who must meet applicable California state requirements.
4. Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals.
5. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. Beneficiaries may concurrently receive Peer Support Services and services from other levels of care.
6. Peer Support Services are based on a plan of care approved by a Behavioral Health Professional (see definition of Behavioral Health Professional above; this term is specific to the administration of Peer Support Services). Services may be provided with the beneficiary or in collaboration with significant support person(s).
    a. Services may include contact with family members or other people supporting the beneficiary (defined as “collaterals”) if the purpose of the collateral’s participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.
7. Service components
    a. Educational Skill Building Groups - providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills in order to help the beneficiary achieve desired outcomes. These groups promote skill building for the beneficiaries in the

areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

b. Engagement services - activities and coaching led by Peer Support Specialists to encourage and support beneficiaries to participate in behavioral health treatment. Engagement may include supporting beneficiaries in their transitions between levels of care and supporting beneficiaries in developing their own recovery goals and processes.

c. Therapeutic Activity - a structured non-clinical activity provided by Peer Support Specialists to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

8. Peer Support Services are delivered and claimed as a standalone service.
9. Services may be provided in a clinical or non-clinical setting.

N. Recovery Services

1. Recovery services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level with emphasis on the beneficiary as the central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management.
2. Service components:
   a. Assessment
   b. Care Coordination
   c. Counseling (individual and group)
   d. Family Therapy
   e. Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the beneficiary's SUD.
   f. Relapse Prevention, which includes interventions designed to teach beneficiaries with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary's SUD.
3. Services may be provided based on the beneficiary's self-assessment or provider assessment of relapse risk.
4. Diagnosis of "remission" is not required to receive Recovery Services.
5. Services may be provided concurrently with MAT services, including NTP services.
6. Services may be provided immediately after incarceration with a prior diagnosis of SUD.
7. Services may be provided in person, by telehealth, or by telephone.

8. Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care described.

O. Care Coordination (this section supersedes in part MHSUDS IN 17-045 regarding the Healthcare Common Procedure Coding System (HCPCS) codes for claiming Case Management).
   1. Care coordination was previously referred to as "case management" for the years 2015-2021.
   2. Care coordination shall be provided in conjunction with all levels of treatment.
   3. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level.
   4. Service components include one of more of the following:
      a. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
      b. Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
      c. Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
   5. Care Coordination may also be delivered and claimed as a standalone service in a DMC-ODS County.
   6. Services can be provided in clinical or non-clinical settings, including the community.
   7. Services may be provided in-person, by telehealth, or by telephone.
   8. Care coordination services shall be provided with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness.

P. Clinician Consultation (this section supersedes, in part, MHSUDS IN 17-045 regarding the Healthcare Common Procedure Coding System (HCPCS) codes for claiming Physician Consultation).
   1. Clinician consultation is not a direct service provided to a beneficiary.
   2. Clinician Consultation replaces and expands the previous "Physician Consultation" service referred to during the years 2015-2021.
   3. Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. Clinician consultation:
      a. Includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific beneficiaries.

b. Consists of DMC-ODS LPHAs consulting with other LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists, to support the provision of care.

4. County may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services.
5. Clinical consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems.

Q. DMC-ODS Financing

1. January 1, 2022, through June 30, 2023
   a. For claiming federal financial participation (FFP), County will certify the total allowable expenditure incurred in providing the DMC-ODS waiver services provided through county-operated providers (based on actual cost, consistent with cost allocation methodology if warranted), contractor fee-for-service providers, or contracted managed care plans (based on actual expenditures).
2. July 1, 2023, and ongoing
   a. DHCS will use intergovernmental transfers from all participating counties to finance the non-federal share of all DMC-ODS payments. County will receive a monthly allocation from the local revenue fund 2011 (2011 Realignment) that is restricted to providing Medi-Cal Specialty Mental Health Services, Drug Medi-Cal services, and other non-Medi-Cal SUD services. County shall first meet the needs of Medi-Cal beneficiaries before spending these restricted funds on non-Medi-Cal services. County shall make monthly transfers to DHCS from these and any other funds eligible under federal law or federal Medicaid reimbursement to finance the non-federal share of all DMC-ODS payments.

R. External Quality Review

1. County shall include in their implementation plan a strategy and timeline for meeting external quality review requirements (438.310-370).

S. Responsibilities of DMC-ODS Counties for DMC-ODS Benefits

The responsibilities of DMC-ODS Counties for the DMC-ODS benefit shall be included in each DMC-ODS County's intergovernmental agreement with DHCS and shall require the DMC-ODS Counties to comply with the following:

1. Selective Provider Contracting Requirements for DMC-ODS Counties (this section of the information notice supersedes MHSUDS IN 19-018)
   a. DMC-ODS Counties select the DMC-certified providers with whom they contract to establish their DMC-ODS provider networks.
   b. DMC-certified providers that do not receive a DMC-ODS County contract cannot receive a direct contract with the State to provide services to residents of DMC-ODS Counties.
2. Contract Denial and Appeal Process
   a. Counties shall serve providers that apply to be a contract provider but are not selected a written decision including the basis for the denial.

b. Any solicitation document utilized by counties for the selection of DMC providers must include a protest provision. Counties shall have a protest procedure for providers that are not awarded a contract. The protest procedure shall include requirements outlined in the State/County contract. Providers that submit a bid to be a contract provider, but are not selected, must exhaust the county's protest procedure if a provider wishes to challenge the denial to DHCS. If the county does not render a decision within 30 calendar days after the protest was filed with the county, the protest shall be deemed denied and the provider may appeal the failure to DHCS. A provider may appeal to DHCS as outlined in Enclosure 4.

3. Residential and Inpatient Treatment Provider
   a. DMC-ODS counties will be responsible for ensuring and verifying that DMC-ODS residential treatment providers licensed by a state agency other than DHCS obtain an ASAM LOC Certification effective January 1, 2024. By January 1, 2024, all providers delivering Residential Treatment services Levels 3.1, 3.3, or 3.5 billed to DMC-ODS must have either a DHCS LOC Designation and/or an ASAM LOC Certification.
4. Access
   a. Each DMC-ODS County must ensure that all required services covered under the DMC-ODS are available and accessible to enrollees of the DMC-ODS in accordance with the applicable state and federal time and distance standards for network providers developed by the DHCS, including those set forth in 42 CFR 438.68, and W&I Section 14197 and any Information Notices issued pursuant to those requirements.
   b. Access to medically necessary services, including all FDA-approved medications for OUD, cannot be denied for beneficiaries meeting criteria for DMC-ODS services nor shall beneficiaries be put on wait lists. DMC-ODS beneficiaries shall receive services from DMC-certified providers. All DMC-ODS services shall be furnished with reasonable promptness in accordance with federal Medicaid requirements and as specified in the State/DMC-ODS County Intergovernmental Agreement.
   c. If the DMC-ODS network is unable to provide medically necessary covered services, the DMC-ODS County must adequately and timely cover these services out-of-network for as long as the DMC-ODS County's network is unable to provide them.
5. Authorization Policy for Residential/Inpatient Levels of Care
   a. DMC-ODS Counties shall provide prior authorization for residential and inpatient services (excluding withdrawal management services) within 24 hours of the prior authorization request being submitted by the provider. DMC-ODS Counties will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service.
6. Authorization Policy for Non-Residential/Inpatient Levels of Care
   a. DMC-ODS Counties may not impose prior authorization or centralized DMC-ODS County-administered ASAM full assessments prior to provision of non-

residential or non-inpatient assessment and treatment services, including withdrawal management services. Brief ASAM-based screening tools may be used when beneficiaries call the DMC-ODS County's beneficiary access number to determine the appropriate location for treatment.

7. Beneficiary Access Number
   a. All DMC-ODS Counties shall have a 24/7 toll free number for both prospective and current beneficiaries to call to access DMC-ODS services. Oral interpretation services and Text Telephone Relay or Telecommunications Relay Service (TTY/TRS) services must be made available for beneficiaries, as needed.
8. DMC-ODS County of Responsibility
   a. The DMC-ODS County is responsible for ensuring that its residents with SUD receive appropriate covered treatment services. If a beneficiary is able to access all needed covered services, then the DMC-ODS County is not obligated to subcontract with additional providers to provide more choices for that individual beneficiary. However, in accordance with 42 CFR §438.206(b)(4), if the DMC-ODS County's provider network is unable to provide needed services to a particular beneficiary, the DMC-ODS County shall adequately and timely cover these services out-of-network for as long as the DMC-ODS County's network is unable to provide them.
   b. 42 CFR 438.62(b) requires that DHCS' transition of care policy ensures continued access to services during a transition from State Plan DMC to DMC-ODS or transition from one DMC-ODS county to another DMC-ODS county when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. As outlined in MHSUDS 18-051, the DMC-ODS county must allow the beneficiary to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the beneficiary would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
   c. Accordingly, the DMC-ODS County shall ensure that beneficiaries receiving Narcotic Treatment Program (NTP) services and working in or travelling to another county (including a county that does not opt-in to the DMC-ODS program) do not experience a disruption of NTP services. In accordance with 42 CFR 438.206, if the DMC-ODS county's provider network is unable to provide necessary services to a particular beneficiary (e.g., when a beneficiary travels out of county and requires daily NTP dosing), the DMC-ODS county shall adequately and timely cover these services out-of-network for the beneficiary, for as long as the DMC-ODS county's provider network is unable to provide them. In these cases, the DMC-ODS county shall coordinate and cover the out-of-network NTP services for the beneficiary. If a beneficiary working in or travelling to another county is not able to receive medically necessary DMC-ODS services, including NTP services, without

paying “out of pocket”, the DMC-ODS county of responsibility has failed to comply with the requirements contained in 42 CFR 438.206.

T. If a beneficiary moves to a new county and initiates an inter-county transfer, the new county is immediately responsible for DMC-ODS treatment services and can claim reimbursement from DHCS through the Short Doyle Medi-Cal System, as of the date of the inter-county transfer initiation. Please see BHIN 21-032 for policy clarifications on DMC-ODS County of Responsibility.

DEFINITIONS

- Adolescent: Refers to beneficiaries under age 21.
- Assessment: Consists of activities to evaluate or monitor the status of a beneficiary’s behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards. Assessment may be initial and periodic and may include contact with family members or other collaterals if the purpose of the collateral’s participation is to focus on the treatment needs of the beneficiary. Assessment services may include one or more of the following components:
    - Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
    - Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing (laboratory testing is covered under the “Other laboratory and X-ray services” benefit of the California Medicaid State Plan).
    - Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the beneficiary’s needs, planned interventions and to address and monitor a beneficiary’s progress and restoration of a beneficiary to their best possible functional level.
- Family Therapy: A rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the beneficiary’s recovery as well as the holistic recovery of the family system. Family members can provide social support to the beneficiary and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of this service, but the service is for the direct benefit of the beneficiary.
- Group Counseling: Consists of contacts with multiple beneficiaries at the same time. Group Counseling focuses on the needs of the participants. Group counseling shall be provided to a group that includes 2-12 individuals.
- Individual Counseling: Consists of contacts with a beneficiary. Individual counseling can include contact with family members or other collaterals if the purpose of the

collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals.

- Medical Psychotherapy: A counseling service to treat SUDs other than OUD conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the beneficiary.
- Medication Services: Includes prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication Services does not include MAT for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and other Non-Opioid Substance Use Disorders. Medication Services includes prescribing, administering, and monitoring medications used in the treatment or management of SUD and/or WM not included in the definitions of MAT for OUD or MAT for AUD services.
- Medications for Addiction Treatment (also known as Medication Assisted Treatment (MAT)) for Opioid Use Disorders (OUD): Includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders. MAT for OUD may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed below in the "Levels of Care" section.
- "Patient Education": education for the beneficiary on addiction, treatment, recovery and associated health risks.
- Prescribing and monitoring MAT for OUD: prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT for OUD.
- SUD Crisis Intervention Services: Consists of contacts with a beneficiary in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the beneficiary's immediate situation and be provided in the least intensive level of care that is medically necessary to treat their condition.
- Withdrawal Management Services: Provided to beneficiaries when medically necessary for maximum reduction of the SUD symptoms and restoration of the beneficiary to their best possible functional level.
  - Observation: the process of monitoring the beneficiary's course of withdrawal. Observation is conducted at the frequency required by applicable state and federal laws, regulations, and standards. This may include but is not limited to observation of the beneficiary's health status.

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## V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 2/6/2023 | All | Adopted |
| 5/8/2023 | IV. | Updates to level of care determination and withdrawal management services procedures |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *05/08/2023* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 3.20 Medical Necessity and Authorization of Specialty Mental Health Services

## I. PURPOSE

- To operationally define medical necessity criteria
- To clarify how Specialty Mental Health Services (SMHS) are authorized
- To describe SLOBHD's utilization management (UM) and utilization review (UR) processes

## II. SCOPE

Applies to authorization of outpatient SMHS for all SLOBHD staff and contracted providers

## III. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) will follow all applicable regulations and contract provisions when determining medical necessity for SMHS and when authorizing treatment. SLOBHD will place appropriate limits on services based on medical necessity and will provide or arrange/pay for services in an amount, duration, and scope reasonably needed to achieve their purpose. SLOBHD will authorize services for beneficiaries with ongoing or chronic conditions in a manner that reflects the beneficiary's ongoing need for services and supports.

## IV. REFERENCES

- Code of Federal Regulations, Title 42, §438.210, §438.330, §438.608
- California Code of Regulations, Title 9, §1830.205, §1830.210
- California Code of Regulations, Title 22, §51340(e-f)
- Welfare & Institutions Code, §14197.1
- Contract with Department of Health Care Services (DHCS), Exhibits A, B
- MHSUDS Information Notice 17-040
- MHSUDS Information Notice 19-020
- MHSUDS Information Notice 19-026
- SLOBHD Policy & Procedure 3.30 *Notice of Adverse Benefit Determination*
- SLOBHD Policy & Procedure 3.21 *Authorization of Out-of-Plan Services for Youth*
- SLOBHD Policy & Procedure 3.22 *Concurrent Authorization of Psychiatric Inpatient Services*
- SLOBHD Policy & Procedure 3.23 *Availability, Timeliness, and Array of Services*
- SLOBHD Policy & Procedure 5.00 *Outpatient Mental Health Assessment*
- SLOBHD Documentation Guidelines
- SLOBHD Implementation Plan
- SLOBHD Assessment Practice Guidelines

V. DEFINITIONS

- Medical Necessity is a set of criteria established in California Code of Regulations, Title 9, §1830.205 that help determine whether a beneficiary qualifies to receive outpatient SMHS. Beneficiaries who do not meet medical necessity criteria, but who could benefit from non-Specialty Mental Health Services, will be referred to CenCal Health for services provided by the Managed Care Plan.

- Assessment Start Date is the date the client keeps a first assessment appointment. This marks the beginning of the Assessment Process.

- Assessment End Date is the date the clinician completes and signs the assessment form. This marks the end of the Assessment Process. The Assessment End date must be before the Treatment Start Date.

- Treatment service is a Case Management, Therapy, Rehab, Med Support, ICC, Plan Development service (any SMHS other than a 2nd Assessment or Crisis Intervention). A treatment service may be face-to-face, telephone, or telehealth and may be provided anywhere in the community.

- Treatment 1st Offered Date is the first offered treatment service after the assessment process and must be within 10 business days of the Assessment Start Date.

- Treatment Start Date is the date of the first kept treatment service

- Authorization follows a determination of medical necessity and is the process whereby SLOBHD staff and/or contract staff (when permitted by contract), in collaboration with the beneficiary, determine the specific SMHS that will be part of the beneficiary's Assessment Initial Treatment Plan (AITP) or Treatment Plan (TP) to produce the outcome necessary to treat the beneficiary's qualifying condition

- Authorization Start Date is the date the clinician has enough information to make an authorization decision. It is usually, but not always, the same as Assessment Start Date.

- Authorization End Date is the date a decision about medical necessity is made. It must be within 5 business days of the Authorization Start Date and is evidenced by signature of LMHP/RA and evidence of client participation and agreement with the AITP.

- Closed Out Date is the date either the Assessment Process or the Treatment process ended due any of the following Closure Reasons:
  - 01 = Beneficiary did not accept any offered assessment dates
  - 02 = Beneficiary accepted, but did not attend assessment appointment
  - 03 = Beneficiary attended assessment, but did not complete assessment process
  - 04 = Beneficiary completed assessment process, but declined offered treatment
  - 05 = Beneficiary accepted, but did not attend initial treatment appointment
  - 06 = Beneficiary did not meet medical necessity criteria.

- Licensed Mental Health Professional (LMHP) is a Physician; licensed, waivered, or registered Psychologist; LMFT/LCSW/LPCC; Nurse Practitioner; or Registered Nurse.

- A Registered Associate (RA) is an individual who is registered with the Board of Behavioral Sciences and is working toward licensure as an LPCC, LMFT, or LCSW.

VI. PROCEDURE

A. Medical Necessity
Medical Necessity is determined following a comprehensive assessment of needs and strengths by an appropriately qualified staff member. See SLOBHD Policy & Procedure 5.00 *Outpatient Mental Health Assessment* for detail. The Assessment process begins with the first kept assessment service and ends when the assessment form is written and signed by a LMHP or Registered Associate working under the direction of an LMHP.

1. Diagnostic Criteria:

   a. The client must have an included mental health diagnosis
   b. See the most current list of included and excluded diagnoses, which are established in SLOBHD's contract with DHCS. The current included list contains DSM 5 F Codes and some additional diagnoses found in ICD 10, but not DSM 5.

      ❖ *A client with an included diagnosis may receive SMHS if an excluded diagnosis is also present; however, SMHS always focus on treating the symptoms and impairments that result from the included diagnosis*

2. Functional Impairment Criteria: (One of the following must be true as a result of the diagnosis)

   a. Client has a significant impairment in an important area of life functioning
      ❖ *The Child Assessment of Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA) rating scales are imbedded in many assessments to improve consistency in rating degree of impairment.*

      ❖ *The CANS or ANSA ratings for life domains or functional impairment will be rated severe due to mental illness when there is a significant impairment in that area*

      a. Client has a probability of significant deterioration in an important area of life functioning

      ❖ *The assessment must clearly document the reason the clinician believes the client will likely deteriorate to a significant level of impairment if this criterion is used to document medical necessity. CANS or ANSA ratings may be moderate when accompanied by an explanation that supports the clinician's belief that deterioration is likely without SMHS.*

      ❖ *Beneficiaries with mild to moderate levels of functional impairment are eligible for non-specialty mental health services provided by CenCal Health. Please see the current referral procedure for details.*

b. For beneficiaries under age 21: There is a reasonable probability child will not progress developmentally as individually appropriate without SMHS
   - ❖ *Documentation must specify how the beneficiary's development will be impaired without SMHS*

c. EPSDT Functional Impairment Criteria, for beneficiaries under age 21: EPSDT services are necessary to correct or ameliorate the mental illness
   - ❖ *A beneficiary may qualify for SMHS under this provision without meeting Functional Impairment criteria a-c, provided the beneficiary has a mental illness that could be corrected with the types of SMHS, including those that are EPSDT entitlements, such as TBS, IHBS, ICC, or other intensive case management services that are not available through the Managed Care Plan. Documentation must include an explanation about how the EPSDT services will help and why other level of care interventions, such as non-Specialty Mental Health Services provided by CenCal Health, would not be enough.*

3. Intervention Criteria: (All three must be true)

a. The focus of the proposed mental health intervention(s) must be to address impairments arising from the included diagnosis
   - ❖ *The interventions listed in a Treatment Plan must have a logical link to the symptoms and impairments that result from the included diagnosis. Services that target impairments from an excluded diagnosis do not support medical necessity for SMHS.*

b. There must be a reasonable expectation that the proposed interventions will significantly diminish the impairment, prevent significant deterioration in functioning, or allow a child to progress developmentally as appropriate.
   - ❖ *When used as part of the reason for denying or terminating services, this criterion is sometimes summarized as "not likely to benefit from services". The specific reasons for this conclusion must be very clearly documented in the Assessment (and NOABD) and must be based on, at minimum, recent treatment (within the last 90 days) and a current assessment of the beneficiary's motivation/readiness for change. If an unsuccessful treatment episode occurred in the more distant past, another trial of treatment is indicated before determining that the client is "not likely to benefit" from treatment now because a person's motivation and readiness for treatment may change significantly over time. Documentation of participation in treatment within the last 90 days that did not maintain or improve a beneficiary's mental health condition is required if the "not likely to benefit" criterion is used as a service denial reason.*

c. The condition would NOT be responsive to physical healthcare-based treatment.
   - ❖ *The final criterion means that physical health care-based treatment is not enough to help the beneficiary and, therefore, SMHS are necessary to improve or maintain the beneficiary's condition.*

- ❖ *Physical health care treatment includes medication and other services provided by a Primary Care Physician and includes the non-specialty mental health services provided by CenCal Health, such as office-based therapy, psychiatry, etc.*
- ❖ *If a beneficiary <u>can</u> benefit from physical healthcare-based treatment, the beneficiary will be referred for services provided by CenCal's authorized provider of non-specialty mental health services. Refer to the current referral procedure for details.*

B. Authorization

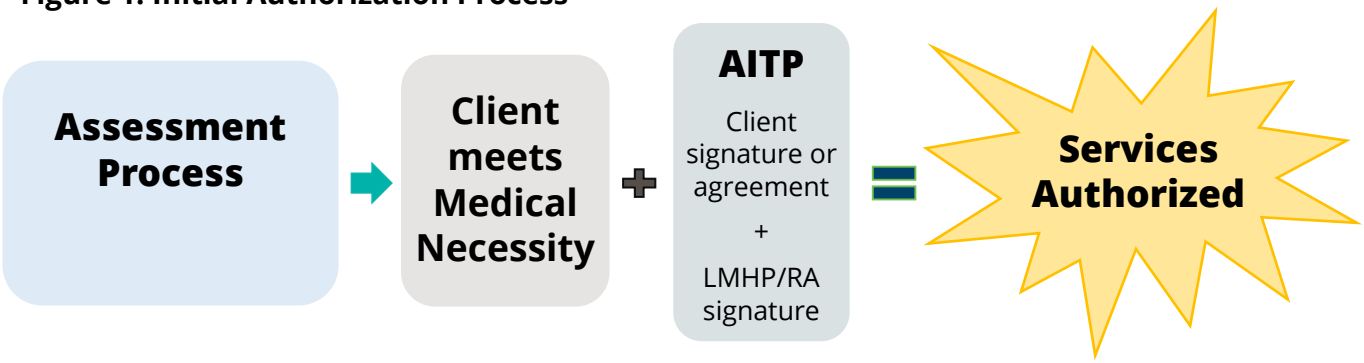
The services listed on an AITP or TP are authorized when the TP contains:

- Documentation of the client's or legally authorized representative's participation and agreement with the TP (this may be a written explanation or may be evidenced by electronic or hardcopy signature)

AND

- Signature of a Licensed Mental Health Professional (LMHP) or Registered Associate (RA)

**Figure 1: Initial Authorization Process**




1. Some services do not need to be on a TP in order to be provided and claimed, including Assessment, Plan Development, Crisis Intervention, and Crisis Stabilization. Due to limitations in EHR functionality, Assessment and Plan Development are added to all SLOBHD TPs to make Progress Noting easier, but the services do not require authorization and are claimable whether they are on the TP or not. Crisis services are not added to the TP, because they are unplanned.

2. Other services may be provided and claimed after they are included on a TP, but before the TP contains the signatures discussed above. These services include urgent Medication Support (the progress note must describe the urgency), Case Management/Intensive Care Coordination (limited to referral/linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services).

3. Routine SMHS not mentioned in 1 or 2 above must only be provided and claimed after they are authorized on a TP that contains evidence of client participation and agreement AND the signature of an LMHP/RA. All the services on the TP are authorized for the duration of the TP, which is up to one year (unless the TP specifies a shorter duration). The authorization begin date is the later of the two elements – client signature/agreement or LMHP/RA signature.

4. Typically, a Program Supervisor or designee reviews, signs, and "Final Approves" TPs, but the LMHP's/RA's signature authorizes services

5. When the assessment results in a determination that the client DOES NOT meet medical necessity and will be referred to CenCal Health for non-SMHS, the assessment services and a Case Management service to make the referral can be documented in an Interim Services Log (ISL)

C. Prior Authorization

1. Some services require pre-authorization. These include:
   a. Day Treatment (Intensive and Rehabilitative)
   b. Therapeutic Behavioral Services (TBS)
   c. Intensive Home-Based Services (IHBS)
   d. Therapeutic Foster Care (TFC)

2. Prior Authorization means that, before these services may be provided or claimed, the beneficiary must first have an assessment to determine medical necessity for SMHS, followed by a separate authorization process to add these services to a TP or to a specialized TP.

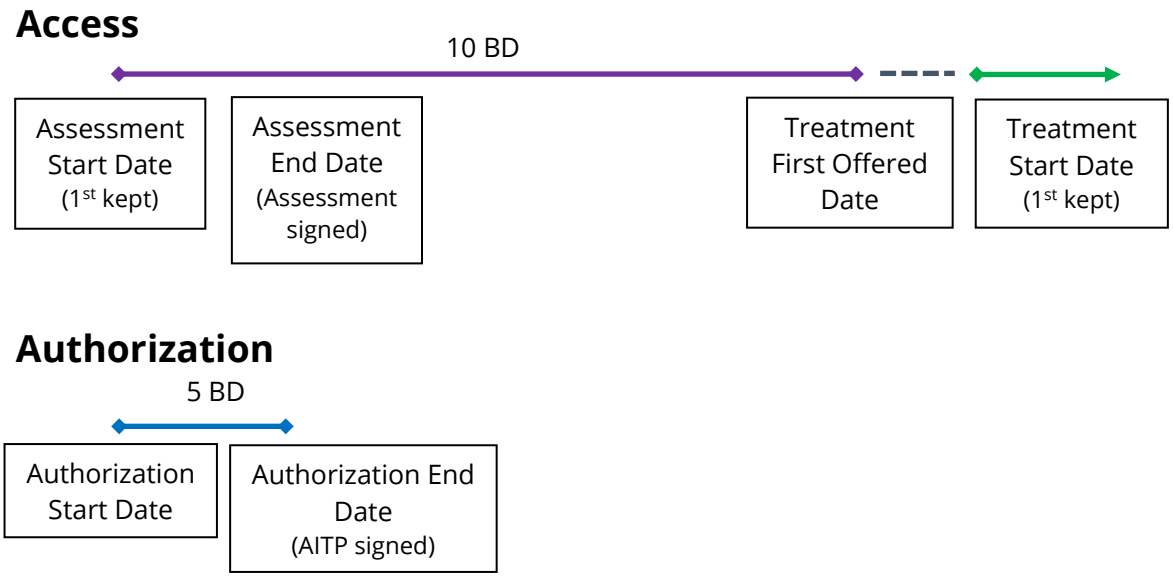
   a. IHBS and TFC are added to the TP after a Child Family Team (CFT) determines that they are medically necessary. Note: When IHBS or TFC are authorized, the AITP no longer is detailed enough and an annual TP is required. See Documentation Guidelines for additional detail.
   b. TBS requires a separate TBS assessment and TBS TP.

3. See TBS, Day Treatment, and Continuum of Care Reform policies for detail.

D. Timelines for Authorization

**Note:** Access timeliness and Authorization timeliness are related, but separate processes. See SLOBHD Policy & Procedure 3.23 *Availability, Timeliness, and Array of Services* for detail about access timelines.

**FIGURE 2: OVERLAP OF ACCESS AND AUTHORIZATION TIMELINES**




1. Standard Authorization:
    a. The authorization process starts when the LMHP/RA completing the assessment has enough information to reasonably make a medical necessity determination. This will typically, but not always, be the date of the first assessment service.
    b. An authorization decision must be made as expeditiously as the beneficiary's mental health condition requires, not to exceed five (5) business days.
    c. As described above, the services listed on an AITP are authorized when the AITP contains documentation of the client's (or legally authorized representative's) participation and agreement with the plan (this may be an explanation or may be evidenced by signature) AND signature of an LMHP/RA.

2. Expedited Authorization:
    a. When the assessing LMHP/RA determines that following the standard timeframe could seriously jeopardize the consumer's life, health or ability to attain, maintain or regain maximum function, the LMHP/RA must make an expedited authorization decision within 72 hours of receipt of request

3. Extensions: An extension of up to 14 additional calendar days is possible if:
    a. The beneficiary requests an extension
    b. The assessing therapist determines that an extension to gather additional information is in the beneficiary's best interest and documents the basis for this decision in a progress note. If the therapist makes this determination, a Notice of Adverse Benefit Determination (Authorization Delay) must be sent to the beneficiary on the same date the decision to extend the authorization period is made.

E. Post Assessment / Authorization Follow-up

1. After completing the assessment and making an authorization decision, the assessing clinician will contact the client to schedule treatment services or to discuss next steps (i.e., referral to a lower level of care or other services)
2. The first treatment service offer date must be within 10 business days of the assessment start date
3. When needed, the assessing clinician will complete a NOABD per current policy

F. Site Approval Team (SAT) or Program Supervisor Review:

1. After completing the assessment and making an authorization decision, the LMHP/RA will route the assessment to the program or clinic where treatment will occur
2. The Program Supervisor will review the assessment and TP to confirm that the record effectively documents medical necessity for SMHS and conforms to SLOBHD guidelines
3. The Program Supervisor will consult with the assessing LMHP/RA and/or the treatment team about the client's needs and available services
4. The Program Supervisor or designee will summarize the results of the consultation on the assessment and is responsible for assigning treatment team members to provide the services on the TP
5. If there is disagreement about whether SMHS are medically necessary, the treatment team and LMHP/RA who completed the assessment will attempt to gather additional information as needed.
6. The SLOBHD Medical Director will be available to assist with resolution of any disagreements not resolved at the clinic or program site

G. Consistency of Treatment Authorizations

1. Program Supervisor/SAT review described above will ensure consistency in authorization decisions
2. The Quality Support Team (QST) clinician will periodically select a sample of completed assessments for review and comparison

H. Notice of Adverse Benefit Determination (NOABD)

1. If services requested by a Medi-Cal beneficiary or provider on behalf of a beneficiary are denied or modified at any point in the assessment or authorization process, an LMHP designated by the Program Supervisor immediately completes and mails an

NOABD per the procedure outlined in P&P 3.30 *Notice of Adverse Benefit Determination*

2. An NOABD is issued anytime a beneficiary is referred to a lower level of care.

I. Ongoing Treatment Authorization:

1. See the current Documentation Guidelines for Annual Assessment Update and TP content, renewal, and signature requirements
2. As with the AITP, the services contained in a TP are authorized by documentation of the client's participation in developing and agreement with the TP and the signature of an LMHP/RA and the TP is valid for up to a year, as specified in the TP
3. In most instances, a Program Supervisor will review and sign the TP to ensure consistency in authorization ongoing treatment decision

J. Crisis Residential Treatment Services and Adult Residential Treatment Services

1. Crisis Residential Treatment (CRT) and Adult Residential Treatment (ART) are subject to concurrent review
2. In most instances, SLOBHD will provide an initial referral that will specify the duration of the initial authorization
3. Subsequent authorization periods must be completed concurrently with the beneficiary's stay and based on beneficiary's continued need for services
4. When a CRT or ART provider submits an authorization request (which may be a TP), SLOBHD staff will review and authorize medically necessary services within 24 hours of receipt of request
5. CRT or ART services will not be discontinued until the beneficiary's treating provider has been notified of the decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary.
6. If SLOBHD denies or modifies the request for authorization, SLOBHD must issue an NOABD to the provider and beneficiary prior to discontinuing services

K. Retrospective Authorization

1. SLOBHD may make retrospective authorizations under certain circumstances
2. Examples include:
    a. When an individual was denied a service due to Medi-Cal ineligibility, but later becomes retroactively eligible
    b. When SLOBHD discovers a Medi-Cal eligibility error in MEDS
    c. When a beneficiary's primary or other health care payor makes a payment decision that affects Medi-Cal responsibility

3. SLOBHD will notify the provider and beneficiary within 30 days of receiving information needed to make a retrospective authorization decision

L. Utilization Review (UR)

1. UR is the process whereby SLOBHD staff review documentation to determine if the documentation meets SLOBHD's and/or DHCS' documentation/medical necessity standards for claiming. UR is retrospective, whereas authorization processes (sometimes called Utilization Management or UM) described in this Policy are prospective.
2. UR includes an examination of under/over claiming, documentation timeliness, proper coding, and quality
3. SLOBHD will reserve the right and responsibility to review documentation and to make determinations about whether documentation supports claiming for payment. At times this process will require services to be voided, paid back to the payor, and recouped from the provider.
4. SLOBHD will provide providers and beneficiaries with the applicable NOABD when disallowing a service so that SLOBHD's Problem Resolution Processes are available to any affected party

M. Additional Administrative Requirements

1. SLOBHD will make providers aware of documentation requirements and UR processes at the time of contracting and contract renewal.
2. SLOBHD will post documentation requirements and policies related to authorization on its public website so that providers and beneficiaries may access information related to authorization
3. SLOBHD will review its authorization processes and policy on at least an annual basis and will revise and repost as necessary

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VII. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/06/2014 | Medical Necessity section | Reformatted text; added clinical decision support and expanded explanations |
| 12/27/2017 | Entire Policy | Formatting |
| 09/20/2018 | V G, I, J, K<br>All | Updated language<br>Reformatting |
| 7/25/2019 | Entire Policy | Revised to comply with Managed Care Final Rule |
| Prior Approval dates: | | |
| 03/30/2009, 08/30/2010, 09/21/2012 | | |

| *Signature on file* | | *07/30/2019* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 3.21 Authorization, Documentation, Billing Process for Out-of-Plan Services (Youth)

I. PURPOSE

To describe the two processes for authorizing, arranging, or providing out-of-plan SMHS and EPSDT services for Medi-Cal eligible youth:

- Service Authorization Request (SAR) processes for Foster Care, KinGAP and Adoption Assistance Program (AAP) youth (SB 785)
- Presumptive Transfer of Medi-Cal responsibility (AB 1299)

II. POLICY

The County of San Luis Obispo Behavioral Health Department's (SLOBHD) will promptly authorize, arrange, pay for, or provide out-of-plan Specialty Mental Health Services (SMHS) and Early Periodic Screening Diagnostic and Treatment (EPSDT) services for youth with Medi-Cal who reside in out-of-home placement. When a service is medically necessary due to an emergency condition, SLOBHD will provide it and/or pay for the service without prior authorization.

III. REFERENCE

- California Code of Regulations, Title 9, Chapter 11, §1830.220(b)(4)(A)
- Welfare and Institutions Code, §14717.1, §11376, and §16125
- DHCS Informational Notices 18-027, 17-032, 06-18, 08-24 and 09-06
- Contract between DHCS and SLOBHD
- SLOBHD Policy 6.11, *Continuum of Care Reform*
- SLOBHD Policy 3.23, *Availability, Timeliness and Array of Services*

IV. PROCEDURE:

A. Point of Contact

The point of contact for all out-of-plan authorization and notification will be the Managed Care Program Supervisor or designee at:

Phone: 1 (800) 838-1381
Email: MH_Managed-Care-Clinicians@co.slo.ca.us
Website at: www.slocounty.ca.gov/Behavioral Health//Managed-Care

B. SB 785 authorization for youth with SLO Medi-Cal who are placed in another county

1. When presumptive transfer does not apply or is waived (i.e., for AAP, KinGAP, etc.), the prospective provider or county MHP will fax a Service Authorization Request (SAR) to the Managed Care Program Supervisor or designee at (805) 781-1177.
   a) The Managed Care Program Supervisor or designee will: Confirm Medi-Cal responsibility in the MEDS
   b) Review, sign, and return the SAR by fax within 3 working days of receipt
   c) Maintain a file containing the SAR and supporting documents and a database to track expiration dates
2. Once completed, the county MHP or provider will fax the Client Assessment and Client Plan to the Managed Care Program Supervisor, along with a request for additional services, if medically necessary. SB 785 approved forms are required by regulation, but in no instance will needed care be denied if alternative forms that meet Medi-Cal documentation standards are used.
3. The Managed Care Program Supervisor or designee will review the supporting documentation and will authorize medically necessary services requested by the county MHP or provider. If the documentation does not establish the need for ongoing treatment, the Managed Care Program Supervisor or designee will send Notice of Adverse Benefit Determination (NOABD) to the provider and client/legally responsible person. SLOBHD staff will make an authorization decision within 3 working days of the request for services.
4. Services will be authorized for up to one-year, as medically necessary. Request for additional services will be submitted to the Managed Care Program Supervisor prior to the expiration of the previous authorization in the form of a Client Assessment Update, a Client Plan that clearly documents continued medical necessity, and a new SAR. SLOBHD periodically reviews records, including those submitted by out-of-county providers, to ensure that documentation meets medical Necessity requirements. SLOBHD will deny claims when documentation does not meet SLOBHD documentation standards. SLOBHD will notify the provider and responsible person in writing of any denial on a NOABD.
5. The provider will send claims to the SLOBHD Fiscal team for payment. If the provider is another county Behavioral Health Department, the provider will bill Medi-Cal directly for services. Services provided without authorization will be denied.

C. SB 785 authorization for youth with another county's Medi-Cal who are placed in SLO

1. When a youth with Out-of-County Medi-Cal is referred for SMHS, Managed Care staff will schedule an assessment for the youth within 10 business days of the request. The Managed Care Program Supervisor or designee will fax a SAR to the County of Responsibility to request authorization.
2. If Managed Care is informed the youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition, Managed Care will

implement a procedure for an expedited transfer within 48-hours of the youth's placement.

3. When the County of Responsibility returns the SAR, Managed Care staff will forward the approved SAR to the Health Information Technician (HIT) maintaining the client's record to scan the approved SAR into Anasazi.
4. The intake clinician will complete the Assessment, Client Plan, and SAR to request ongoing services and will forward copies to the Managed Care Program Supervisor.
5. The Managed Care Program Supervisor or designee will fax any required documentation to the County of Responsibility.
6. The Managed Care Program Supervisor or designee will maintain a database to track expiration dates and will forward the approved SAR to by the HIT maintaining the client's record for scanning.
7. The clinic HIT will run a monthly MEDS screen to verify Medi-Cal eligibility and responsibility. If eligibility changes, the HIT will notify the client's SAI and Managed Care Program Supervisor.
8. The SAI will request additional services prior to expiration of the authorization by completing an Assessment Update, Treatment Plan and SAR and then sending the forms to Managed Care. The Managed Care Program Supervisor or designee will submit the request to the County of Responsibility. If a Network Provider treats the youth, the Managed Care Program Supervisor will request the additional services.
9. The County of Responsibility will return the SAR to Managed Care, detailing the services authorized. The Managed Care Program Supervisor will notify the SAI of the authorization and the HIT will scan the SAR into Anasazi.
10. SLOBHD will provide all medically necessary services authorized by the County of Responsibility.

D. AB 1299 Presumptive Transfer from SLO <u>to</u> another county

1. When a youth with SLO Medi-Cal will be placed in another county and presumptive transfer will apply, the placing agency will notify the host county MHP contact.
2. The placing agency will fax a Presumptive Transfer Notification form to the SLOBHD Managed Care Supervisor.
3. The Managed Care Program Supervisor or designee will coordinate transfer of care and provision of records to the new provider if such records exist.

E. AB 1299 Presumptive Transfer <u>waived</u> from SLO to another county

1. When a youth with SLO Medi-Cal will be placed in another county and a waiver of presumptive transfer is requested, the placing agency will notify the host county MHP contact.
2. The placing agency will fax a Presumptive Transfer Notification form to the SLOBHD Managed Care Supervisor.

3. When the waiver is approved, SLOBHD will contract with a provider in the host county within 30 days (if a contract is not already in place) and will authorize and pay for medically necessary services. Examples of situations in which Presumptive Transfer may apply include but are not limited to STRTP placements.
4. The Managed Care Program Supervisor or designee will coordinate transfer of care and provision of records to the new provider if such records exist.

F. AB 1299 Notification of Presumptive Transfer <u>from</u> another county to SLO

1. When a youth with another County Medi-Cal will be placed in SLO and presumptive transfer will apply, the placing agency will notify the SLOBHD Managed Care Program Supervisor or designee and will arrange for records to be forwarded to SLOBHD. Those records will be used to help determine medical necessity and may be updated as needed to determine the services the youth requires, but staff are not required to complete a new assessment prior to beginning treatment, as SLOBHD will accept the existing assessment if one comes with the youth from another county.
2. The Managed Care Program Supervisor or designee will promptly schedule an appointment with a provider at the clinic closest to the youth's residence. Timely access to service requirements are the same for a presumptively transferred youth as for any SLO Medi-Cal beneficiary. See Policy 3.23 for detail regarding routine (10 business days) and urgent (96 hours for services that require preauthorization and 48 hours for those services – Assessment, Crisis, and Plan Development – that do not).
3. SLOBHD will assume responsibility for the ongoing care of the youth. The full array of SMHS and EPSDT services will be available to youth whose eligibility was presumptively transferred to SLOBHD as long as medical necessity criteria are met or until the youth returns to the originating county.
4. In situations when a foster child or youth is in imminent danger to self or others or is experiencing an emergency psychiatric condition, SLOBHD will provide SMHS immediately without prior authorization.

G. Documentation Standards and Monitoring Process

1. Managed Care will maintain tracking logs for SARs and Presumptive transfers
2. Documentation provided to SLO Medi-Cal beneficiaries in out-of-County placement must meet SLOBHD documentation standards.
3. Out-of-County Residential Treatment Centers will be notified in writing of SLOBHD's documentation requirements and billing processes when entering into a contract with SLOBHD. See the most recent Residential Treatment Center Documentation Requirements procedure for detail.
4. SLOBHD Fiscal staff will monitor contracts by conducting regular telephone and face-to-face monitoring activities. SLOBHD Quality Support Team and Managed

Care staff will conduct regular chart reviews to ensure that medical necessity criteria are met.

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V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 10/08/2015 | All | Reformatted and updated to reflect electronic process |
| 09/11/2017 | All | Added AB 1299 Procedure |
| 03/09/2018 | All | Updates regarding presumptive transfer process |
| 09/07/2018 | References, F | Added IN 18-027 and F 5 |
| Prior Approval dates: | | |
| 02/27/2009, 08/08/2011, 1/20/2012 | | |

| | | |
|---|---|---|
| *E-Signature on file* | | *02/09/2022* |
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 3.22 Medical Necessity and Concurrent Authorization of Psychiatric Inpatient Hospital Services and Psychiatric Health Facility Services

I. PURPOSE

- To define medical necessity criteria for Psychiatric Inpatient Hospital Services and Psychiatric Health Facility (PHF) Services
- To clarify how SLOBHD authorizes Psychiatric Inpatient Hospital Services
- To describe SLOBHD's concurrent authorization, also known as Utilization Management (UM), and Utilization Review (UR) processes
- To ensure access for beneficiaries who require emergency services while out-of-county or who are placed out-of-county for treatment

II. SCOPE

Applies to authorization of all out-of-county Psychiatric Inpatient Hospital Services and to acute admissions to SLOBHD's PHF for Medi-Cal beneficiaries

III. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) will follow all applicable regulations and contract provisions when determining medical necessity for Psychiatric Inpatient services and Psychiatric Health Facility services and when authorizing treatment. SLOBHD will place appropriate limits on services based on medical necessity and will provide or arrange/pay for services in an amount, duration, and scope reasonably needed to achieve their purpose. SLOBHD will authorize services for beneficiaries with ongoing or chronic conditions in a manner that reflects the beneficiary's ongoing need for services and supports. SLOBHD will not require or permit prior authorization for an emergency admission when a beneficiary meets medical necessity for admission; SLOBHD will require concurrent authorization of continued stay services.

IV. REFERENCES

- Code of Federal Regulations, Title 42, §438.210, §438.330, §438.608
- California Code of Regulations, Title 9, §1820.100 – 1820.230
- California Code of Regulations, Title 22, §77113, §77135
- Contract with Department of Health Care Services (DHCS), Exhibits A, B
- MHSUDS Information Notice 19-026
- SLOBHD Policy & Procedure 3.20 *Medical Necessity and Authorization of Outpatient SMHS*
- SLOBHD Policy & Procedure 3.30 *Notice of Adverse Benefit Determination*
- SLOBHD PHF Policy & Procedure 3.01 *PHF Crisis Services*
- SLOBHD Utilization Review Plan

V. DEFINITIONS

**Medical Necessity** is a set of criteria established in California Code of Regulations, Title 9, § 1820.205:

Admission:
(1) Must have an included DSM 5/ICD 10 diagnosis (Inpatient Included List) AND
(2) Both the following criteria:
(A) Cannot be safely treated at a lower level of care AND
(B) Requires psychiatric inpatient hospital services
1. Has symptoms or behaviors due to a mental disorder that (one or more):
a. Represent a current danger to self, others, or significant property destruction (
b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter
c. Present a severe risk to the beneficiary's physical health
d. Represent a recent, significant deterioration in ability to function
2. Require admission for one of the following:
a. Further psychiatric evaluation
b. Medication treatment
c. Other treatment that can reasonably be provided only if the patient is hospitalized

Continued stay services:
(1) Continued presence of indications that meet the admission medical necessity criteria
(2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization
(3) Presence of new indications that meet medical necessity criteria specified in (a)
(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a hospital

Additional Restrictions for PHF Admission:
California Code of Regulations, Title 22 § 77113 limits diagnoses for PHF admission:
- Major mental disorders only
- No admissions when the primary diagnosis is an Eating Disorder
- No admissions when the primary diagnosis is a Substance Use Disorder, Substance intoxication, withdrawal, or detoxification, or substance-induced delirium

California Code of Regulations, Title 22 § 77135 limits medical conditions for PHF admission:
- No admission of patients with known reportable communicable disease
- No admission of patients with injuries or diseases that require inpatient medical care.
- Admission of patients with injury or disease that would ordinarily be treated on an outpatient basis only if the facility has appropriate policies, procedures and resources to ensure the safety of other patients and staff

**Concurrent authorization** is permission from SLOBHD to a provider to deliver specific services in a specified time frame. It is an agreement to pay for those services when the written record documents that the services were medically necessary. Concurrent authorization must occur immediately upon receipt of information necessary to establish medical necessity. Concurrent authorization is prospective.

**Utilization Review (UR)** is a review of records to ensure the documentation of medical necessity so that payment decisions are consistent with SLOBHD, State, and Federal standards. UR is retrospective and is part of SLOBHD's compliance program to help prevent waste, fraud, and abuse in claiming.

VI. PROCEDURE

A. Notification of Admission

1. When an out-of-county Psychiatric Hospital admits a San Luis Obispo County resident who is a SLO Medi-Cal beneficiary for Psychiatric Inpatient Hospital Services or Psychiatric Health Facility (PHF) Services, the admitting facility must notify SLOBHD at (805) 781-4706 or 800-838-1381 as soon as possible upon admission.
   a. When a beneficiary has relocated out-of-county, SLO may not be financially responsible for the care of the beneficiary, even if the State's MEDS file lists SLO as the county of responsibility
   b. SLOBHD staff who receive notification from out-of-county facilities will ask the facility to identify the beneficiary's residence address, which will help determine the current county of responsibility
   c. In certain instances, with approval of the Staff Psychiatrist, a SLO beneficiary may be transported back to the SLO PHF for acute care. In these instances, SLOBHD will authorize acute care until transportation can be arranged.
2. Emergency psychiatric services do not require authorization for the day of admission, provided the beneficiary meets medical necessity criteria
3. When SLOBHD or SLOBHD contractor staff arrange a placement for Psychiatric Inpatient Hospital Services, the facility does NOT need to further notify SLOBHD

B. Concurrent Authorization

1. SLOBHD has entered into a participation agreement with CalMHSA to utilize a CalMHSA vendor, Acentra Health, to complete concurrent review and authorization of medically necessary inpatient psychiatric services.
2. Upon notification of admission and documentation that the beneficiary continues to meet medical necessity for inpatient psychiatric services, Acentro Health staff will provide the facility with a written concurrent authorization for one to five calendar days of service.
3. Prior to the end of any authorization period, the facility must submit clinical documentation to establish that any additional services requested by the facility are medically necessary. Continued stay days provided prior to authorization will be denied.
4. Administrative day services will be authorized when the hospital has documented having made at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status. Once five contacts have been made and documented, any remaining days within the seven consecutive day period from the day the beneficiary is placed on administrative day

status can be authorized. The hospital will not receive authorization for the days in which a contact has not been made until and unless all five required contacts are completed and documented.

C. Notice of Adverse Benefit Determination (NOABD)
   1. Acentra Health staff will issue a NOABD to the provider and to the beneficiary within 24 hours of the decision when:
      a. Payment for services will be denied or recouped
      b. When an inpatient facility requests authorization, but SLOBHD determines that the requested service is not medically necessary
   2. See SLOBHD Policy & Procedure 3.30 *Notice of Adverse Benefit Determination* for detail
   3. Care will not be discontinued until the beneficiary's treating provider has been notified of SLOBHD's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that beneficiary

D. Beneficiary and Provider Problem Resolution Processes
   1. When a provider does not agree with Acentra Health staff's concurrent authorization decision, the provider and/or the beneficiary may appeal the decision
   2. The NOABD will detail the appeal and Fair Hearing processes available to the provider and beneficiary

VII. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 06/12/2019 | New P&P | Prior policy focused on retrospective review of TAR and Short Doyle claims, and is now a Managed Care desk guide |
| 2/8/2022 | VI.B.6. | Added information regarding administrative day review |
| 09/09/2024 | B, C, D | Procedure changes documented |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *09/10/2024* |
|---|---|---|
| Approved by: | Star Graber, PhD, LMFT, Behavioral Health Administrator | Date |

# 3.23 Network Adequacy, Access Timeliness, and Array of Services

I. PURPOSE

- To clarify how SLOBHD evaluates and ensures network adequacy
- To clarify the SLOBHD's provider network monitoring process
- To clarify access timelines and time/distance standards for the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS)
- To describe SLOBHD's array of services

II. POLICY

SLOBHD will deliver medically necessary Specialty Mental Health Services (SMHS) and DMC-ODS services in an amount, duration, and scope sufficient to achieve symptom reduction or improvement in functioning to eligible Medi-Cal beneficiaries. To accomplish this, SLOBHD will maintain and monitor a provider network sufficient in size, geographic location, specialization, availability, and cultural competence to provide services to ensure timely access and ongoing care for eligible beneficiaries.

III. REFERENCES

- Code of Federal Regulations, Title 42, §438.10, §438.68, §438.206-214
- California Code of Regulations, Title 9, §1810.405, §1810.410
- California Code of Regulations, Title 28, §1300.67.2.2
- California Health & Safety Code §1367.03 – 1367.04
- California Welfare & Institutions Code, Division 9, Part 3, Chapter 7, Article 6.3, §14197
- DHCS MHSUDS Information Notice 18-011
- MHP Contract with DHCS, Exhibit A, Attachment 1
- DMC-ODS Contract with DHCS
- Welfare & Institutions Code § 5600.2

Related Policies:

- Access to Services
- Notices of Adverse Beneficiary Determination
- Culturally Competent, Multilingual Services
- SLO Health Agency Nondiscrimination and Language Access Plan
- Services for Hearing and Vision Impaired Consumers
- Continuity of Care
- Telepsychiatry Service Delivery

IV. PROCEDURE

**A. Network Adequacy**

1. Needs assessment

   a) SLOBHD will conduct a needs assessment by utilizing beneficiary data from CenCal Health, the County of San Luis Obispo's Managed Care Plan, and service data gleaned from SLOBHD's electronic Health Record (EHR). SLOBHD will consider key characteristics of the target population, including:

   - Anticipated Medi-Cal enrollment
   - Expected utilization of services
   - Health care needs
   - Geographic distribution of beneficiaries and proximity to services
   - Language and cultural needs
   - Physical access/accommodation needs

   b) SLOBHD will submit needs assessment and mapping as specified in DHCS MHSUDS Information Notice 18-011.

   c) The needs assessment will be reviewed and updated at least annually.

   d) When necessary, SLOBHD will request permission from DHCS to use an alternative access standard to meet the needs of beneficiaries.

2. Provider network composition and monitoring requirements

   a) SLOBHD will maintain a panel of staff, contractors, and individual Network Providers sufficient to provide timely and accessible services.

      i. SLOBHD will meet time and distance standards through a combination of services at clinic sites, in the community, and via telehealth modalities

      ii. Whenever possible, SLOBHD will involve beneficiaries in decisions about location of services to improve access and engagement

3. SLOBHD will conduct targeted recruitments to ensure that the network will meet the needs of beneficiaries in terms of geographic location, specialization, availability, and cultural competence.

4. SLOBHD will regularly monitor access timeliness for initial assessment and for key follow up appointments, including access to psychiatric care.

   a) SLOBHD Quality Support Team (QST) staff will track and report key access metrics, including wait time for initial assessment, follow up, and psychiatric assessment wait time in quarterly QST meetings. See current QST Work Plan for detail of metrics and Work Plan Evaluation for results.

b) In the event that access is delayed beyond the SLOBHD standard, the QST Division Manager will consult with the Division Manager and Program Supervisor of the site with delays to develop a corrective action plan

5. Out-of-network access

a) Crisis services do not require preauthorization. SLOBHD will pay for crisis services provided to a SLO Medi-Cal beneficiary following retrospective review of the record to determine that the service meets medical necessity criteria for the service claimed.

b) SLOBHD will authorize and pay for routine out-of-network care in the event that the resources within the network are insufficient to meet a beneficiary's needs.

**B. Authorization**

1. Authorization of outpatient SMHS and DMC-ODS services
Definition: Authorization refers to the process of making a decision about and approving medically necessary services. The following timeline applies, based on the urgency of the client request for services.

| **Authorization Timeline** | | | |
|---|---|---|---|
| | Routine | Urgent | Crisis/Emergency |
| Definition | Beneficiary's condition requires assessment within standard timeline | Beneficiary's condition requires prompt intervention to prevent a crisis | Beneficiary's condition requires immediate attention to avoid an immediate emergency psychiatric condition (hospitalization) |
| Response Timeline | 5 business days* | 96 hours or less based on the urgency of the condition | Crisis services do not require preauthorization |
| Examples | • All routine requests for outpatient treatment | • Requests for outpatient treatment with significant risk factors<br>• Referrals for follow up from PHF or an out-of-county psychiatric inpatient setting | • Requests for outpatient treatment with very significant risk factors, which pose an imminent danger to the consumer or others<br>• Walk-In or Mental Health Evaluation Team (MHET) |

** An extension of up to 14 additional calendar days is possible if:*
- The beneficiary requests an extension or
- The assessing therapist determines that an extension to gather additional information is in the beneficiary's best interest and documents the basis for this decision in a progress note

2. Authorization of DMC-ODS Residential Treatment: When a beneficiary requests Residential Treatment, SLOBHD will offer the beneficiary an assessment appointment with an Assessment Coordinator that is within 24 hours of the request (or on the next business day if the beneficiary makes the request on a weekend or holiday). The assessment will determine the appropriate level of care per American Society of Addiction Medicine (ASAM) criteria.

## C. Access

1. Access timeliness for SMHS and DMC-ODS: Access timeliness standards refer to the time between a beneficiary's request for services and the first offered service. The request may be by phone, in person, in writing, or by electronic means (website, email, etc.).

2. Distance for SMHS and DMC-ODS: SLOBHD calculates distance in miles from the location of the service; in most instances, this means from a certified site (clinic, school, or community location) to the beneficiary's residence, unless SLOBHD uses mobile services to meet the distance standard.

**Time and Distance Standards**

| Service | | Timely Access[1] | Distance |
|---|---|---|---|
| Psychiatry | | • Initial psychiatric assessment: 15 business days from written request<br>• Follow-up: As determined by the provider | 45 miles |
| SMHS | Routine | • Initial appointment: within10 business days of request<br>• Follow-up appointment: within 10 business days of assessment<br>• Ongoing care: As determined by the provider | 45 miles |
| | Urgent | • Initial appointment: 96 hours (when preauthorization required)<br>• Post hospital follow-up appointments: 7 calendar days from discharge | |
| | Crisis | • Initial appointment: 48 hours[2] (when no preauthorization is required) | |
| DMC-ODS<br>• Outpatient<br>• Intensive Outpatient (IOT) | | • Initial appointment: within10 business days of request<br>• Follow-up appointment: within 10 business days of screening/assessment<br>• Ongoing care: As determined by the provider | 60 miles |
| DMC-ODS<br>• Opioid Treatment Programs (OTP)[3] | | • Initial appointment: 3 business days<br>• Follow up appointment: 10 business days<br>• Ongoing care: As determined by the provider | 45 miles |

[1] *The mental health services appointment time standards may be extended if the referring or treating provider, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, determines and notes in the beneficiary's record that a longer waiting time will not have a detrimental impact on the health of the beneficiary. In addition, periodic office visits (i.e., ongoing care appointments) to monitor and treat mental health conditions may be scheduled consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of his or her practice. (Title 28, CCR, §1300.67.2.2)*

[2] *SLOBHD provides crisis services as quickly as needed, based on the beneficiary's condition. In most cases, services are immediately or within an hour of the request.*

[3] *OTP includes Medication Assisted Treatment (MAT) and Narcotic Treat Program (NTP)*

3. Same day/next day services

   a) SLOBHD clinic sites accommodate walk in, same day services.
   b) Next day services are available when needed to meet a beneficiary's needs.

4. Field-based and Home-based services

   a) SLOBHD is committed to providing services to beneficiaries in the least restrictive setting. Certain programs are primarily school-based, field-based or home-based.
   b) SLOBHD counts alternative services and sites in its time and distance calculations.

5. Telepsychiatry

   a) SLOBHD is committed to maximizing service delivery to beneficiaries and may use telemedicine to accomplish this goal.
   b) SLOBHD counts alternative delivery approaches such as telemedicine in its time and distance calculations.

6. Ensuring Timely Access to Services

   a) Managed Care and clinic staff will reserve routine assessment and walk in screening appointments times in sufficient quantity to meet the SLOBHD's access standards.
   b) Central Access Line staff will monitor access timelines. In addition to routine assessment slots, the Managed Care Program Supervisor may request additional appointments to accommodate routine or urgent needs. Clinic sites will accommodate these requests by making appointments available as needed.
   c) SLOBHD Quality Support Team will monitor timeliness of access to services and report the results to the Quality Support Team Committee on a monthly basis. SLOBHD will establish goals for timely access in its QST Work Plans.
   d) The Managed Care Program Supervisor will notify the clinic Program Supervisor, Division Manager, and SLOBHD's Quality Support Division Manager of any instances of delayed access. The involved supervisory staff will develop a corrective action plan to ensure timely access.

## D. Array of Services

1. Prevention and SMHS

**SLOBHD Array of Prevention and SMHS**

**ACUITY**

| | Prevention | Outpatient | Intensive | Crisis Services | Crisis Stabilization | Inpatient |
|---|---|---|---|---|---|---|
| **Programs** | Innovation projects<br><br>Prevention and Early Intervention | • SLOBHD clinics<br>• School-based sites<br>• Community-based sites<br>• SAFE & Family Resource Centers<br>• Martha's Place Children's Assessment Center<br>• Forensic Re-Entry & Forensic Coordination Team<br>• Network Providers | • FSP Teams<br>o HOT<br>o BHTC<br>o Youth<br>o TAY<br>o Adult<br>o Older Adult<br>• Veteran's Treatment Court<br>• Wraparound<br>• Katie A Intensive Teams<br>• Day Treatment Intensive | • Crisis Response Team (CRT)<br>• Mental Health Evaluation Team (MHET) | • CSU<br><br>(4 beds) | • Psychiatric Health Facility (PHF)<br><br>(16 bed)<br>• Out-of-county acute care facilities |
| **Services** | Prevention<br>Education<br>Training<br>Outreach<br>Engagement | Assessment<br>Targeted Case Management<br>Medication Support<br>Crisis Intervention<br>Plan Development<br>Therapy<br>Day Treatment<br>Collateral Services<br>Therapeutic Behavioral Services (TBS)<br>Intensive Care Coordination (ICC)<br>Intensive Home Based Services (IHBS) | | | Crisis Stabilization<br><br>(up to 23 hours/day care) | PHF services<br><br>Inpatient services<br><br>(24 hour care) |

**E. DMC-ODS array of services**

SLOBHD will complete an ASAM level of care rating for each beneficiary who participates in a Substance Use Disorder Assessment. SLOBHD will provide the following ASAM-identified levels of care:

0.5 Early Intervention

1 Outpatient Services
- Up to nine hours of service per week for adults
- Up to six hours of service per week for adolescents

1.1 Intensive Outpatient
- 9-19 hours of service per week for adults
- 6-19 hours of service per week for adolescents
- Some beneficiaries will be eligible for placement in a Recovery Residence while participating in IOT services

3.1 Clinically Managed Low-Intensity Residential Services
- Perinatal and non-perinatal residential services are available

3.3 Clinically Managed Population-Specific High-Intensity Residential Services and 3.5 Clinically Managed High-Intensity Residential Services will be available by or before the end of implementation year three

OTS Opioid Treatment Program (OTP) and Withdrawal Management (WD) are available at SLOBHD Drug & Alcohol clinics and by contract with Aegis Treatment Center. Aegis provides Narcotic Treatment Program (NTP) Services and Medication Assisted Treatment (MAT). SLOBHD Drug & Alcohol clinics provide WD and MAT.

Additional levels of care, including 3.3, 3.5, 3.7 and 4, will be available by contract providers located outside SLO County.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 3/1/2018 | | Adopted |
| Prior Approval dates: | | |
| | | |

| | |
|---|---|
| *Signature on file* | *03/23/2018* |

Approved by: Anne Robin, LMFT Date
Behavioral Health Administrator

# 3.30 Notices of Adverse Benefit Determination

## I. PURPOSE

To clarify the process for notifying beneficiaries of actions taken by San Luis Obispo Behavioral Health Department (SLOBHD) and all contracted providers who deliver Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS) to Medi-Cal beneficiaries.

## II. POLICY

SLOBHD will make timely authorization decisions and will promptly notify Medi-Cal beneficiaries and providers of those actions. A written Notice of Adverse Benefit Determination (NOABD) will inform an affected beneficiary and/or provider of SLOBHD's decisions and will provide information about the SLOBHD's problem resolution processes. SLOBHD will maintain a log of all NOABDs and will report adverse determinations to the California Department of Health Care Services (DHCS) as required by law.

## III. REFERENCE(S)

- Code of Federal Regulations (CFR), Title 42, §§438.404 – 438.424, 438.10, 431.213 – 431.214
- California Code of Regulations, Title 9, §1810.200; §1850.210(a-j); §1850.212
- California Code of Regulations, Title 22, §51341.1(p)
- DHCS contract with SLOBHD for Specialty Mental Health Services
- DHCS contract with SLOBHD for Drug Medi-Cal-Organized Delivery System (DMC-ODS)
- DHCS Information Notice 18-010 *Grievance and Appeal System*

Related SLOBHD Policy and Procedure(s)

- *Beneficiary Grievances, Appeals, and Expedited Appeals*
- *Fair Hearing Process*
- *Beneficiary Rights and Informing Processes*
- *Provider Problem Resolution Processes*

## IV. DEFINITIONS

An Adverse Benefit Determination means any of the following actions (adverse determinations) taken by SLOBHD regarding the treatment of any Medi-Cal beneficiary:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of services, medical necessity, appropriateness, setting, or effectiveness of a covered benefit
2. The reduction, suspension, or termination of a previously authorized service
3. The denial, in whole or in part, of payment for a service

4. The failure to provide or authorize services in a timely manner
5. The failure to act within the required timeframes for standard resolution of grievances and appeals
6. The denial of a beneficiary's request to dispute their financial liability

V. PROCEDURE

A. Written Notice of Adverse Benefit Determination Requirements

1. Beneficiaries must receive a written NOABD when SLOBHD takes any action described above. Decisions should be communicated first by telephone or in person and then in writing, except for decisions rendered retrospectively (i.e., chart review of an inpatient stay after the beneficiary is discharged) when the decision is communicated in writing only.

2. SLOBHD staff must communicate any adverse determination that affects a contracted provider by telephone or fax within 24 hours of the decision, except for decisions rendered retrospectively (by review of a medical record after the provider delivered the service). SLOBHD staff must mail a NOABD to the provider as described below. SLOBHD will include the name and telephone number of the decision-maker on the NOABD to the provider.

3. The NOABD must explain all of the following:

a) The adverse benefit determination SLOBHD made or intends to make
b) **A clear and concise explanation of the reason(s) for the decision, written in plain language, not jargon. For determinations based on medical necessity criteria, the notice must include clinical reasons for the decision. SLOBHD staff will explicitly state why the beneficiary's condition does not meet specialty mental health services and/or DMC-ODS medical necessity criteria**.
c) A description of the criteria used. This includes a description of the specific medical necessity criteria not met, and any processes, strategies, or evidentiary standards used in making such determinations, such as ratings on the Children's Assessment of Needs and Strengths (CANS), Pediatric Symptom Checklist (PSC), Adult Needs and Strengths Assessment (ANSA), or American Society of Addiction Medicine (ASAM) scales.
d) How a beneficiary can appeal SLOBHD's decision
e) How the beneficiary may request and receive reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination. Access is free of charge.
f) How a beneficiary who is currently receiving services may continue to receive services during an appeal
g) How the beneficiary may obtain information in an alternative format or language and how to get help with an appeal.

B. Types of NOABDs:

| **NOABD Denial Notice** (Denial of requested service by a Beneficiary or Provider) | |
|---|---|
| Action: | Sent to beneficiary (and provider, when the request comes from a provider) when SLOBHD denies a request for a service. Similar to the former NOA A. Denial reasons may include:<br><br>Lack of medical necessity for a type or level of a service based on:<br>• An excluded diagnosis<br>• Evidence that the requested service is not likely to reduce the beneficiary's impairment or prevent deterioration in functioning<br>• Evidence that the requested setting is inappropriate for the beneficiary (i.e., beneficiary requests residential treatment but does not need that level of care, or requests treatment by a Network Provider, but cannot safely be treated in a private office)<br>• Client requests DMC-ODS residential service, but does not meet medical necessity for this level of care |
| Who: | Site Authorization Team (SAT), Designated LPHA staff |
| To/ When: | Provider (if applicable): By phone/fax within 24 hours; mailed within two business days<br>Beneficiary, Parent/Legally Responsible Person: Mailed within two business days |

| **NOABD Other Level of Care Notice** (Referral to Holman or CenCal Health) | |
|---|---|
| Action: | Sent to beneficiary when SLOBHD determines that the beneficiary does not meet the criteria to be eligible for Specialty Mental Health Services (SMHS) or Substance Use Disorder Services (SUDS) at SLOBHD, but will be referred to CenCal Health, Holman Group, Community Health Centers, or other provider for a non-SMHS or Screening, Brief Intervention, and Referral to Treatment (SBIRT) or ASAM level .5 services. Similar to the former NOA A. |
| Who: | Managed Care, clinic, or QST staff (LPHA required) |
| To/ When: | Beneficiary, Parent/Legally Responsible Person: Mailed within two business days |

| **NOABD Timely Access Notice** (Delay in access) | |
|---|---|
| Action: | Sent to beneficiary when there is a delay in providing the beneficiary with timely services. Similar to the former NOA E. |

| | |
|---|---|
| | Access Standard:<br>1. Initial appointment (MH and DMC-ODS)<br>• Routine = within 10 business days of request<br>• Urgent = within 96 hours of request<br>• Crisis = within 48 hours of request<br>2. Follow-up appointment within 10 business days of assessment<br>3. Psychiatric assessment within 15 business days of written request<br>4. DMC-ODS Opioid Treatment Programs = within 3 business days of request |
| Who: | Clinical Staff, usually Managed Care or clinic staff |
| To/ When: | Provider (if applicable): By phone/fax within 24 hours; mailed within two business days<br>Beneficiary, Parent/Legally Responsible Person: Mailed within two business days |

| **NOABD Termination Notice** (Termination of previously authorized services) | |
|---|---|
| Action: | Sent to beneficiary and provider when SLOBHD terminates, reduces or suspends a previously authorized service. Examples may include notice to discontinue a specific service or all services, even though the beneficiary still requests services, or a provider requests authorization to continue services. Reasons for this adverse determination may include evidence that the interventions are not reasonably likely to reduce impairment or prevent deterioration. The specific reasons for a "not likely to benefit" from a specific service conclusion must be clearly documented and must be based on recent treatment (within the last 90 days) and a current assessment of the beneficiary's motivation/readiness for change.<br><br>For DMC-ODS staff, this NOABD replaces the NOA issued prior to termination of services required by CCR, Title 22, §51341.1(p) |
| Who: | Clinical Staff, often Managed Care staff (LPHA required) |
| To/ When: | Provider: By phone/fax within 24 hours; mailed **at least 10 days before** the date of action<br>Beneficiary, Parent/Legally Responsible Person: Mailed **at least 10 days before** the date of action |

| **NOABD Modification Notice** | |
|---|---|
| Action: | Sent to beneficiary and provider when SLOBHD modifies or limits a provider's new request for service, including reductions in frequency and/or duration of |

| | |
|---|---|
| | services, limits on the number of services available, or denies a request for alternative treatments and services. This NOABD is sent before services were authorized or provided. Similar to the former NOA B. |
| Who: | SAT Designee, usually Managed Care staff (LPHA required) |
| To/ When: | Provider: By phone/fax within 24 hours; mailed within two business days<br>Beneficiary, Parent/Legally Responsible Person: Mailed within two business days |

| **NOABD Payment Denial Notice** (Denial of payment for services rendered) | |
|---|---|
| Action: | Sent to the beneficiary and provider when SLOBHD denies, in whole or in part, for any reason, a provider's request for payment for services that have already been delivered to a beneficiary. Similar to the former NOA C. |
| Who: | Managed Care, clinic, or QST staff (LPHA required) |
| To/ When: | Provider: By phone/fax within 24 hours; mailed within two business days<br>Beneficiary, Parent/Legally Responsible Person: Mailed within two business days |

| **NOABD Authorization Delay Notice** | |
|---|---|
| Action: | Sent to beneficiary when there is a delay in processing a beneficiary's or a provider's request for authorization of behavioral health services, including substance use disorder residential services. When we extend the timeframe to make an authorization decision, we would send an NOABD, including when the extension is at the request of the beneficiary or provider. Example: Late SAT |
| Who: | Managed Care, Clinic SAT, Fiscal |
| To/ When: | Beneficiary, Parent/Legally Responsible Person: Mailed within two business days |

| **NOABD Financial Liability Notice** | |
|---|---|
| Action: | Sent to the beneficiary when SLOBHD denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities. |
| Who: | Managed Care, Fiscal |
| To/ When: | Beneficiary, Parent/Legally Responsible Person: Mailed within two business days |

| **NOABD Grievance and Appeal Delay Notice** | |
|---|---|
| Action: | Sent to the beneficiary when the Patients' Rights Advocate does not respond to a grievance or appeal in a timely manner |
| Who: | Patients' Rights Advocate |
| To/ When: | Beneficiary, Parent/Legally Responsible Person: Mailed within two business days |

C. NOABD Attachments

1. SLOBHD staff will enclose three attachments provided by DHCS when sending any NOABD to a beneficiary. For ease of use, the attachments are combined into one PDF and posted on the SLOBHD website.

    a) "Your Rights" informs beneficiaries of critical appeal, expedited appeal, and State Hearing rights, along with problem resolution processes
    b) Beneficiary Non-Discrimination Notice informs beneficiaries of SLOBHD's obligation to avoid discrimination and provides additional information about resources and supports
    c) Language Assistance Taglines describe how individuals who speak/read the top non-English languages in California may receive language assistance services. This is an Affordable Care Act requirement.

2. The attachments will be printed and enclosed with the NOABD when mailed to a beneficiary; they will not be Cerner assessments.

D. Workflow:

1. A clinical staff person will complete the applicable NOABD and then sign and route it to the program's Health Information Technician (HIT) or Administrative Assistant (AA). Completion in Cerner will create the log of NOABD's required in regulation.

2. The HIT or AA will:

    a) Copy and paste the information from the Cerner NOABD into the correct PDF version. The PDF version is in 12 point font, which is a Federal and State regulatory requirement. PDF NOABDs and attachments will be posted on the County of SLO website: https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Patients-Rights-Advocate/Notice-of-Adverse-Benefit-Determination.aspx
    b) Print and mail the PDF version and the attachments to the client. Mail a copy to the provider (if applicable). The provider does not receive the attachments.
    c) Final Approve the Cerner NOABD

3. In some instances (field-based programs, for example), clinical staff will complete all associated tasks. Program Supervisors of each program will clarify the workflow for staff.

E. Electronic NOABD completion requirements and NOABD log

1. SLOBHD must maintain a log of all NOABDs issued to beneficiaries to comply with Federal and State regulations. SLOBHD's log is a report run from the electronic health record.

2. Therefore, while paper versions of the NOABDs are available and may be used, staff must also launch and complete an electronic version of the NOABD so that the log is complete.

F. Spanish language NOABD forms

1. When SLOBHD staff make an adverse benefit determination that affects the treatment of a Spanish-speaking client, the beneficiary and legally responsible person must receive information in Spanish.
2. In these instances, bilingual clinical staff (or monolingual clinical staff with the aid of a translator) will complete the Cerner NOABD text boxes both in English and in Spanish. Spanish-language NOABDs will not be needed in Cerner, because the documents that will be mailed will be the translated PDF versions.
3. The HIT, AA, or clinician who processes the PDF NOABD will select the applicable Spanish language NOABD and will copy the clinician's written Spanish statements into the Spanish-language form.

G. Staff signature requirements

1. A licensed clinician or Registered Associate must sign the Cerner version of an NOABD that documents an authorization decision. Applies to NOABD Denial Notice, Payment Denial Notice, Other LOC Notice, Modification Notice, Authorization Delay Notice, and Termination Notice.
2. Any staff member may sign the Cerner version of an NOABD that documents an issue other than an authorization decision. Applies to Timely Access Notice, Grievance or Appeal Delay Notice, and Financial Liability Notice.
3. The HIT or AA who processes the PDF version will:
   a) Enter the name and contact information of the staff member who completed the Cerner version below the "Staff Signature" line
   b) Type or write "Electronically signed" or "Signature on file" on the staff signature line

VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 3/19/2018 | All | Revised to match Managed Care Final Rule regulations |
| 4/4/2018 | Procedure | Added Authorization Delay and Grievance/Appeal Notices; added direction for staff who send information in Spanish; expanded signature procedure |
| Prior Approval dates: | | 10/12/2012 |
| *Signature on file* | | *04/04/2018* |
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

Sample NOABD statements:

1. NOABD Denial Notice

*"Based on review of records and clinical history, Benjamin meets criteria for Autism Spectrum Disorder and the significant difficulties he experiences in social relationships, school, and at home are likely related to this diagnosis. Autism Spectrum Disorder is not an included diagnosis for specialty mental health services by SLOBHD. We recommend that you contact your TCRC case manager and IEP coordinator to discuss service options."*

*"Based on your report that neither you nor family members have a history of significant mental illness and that the upsetting visions and thoughts you experience began after a period of heavy substance use, we do not believe that you qualify for specialty mental health services. We encourage you to contact us to arrange follow up at our Drug & Alcohol Services clinic."*

*"You asked us to refer you to an out-of-county residential treatment program, but based on our assessment and the American Society for Addiction Medicine (ASAM) standards, we believe that the best level of treatment for you is in our Intensive Outpatient Treatment program at (specify clinic or program). We will be looking for a Recovery Residence in SLO County for you as well. Please talk with you counselor about all your treatment options."*

2. NOABD Payment Denial Notice

*"The progress notes submitted by Sally Therapist for the dates of service listed do not meet SLOBHD's documentation standards. Please refer to the Documentation Guidelines for detailed directions. Specifically, the progress notes we denied do not meet the Title 9 definition for therapy (California Code of Regulations, Title 9, §1810.250) and do not document that you provided an intervention that would diminish the client's impairment or prevent deterioration in functioning (CCR, Title 9, §1830.205 (b)(3)(A-C))."*

*"The documentation presented by Dr. Feelgood for 12/25/18 does not establish medical necessity for an inpatient continued stay service as required in California Code of Regulations, Title 9, §1820.205(b). Specifically, the progress note does not document the presence of danger to self that resulted in the admission."*

3. NOABD Other Level of Care Notice

"*We will refer you to CenCal Health and the Holman Group for therapy because, based on our assessment, we believe that your depression can be treated by discussing medication with your primary care doctor and by participating in outpatient therapy. We believe that you are seeking treatment early and have many positive supports and strengths that will help you in treatment before your symptoms become overwhelming. Information about "medical necessity" can be found in California Code of Regulations, Title 9, §1830.205."*

4. NOABD Modification Notice

*"Your Network Provider, Sally Therapist, asked us to authorize therapy for you 3 times per week for the next 3 years. Instead, we authorized 16 therapy sessions for you for the next four months to meet your treatment needs. Your provider may document the need for additional services before this authorization ends and we will review her request."*

*"On 1/1/2018, ACME Residential Treatment Center requested an additional 180 days of residential care for you. Instead, we authorized 90 days of service to meet your treatment needs."*

5. NOABD Termination Notice

*"We previously authorized you to receive weekly individual therapy during the current year. We will no longer authorize individual therapy for you because we do not believe that ongoing therapy will help you learn to get along better with others. We are making this decision because you told us that you only want to use your therapy sessions "to have someone to yell at" and that you "do not want to make any changes in your life right now." For us to authorize therapy, we must be able to show that it will help you deal with your feelings in a positive way. (California Code of Regulations, Title 9, §1830.205 (b)(3)(A-C)).*

*"We are ending your substance use treatment services with us because you continue to bring narcotics with you to group sessions and tell us that you are not willing to stop doing so. We told you that we are required to operate an abstinence-based program and cannot allow unlawful use of substances in the program."*

6. NOABD Financial Liability Notice

*"While we understand that your Share of Cost is a burden to you, we are not permitted to adjust your Share of Cost or claim reimbursement from Medi-Cal until your Share of Cost obligations are met (California Code of Regulations, Title 9, §1810.345 and Title 22, §50651-50659). Please work with the Department of Social Services to see if you qualify for a type of Medi-Cal that has no Share of Cost."*

# 3.50 Transition of Care

## I. PURPOSE

To describe the County of San Luis Obispo Behavioral Health Department's (SLOBHD) procedures for ensuring safe transfer of care and continuity of care for Medi-Cal beneficiaries

## II. BACKGROUND

SLOBHD's Drug Medi-Cal Organized Delivery System (DMC-ODS) and Mental Health Plan (MHP) operate as a type of managed care organization to authorize, provide, or arrange for all Substance Use Disorder Services (SUDS) and Specialty Mental Health Services (SMHS) for SLO Medi-Cal beneficiaries.

To accomplish its mission as the DMC-ODS and MHP, SLOBHD maintains a network of providers that includes employees, contract providers, and individual Network Providers to deliver a broad array of services in a variety of levels of care. The service array and provider network consider the needs for different types of services and providers as well as the cultural and linguistic needs of SLO Medi-Cal beneficiaries.

SLOBHD recognizes that treatment of mental health and substance use disorders requires collaborative treatment relationships between providers and beneficiaries. Abrupt ending to treatment may result in poorer outcomes. SLOBHD will implement a Transition of Care Policy that will allow eligible beneficiaries the opportunity to maintain treatment relationships with their eligible existing providers.

## III. SCOPE

Transition of Care applies to all SLO Medi-Cal beneficiaries who meet medical necessity for SUDS or SMHS from SLOBHD. It applies equally to beneficiaries whose treatment will be provided by employees, contractors, and Network Providers.

## IV. POLICY

SLOBHD will authorize and pay for medically necessary SUDS or SMHS for eligible Medi-Cal beneficiaries who have an existing treatment relationship with an eligible out-of-network provider when, in the absence of continued services with the provider, the beneficiary would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. SLOBHD's time-limited Transition of Care authorizations will allow the beneficiary to complete of a course of treatment and/or to arrange for a safe transfer to a provider within SLOBHD's provider network.

V. APPLICABLE STANDARDS/REGULATIONS

- Code of Federal Regulations (CFR) Title 42, Chapter IV, §438.62
- California Health & Safety Code, Division 2, Chapter 2.2, §1373.96
- Department of Health Care Services (DHCS) MHSUDS Information Notice 18-051
- Department of Health Care Services (DHCS) MHSUDS Information Notice 18-059

VI. REFERENCES

- SLOBHD Policy & Procedure
- 3.20 Authorization of Services and Medical Necessity
- 3.21 Authorization…Out-of-Plan Services for Youth
- 3.30 Notice of Adverse Benefit Determination
- 4.07 Beneficiary Grievance, Appeals, & Expedited Appeals
- 6.11 Continuum of Care Reform
- 8.00 Coordination of Care with Other Health Care Providers
- 10.10 Network Provider Panel Membership and Credentialing
- 10.13 Credentialing Former Employees as Network Providers
- 12.08 Staff Eligibility Verification and Provider Credentialing

VII. DEFINITIONS / CRITERIA

A. Client Eligibility Criteria
   1. Client must meet medical necessity criteria for the SUDS or SMHS for which transition of care is requested
   2. SLOBHD must determine that change of provider to an in-network provider would result in "serious detriment to client's health or place client at risk of hospitalization or institutionalization"

B. Existing Treatment Relationship Criteria
   1. SUDS: Evidence (not just client self-report) that the beneficiary received services from the provider prior to the date of beneficiary "transition to the DMC-ODS county" (i.e., the date eligible for SLO County Medi-Cal)
   2. SMHS: One or more of the following
      a. Evidence that the beneficiary received mental health services at least once during the 12 months prior to the date of client's "initial enrollment in the MHP" (i.e., the date eligible for SLO County Medi-Cal)
      b. Evidence that the beneficiary was receiving SMHS from the provider at the time SLOBHD or the provider terminated a contract or employment relationship
      c. Evidence that the beneficiary was receiving SMHS from the provider at the time of client's a move to SLO County from another MHP's jurisdiction
      d. Evidence that, at the time of a client's transition to the MHP (i.e., at the time the beneficiary meets medical necessity for SMHS), the beneficiary was receiving non-SMHS from:
         i. A Medi-Cal Fee-for-Service provider
         ii. A CenCal-contracted provider (i.e., Holman Group, CHCC, or other provider approved by CenCal Health)

C. Provider Eligibility Criteria
   1. Rate Agreement:
      a. SUD: Provider must agree to accept higher of DMC-ODS or DMC rates
      b. SMHS: Provider must agree to accept the higher of SLOBHD's Network Provider contract rates or MC FFS rates (or previous contract rate with MHP rate if applicable)
   2. Provider must meet applicable professional standards for their discipline
   3. Provider must be free from disqualifying quality of care concerns. If SLOBHD verifies and documents quality of care concerns about the provider such that the provider would be ineligible to provide services to other beneficiaries, the provider does not meet this criterion.
   4. Provider must be willing to enter a contract with SLOBHD for provision of services to the beneficiary
   5. Provider must give SLOBHD all relevant treatment information to for SLOBHD to determine medical necessity. For SMHS, the provider must also give SLOBHD the current Treatment Plan, Progress Notes, and Assessment.
   6. Additional provider requirements:
      a. SUD:
         i. Provider must be verified as a current DMC provider
         ii. Provider must give SLOBHD all outcomes data (ASAM and CalOMS)
         iii. Provider must agree in writing not to refer the beneficiary to another out-of-network provider
      b. SMHS
         i. Provider type must be consistent with State Plan (i.e., must be a provider type who can provide SMHS)
         ii. Provider agrees in writing to adhere to DHCS/SLOBHD documentation standards

VIII. PROCEDURE

**A. Requests for Transition of Care**

1. A Medi-Cal beneficiary, authorized representative, or provider may submit a request for transition of care authorization to SLOBHD by phone, in person, or writing
2. When needed, SLOBHD will make reasonable assistance available, for example, using bilingual staff or Language Line, transcribing the beneficiary or provider's request, etc.
3. Requests for Transition of Care will be forwarded to Managed Care on the day received
4. Managed Care staff will acknowledge receipt of the request in writing within three business days of the request. The acknowledgement will be sent to the beneficiary and to the provider. Attachment A is a sample acknowledgment letter.

## B. Evaluation Process

1. SLOBHD staff (usually from Managed Care) will complete the Transition of Care Authorization assessment (Attachment B) to document the results of the evaluation
2. SLOBHD staff (usually from Managed Care) must determine that the beneficiary meets the Client Criteria
    a. Assessment to determine medical necessity and risk without Transition of Care authorization may vary depending on the type of request and the information available to SLOBHD staff.
        i. In some circumstances, as when the client is new to SLOBHD, a face-to-face contact with the client and completion of a comprehensive assessment may be required
        ii. At other times, as when a client asks to continue a course of treatment with a terminated employee, a review of records obtained from SLOBHD's EHR and a telephone contact with the beneficiary may be sufficient
    b. SLOBHD staff will apply current medical necessity criteria for the service requested to make their determination. For additional information about medical necessity, refer to SLOBHD the applicable policy and Documentation Guidelines for the service requested.
    c. In addition to meeting medical necessity criteria, the beneficiary must be at risk of "serious detriment" to the beneficiary's health or risk of hospitalization or institutionalization if treatment with the current provider is not continued.
3. SLOBHD staff (usually from Managed Care) must determine that Existing Treatment Relationship Criteria are met
4. SLOBHD staff (usually from Managed Care) must determine if Provider Eligibility Criteria are met
    a. SLOBHD staff will contact the provider to evaluate provider's willingness to treat beneficiary under the terms of this policy (i.e., rate acceptance, etc.)
    b. SLOBHD staff will begin a good faith effort to expedite credentialing /contract development
        i. For individual providers, Managed Care credentialing staff will complete this step
        ii. For agency providers, a Fiscal Division contract manager will complete this step

## C. Notification of Approval or Denial

1. Approval
    a. SLOBHD staff will notify the beneficiary and the provider in writing of the conclusion of the evaluation. See section C 3iii below for time limits.
    b. If the Transition of Care Request is approved, the notification will:
        i. Specify the duration of the authorization
            a) SUDS (whichever is shorter):
                (1) Until medical necessity criteria are no longer met
                (2) 90 days (may be extended to up to 12 months if medically necessary)

b) SMHS (whichever is shorter):
(1) Until medical necessity criteria are no longer met
(2) Until a course of treatment is completed
(3) Until safe transition to an in-network provider can be arranged
(4) Not to exceed 12 months

ii. Describe the transition process back to SLOBHD
iii. State that the beneficiary may request a transition back to SLOBHD at any time during the authorization period
iv. State that continuous Medi-Cal eligibility is a requirement for the Transition of Care authorization. SLOBHD is not responsible to pay for services that are rendered during a lapse in Medi-Cal eligibility

c. Appendix C is a sample Approval Letter

2. Denial
a. Denial reasons
i. Beneficiary does not meet Client Criteria (VII A) (doesn't meet medical necessity criteria, no evidence of risk without treatment by requested provider)
ii. No evidence of Existing Treatment Relationship Criteria (VII B)
iii. Provider declines to continue treatment
iv. Provider does not meet Provider Criteria (VII C)
a) SLOBHD verifies and documents disqualifying quality of care issues
b) Provider does not meet criteria
c) SLOBHD and the provider are not able to enter into a contract (includes when SLOBHD makes a good faith effort to enter into a contract and the provider is non-responsive for 30 days)

b. Denial Process
i. SLOBHD staff will issue a NOABD – Denial.
a) See Policy 3.30 Notice of Adverse Benefit Determination
b) The NOABD will describe in plain language the reason for the adverse decision
c) The NOABD will be mailed to the beneficiary, authorized representative, and provider and will explain appeal options
ii. SLOBHD will offer the beneficiary at least one in-network alternative
iii. and describe how the beneficiary can access services within SLOBHD's network
iv. SLOBHD will make available the Beneficiary Handbook and the Provider Directory

3. Timeline for evaluation and written notification (Approval Letter or NOABD)
   a. Written notification of the authorization decision will be mailed within the following timelines, from the date the request was received:
      i. SUDS (all requests) and SMHS (routine requests): 30 calendar days
      ii. SMHS (urgent requests – includes situations when upcoming appointments have already been scheduled for services and a delay would negatively affect the beneficiary): 15 calendar days
      iii. SMHS (crisis requests – includes situations when a delay would cause serious harm to the beneficiary): three (3) calendar days

- **Note:** A contract does not need to be fully executed before the Authorization decision is made. Services may begin after the Credentialing Attestation and contract are signed by the provider while awaiting final execution and approval of the contract by the Board of Supervisors.

**D. Transition to SLOBHD for ongoing care**

1. Unless a client is open for services at a BH clinic, transitions back to SLOBHD in-network providers will be coordinated by Managed Care staff
2. If the beneficiary remains in treatment for the duration of the authorization, SLOBHD Managed Care staff will:
   a. Notify the beneficiary and provider in writing 30 calendar days before the end of the authorization
   b. Describe the transition process
   c. Engage the beneficiary and provider by phone to ensure a smooth transition
3. If during the Transition of Care authorization period the beneficiary elects or the provider determines that the beneficiary must to transfer care to SLOBHD, Managed Care staff will facilitate the transfer. This may involve a re-assessment to determine the most appropriate level of care.

**E. Medical Necessity and Documentation**

1. SLOBHD Managed Care and Quality Support Team staff will complete periodic documentation reviews to ensure that documentation meets medical necessity standards for claiming
2. The provider will make available to SLOBHD staff any records requested to complete quality management activities
3. As described in the contract between SLOBHD and the provider, SLOBHD will neither pay a provider for nor claim to Medi-Cal any services that do not meet applicable documentation standards. In all instances, the provider is responsible for reimbursing SLOBHD for services that were claimed and paid for but are not documented to SLOBHD's standards.

**F. Tracking**

1. The Managed Care HIT will:
   a. Open an assignment (1001, 1002) to a Managed Care clinical staff member for

tracking
   b. Create a Client Action Schedule to alert the clinician that transition planning must begin no later than eleven months after the final approval of the BH Transition of Care Authorization assessment.
   c. Open the Transition of Care Client Category for reporting purposes

## G. Retroactive Requests

1. SLOBHD will retroactively approve transition of care requests and will reimburse out-of-network providers for services already provided under the following circumstances:
   a. SUDS:
      i. Must be submitted in writing within 30 calendar days of the first service to which the request applies
      ii. Must have dates of services that occurred after the beneficiary became eligible for SLO Medi-Cal
   b. SMHS
      i. Must have dates of services that occurred after the beneficiary became eligible for SLO Medi-Cal
      ii. Must have dates of services that occurred after the beneficiary was referred (or self-referred) to SLOBHD and after the beneficiary was determined to meet medical necessity for SMHS
2. SLOBHD staff will mail a NOABD – Payment Denial to the beneficiary and provider to deny a request for retractive payment for a transition of care service

## H. Outreach and informing requirements

1. SLOBHD will include information about transition of care in its informing materials. Appendix D is a sample brochure that will be made available on the SLOBHD website and lobby Client Information Centers

## I. DHCS reporting

1. The Patients' Rights Advocate will report DMC-ODS transition of care requests to DHCS in the quarterly Grievance and Appeals log reporting
2. The QST Division Manager will report MHP transition of care requests to DHCS in quarterly Network Adequacy submissions
3. Reporting will include:
   a. Beneficiary's name
   b. Date of Request
   c. Provider name and address
   d. Status update – whether the provider agreed to contract, timeline for approval/denial, outcome of the request (if known at the time of submission)

### J. Other requirements

1. SUDS: SLOBHD must submit DMC-ODS Provider Form to Master Provider File unit
2. SMHS: Repeated requests for continuity of care (SMHS only):
   a. Beneficiary may request a second transition of care period if the beneficiary was served by the MHP, subsequently moved to a lower level of care, and then transitions back to the MHP
   b. When the beneficiary changes county of residence more than once in a 12-month period the transition of care period may start over with a second (and third) MHP, but not after the third change of county.

## IX. ATTACHMENTS

A. Acknowledgement Letter (sample)
B. Transition of Care Authorization Form (sample)
C. Approval Letter (sample)
D. Informing materials (sample)

## X. DOCUMENT HISTORY

| **Effective/Revision Date:** | **Sections Revised** | **Author** | **Status: Initial/ Revised/Archived Description of Revisions** |
|---|---|---|---|
| 02/01/2019 | Entire Policy | Greg Vickery, LMFT QST Manager | Initial Release |
| Prior Approval dates: | | | |
| | | | |

| *Signature on file* | | *09/11/2017* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

**ATTACHMENT A**

COUNTY OF SAN LUIS OBISPO
HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT
**Michael Hill,** *Health Agency Director*
**Anne Robin, LMFT** *Behavioral Health Director*

January 22, 2019

Client Name
Client Address
City/State/ZIP

Provider Name
Provider Address
City/State/ZIP

Subject: Receipt of your transition of care request

Dear ____,

We received your request for transition of care on (date). You asked that we authorize (provider name) to continue to provide services for you. We will review your request and give you a written response within 30 calendar days of the date we received your request.

If you have questions or concerns about the review process or timeline, please contact San Luis Obispo Behavioral Health Department's Managed Care team at 800-838-1381.

Sincerely,



**County of San Luis Obispo Health Agency**
2180 Johnson Avenue | San Luis Obispo, CA 93401 | (P) 805-781-4719 | (F) 805-781-1273
info@slocounty.ca.gov | slocounty.ca.gov

**Attachment B**
**(Mock up – Anasazi assessment will look slightly different)**

**BH Transition of Care Evaluation and Authorization**

Medi-Cal Criteria
O Yes O No Client has full scope Medi-Cal and SLO is the County of Responsibility

Client Criteria
O Yes O No Client meets medical necessity for:
- ☐ SMHS
- ☐ SUDS

Describe process used to determine medical necessity

O Yes O No Client is at risk of "serious detriment" to health or risk of hospitalization or institutionalization if the request to continue services with the provider is denied

Existing Relationship Criteria
O Yes O No Evidence of an existing treatment relationship (check all that apply)
- ☐ SUDS: Beneficiary received services from the provider prior to becoming SLO Medi-Cal eligible
- ☐ SMHS: Beneficiary received services from the provider in the 12 months prior to the TOC request, OR prior to the termination of contract/employment with the provider, OR prior to move to SLO, OR at the time of transition from Holman/other non-specialty MH provider/FFS provider



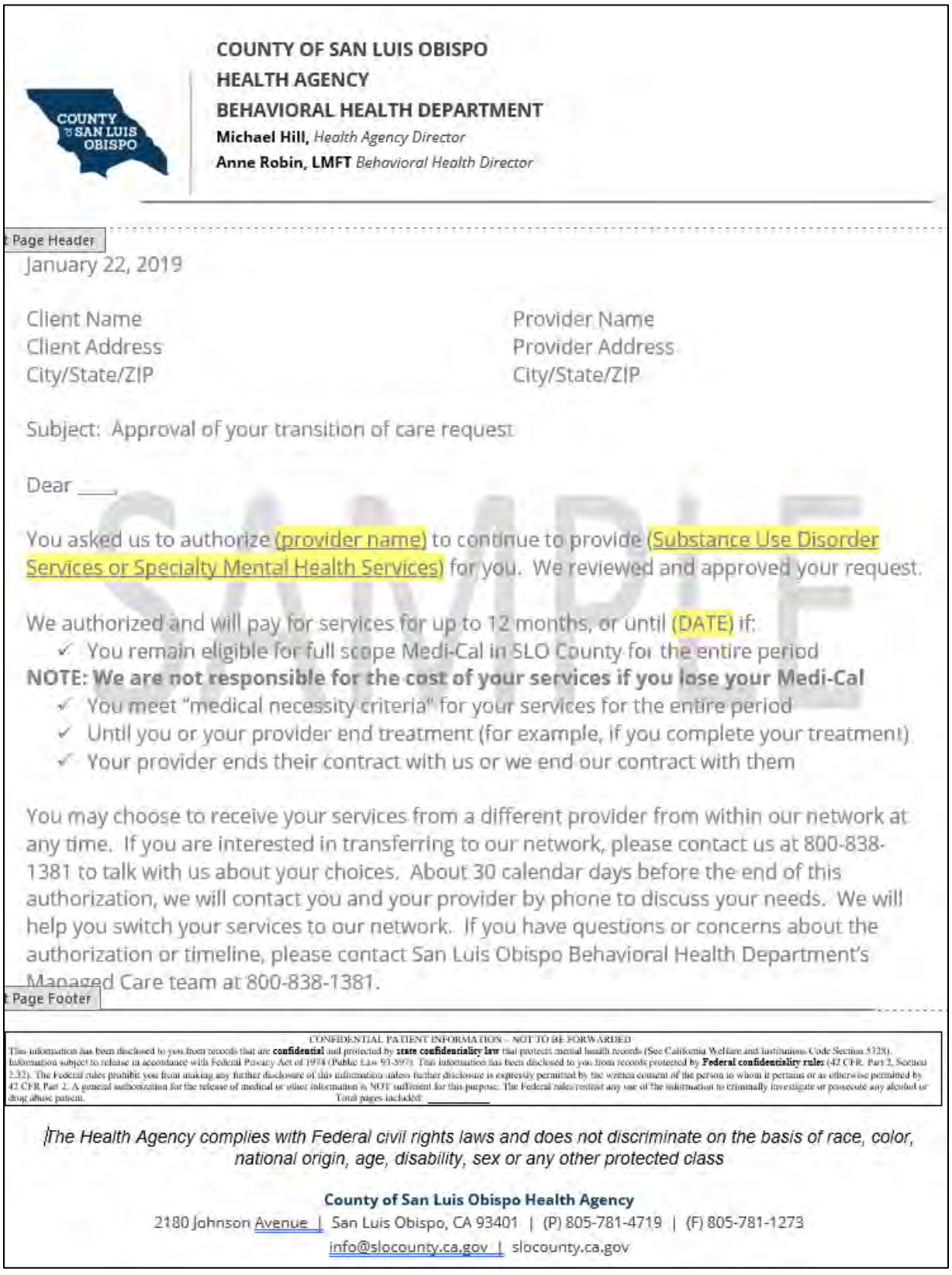
Provider Criteria
O Yes O No Provider agrees to accept SLOBHD rates
O Yes O No Provider appears to meet applicable professional standards
O Yes O No Provider appears to be free from verified, documented quality of care concerns
O Yes O No Provider is willing to enter contract with SLOBHD
O Yes O No Provider is willing to provide relevant client records
O Yes O No Provider meets additional requirements based on services requested:
- ☐ SMHS: Provider type meets State Plan requirements; provider agrees to DHCS/SLOBHD documentation standards
- ☐ SUDS: Provider is a current DMC provider; provider willing to provide ASAM and CalOMS; provider agrees not to refer client to another out-of-network provider

O Yes O No TOC Request Approved?

If yes, duration of TOC Authorization (Check all that apply)
- ☐ SUDS: Until medical necessity criteria are no longer met or 12 months, whichever comes first
- ☐ SMHS: Until medical necessity criteria are no longer met, OR a course of treatment is completed, OR it is safe to transfer the beneficiary to an in-network provider, OR 12 months, whichever comes first
- ☐ Date of TOC termination planning (30 calendar days prior to end of TOC authorization): ☐
- ☐ Date Authorization letter sent to beneficiary and provider ☐

If no, date NOABD sent to beneficiary and provider ☐

**ATTACHMENT C**



**COUNTY OF SAN LUIS OBISPO**
**HEALTH AGENCY**
**BEHAVIORAL HEALTH DEPARTMENT**
**Michael Hill,** *Health Agency Director*
**Anne Robin, LMFT** *Behavioral Health Director*

Page Header

January 22, 2019

Client Name
Client Address
City/State/ZIP

Provider Name
Provider Address
City/State/ZIP

Subject: Approval of your transition of care request

Dear ____,

You asked us to authorize (provider name) to continue to provide (Substance Use Disorder Services or Specialty Mental Health Services) for you. We reviewed and approved your request.

We authorized and will pay for services for up to 12 months, or until (DATE) if:

- ✓ You remain eligible for full scope Medi-Cal in SLO County for the entire period

**NOTE: We are not responsible for the cost of your services if you lose your Medi-Cal**

- ✓ You meet "medical necessity criteria" for your services for the entire period
- ✓ Until you or your provider end treatment (for example, if you complete your treatment)
- ✓ Your provider ends their contract with us or we end our contract with them

You may choose to receive your services from a different provider from within our network at any time. If you are interested in transferring to our network, please contact us at 800-838-1381 to talk with us about your choices. About 30 calendar days before the end of this authorization, we will contact you and your provider by phone to discuss your needs. We will help you switch your services to our network. If you have questions or concerns about the authorization or timeline, please contact San Luis Obispo Behavioral Health Department's Managed Care team at 800-838-1381.

Page Footer

CONFIDENTIAL PATIENT INFORMATION – NOT TO BE FORWARDED
This information has been disclosed to you from records that are **confidential** and protected by **state confidentiality law** that protects mental health records (See California Welfare and Institutions Code Section 5328). Information subject to release in accordance with Federal Privacy Act of 1974 (Public Law 93-597). This information has been disclosed to you from records protected by **Federal confidentiality rules** (42 CFR. Part 2, Section 2.32). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Total pages included: _____

*The Health Agency complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or any other protected class*

**County of San Luis Obispo Health Agency**
2180 Johnson Avenue | San Luis Obispo, CA 93401 | (P) 805-781-4719 | (F) 805-781-1273
info@slocounty.ca.gov | slocounty.ca.gov

# 3.40 Emergency Referrals

## I. PURPOSE

The County of San Luis Obispo Behavioral Health Department (SLOBHD) providers and contracted providers will ensure that all beneficiaries and program staff have immediate access to referral information for physical health, mental health, and substance use crisis related emergencies.

## II. POLICY

SLOBHD will post emergency referral information in a place visible to all beneficiaries and program staff. The posting will include the name, address, and telephone number of the fire department, a crisis center, local law enforcement, and a paramedical unit or ambulance service. Emergency referral information will notify the beneficiary of how to obtain physical health, mental health, and substance use crisis emergency services. Additionally, for Drug & Alcohol Services clients, information about emergency services will be supplied directly to the client via the Drug & Alcohol Services Client Handbook upon admission.

## III. REFERENCE

- Alcohol and/or other Drug Program Certification Standards, Section 7060 http://www.dhcs.ca.gov/provgovpart/Documents/MHSUDS_Information_Notice_17-017_AOD_Certification_Standards.pdf
- California Code of Regulations Title 9, §1810.209

## IV. DEFINITIONS

A. Substance Use Crisis: When a client is at imminent risk of relapse or has relapsed, or client is experiencing other immediate needs that place them at risk of relapse.
B. Mental Health Crisis: A situation experienced by the client that, without timely intervention, is likely to result in an immediate emergency psychiatric condition.

## V. PROCEDURE

A. The following emergency information will be posted in the Client Information Center at each clinic site:
    1. Physical Emergency: Beneficiaries will be referred to contact 911 or their nearest hospital.
    2. Behavioral Health Emergency: Beneficiaries will be referred to the Central Coast Hotline number: 1-800-783-0607.

B. The toll-free Central Coast Hotline crisis number (1-800-783-0607) will be posted on the outside door/window of each clinic.

## VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 09/09/2024 | All | Formatting |
| | | |
| Prior Approval dates: | | |
| 4/19/2018 | | |

| *Signature on file* | | *09/10/2024* |
|---|---|---|
| Approved by: | Star Graber, PhD, LMFT, Behavioral Health Administrator | Date |

# Section 4

# Beneficiary Protection

# 4.00 Patients Rights' Advocate

## I. PURPOSE

To clarify the duties, role and responsibilities of the Patient's Rights Advocate (PRA)

## II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will implement a problem resolution process that enables each beneficiary to resolve problems or concerns about any issue related to SLOBHD's performance of its duties. The PRA will ensure that beneficiary rights are promoted and protected and that the problem resolution process works effectively for SLOBHD beneficiaries

## III. Reference

- Welfare & Institutions Code, §§ 5510 – 5523
- Code of Federal Regulations, Title 42, §438.10

## IV. PROCEDURE

### A. Beneficiary Informing

1. The PRA will ensure that beneficiaries are informed of their rights and have access to the problem resolution processes. Informing materials will be provided to clients at the beginning of services and upon request thereafter. Informing materials will be available in English, Spanish and alternative formats.
2. The PRA will ensure that the Beneficiary Handbooks, Guide to Mental Health Services and Guide to Substance Use Disorder Services, which contain detailed information about the problem resolution and rights, will be available at all certified sites, through the 24/7 Central Access line at: 800-838-1381 and online at SLOBHD's website.
3. The PRA will ensure that SLOBHD's Client Information Centers contain notices explaining grievance, appeal, and expedited appeal process and patient's rights so that the information will be readily available to both beneficiaries and staff.
4. The PRA will ensure that Consumer Request Forms and postage paid, self-addressed envelopes will be available in each Client Information Center. Clients will be able to obtain, complete and return a Consumer Request Forms without having to make a verbal or written request to anyone.
5. The PRA will ensure that contact information for the PRA and the State Office of Patients' Rights will be posted in all Behavioral Health facilities.

B. Problem Resolution
   1. The PRA will receive, investigate and resolve complaints received from providers or beneficiaries about violations of patient's rights. Refer to Policy 4.07 Grievances, Appeals and Expedited Appeals for detail.
   2. The PRA will track, log and respond to advocates to beneficiaries and/or representatives regarding requests for Second Opinions, Change of Provider, Grievances, Appeals and Expedited Appeals.
   3. The PRA will, at the beneficiary's request, assist the beneficiary with problem resolution processes. Assistance will include, but not be limited to, help writing the grievance/appeal/expedited appeal on a Consumer Request Form.
   4. The PRA will coordinate prompt resolution of grievances and appeals and will notify beneficiaries of the disposition of the problem.

C. Monitoring for compliance
   1. The PRA will monitor Behavioral Health facilities, services and programs for compliance with statutory and regulatory patients' rights provisions.
   2. The PRA will review instances when a specific right has been denied to a patient at the SLOBHD Psychiatric Health Facility.

D. Training and Education
   1. The PRA will provide training and education about Behavioral Health law and patients' rights to Behavioral Health providers.
   2. The PRA will provide training and education about Behavioral Health law and patients' rights to family and community members.

E. Coordination with State Agencies
   1. The PRA will provide de-identified data to the Department of Health Care Services (DHCS) on an annual basis. The information from the Grievance/Appeal Log is used by DHCS to monitor SLOBHD's performance.
   2. The PRA will coordinate with the State Office of Patients' Rights.

F. Quality Improvement and System Change
   1. The PRA will present problem resolution issues to the Quality Support Team (QST) Committee a quarterly basis (more frequently if needed) for quality improvement purposes.
   2. The PRA will participate on key QST committees and subcommittees to ensure that beneficiaries concerns have a voice in SLOBHD decision making.
   3. The QST Committee and the PRA will forward concerns to the Behavioral Health Administrator as needed to effect system changes.

G. Organizational Structure
   1. The PRA will directly report to the Behavioral Health Administrator.
   2. The PRA will receive additional support from the QST Division Manager.

H. DUTIES: the PRA will:

- Ensure beneficiaries are informed of their rights
- Have knowledge of patients' rights in institutional and community facilities
- Have knowledge of civil commitment statutes and procedures
- Have knowledge of state and federal laws and regulations affecting recipients of Behavioral Health services
- Work effectively with service recipients and providers, public administrators, community groups, and the judicial system
- Be skillful in interviewing and counseling service recipients, including giving information and appropriate referrals
- Be able to investigate and assess complaints and screen for legal problems
- Have knowledge of administrative and judicial due process proceedings in order to provide representation at administrative hearings and to assist in judicial hearings when necessary
- Have knowledge of, and commitment to, advocacy ethics and principles.
- Ensure beneficiaries are informed of their rights
- Advocate for beneficiaries
- Receive and investigate complaints
- Monitor behavioral health facilities, services and programs for compliance with patient's rights provisions
- Provide training and education for providers and beneficiaries
- Shall serve as a liaison between SLOBHD County patients' rights and the State Department of Health Care Services
- Exchange information with the State Patient's Rights Program

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V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/18/2015 | All | Added purpose, reformatted, added F |
| 08/17/2017 | All | Reformatted, New CRF language |
| 11/28/2018 | Entire Policy | PHF (SAP) 12.00 reviewed, hyperlinked to original Outpatient 4.00 |
| Prior Approval dates: | | |
| 5/30/2009, 6/5/2010, 10/12/2012 | | |

| | | |
|---|---|---|
| *Signature on file* | | *08/24/2017* |
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 4.01 Mental Health Services Act –Issue Resolution Process

## I. PURPOSE

To provide a process for addressing issues, complaints and grievances about the County of San Luis Obispo's Mental Health Services Act (MHSA) planning process and subsequent activities.

## II. POLICY

County of San Luis Obispo County's Behavioral Health Department (SLOBHD) has a system for community members and stakeholders to resolve concerns or grievances regarding the activities of the MHSA.

## III. REFERENCE(S)

- California Code of Regulations, Title 9, Chapter 14, Section 529
- Welfare & Institutions Code §§ 5650 and 5651
- AB100

## IV. BACKGROUND

A. SLOBHD is committed to:
   - Addressing MHSA-related issues and concerns in an expedient and appropriate manner.
   - Providing several avenues to file an issue, complaint or grievance.
   - Ensuring assistance is available, if needed, for the community member to file their issue.
   - Honoring the Issue Filer's confidentiality.

B. Types of MHSA Issues to be resolved in this process are:
   - Appropriate of use of MHSA funds
   - Inconsistency between approved MHSA Plan and implementation
   - San Luis Obispo County Community Program Planning Processes
   - Access to MHSA Programs

## V. PROCEDURE

A. The State requires that the local issue resolution process be exhausted before accessing State entities [including Department of Health Care Services (DHCS), the Mental Health Services Oversight and Accountability Commission (MHSOAC)) or California Mental Health Planning Council (CMHPC)] to seek issue resolution or to file a complaint or grievance. San Luis Obispo County Behavioral Health Department's Mental

Health Services provides this issue resolution process for filing and resolving issues related to MHSA services, community program planning processes, and consistency between program implementation and approved plans.

B. If any community member or stakeholder (including consumers/family members, providers, or members of the general public) is dissatisfied with any MHSA activity or process, the individual may file a grievance at any point with the Grievance Coordinator or the MHSA Division Manager.
C. Issues are forwarded to the Grievance Coordinator (i.e. Patient's Rights Advocate), either orally or in writing, by completing a Consumer Request Form (See Attachment A) or in a letter.
D. Within one (1) working day of the Grievance Coordinator's receipt of the grievance, the Grievance Coordinator determines if the issue is to be addressed through the MHSA Issue Resolution Process or if it is an issue of service to be addressed by the County Grievance Process. The Grievance Coordinator acknowledges the receipt of the complaint in writing to the filer within two (2) working days.
E. If the issue is MHSA-related and not regarding service delivery to consumers:
    1. The Grievance Coordinator notifies the County's MHSA Coordinator of the issue received. The Grievance Coordinator communicates with the Issue Filer regarding the grievance and informs him/her of the resolution to the grievance within 60 days.
    2. The County MHSA Coordinator attempts to resolve the issue, at which point the Grievance Coordinator is informed and directed to provide a response to the Issue Filer within 60 days from filing the grievance.
    3. In case the MHSA Coordinator cannot resolve the issue, an ad-hoc panel subcommittee of the Mental Health Board known as the MHSA Issue Resolution Committee (IRC) (including consumers/family members, community members, and other stakeholders) is convened to address the issue. If needed, the IRC conducts a review of the issue and hold interviews or other investigative actions to determine a pathway to resolution. In this case, the 60-day window for a resolution will be extended.
    4. Upon completion of review, the IRC issues a committee report to the Behavioral Health Administrator. The report includes a description of the issue, brief explanation of the review, and the IRC's recommendation for the County resolution to the issue.
    5. The Grievance Coordinator responds to the Issue Filer of the resolution in writing and provides information regarding the appeal process and State level opportunities for additional resolution, if desired.
    6. The Behavioral Health Administrator provides a quarterly MHSA Issue Resolution Report to the Mental Health Board.
F. If the grievance is related to service delivery to a consumer, refer to policy 4.07, Beneficiary Grievances, Appeals & Expedited Appeals

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VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/30/2015 | All | Reformatting |
| 12/27/2017 | All | Reformatting |
| Prior Approval dates: | | |
| 1/20/2012 | | |

| *Signature on file* | | *11/23/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 4.03 Change of Provider Request

I. PURPOSE

To clarify the Change of Provider Request process

II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will, whenever feasible, provide beneficiaries an opportunity to choose or change persons providing outpatient Specialty Mental Health Services (SMHS) and Substance Abuse Disorder Services (SUDS). SLOBHD will limit the choice to another provider employed by or contracting with SLOBHD.

III. Reference

- California Code of Regulations, Title 9, §1830.225
- Code of Federal Regulations, Title 42, §438.10, §438.406
- MHP Contract, Exhibit A, Attachment I, Section 7

IV. PROCEDURE

A. Beneficiary Informing

1. Beneficiaries will be informed of the right to request a change of provider at the beginning of services and upon request thereafter.

2. The Beneficiary Handbooks, Guide to Mental Health Services and/or Guide to Substance Use Disorder Services, contain detailed information about the process and will be available at all certified sites, through the 24/7 Central Access line at: 800-838-1381, and posted on the SLOBHD website.

3. SLOBHD will post Client Information Centers at each certified site. Consumer Request Forms and postage paid, self-addressed envelopes will be available in each Client Information Center. Clients are able to obtain, complete and return a Consumer Request Forms without having to make a verbal or written request to anyone.

B. A change of provider request that is the result of beneficiary dissatisfaction with any aspect of care will be considered a grievance, and will be processed according to Policy 4.07 Grievances, Appeals and Expedited Appeals.

C. A beneficiary may request a change of provider at any time, either orally or on a written Consumer Request Form, whether or not dissatisfied with an aspect of care.

D. SLOBHD staff, including the Patient's Rights Advocate (PRA), will be available to assist the beneficiary with completing the Consumer Request Form

E. The Consumer Request Form will be sent to the PRA, who will review the form and take following action:

1. Log the change of provider request and send the consumer a confirmation letter to the beneficiary within one working day.

2. If the request has been resolved at the clinic or program level, the PRA will confirm the disposition of the request with the beneficiary in writing.

3. If the request has not been resolved, the PRA will then send a copy of the Consumer Request Form to the appropriate Program Supervisor or Medical Director for review and disposition.

4. The Program Supervisor or Medical Director will notify the PRA of the resolution of the request within 90 calendar days of the request.

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V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/01/2015 | All | Reformatting |
| 08/17/2017 | All | Reformatting, Added new CFR language |
| 09/22/2018 | All | Reformatting & updated language |
| Prior Approval dates: | | |
| 05/30/2009, 06/05/2010 | | |

| *Signature on file* | | *10/10/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 4.04 Second Opinions

## I. PURPOSE

To clarify when Medi-Cal beneficiaries are entitled to a second opinion.
To clarify other instances when client may request and receive a second opinion.

## II. POLICY

At the request of a client, San Luis Obispo County Behavioral Health Department (SLOBHD) will provide for a second opinion by a licensed Behavioral Health professional when SLOBHD determines that medical necessity criteria have not been met and that the client is, therefore, not entitled to any Specialty Mental Health services (SMHS) or Substance Use Disorder Services (SUDS).

SLOBHD will honor all other requests for second opinions to the extent resources are available and when the request is consistent with sound clinical practice/clinically indicated.

## III. REFERENCE

- California Code of Regulations, Title 9, §§ 1810.405(e)
- Code of Federal Regulations, Title 42, §438.206(b)(3)
- MHP Contract, Exhibit A, Attachment I, Section 1(d)
- Policy 4.07, Grievances, Appeals and Expedited Appeals
- Policy 3.30, Notices of Adverse Benefit Determination

## IV. PROCEDURE

### A. Beneficiary Informing

1. Information regarding second opinions will be provided to clients at the beginning of services and upon request thereafter.
2. The Beneficiary Handbooks, "*Guide to Mental Health Services*" and/or *"Guide to Substance Use Disorder Services"*, contain detailed information about the process and will be available at all certified sites, through the 24/7 Central Access line at 800-838-1381, and are posted on SLOBHD's website.
3. SLOBHD will post Client Information Centers at each certified site, which will contain notices explaining second opinions to ensure that the information is readily available to both beneficiaries and staff.
4. Consumer Request Forms and postage paid, self-addressed envelopes will be available in each Client Information Center. Clients are able to obtain, complete and return a Consumer Request Forms without having to make a verbal or written request to anyone.
5. SLOBHD will provide the beneficiary with a Notice of Adverse Benefit Determination (NOABD) when SLOBHD determines that the client does not meet the medical

necessity criteria and, therefore, is not entitled to any SMHS or SUDS. The NOABD will provide the beneficiary with information about how to file an appeal or expedited appeal.

B. A request for second opinion following a NOABD will be considered an appeal or an expedited appeal and will be processed according to policy 4.07 Grievances, Appeals and Expedited Appeals. Refer to policy 4.07 for details regarding:

- Filing the appeal/second opinion request
- Assistance from SLOBHD staff including the Patient's Rights Advocate (PRA)
- Logging/confirming receipt by the PRA
- Timeline for resolution (30 days from receipt of appeal)
- Review process, including the beneficiary's access to the record and ability to present evidence
- Notification of Disposition
- Payment for services, including "aid paid pending"

C. SLOBHD will utilize licensed Behavioral Health professionals (other than a licensed psychiatric technician or a licensed vocational nurse) who were not involved in the initial assessment to review evidence and make decisions on second opinion appeals/expedited appeals.

D. SLOBHD will determine whether the second opinion requires a face-to-face encounter with the beneficiary.

E. SLOBHD will train staff in documentation training that second opinions are offered at no cost to clients and will be documented in the health record utilizing the "Non-billable Service Must Document" procedure code to document the assessment service.

F. Clients who seek a second opinion will not be subject to discrimination or any other penalty.

G. Appealing the Second Opinion Decision
If the second opinion/appeal is not resolved wholly in favor of the beneficiary, the PRA will inform the beneficiary of the right to a fair hearing and the procedure for filing for a fair hearing after the appeal process has been exhausted.

H. Other Second Opinion Requests
When client disputes a clinical decision or requests a second opinion at a time other than described in B above, SLOBHD will honor the request to the extent resources are available and if the request is clinically indicated.

I. Second Opinion regarding medication

1. Applies to any client who requests a second opinion about medication. Unlike second opinions related to the denial of a service, which are an entitlement and are limited

to Medi-Cal beneficiaries, any client may request a second opinion about medication. The Medical Director will determine whether to schedule a second opinion and with whom to schedule. SLOBHD will honor requests for second opinions about medication to the extent resources are available and to the extent that the request is clinically appropriate. When the requested medication is clinically contraindicated or is inconsistent with sound medical practice, the Medical Director need not approve a second opinion.

2. This type of second opinion is not the result of an Adverse Benefit Determination and does not require a NOABD. A second medical opinion may, but is not automatically, a Grievance.
3. "Client's representative" may substitute for "client" below.

J. ***Procedure:*** When a client requests a second opinion about medication, the treatment team (Medication Manager and/or MD/NP) will:

1. Clarify with the client and document in the record the specific concerns or questions raised by the client and attempt to resolve those issues with the current provider(s)
2. When concerns cannot be resolved at this level, the client will complete a Consumer Request Form (CRF) to request a second medical opinion. Treatment team will offer to help the client complete the form as needed or may refer the client to the Patient's Rights Advocate (PRA) for assistance with the CRF.

K. ***Procedure:*** When the PRA receives a request for a Second Opinion regarding medication, the PRA will:

1. Assist the client in completing the CRF (if needed) and will clarify the reason for the request
2. Discuss the above with the Medical Director and obtain approval to arrange a second opinion with a provider designated by the Medical Director
3. Contact the client to provide the clinic and provider information for the second opinion and direct the client to contact the AA at the site where the second opinion will occur to schedule
4. If the client is complaining about an aspect of care, the PRA will log the client's Grievance
5. If the Medical Director determines that a second opinion is not warranted, the PRA will inform the client by phone and in writing of the findings according to Grievance procedures

L. When the client calls to schedule, the AA at the second opinion site will:

1. Schedule an appointment with the provider approved by the Medical Director. When scheduling, select "Medical Non-billable Note" for the Billing Type. This will prevent the service from claiming.
2. Notify the site HIT

M. The second opinion site HIT will:

1. Enroll client in clinic program to the MD/NP who will conduct the second opinion and set the discharge date for 21 days after scheduled second opinion
2. The original site assignments will remain open

N. The provider who completes the second opinion will:

1. Discuss treatment recommendations with the client
2. Document the findings and recommendations in a Progress Note in the client's record
3. Email the original prescriber and the Medical Director to alert the provider to the completion of the evaluation

O. The original provider will:

1. Review the second opinion recommendations
2. Discuss the recommendations with the provider who conducted the second opinion (and with the Medical Director, as needed)
3. Discuss second opinion and all treatment options with the client to develop an agreed upon course of treatment
4. Implement agreed upon course of treatment, which may match the original course of treatment, the second opinion recommendations, or may be different than both

P. If the original provider and client are unable to reach an agreed upon course of treatment, the client will request a change of provider

Q. The PRA will present second opinion request data to the SLOBHD Quality Improvement Committee (QIC) on a quarterly basis (more frequently if needed) for quality improvement purposes. The QIC will forward concerns to the Behavioral Health Administrator as needed to effect system changes.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/01/2015 | All | Reformatting |
| 08/17/2017 | All | Reformatting, New CRF language |
| 01/02/2018 | All | Reformatting |
| 08/15/2018 | Section I | Added section from current procedure |
| 06/21/2024 | IV. E, K.3, L.1 & M.1 | Update to reflect changes in EHR documentation |
| Prior Approval dates: | | |
| 5/30/2009, 6/5/2010, 10/12/2012 | | |

| *Signature on file* | | *07/25/2024* |
|---|---|---|
| Approved by: | Star Graber, PhD., LMFT, Behavioral Health Administrator | Date |

# 4.07 Beneficiary Grievances, Appeals & Expedited Appeals

I. PURPOSE

To ensure that all Medi-Cal beneficiaries are informed of and have access to effective problem resolution processes.

II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will implement a problem resolution process that enables each beneficiary to resolve problems or concerns about any issue related to SLOBHD's performance of its duties. The Appeals and Expedited Appeals processes will ensure that beneficiaries have a means to respond to any adverse benefit determination taken by SLOBHD. The Grievance process will ensure that beneficiaries have a means to resolve all other concerns about the care they receive at SLOBHD.

SLOBHD will ensure that all Medi-Cal beneficiaries are well informed about the grievance and appeals processes and will implement the processes in a manner that addresses beneficiaries' cultural and linguistic needs.

SLOBHD will process Grievances, Appeals and Expedited Appeals within the periods established by law.

III. REFERENCE

- California Code of Regulations, Title 9, §§ 1810.200, 1810.375, 1810.203.5, 1810.216.2,1850.205 – 1850.208
- Code of Federal Regulations, Title 42, §§ 438.400 – 438.424, 438.3(h)
- MHP Contract, Exhibit A, Attachment I, Sections 7 and 15
- DMC-ODS Waiver Contract
- DMH Letter 05-03
- MHSUDS Information Notice 18-010E

IV. PROCEDURE

## A. Beneficiary Informing

1. Information regarding the problem resolution processes will be provided to clients at the beginning of services and upon request thereafter. See *Beneficiary Rights and Informing Processes* for detail regarding availability of materials in alternative formats and electronic form on the SLOBHD website.

2. The Beneficiary Handbooks, *Guide to Mental Health Services* and *Drug Medi-Cal Organized Delivery System Guide to Beneficiary Services* contain detailed information about the processes and will be available at all certified sites, through the 24/7 Central Access line at: 800-838-1381, and posted on the SLOBHD website in a machine readable and downloadable format.
3. SLOBHD will post Client Information Centers at each certified site, which will contain notices explaining grievance, appeal, and expedited appeal processes to ensure that the information is readily available to both beneficiaries and staff.
4. Consumer Request Forms and postage paid, self-addressed envelopes will be available in each Client Information Center. Clients can obtain, complete and return a Consumer Request Forms without having to make a verbal or written request to anyone.

**B. General Provisions**

1. A beneficiary may authorize, in writing, another person to act on the beneficiary's behalf (representative). A representative may be a health care provider, another individual known to the beneficiary, or the legal representative of a deceased beneficiary's estate. The beneficiary's representative may use the grievance, appeal, expedited appeal, or State Hearing processes on the beneficiary's behalf.
2. All grievances/appeals/expedited appeals will be directed to the Patients' Rights Advocate (PRA) for logging and assistance.
3. A beneficiary or a provider will not be subject to discrimination or any other penalty or punitive adverse benefit determination for filing a grievance/appeal/expedited appeal.
4. All grievances/appeals/expedited appeals will be resolved in a confidential manner that respects the rights, dignity, and cultural or language needs of the beneficiary.
5. The PRA will be a standing member of SLOBHD's Quality Support Team (QST) Committee. On a quarterly basis for DAS (or more frequently if needed) and an annual basis (or more frequently if needed) for MH, the PRA will present problem resolution issues to the committee for quality improvement purposes. The QST Committee will forward concerns to the Behavioral Health Administrator as needed to effect system changes.

**C. Filing a Grievance/Appeal/Expedited Appeal**

1. The Consumer Request Form (CRF) will be available for written submission of grievances/appeals/expedited appeals, but beneficiaries are not required to use the CRF.
2. The PRA will, at the beneficiary's request, assist with these filing processes. Assistance will include, but not be limited to, help writing the grievance, appeal, or

expedited appeal on a CRF and arranging for interpreter services, including ASL and/or California Relay Service for TTY/TTD.

3. The date and time of the initial oral or written submission starts the disposition timeline.
4. Grievances may be filed orally or in writing at any time.
5. Appeals and expedited appeals must be filed within 60 days of the date on the Notice of Adverse Benefit Determination (NOABD) that is being appealed.
6. Appeals will be initially filed orally or in writing. An oral appeal must be followed up by a written, signed appeal. If a written, signed appeal is not received, the resolution of the appeal will not be dismissed or delayed.
7. Expedited appeals can be filed orally without requiring that the request be followed by a written appeal.

**D. Standard Grievances**

1. Acknowledgement
   a. SLOBHD will provide to the beneficiary written acknowledgement of receipt of the grievance. The acknowledgement letter shall include the date of receipt, as well as the name, telephone number and address of the PRA, who the beneficiary may contact about the grievance.
   b. The written acknowledgement to the beneficiary must be postmarked within five calendar days of the receipt of the grievance.
2. Resolution timeline:
   a. SLOBHD will resolve grievances as expeditiously as the beneficiary's condition requires, not to exceed 90 calendar days from the day SLOBHD receives the grievance.
   b. SLOBHD may extend the timeframe for an additional 14 calendar days if the beneficiary requests the extension or if SLOBHD shows that there is need for additional information and how the delay is in the beneficiary's interest.
   c. If SLOBHD extends the timeframe not at the request of the beneficiary, staff will:
      i. Give the beneficiary prompt oral notice of the delay
      ii. Give the beneficiary written notice of the reason for the decision to extend the timeframe within two calendar days of the making the decision
      iii. Inform the beneficiary of the right to file a grievance if he/she disagrees with that decision. The timeframe for resolving grievances related to disputes of a decision SLOBHD has made to extend the timeframe for making an authorization decision will not exceed 30 calendar days.
      iv. Resolve the grievance no later than the date the extension expires.
   d. If a resolution of a standard grievance is not reached within 90 calendar days as required, SLOBHD will provide the beneficiary with an NOABD, and include the

status of the grievance and the estimated date of resolution, which shall not exceed 14 additional calendar days.

3. Notification of Resolution
   a. Resolved means that SLOBHD has reached a decision with respect to the beneficiary's grievance and notified the beneficiary of the disposition. It does not automatically mean that SLOBHD agrees with the beneficiary.
   b. The PRA will provide written notification of resolution to beneficiaries, representatives, and any provider involved in or identified by the beneficiary of the final disposition of the process.
   c. SLOBHD will use a Notice of Grievance Resolution (NGR) to provide this notification. The NRG will contain a clear and concise explanation of SLOBHD's decision.
4. Grievance Exemptions
   a. Grievances received over the telephone or in-person or by SLOBHD or a provider that are resolved to the beneficiary's satisfaction by the close of the next business day following receipt, are exempt from the requirement to send a written acknowledgement and disposition letter.
   b. Exempt grievances must still be logged and reported to DHCS annually.

## E. Standard Appeal Process

1. SLOBHD shall have only one level of appeal for beneficiaries.
2. The appeal process is available for beneficiaries after SLOBHD makes an adverse benefit determination.
3. SLOBHD will consider an oral inquiry seeking to appeal an adverse benefit determination as an appeal to establish the earliest possible filing date for the appeal and must acknowledge receipt of the oral appeal in writing.
4. Acknowledgement
   a. SLOBHD will provide the beneficiary with written acknowledgement of receipt of the appeal. The acknowledgement letter shall include the date of receipt, as well as the name, telephone number and address of the PRA, who the beneficiary may contact about the appeal.
   b. The written acknowledgement to the beneficiary must be postmarked within five calendar days of the receipt of the appeal.
5. Resolution Timelines, Standard Appeal
   a. SLOBHD will resolve the appeal as expeditiously as the beneficiary's condition requires, not to exceed 30 calendar days from the date of receipt.
   b. SLOBHD may extend the resolution timeframe for standard appeals by up to 14 calendar days if either of the following two conditions apply:

c. the beneficiary requests the extension or,
    i. SLOBHD demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the beneficiary's best interest.
d. For any extension not requested by the beneficiary, SLOBHD will:
    i. Provide the beneficiary with written notice of the reason for delay
    ii. Make reasonable efforts to provide the beneficiary with prompt oral notice of the delay
    iii. Resolve the appeal as expeditiously as the beneficiary's health condition requires
e. SLOBHD will not extend the resolution beyond the 14-calendar day extension
f. If SLOBHD fails to adhere to the timing requirements, the beneficiary is deemed to have exhausted the SLOBHD's appeal process and may initiate a State Hearing.

6. Notification of Resolution
    a. The PRA will provide written notification of resolution to beneficiaries, representatives, and any provider involved in or identified by the beneficiary of the final disposition of the process using the Notice of Appeal Resolution (NAR) form and the "Your Rights" attachment.
    b. The NAR will include the following:
        i. The results of the resolution and date it was completed
        ii. The reason for the determination, including criteria, clinical guidelines and policies used in reaching the determination
        iii. For appeals resolved in the favor of the beneficiary, the response shall contain an explanation of the reason, including why the decision was overturned
        iv. For appeals not resolved wholly in the favor of the beneficiary, the right to request a State Hearing and how to request is
        v. For appeals not resolved wholly in the favor of the beneficiary, the right to request and receive benefits while the hearing is pending and how to make the request
        vi. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds SLOBHD's adverse benefit determination
    i. The "Your Rights" Attachment provides beneficiaries with the following required information pertaining to the NAR:
        i. The beneficiary's right to request a State Hearing no later than 120 calendar days from the date of the written appeal resolution and instructions on how to request a State Hearing.
        ii. The beneficiary's right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made (within

ten days from the date the letter was post-marked or delivered to the beneficiary)

**F. Expedited Appeal Process**

1. An Expedited Appeal allows the beneficiary or representative to request a review of an adverse benefit determination that would seriously jeopardize the beneficiary's life, health or ability to attain, maintain or regain maximum function.
2. Determination about whether an appeal is expedited or standard
   a. When a beneficiary or representative request an expedited appeal, SLOBHD must determine whether an appeal as expedited in a timely fashion so that the matter may be resolved within the expedited appeal timeline
   b. If SLOBHD agrees that the matter is an expedited appeal, the resolution will proceed as described beginning with 3 below
   c. If SLOBHD denies a beneficiary's request for an expedited appeal resolution, the PRA will:
      i. Make reasonable efforts to provide prompt oral notice to the beneficiary and/or representative of the denial of the request for an expedited appeal
      ii. Provide written notice within two calendar days of the date of the denial and notify the beneficiary and representative of the right to grieve SLOBHD's decision
      iii. Resolve the appeal as expeditiously as the beneficiary's health condition requires and within the timeframe for a standard resolution of an appeal
3. Resolution Timeline, Expedited Appeal
   a. SLOBHD will resolve the appeal within 72 hours of the oral or written request
4. Notification of Resolution
   a. SLOBHD will make a reasonable effort to provide prompt oral notice to the beneficiary and representative
   b. SLOBHD will follow the written notification process described in D6 for expedited appeals.

**G. Review process for Grievances, Appeals and Expedited Appeals**

1. SLOBHD will allow the beneficiary and representative to examine the beneficiary's medical records, any other documents or records and any new or additional evidence considered, relied upon, or generated by SLOBHD related to the adverse benefit determination, grievance, appeal or expedited appeal. Access will be granted before and during the grievance, appeal, or expedited appeal process. This information will be provided free of charge and sufficiently in advance of the

resolution timeframe for the grievance, appeal, or expedited appeal t allow review of the record.

2. SLOBHD will provide the beneficiary with a limited opportunity to present evidence, in person or in writing, and to make legal and factual arguments pertaining to the grievance, appeal, or expedited appeal, and will advise the beneficiary of any time constraints for presenting information.
3. SLOBHD will consider all comments, documents, records, and other information submitted by the beneficiary or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
4. SLOBHD will utilize staff to review grievances, appeals, and expedited appeals who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual and who have authority to make binding recommendations.
5. If a grievance, appeal, or expedited appeal is about a clinical issue, including whether medical necessity criteria are met, or about the decision to deny a request for expedited appeal, SLOBHD will utilize staff with appropriate clinical expertise to review and make decisions on the matter.
6. The PRA will monitor progress of the review and will advise the beneficiary, representative, and provider of the status upon request.

**H. After the Review of an Appeal, Expedited Appeal, or State Hearing**

1. SLOBHD will promptly provide or arrange and pay for the disputed services if the decision of the appeal, expedited appeal, or State Hearing reverses a decision to deny, limit, or delay services.
2. SLOBHD will authorize (schedule or provide) services no later than 72 hours from the date/time the reverse determination was authorized.

**I. Continuation of Benefits During an Appeal or State Hearing**

1. SLOBHD will provide continuation of benefits when:
   a. The beneficiary filed a timely appeal
   b. The beneficiary requested continuation of benefits within 10 calendar days of the date the NOABD was mailed given to the beneficiary
   c. The appeal or expedited appeal is due to the termination, suspension, or reduction of a previously authorized service
   d. The services were requested by a SLOBHD provider
   e. The authorization has not expired

2. When SLOBHD authorizes a continuation of benefits, the authorization is valid until:
   a. The beneficiary withdraws the appeal, expedited appeal, of State Hearing request

b. The beneficiary fails to request a State Hearing within 10 calendar days of the adverse appeal NAR
c. The State Herring office issues an adverse ruling to the beneficiary

3. If the State Hearing office upholds SLOBHD's adverse appeal determination, SLOBHD may elect to recover costs of continued benefits

### J. Grievance/Appeal Log

1. The PRA will record each grievance/appeal/expedited appeal in a Grievance/Appeal
2. Log within one working day of receipt. The log will contain all the following:
   a. Name of the beneficiary
   b. A general description of the reason for the appeal or grievance
   c. The date and time of receipt of the grievance or appeal
   d. The name of the representative recording the grievance or appeal
   e. A description of the action taken to investigate and resolve the grievance or appeal
   f. Date of resolution
   g. Persons responsible for resolution
   h. Final resolution
   i. Date the written decision is sent to the beneficiary
3. The PRA will report de-identified data to DHCS from the log on an annual basis that summarizes beneficiary grievances, appeals and expedited appeals. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas and by disposition.
4. The details of beneficiary grievances, appeals, and expedited appeals will be available for DHCS review upon request
5. The PRA will retain the log and records for a period of no less than 10 years.

## V. DEFINITIONS:

- **Adverse benefit determination**:
  - ❖ The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
  - ❖ The reduction, suspension, or termination of a previously authorized service.
  - ❖ The denial, in whole or in part, of payment for a service.
  - ❖ The failure to provide services in a timely manner, as defined by SLOBHD
  - ❖ A failure to act within the timeframes for resolution of grievances, appeals, or expedited appeals

- **Appeal**
  - ❖ A review by SLOBHD of an adverse benefit determination when requested by a beneficiary or provider.

- ❖ A request by a beneficiary or a beneficiary's representative for review of an adverse benefit determination.
- ❖ A request by a beneficiary or a beneficiary's representative for review of a provider's determination to deny or modify a beneficiary's request for Specialty Mental Health Services (SMHS) and/or Substance Use Disorder Services (SUDS).
- ❖ A request by a beneficiary or a beneficiary's representative for review of the timeliness of the delivery of a SMHS or SUDS when the beneficiary believes that services are not being delivered in time to meet the beneficiary's needs, whether or not SLOBHD has established a timeliness standard for the delivery of service.

- **Expedited Appeal: The accelerated resolution of an appeal when SLOBHD determines** or the beneficiary and/or the beneficiary's provider certifies that following the timeframe for an appeal would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

- **Grievance:** A beneficiary's verbal or written expression of dissatisfaction about any matter other than a matter covered by an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by SLOBHD to make an authorization decision.

VI. DOCUMENT HISTORY

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| 11/18/2015 | Purpose<br>All | Added Purpose<br>Combined Policies 4.02, 4.07, 4.08, 4.10 |
| 08/15/2017 | All | Updated with CFR 42 language and timeliness |
| 09/17/2018 | All | Updated references |
| 10/04/2018 | All | Minor edits to improve organization and flow |
| 11/28/2018 | All | PHF (SAP) review no revisions. Original OP 4.07 hyperlinked to 12.04 PHF |
| 2/2/2022 | IV.G | Word change to #2 |
| /Prior Approval dates: 5/30/2009, 6/5/2010, 10/12/2015 | | |

| *Signature on file* | | *2/8/2022* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 4.09 Fair Hearing Process

I. PURPOSE

To ensure that all Medi-Cal beneficiaries are informed of and have access to effective problem resolution processes

To clarify that a Fair Hearing is the last stage in the problem resolution process and is available when a beneficiary has exhausted the SLOBHD's problem resolution process

II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will implement a problem resolution process that enables each beneficiary to resolve problems or concerns about any issue related to SLOBHD's performance of its duties.

SLOBHD will inform beneficiaries of the availability of the Fair Hearing process and how to file for a Fair Hearing. SLOBHD will assist beneficiaries with filling upon request.

III. REFERENCE

- California Code of Regulations, Title 9, §§1810.216.4, 1810.216.6 1850.205, 1850.207, 1850.210 –1850.215,
- California Code of Regulations, Title 22, §§51014.1 – 51014.2, 50951 – 50955
- Welfare & Institutions Code §§10950 – 10965
- Code of Federal Regulations, Title 42, §§438.400 – 438.424
- MHP Contract, Exhibit A, Attachment I, Sections 7 and 15
- DMH Letter No. 05-03
- SLOBHD Policy 4.07 Grievances, Appeals and Expedited Appeals
- SLOBHD Policy 3.30 Notices of Adverse Benefit Determination

IV. PROCEDURE

A. Beneficiaries shall have the right to a State Fair Hearing if dissatisfied with any Notice of Adverse Benefit Determination (NOABD) of SLOBHD.

B. Beneficiary Informing

1. Information regarding the problem resolution processes will be provided to beneficiaries at the beginning of services and upon request thereafter.
2. The Beneficiary Handbooks, *Guide to Mental Health Services* and/or *Guide to Substance Use Disorder Services*, contain detailed information about the appeal and Fair Hearing

processes andwill be available at all certified sites, through the 24/7 Central Accessline at: 800-838-1381, and on SLOBHD's website.

3. SLOBHD will post Client Information Centers at each certified site, which will contain notices explaining appeal and expedited appeal processesto ensure that the information is readily available to both beneficiaries and staff.
4. Written notice of the right to a Fair Hearing shall specify:

    - The method by which a Hearing may be obtained
    - The time limit for requesting a Fair Hearing
    - The circumstances under which the services shall be continued pending decision on the Fair Hearing
    - That the beneficiary may be either:
    - Self-represented
    - Represented by an authorized third party such as legal counsel, relative, friend or any other person.

5. The second page of the Notice of Adverse Benefit Determination (NOABD) explains how to file for a Fair Hearing. A NOABD will be sent to each beneficiary when SLOBHD takes any action that could result in an appeal. Refer to Notices of Adverse Benefit Determination for detail. However, requests for Fair Hearing maybe filed even if no NOABD was received.

6. The SLOBHD Patients' Rights Advocate (PRA) will notify the beneficiary and/or his or her representative of the resolution of the grievance or appeal in writing. If an appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain information regarding the beneficiary's right to a Fair Hearing and the procedure for filing for a Fair Hearing. Refer to Policy Grievances, Appeals and Expedited Appeals for detail.

C. General Provisions

1. The beneficiary must request a State Fair Hearing no later than 120 calendar days from the date of SLOBHD's notice of resolution.

2. A beneficiary may authorize another person to act on the beneficiary's behalf.

3. All Fair Hearing requests will be directed to the PRA for logging and assistance. The PRA will, at the beneficiary's request, assist with the filing process. Assistance will include, but not be limited to, help writing the Fair hearing request.

4. A beneficiary or a provider will not be subject to discrimination or any other penalty or punitive action for filing a Fair hearing request.

5. All Fair hearing requests will be resolved in a confidential manner that respects the rights and dignity of the beneficiary.

6. The PRA will present problem resolution issues to the Quality Support Team (QST) Committee a quarterly basis (more frequently if needed) for quality improvement purposes. The QST Committee will forward concerns to the Behavioral Health Administrator as needed to effect system changes.

D. Fair Hearing

1. The Managed Care Program Supervisor will represent SLOBHD as the Fair Hearing Officer in the Fair hearing, and will present evidence for the action taken by SLOBHD.

2. SLOBHD will provide continuation of Specialty Mental Health Services (SMHS) and/or Substance Use Disorder Services (SUDS) pending a Fair hearing.

3. SLOBHD will promptly implement the terms of the Fair hearing if the decision of the Administrative Law Judge or other hearing officer reverses the previous action taken by SLOBHD.

4. Services not furnished while the appeal is pending. If SLOBHD or the State Fair Hearing officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, SLOBHD must authorize or provide the disputed services promptly and as expeditiously as the beneficiaries' health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

5. Services furnished while the appeal is pending. If SLOBHD or the State Fair Hearing officer reverses a decision to deny authorization of services, and the beneficiary received the disputed services while the appeal was pending, SLOBHD or the State must pay for those services.

E. Aid Paid Pending

1. SLOBHD will provide "aid paid pending" (APP) services during the resolution of a Fair hearing to beneficiaries who have filed a timely Fair hearing request (10 days from the date the NOABD was mailed or 10 days from the date the NOABD was personally given to the beneficiary).

2. The beneficiary must have an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by SLOBHD.

3. This action will permit a beneficiary to continue to receive their existing services until the period covered by the existing authorization expires, a hearing decision is rendered, or the appeal is withdrawn or closed, whichever is earliest.

4. APP services will be provided at no cost to the beneficiary.

V. DEFINITIONS

a. **Expedited Fair Hearing**: a Fair Hearing that can be used when SLOBHD determines or the beneficiary and/or the beneficiary's provider certifies that that following the timeframe for a Fair hearing would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

**b. State Fair Hearing:** State Hearing provided to beneficiaries. A Fair Hearing is an independent review of requests for Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS) conducted by the California Department of Social Services to ensure beneficiaries receive the services to which they are entitled under the Medi-Cal program. A request for FAIR hearing is the final level of review for an appeal**.**

VI. DOCUMENT HISTORY

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| 11/18/2015 | All | Reformatted |
| 08/17/2017 | All | Changed language to match CFR 42 |
| Prior Approval dates: | | |
| Prior Approval dates: 5/30/2009, 6/5/2010, 10/12/2012 | | |

| *Signature on file* | | *08/24/2017* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 4.20 Beneficiary Rights and Informing Process

## I. PURPOSE

To describe beneficiary rights and beneficiary informing practices

## II. POLICY

- County of San Luis Obispo Behavioral Health Department (SLOBHD) will comply with all Federal and State laws that pertain to beneficiary rights, and will ensure that all staff and providers take those rights into account when furnishing services.

- SLOBHD will ensure that each beneficiary is informed, in a language and format that the beneficiary can understand, of available services and the benefits, requirements and protections (rights) afforded to them.

- SLOBHD will ensure written materials are produced in alternative formats that take into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency and for those who have auditory limitations.

- SLOBHD will ensure that written materials are readily accessible on the SLOBHD website, which is compliant with Web Content Accessibility Guidelines (WCAG) 2.0 guidelines in a machine readable and printable format.

- SLOBHD will ensure that each beneficiary is free to exercise his or her rights, and that the exercise of those rights will not adversely affect treatment.

## III. REFERENCE

- California Code of Regulations, Title 9, § 1810.360
- Code of Federal Regulations, Title 42, §§ 438.10 and 438.100
- MHP Contract, Exhibit A, Attachment I, Sections 7 and 15
- DMH Letter No. 04-05
- SLOBHD Policy 2.00 Culturally Competent, Multilingual Services
- SLOBHD Policy 4.00 Patient's Rights Advocate
- SLOBHD Policy 4.03 Change of Provider
- SLOBHD Policy 4.07 Grievances, Appeals and Expedited Appeals
- SLOBHD Policy 4.09 Fair Hearing Process
- SLOBHD Policy 4.23 Advanced Medical Directives
- SLOBHD Policy 4.24 Provider List Availability

IV. PROCEDURE

A. SLOBHD will inform beneficiaries of their rights, protections and processes in the following ways:

1. The Beneficiary Handbooks, *Guide to Mental Health Services and Guide to Substance Use Disorders Services*, will contain detailed information about rights, protections and access. It will be available in English and Spanish in regular, large print (minimum 18 point font) and audio versions.

   a. The handbook will be:

      - Provided to each beneficiary at the beginning of services and upon request thereafter
      - Available at all sites and by request through the 24/7 Central Access line at: 800-838-1381 within 5 business days
      - Posted in the lobby at each site
      - Available on the SLOBHD website

   b. The handbook content will comply with contract requirements for informing beneficiaries about their rights

2. Client Information Centers at each site will make information readily available to both beneficiaries and staff, in English and Spanish. Beneficiaries will be able to obtain, complete and return a Consumer Request Form without having to make a verbal or written request to anyone. Client Information Centers will contain:

   a. "What are my Rights?" poster
   b. Crisis Services poster
   c. Provider List
   d. Notice of Privacy Practices
   e. Notification that:
      - Alternative formats are available
      - Free language assistance is available
      - Assistance with forms is available
   f. Consumer Request Form, which will describe problem solving processes, and:
      - Instructions
      - Patient's Rights Advocate contact information
      - Postage paid/addressed envelopes
   g. Consumer Request Drop Box (locked)

3. Informing materials regarding Advance Medical Directives will be given to each adult consumer at the beginning of services.
4. The Consent for Treatment form will be explained to, signed by and given to each beneficiary at the start of treatment. It will further describe rights, responsibilities and payment processes.

5. The Notice of Privacy Practices will explain the manner in which SLOBHD will maintain and use the beneficiary's medical record. An acknowledgement of receipt will be signed by each beneficiary.
6. Beneficiaries will also be inform of rights and benefits verbally by:
    a. Clinical and administrative staff
    b. Patients' Rights Advocate (PRA)
7. The PRA will make informing materials, including the handbook titled, "Rights for Individuals in Mental Health Facilities" available to consumers.
8. The Patient's Rights Advocate will regularly train staff regarding beneficiary rights, including how to assist a beneficiary with completing the Consumer Request Form.

B. Documentation of Informing:

1. Distribution of the Beneficiary Handbooks and Provider lists will be documented by:
    - Client signature on the Behavioral Health Consent for Treatment form indicating receipt
    - Clinician attestation on the Assessment Progress Note
2. Right to Change Providers/limits on freedom of choice will be documented by clinician attestation on the Assessment Progress Note
3. Beneficiary signature on Consent for Treatment and Acknowledgement of Notice of Privacy Practices will be maintained in the medical record.

V. DEFINITION(S)

A. Each beneficiary has the right to:

- Be treated with personal respect, dignity and with respect for privacy
- Receive information on available treatment options and alternatives
- Have treatment options resented in an understandable manner
- Obtain services in a language of choice, without cost for interpretation services
- Participate in decisions regarding care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of his/her medical records
- Request that medical records be amended or corrected
- Receive appropriate, available and accessible services
- Access other community services regardless of participation in treatment
- Access other government supported services and providers regardless of participation in treatment
- Request a change of provider
- Access the problem resolution processes, including the Grievance, Appeal, Expedited Appeal and Fair Hearing processes, without fear of any punitive action as a result

VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/18/2015 | All | Added purpose, reformatted, added F |
| 08/17/2017 | All | Reformatted, New CRF Language |
| 09/22/2018 | All | Reformatting & Updated language |
| Prior Approval dates: | | |
| 02/27/2009, 08/08/2011, 1/20/2012 | | |

| *Signature on file* | | *10/10/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 4.23 Advance Medical Directives

## I. PURPOSE

To clarify that each beneficiary will receive written information about Advance Medical Directives at the start of treatment

## II. POLICY

County of San Luis Obispo Behavioral Health Department (SLOBHD) will comply with all Federal and State laws that pertain to beneficiary rights, including the rights to make informed choices about treatment, to designate someone to make decisions for the beneficiary, and to formulate an Advance Medical Directive.

SLOBHD will not condition treatment or otherwise discriminate against a beneficiary based on whether or not the individual has executed an Advance Medical Directive.

## III. REFERENCE

- Code of Federal Regulations, Title 42, §§ 438.6, 422.128, 417.436, 489.100
- Probate Code, §§ 4600-4678; 4695-4698; and 4735-4736
- MHP Contract, Exhibit A, Attachment I, Sections 7 and 15
- DMH Letter No. 04-08
- Related Policy: 4.20 Beneficiary Rights and Informing Practices

## IV. PROCEDURE

A. SLOBHD staff and/or contracted providers will provide written information regarding Advance Medical Directives to each adult beneficiary at the onset of services and thereafter upon request.

1. Informing material regarding Advance Medical Directives will be maintained in compliance with California law and will be updated to reflect any changes in State law within 90 days of a change

2. SLOBHD will provide the informing materials to a family member or representative in the event that an adult beneficiary is incapacitated or unable to receive the information.

3. Clinical staff will discuss the written information with the beneficiary at the initial assessment

4. Clinical staff will document that the beneficiary received the informing materials by checking the appropriate box in the Assessment Progress Note.

B. Limits on beneficiary directives:

1. SLOBHD will limit treatment to conditions identified in Title 9, §§ 1830.205, 1820.205, and in the DMC-ODS waiver. Treatment will be limited to those beneficiaries who meet medical necessity criteria for Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS). An Advance Medical Directive will not be used to expand eligibility for SMHS/SUDS.

2. SLOBHD staff will discuss a range of treatment options with each beneficiary and/or representative and will make the full range of SMHS/SUDS available to each beneficiary. SLOBHD will limit the services provided to those that are medically necessary. An Advance Medical Directive will not be used to expand the range or application of SMHS/SUDS.

3. SLOBHD will provide treatments that are voluntary, evidence-based and recognized as standard models of care. An Advance Directive will not be used to authorize any of the types of treatment prohibited by Probate Code 4652 or any other experimental treatment.

C. SLOBHD staff will scan or otherwise place a completed, appropriately witnessed, signed, and executed Advance Medical Directive in beneficiary's medical record where its presence is noted prominently in the chart

D. SLOBHD will educate of staff and community members concerning advance directives.

E. Beneficiaries will be informed that complaints concerning non-compliance with an Advance Directive may be filed with the Department of Health Services, Licensing and Certifications Division

V. DEFINITIONS

a. **Advance medical directive**: a written instruction, such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when the individual is incapacitated.

b. **Capacity:** a person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives.

c. **Health Care Decision:** a decision made by a patient or the patient's agent, conservator, or surrogate, regarding the patient's health care, including the following:

1. Selection and discharge of health care providers and institutions.
2. Approval or disapproval of diagnostic tests, surgical procedures, and programs of medication.

3. Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

###

VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/20/2015 | All | Added I, IV, expanded V, reformatted |
| 08/17/2014 | All | Reformatting, New CRF language |
| 01/02/2018 | All | Reformatting |
| Prior Approval dates: | | |
| 05/30/2010 | | |

| *Signature on file* | | *08/29/2017* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# ADVANCE MEDICAL DIRECTIVES

- Your Right to Make Decisions About Medical Treatment

- This brochure explains your right to make healthcare decisions and how you can plan now for your medical care if you are unable to speak for yourself in the future.

- A federal law requires us to give you this information. We hope this information will help increase your control over your medical treatment.

- **Who decides about my Treatment?**

Your doctors will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment you don't want – even if the treatment might keep you alive longer.

- **How do I know what I want?**

Your doctor must tell you about your medical condition and about what different treatments and pain management alternatives can do for you. Many treatments have "side effects." Your doctor must offer you information about problems that medical treatment is likely to cause you.

Often, more than one treatment might help you – and people have different ideas about which is best. Your doctor can tell you which treatments are available to you, but your doctor can't choose for you. That choice is yours to make and depends on what is important to you.

- **Can other people help with my decisions?**

Yes. Patients often turn to their relatives and close friends for help in making medical decisions. These people can help you think about the choices you face. You can ask the doctors and nurses to talk with your relatives and friends. They can ask the doctors and nurses questions for you.

- **Can I choose a relative or friend to make healthcare decisions for me?**

Yes. You may tell your doctor that you want someone else to make healthcare decisions for you. Ask the doctor to list that person as your healthcare "surrogate" in your medical record. The surrogate's control over your medical decision is effective only during treatment for your current illness or injury or, if you are in a medical facility, until you leave the facility.

- **What if I become too sick to make my own healthcare decisions?**

If you haven't named a surrogate, your doctor will ask your closest available relative or friend to help decide what is best for you. Most of the time that works. But sometimes everyone

doesn't agree about what to do. That's why it is helpful if you can say in advance what you want to happen if you can't speak for yourself.

- **Do I have to wait until I am sick to express my wishes about health care?**

No. In fact, it is better to choose before you get very sick or have to go into a hospital, nursing home, or other healthcare facility. You can use an **Advance Health Care Directive** to say *who* you want to speak for you and *what* kind of treatments you want. These documents are called "advance" because you prepare one before healthcare decisions need to be made. They are called "directives" because they state who will speak on your behalf and what should be done.

In California, the part of an advance directive you can use to appoint an agent to make healthcare decisions is called a **Power of Attorney for Health Care**. The part where you can express what you want done is called an **Individual Health Care Instruction**.

- **Who can make an advance directive?**

You can if you are 18 years or older and are capable of making your own medical decisions. You do not need a lawyer.

- **Who can I name as my agent?**

You can choose an adult relative or any other person you trust to speak for you when medical decisions must be made.

- **When does my agent begin making my medical decisions?**

Usually, a healthcare agent will make decisions only after you lose the ability to make them yourself. But, if you wish, you can state in the **Power of Attorney for Health Care** that you want the agent to begin making decisions immediately.

- **How does my agent know what I would want?**

After you choose your agent, talk to that person about what you want. Sometimes treatment decisions are hard to make, and it truly helps if your agent knows what you want. You can also write your wishes down in your advance directive.

- **What if I don't want to name an agent?**

You can still write out your wishes in your advance directive, without naming an agent. You can say that you want to have your life continued as long as possible. Or you can say that you would not want treatment to continue your life. Also, you can express your wishes about the use of pain relief or any other type of medical treatment.

Even if you have not filled out a written **Individual Health Care Instruction**, you can discuss your wishes with your doctor, and ask your doctor to list those wishes in your medical record. Or you can discuss your wishes with your family members or friends. But it will

probably be easier to follow your wishes if you write them down.

- **What if I change my mind?**

You can change or cancel your advance directive at any time as long as you can communicate your wishes. To change the person you want to make your healthcare decisions, you must sign a statement or tell the doctor in charge of your case.

- **What happens when someone else makes decisions about my treatment?**

The same rules apply to anyone who makes healthcare decisions on your behalf – a healthcare agent, a surrogate whose name you gave to your doctor, or a person appointed by a court to make decisions for you. All are required to follow your **Health Care Instructions** or, if none, your general wishes about treatment, including stopping treatment. If your treatment wishes are not known, the surrogate must try to determine what is in your best interest.

The people providing your health care must follow the decisions of your agent or surrogate unless a requested treatment would be bad medical practice or ineffective in helping you. If this causes disagreement that cannot be worked out, the provider must make a reasonable effort to find another healthcare provider to take over your treatment.

- **Will I still be treated if I don't make an advance directive?**

Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make decisions, someone else will have to make them for you.

- **How can I get more information about making an advance directive?**

Ask your doctor, nurse, social worker, healthcare provider, or Patient's Rights Advocate to get more information for you. You can have a lawyer write an advance directive for you, or you can complete an advance directive by filling in the blanks on a form.

**Remember that:**

- **A Power of Attorney For Health Care** lets you name an agent to make decisions for you. Your agent can make most medical decisions – not just those about life sustaining treatment – when you can't speak for yourself. You can also let your agent make decisions earlier, if you wish.

- You can create an **Individual Health Care Instruction** by writing down your wishes about health care or by talking with your doctor and asking the doctor to record your wishes in your medical file. If you know when you would or would not want certain types of treatment, an **Instruction** provides a good way to make your wishes clear to your doctor and to anyone else who may be involved in deciding about treatment on your behalf.

- These two types **of Advance Healthcare Directives** may be used together or separately.

For further assistance or to answer questions call:

Patient's Rights Advocate
805-781-4738

If you have difficulties concerning non-compliance with an Advanced Directive, you may file a complaint with the state survey and certification agency:

Department of Health Services
Licensing and Certification Division
Ph. 1-800-2369747

# DIRECTIVAS MÉDICAS AVANZADAS

- Su Derecho a Tomar Decisiones Sobre Su Tratamiento Médico.
- Este folleto explica su derecho a tomar decisiones sobre la atención de su salud y cómo puede hacer planes ahora para su atención médica, en caso de que en el futuro no pueda hablar por usted mismo.
- Una ley federal requiere que le demos osta información. Esperamos que ésta le ayude a tener un mayor control sobre su tratamiento médico.

- **¿Quién toma las decisiones sobre mi tratamiento?**

Sus doctores le darán información y le aconsejarán sobre su tratamiento. Usted tiene derecho a elegir. Puede decir "Si" a los tratamientos que podrá recibir. Puede decir "No" a cualquier tratamiento que no quiera recibir, aunque este pudiera prolongarle la vida.

- **¿Cómo sabré qué quiero?**

Su doctor debe darle información sobre su problema médico y sobre qué pueden hacer por usted distintos tratamientos y métodos para aliviar el dolor. Muchos tratamientos tienen "efectos secundarios". Su doctor debe ofrecerle información sobre los problemas que probablemente le causará el tratamiento médico.
Con frecuencia, más de un tratamiento podría ayudarle, y las personas tienen diferentes opiniones sobre cuál es el mejor, Su doctor puede decirle qué tratamientos están disponibles en su caso, pero él o ella no puede elegir por usted. Esa elección es suya y depende de qué es importante para usted

- **¿Otras personas pueden ayudarme a tomar las decisiones?**

Sí, Los pacientes a menudo recurren a sus familiares y amigos cercanos para que los ayuden a tomar decisiones médicas. Estas personas pueden ayudarle a pensar en las opciones a las que se enfrenta. Puede pedirle a los doctores y enfermeras que hablen con sus familiares amigos. Ellos pueden hacerles preguntas a los doctores y enfermeras por usted.

- **¿Puedo elegir a un familiar o amigo para que tome las decisiones sobre la atención de mi salud en mi nombre**?

Sí, Puede decirle a su doctor que desea que otra persona tome las decisiones sobre la atención de su salud por usted. Pídale al doctor que anoté a esa persona como su "sustituto" para la atención de su salud en su historia clínica. El control de su sustituto sobre las decisiones médicas rige sólo durante el tratamiento de su enfermedad o lesión actual o, si se encuentra en un centro médico, hasta que abandone el centro.

- **¿Qué sucede si estoy demasiado enfermo como para tomar mis propias decisiones sobre la atención de mi salud?**

Si no ha nombrado un sustituto, su doctor le pedirá a su familiar o amigo más cercano que esté disponible que le ayude a decidir qué es lo mejor para usted, La mayoría de las veces esto funciona, pero en ocasiones no todos están de acuerdo en qué hacer. Por eso es conveniente que usted diga con anticipación que desea que ocurra si en el futuro no puede hablar por usted mismo.

- **¿Debo esperar hasta estar enfermo para expresar mis deseos sobre la atención de mi salud?**

No, De hecho, es mejor que elija antes de estar muy enfermo o tener que ingresar a un hospital, clínica de recuperación u otro centro de atención médica, Puede utilizar Directivas por anticipado sobre la atención de la salud para decir quién desea que hable por usted y qué tipo de tratamientos quiere. Este documento se llama "por anticipado" porque usted lo preparo antes de que sea necesario tomar decisiones sobre la atención de su salud. Se llaman "directivas" porque indican quién hablará en su nombre y qué se debe hacer.

En California, la parte de las directivas por anticipación en la que puede nombrar a un representante que tome las decisiones sobre la atención de su salud se llama **Poder Notarial Para la Atención Médica.** La parte en la que expresa qué quiere que se haga se llama Instrucción Sobre Atención Médica Personal.

- **¿Quién puede preparar directivas por anticipado?**

Usted puede hacerlo si tiene 18 años de edad o más y es competente para tomar sus propias decisiones médicas. No necesita un abogado.

- **¿A quién puedo nombrar mi representante?**

Puede elegir a un familiar adulto o a cualquier otra persona en la que confíe para hablar en su nombre cuando se deban tomar decisiones médicas.

- **¿Cuándo comienza mi representante a tomar las decisiones sobre mi atención médica?**

Generalmente, el representante para la atención de la salud sólo tomará decisiones a partir del momento en que usted pierda la capacidad de hacerlo por usted mismo. Sin embargo, si lo prefiere, puede indicar en el **Poder Notarial Para la Atención Médica** que desea que el representante comience a tomar las decisiones inmediatamente.

- **¿Cómo sabe mi representante cuáles serían mis deseos?**

Después de elegir a su representante, hable sobre sus deseos con esta persona. A veces, las decisiones sobre el tratamiento son difíciles de tomar y realmente ayuda mucho si su representante sabe qué quiere usted. También puede escribir sus deseos en sus directivas por anticipado.

- **¿Qué ocurre si no deseo nombrar un representante?**

De todos modos, puede escribir sus deseos en sus directivas por anticipado sin nombrar un representante. Puede decir que quiere que su vida se prolongue lo más posible. O puede decir que no quisiera recibir ningún tratamiento para prolongar su vida. Además, puede expresar sus deseos con respecto a la utilización de tratamientos para aliviar el dolor u otro tipo de tratamiento médico. Aunque no haya llenado una Instrucción sobre atención médica personal, puede conversar sobre sus deseos con su doctor, y pedirle que incluya estos deseos en su historia clínica. O puede conversar sobre sus deseos con sus familiares o amigos. Pero probablemente será más fácil cumplir sus deseos sí los escribe.

- **¿Qué pasará si cambio de opinión?**

Puede modificar o anular sus directivas por anticipado en cualquier momento mientras pueda comunicar sus deseos. Para cambiar a la persona que desea que tome las decisiones sobre la atención de su salud, debe firmar una declaración o decírselo al doctor a cargo de su atención.

- **¿Qué ocurre cuando otra persona toma las decisiones sobre mi tratamiento?**

Se aplican las mismas reglas a cualquier persona que tome decisiones sobre la atención de su salud en su nombre, sea un representante para atención médica, un sustituto cuyo nombre le haya dado usted a su doctor, o una persona designada por un tribunal para tomar decisiones en su nombre. Todas estas personas deben seguir sus Instrucciones Sobe Atención Médica o, si no las hubiera, sus deseos generales sobre el tratamiento, incluyendo terminar el tratamiento. Si se desconocen sus deseos con respecto al tratamiento, el sustituto debe tratar de determinar qué es lo más conveniente para usted.
Las personas que le proporcionan atención médica deben respetar las decisiones de su representante o sustituto, a menos que un tratamiento solicitado constituya una práctica médica inadecuada o ineficaz para ayudarle. Si esto causa un desacuerdo que no puede ser resuelto, el proveedor debe hacer un esfuerzo razonable por encontrar otro proveedor de atención médica que se haga cargo de su tratamiento.

- **¿Aún se me tratará si no preparo directivas por anticipado?**

Por supuesto. De todos modos, recibirá tratamiento médico. Sólo queremos que sepa que si llega a estar demasiado enfermo como para tomar decisiones, otra persona tendrá que tomarlas por usted.

**Recuerde que:**

- **Un Poder Notarial Para la Atención Médica** le permite nombrar un representante que tome las decisiones por usted. Su representante puede tomar la mayoría de las decisiones médicas no sólo las que se refieran a un tratamiento para mantenerlo con vida cuando usted no pueda hablar por usted mismo. También puede permitir que su representante tome las decisiones antes, si lo desea.
- **Puede crear una Instrucción Sobre Atención Médica Personal** escribiendo sus deseos relacionados con la atención de su salud o hablando con su doctor y pidiéndole que anote sus deseos en su expediente médico. Si sabe que querrá o no querrá recibir ciertos tipos de tratamiento, una Instrucción es una forma conveniente de comunicar sus deseos a su doctor y a todas aquellas personas que puedan participar en las decisiones sobre el tratamiento en su nombre.
- Estos dos tipos de Directivas por anticipado sobre la atención de la salud se pueden utilizar juntas o por separado.

**Para obtener más ayuda o para responder preguntas llame a:**

**Defensor de los Derechos del Paciente**
**805-781-4738**

Si tiene dificultades relacionadas con el incumplimiento y la Directiva Avanzada, puede presentar una queja ante la agencia estatal de encuestas y certificación:

Departamento de Servicios de Salud
División de Licencias y Certificación
Tel. 1-800-236-9747

# 4.24 Provider Directory

## I. PURPOSE

To describe the content, maintenance, and beneficiary access to the Provider Directory

## II. SCOPE

Applies to all county-owned and operated providers, contracted organizational providers, and individual network providers of specific license types who deliver Medi-Cal services. Medi-Cal services include both outpatient Specialty Mental Health Services (SMHS) and outpatient or intensive outpatient Drug Medi-Cal-Organized Delivery System Substance Use Disorder Services (SUDS).

## III. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) will maintain and make available Provider Directories that will enable beneficiaries to make decisions about services.

## IV. REFERENCE

- California Code of Regulations, Title 9, §§ 1810.360, 1810.110, 1810.235
- Code of Federal Regulations, Title 42, §438.10(h)
- MHP Contract, Exhibit A, Attachment 1, Section 7
- DMC-ODS Contract, Exhibit A, Attachment I, Section II, (B)(xv)
- SLOBHD Policy 4.20 Beneficiary Rights and Informing Practices
- SLOBHD Policy 4.03 Change of Provider Request
- SLOBHD Policy 4.07 Grievances, Appeals and Expedited Appeals
- MHSUDS Information Notice 18-020

## V. PROCEDURE

### A. Format

1. SLOBHD will post the Provider Directories in electronic form on the SLOBHD website: http://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Forms-Documents/Quality-Support-Team/Network-Provider-List.aspx

2. SLOBHD will post a paper version in the Client Information Center at certified sites. A free paper copy will be available upon request.

### B. Content

1. Provider–specific content:
   a. Provider Contact Information: Name, business address, business phone, business email address, website URL
   b. Provider License Information: Type, license number, National Provider Identifier (NPI) number
   c. Specialties and relevant board or treatment certification
   d. Services and treatment modalities provided
   e. Age groups served
   f. Cultural capabilities/subgroups served (includes ethnic, religious or other cultural subpopulations, such as Veterans, Transitional Aged Youth, LGBTQ, etc.)
   g. Language capability of the provider
   h. Whether the provider's site is accessible to individuals with physical disabilities
   i. Whether to provider location is near public transportation
   j. Whether the provider completed cultural competence training

2. Treatment Team Disclaimer: The Provider Directory will include the statement, "Services may be delivered by an individual provider or a team of providers, working under the direction of a licensed practitioner operating within their scope of practice. Only licensed, waivered, or registered mental health providers and licensed substance use disorder services providers are listed on the Provider Directory."

3. Access Disclaimer: The Provider Directory will include directions on how to access services when prior authorization is required before beginning services

4. Freedom of Choice Disclaimer: The Provider Directory will include information about any restrictions on a beneficiary's choice of provider and how the beneficiary may request a change of provider

5. "Accepting New Beneficiaries" Disclaimer: The Provider Directory will indicate that, in most instances, beneficiaries will contact SLOBHD Central Access at 1-800-838-1381 to determine whether a provider has current treatment openings

C. Language and Accessibility

1. SLOBHD staff will be write the Provider Directory in a clear and understandable manner, in 12 point or larger font size (except for the large print tagline in 18 point font, described below)

2. SLOBHD staff will include a large print tagline (18 point font or larger) that will contain information on how to request auxiliary aids and services, including the provision of materials in alternative formats, at no cost to the beneficiary

3. SLOBHD staff will include the toll free, 24/7 Access Line and information about how to access California Relay Service for beneficiaries with hearing impairments

4. The Provider Directory will be available in English and Spanish

5. The electronic version posted on SLOBHD's website will be in a machine-readable format

D. Maintaining the Provider Directory

1. The SLOBHD Managed Care Program Supervisor or designee will review the Provider Directory as needed to ensure that it remains up-to-date. Normally, this review will be on a monthly basis.

2. The SLOBHD Managed Care Program Supervisor or designee will update the electronic Provider Directory within 30 calendar days of receipt of updated provider information

3. The SLOBHD Managed Care Program Supervisor or designee will notify clinic staff when updating the Provider Directory. A clinic designee will print and restock the Client Information Center with the most current directory.

E. Availability and Beneficiary Informing about the Provider Directory

1. SLOBHD staff will inform beneficiaries of the Provider Directory at initial assessment

2. The Provider Directory will be:
   a. Included in the Client Information Centers in all clinic sites
   b. Available electronically on the SLOBHD website
   c. The Consent for Treatment form will contain a link to the Provider Directory on the SLOBHD website
   d. Available in paper form upon request. When a beneficiary requests a paper copy, clinic staff will print from the website to provide the most current version

F. Community Based Organizations (CBOs) may, with SLOBHD's written approval, maintain their own Provider Directory under the following conditions:

1. The CBO's Provider Directory meets all the requirements in this policy and in DHCS Information Notice 18-020

2. The CBO provides a hyperlink to the SLOBHD Managed Care Program Supervisor, who will embed the hyperlink to the CBO's Directory into the SLOBHD Provider Directory

G. Verification, Updates, and Changes
1. Provider and/or organizations included in the SLOBHD Provider Directory will verify

the information included in the SLOBHD Provider Directory

2. When necessary, providers will promptly notify the SLOBHD Managed Care Program Supervisor of any needed updates, corrections, or additions or deletions

###

VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/01/2015 | All | Added Purpose, reformatted |
| 08/17/2017 | All | Formatting |
| 08/01/2018 | All | Reamed and revised to comply with Medicaid and Children's Health Insurance Program Managed Care Final Rule1 |
| Prior Approval dates: | | |
| 05/30/2010, 11/01/2015, 8/17/17 | | |

| *Signature on file* | | *08/01/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 4.25 EPSDT and TBS Distribution of State Services

I. PURPOSE

To clarify when TBS/EPSDT notification is given

II. POLICY

San Luis Obispo County Behavioral Health (SLOBH) will notify the beneficiary and responsible person about the availability of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) / Therapeutic Behavioral Services (TBS) as required.

III. REFERENCE(S)

- California Code of Regulations, Title 9, §§ 1810.310, 1810.215
- California Code of Regulations, Title 22, Section 51184(c) and 51340(e-f);
- DMH Letters 01-07 and 04-11
- DMH Information Notices 08-38 and 09-10
- SLOBHD Policy 6.06 Therapeutic Behavioral Services Authorization

IV. DEFINITIONS

Therapeutic Behavioral Services (TBS) area one-to-one behavioral mental health service available to children/youth with serious emotional challenges who are under age 21 and who have full scope Medi-Cal.

V. PROCEDURE

A. MHP will provide EPSDT/TBS notices (See Attachment A) to children and youth who:

1. Are under 21 years of age

2. Have full-scope Medi-Cal

3. Have been admitted with an emergency psychiatric condition to a hospital

4. At the time of placement in a Rate Classification Level (RCL) 13-14 group home and/or a locked treatment facility for the treatment of mental health needs

5. At the time of placement in an RCL 12 foster care group home if the MHP is involved in the placement.

6. Have undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months.

B. Notification will be provided to the minor and to the legally responsible person.

C. At the time of discharge from the SLOBH Psychiatric Health Facility, the EPSDT/TBS Notification will be given or mailed to the minor and legally responsible person.

VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/20/2015 | All | Added Purpose, reformatted |
| 01/02/2018 | All | Formatting |
| Prior Approval dates: | | |
| 05/30/2009 | | |

| *Signature on file* | | *11/23/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 4.26 Provider Problem Resolution Process

I. PURPOSE

To describe provider informal problem resolution process and formal appeal process

II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will implement problem resolution and appeal processes that enable each provider to resolve problems or concerns about any issue related to SLOBHD's performance of its duties, including payment authorization. SLOBHD will not subject a provider to discrimination or any other penalty for using the provider problem resolution and appeal processes.

SLOBHD will give providers written information about the problem resolution and appeal processes at the time a contract is established and again if SLOBHD makes an adverse authorization decision.

III. REFERENCE

- California Code of Regulations, Title, 9, §§ 1850.305 - 1850.320, 1850.350
- Code of Federal Regulations, Title 9, §§ 438.400 – 438.424
- Department of Health Care Services (DHCS) – Mental Health Plan (MHP) Contract, Exhibit A, Attachment I, section 15
- SLOBHD Policy 3.30, Notices of Action
- SLOBHD Policy 4.07, Beneficiary Grievances, Appeals and Expedited Appeals
- SLOBHD Policy 10.21 Contracting and Monitoring of Services
- SLOBHD Policy 10.14, Monitoring and Authorizing Network Provider Services
- SLOBHD Network Provider Handbook

IV. PROCEDURE

A. Provider Problem Resolution Process (informal)

1. Network Providers will contact Managed Care staff during regular business hours to discuss concerns.

2. Other Contracted Providers will contact the SLOBHD Fiscal contract manager during regular business hours to discuss concerns.

3. Every effort will be made to resolve the issue at this level.

4. The Provider Appeal Process may be initiated by the provider at any time before, during, or after the Informal Provider Problem Resolution process.

B. Provider Appeals Process (formal)

1. SLOBHD will provide an appeals process for Network Providers and Contract Providers to use only when the appeals issue involves a payment or authorization denial or modification.

2. SLOBHD will notify the provider in writing when a decision is made to modify, reduce, deny or terminate an authorization before or after the service was provided (this may be a Notice of Adverse Benefit Determination NOABD or other written response to the provider from SLOBHD).

3. The provider will submit a written appeal to the Managed Care Program Supervisor (Network Providers) or to the Fiscal contract manager (other providers) within 90 calendar days of the receipt of non-approval of payment. This appeal is often called a "first level appeal".

4. A copy of the appeal will be forwarded to the Patient's Rights Advocate for logging and tracking purposes.

5. When the appeal concerns the denial or modification of a payment authorization request, SLOBHD will utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

   a) QST staff will review appeals from Network Provider staff.
   b) Managed Care staff will review appeals for other contract provider staff.

6. Within 60 calendar days from the receipt of the appeal, SLOBHD will:

   a) Inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider.
   b) Inform the provider of any action required by the provider to implement the decision.
   c) If the appeal is not granted in full the provider will be notified of any right to submit an appeal to DHCS.

7. If a provider chooses to appeal further, the provider will submit an appeal to the DHCS, in writing, within 30 calendar days of receipt of SLOBHD's appeal letter. This appeal is often called a "second level appeal".

8. DHCS will request documentation from SLOBHD, and will render a decision within 60 calendar days of receipt of documentation.

C. Client Record Review Findings Appeal Process

1. When the appeal is related to disallowances of paid claims resulting from client record review findings, the provider may request an informal appeal by DHCS.
    a) The appeal must be filed, in writing, within 60 calendar days of the denial.
    b) The appeal must include written documentation supporting the rationale for the informal appeal for each disallowance in dispute.

2. The provider may request a formal appeal if DHCS does not resolve the matter in the provider's favor.

V. DEFINITIONS

**1. Action:**

a) A determination that medical necessity criteria have not been met and the beneficiary is not entitled to any Specialty Mental Health Service (SMHS)
b) A denial, modification or reduction of a provider's request for authorization prior to the delivery of the service
c) A denial, modification, reduction or termination of a provider's request for payment authorization after the service after the service was provided
d) A failure to act within the timeframes for resolution of grievances, appeals, or expedited appeals
e) A failure to provide a specialty mental health service within the timeframe established by the MHP.

**2. Appeal:**

a) A request by a beneficiary or representative for review of an Action
b) A request by a beneficiary or representative for review of SLOBHD's determination to deny or modify a beneficiary's request for a covered SMHS
c) A request by a beneficiary or representative for review of the timeliness of the delivery of SMHS
d) A request by a provider for review of client record review findings that resulted in the disallowance of paid claims

**3. MHP Payment Authorization**

The written, electronic or verbal authorization given by an MHP to a provider for reimbursement of specialty mental health services provided to a beneficiary.

###

VI. DOCUMENT HISTORY

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| 11/18/2015 | All | Added purpose, reformatted, added F |
| 08/17/2017 | All | Reformatted, New CRF Language |
| 01/25/2018 | All | Reformatted |
| Prior Approval dates: | | |
| Prior Approval dates: 5/30/2009, 6/5/2010, 10/12/2012 | | |

| *Signature on file* | | *08/24/2017* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# Section 5

# Service Delivery

# 5.00 Outpatient Mental Health Assessment

I. PURPOSE

To provide guidance regarding assessment/reassessment content and frequency standards

II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will provide medically necessary Specialty Mental Health Services (SMHS) in an amount, duration, and scope sufficient to reasonably achieve symptom reduction or improvement in functioning to eligible Medi-Cal beneficiaries. Medi-Cal beneficiaries will receive a comprehensive assessment to establish medical necessity for initial levels of care and a periodic re-assessment to determine need for ongoing SMHS or referral to an appropriate level of care, depending in the beneficiary's level of impairment and clinical need. Outpatient assessments will be completed by staff working within the scope of practice established by law for each respective discipline and may be multi-disciplinary in nature. Assessments will be conducted in a culturally sensitive manner in the consumer's primary language and information will be gathered and documented in a strength-based manner.

III. REFERENCE

- California Code of Regulations (CCR) Title 9, §§1810.204, 1810.415, 1830.205, 1830.210
- California Code of Regulation Title 16, Division 25, Sections 2518.5 and 2576.5
- Code of Federal Regulations (CFR) Title 42, §§438.206 – 438.210 and 440.169(d)(1)
- California Welfare and Institutions Code §5600
- Contract between SLOBHD and the Department of Health Care Services (DHCS)
- MHSUDS Information Notice 17-040

Related SLOBHD Policies & Procedures and support documents:

- SLOBHD Mental Health *Documentation Guidelines*, pp 4-9; 16-18; Appendix H
- SLOBHD Policy 3.00 *Access to Services*
- SLOBHD Policy 3.20 *Medical Necessity and Authorization of SMHS*
- SLOBHD Policy 3.21 *Authorization …. of Out-of-Plan Services (Youth)*
- SLOBHD Policy 3.30 *Notices of Adverse Benefit Determination (NOABD)*
- SLOBHD Policy 5.10 *CANS and PSC*
- SLOBHD Policy 13.12 *Complete Health Records*
- Practice Guideline: Adult Assessment and Assessment Update 10/1/2017

IV. PROCEDURE

**A. Staff Qualifications:**

1. Many assessment activities, including formulating/rendering a diagnosis, conducting a mental status examination, and authorizing/denying services, can only be completed by an "approved category of staff", which includes:

   - Psychiatrist or Nurse Practitioner
   - Licensed, Registered, or waivered Psychologist
   - Licensed Clinical Social Worker or Registered Associate Clinical Social Worker
   - Licensed Marriage Family Therapist or Registered Associate MFT
   - Licensed Professional Clinical Counselor or Registered Associate PCC
   - Registered Nurse with a MA/MS in a Psychiatric Clinical Specialty

   **Note:** Trainees may complete these activities with co-signature by an appropriately licensed Clinical Supervisor. Registered Associates who are awaiting SLOBHD's internal waiver process may complete the above activities but will have their work reviewed and approved by a licensed staff member, usually a Clinical Supervisor or Program Supervisor.

2. Other assessment activities, including documenting personal and medical history, documenting client report of symptoms, impairment, or progress, and rating CANS or ANSA scales, etc., may be completed by any staff member functioning with the scope of their practice and training.

**B. Timelines for Assessment:**

1. Initial Assessment
   An initial Assessment is a comprehensive review of history, symptoms, impairments, mental status, etc. – all the elements in SLOBHD's contract with DHCS. Each client record must include one comprehensive assessment, usually completed at the time the client begins services. The relevant comprehensive assessment form in the electronic health record (EHR) must be completed as promptly as practically possible, as an authorization decision must be made within 5 business days of the first kept assessment session. At times, an extension of up to 14 additional calendar days to gather additional information will be allowed if the consumer requests an extension or if the assessing therapist determines that an extension to gather additional information if it is in the consumer's best interest. The assessing therapist will document the reason for an extension in a progress note.

2. Re-opening
   If a client leaves treatment and the case is closed, the episode can be re-opened within 90 days of the closing based on the most recent assessment. However, if the client had an inpatient hospitalization, incarceration, or other major change in life circumstances during the time the case was closed, an Assessment Update will be **required** (a new comprehensive assessment may be requested by the site Program Supervisor). However, a new assessment should not delay access to other

necessary SMHS. See the MP's most recent *Documentation Guidelines* for details on re-opening.

3. Annual Treatment Summary
   A Treatment Update/Summary will be completed annually (more frequently if needed to meet the client's treatment needs or to document a significant change in client status). The update will document medical necessity for ongoing care. An Annual Treatment Summary/Assessment Update contains many, but not all, of the elements in a comprehensive assessment. Other assessment elements will be found in Progress Notes, especially Psychiatry notes. Staff do not need to repeat static elements like family or developmental history if those elements are in the comprehensive assessment in Anasazi. Staff will use the Annual Treatment Summary to document changes since the last assessment and to update for other elements, such as treatment history, progress, etc. Staff will document the current functional impairment, risk, and need for services with each update.

   Ideally, the Annual Treatment Summary will be completed just prior to completion of the annual Treatment Plan.

4. Re-Assessment
   An updated assessment may be completed at any time, with no pre-authorization, if the treatment team believes it is appropriate for diagnostic clarification or improved consumer care. The clinician who completes the re-assessment may elect to document the updated assessment either on an Annual Treatment Summary or on a comprehensive assessment form in the EHR. Staff may complete an additional comprehensive assessment whenever clinically indicated. Alternatively, staff may use an Annual Treatment Summary/Assessment Update to add new assessment information to the client record when a comprehensive assessment is in the electronic record.

5. CANS ratings
   The Children's Assessment of Needs and Strengths (CANS) 50 is a DHCS-required outcome measure. SLOBHD integrated the rating scales into the comprehensive assessment and updates for youth. See Policy 5.10 *CANS and PSC* for content and frequency requirements.

## C. Authorization of Services

1. Authorization of services is related to, but separate from the completion of the comprehensive assessment or re-assessment. Services outlined in the assessment are authorized by signature of an approved category of staff and documentation of client participation and agreement on an Assessment Initial Treatment Plan (AITP) or Treatment Plan (TP) in the EHR. See *Documentation Guidelines* and Policy 3.20 for additional detail.

2. Authorization Timelines

| Intensity Type | Timeline for Authorization Decision | Extension |
|---|---|---|
| Routine | 5 business days | Up to 14 calendar days[1] |
| Urgent[2] | 96 hours (4 calendar days) | Up to 14 calendar days[1] |

*[1] An extension of authorization for up to 14 additional calendar days is possible if the consumer requests an extension or if the assessing therapist determines that an extension to gather additional information if it is in the consumer's best interest. The assessing therapist documents the basis for this decision in a progress note. If the therapist determines that, a NOABD must be sent to the consumer on the same date the decision to extend the authorization period is made. See Policy titled Notices of Adverse Benefit Determination for more detail.*

*[2] Post hospitalization follow up is an urgent service that occurs within seven calendar (7) days of discharge from acute care, and can be a considered assessment if completed by an approved category of staff. When other staff complete the initial outpatient contacts after hospitalization or CSU services, staff will follow the steps in the current Urgent Service procedure to ensure rapid access to care while a comprehensive assessment is completed.*

**D. Comprehensive Assessment Content Requirements** (from MHP/DHCS Contract):

1. Presenting Problem:
   a. Chief complaint
   b. History of the presenting problem(s), including current level of functioning
   c. Relevant family history and current family information
   d. Relevant conditions and psychosocial factors affecting the consumer's physical/mental health (e.g., living situation, daily activities, social support, cultural/ linguistic factors and history of trauma or exposure to trauma)

2. Mental Health History:
   a. Previous treatment (providers, therapeutic modality and response)
   b. Inpatient admissions
   c. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports

3. Medical History:
   a. Relevant physical health conditions reported by the consumer or a significant support person
   b. Name and address of current source of medical treatment
   c. For children and adolescents, include prenatal and perinatal events and relevant/significant developmental history
   d. If possible, include other medical information from medical records or relevant consultation reports

4. Medications:
   a. Current and past significant medications to treat mental health and medical conditions, including duration of medical treatment
   b. Allergies or adverse reactions to medications
   c. Informed consent for medications (contained in a separate assessment)

5. Substance Exposure/Substance Use:
   Past and present use of tobacco, alcohol, caffeine, over-the-counter and illicit drugs

6. Client Strengths:
   Documentation of the consumer's strengths in achieving client plan goals

7. Risks:
   a. Situations that present a risk to the consumer and/or others
   b. Includes past or current trauma

8. Mental Status Examination:
   (Must be completed by an approved category of staff)

9. Diagnosis: (Must be rendered by an Approved Category of staff)
   a. A complete diagnosis from the most current DSM or ICD, recorded on the Diagnostic Review.
   b. Diagnosis must be consistent with the presenting problem(s), history, mental status examination and/or other clinical data. Each assessment must document symptoms and functional impairments sufficiently to support (at minimum) the primary diagnosis.

10. Additional clarifying information, as needed

11. Plan of Action:
    The Plan of Action reflects the initial services captured in the AITP

12. Each assessment is accompanied by a completed Assessment Progress Note. This note lists the required informing documents that were discussed and given to the consumer at intake/update time. See the MHP's most recent *Documentation Guidelines* for detail.

**E. Diagnosis Review:**

A Diagnosis Review must be completed in conjunction with a comprehensive mental health assessment to record the diagnoses described in detail in the assessment. The symptoms and impairments supporting the primary diagnosis do not need to be repeated on the Diagnosis Review if documented in the assessment and incorporated by reference (The Diagnosis Review may state, "See comprehensive assessment dated x/xx/2019 for detail regarding diagnostic criteria").

## V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 04/29/2014 | 2, 4 | Added Annual Treatment Summary |
| 01/02/2018 | All | Formatting |
| 07/31/2019 | All | Minor edits for consistency and to identify frequency |
| Prior Approval dates: | | |
| 04/30/2009, 04/30/2010, 8/8/2011, 12/21/2012 | | |

| *Signature on file* | | *08/13/2019* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 5.02 Outpatient Discharge Planning

## I. PURPOSE

To link client to appropriate resources during the discharge process and to develop a plan with the client that will support the maintenance of their stability/recovery following discharge with support services or means to access services if necessary.

## II. POLICY

It is the policy of County of San Luis Obispo Behavioral Health to assist clients in developing a discharge plan that includes initiating referrals and connections with community providers and supports when clients are terminating from County Behavioral Health services.

## III. REFERENCE(S)

DHCS DMC-ODS Intergovernmental Agreement Exhibit A. Section III.G. Coordination of Care & Section III.PP.17 Discharge.
MHP Contract with DHCS, Exhibit A, Attachment 9

## IV. PROCEDURE

A. Elements of Successful Discharge Planning:

1. It is developed collaboratively with clients and solicits feedback from significant support persons.

2. It addresses appropriate referrals to community-based providers to ensure that each client has a plan to obtain follow-up services as necessary.

B. Discharge criteria (one or more of the following):

1. Client no longer meets Access Criteria definitions including diagnosis, impairment, and intervention related criteria, and is able to receive treatment through the primary health care system or through community-based supportive programs/services.

2. Client has met the goals of treatment.

3. Client has not been attending appointments and client (parent or guardian if client is a minor) has not responded to attempts to re-engage.

4. Client wishes to terminate treatment.

5. Client has moved out of the County.

6. If involved with the Homeless Outreach and Engagement Service, client has had 3 months of non-contact and documented efforts to locate the individual have been unsuccessful.

7. If a client threatens a staff with violence in any form that would create a fear for one's safety and whose care cannot be appropriately transferred to or managed by other County staff (Refer to Workplace Violence Awareness County Policy).

    a. If a client or legal guardian displays behaviors that raise safety concerns staff will utilize a Behavioral Agreement assessment in Anasazi to discuss the concerns, set expectations, and describe potential consequences if the behavior(s) continue. These discussions will be documented in the Electronic Health Record and the staff will work closely with program and/or clinical supervisor(s) to formulate appropriate course of action.

Note**:** Clients who have initiated a request for a second opinion on the closing of their case, or an appeal on the closing of their case, cannot be discharged until there is a resolution to their request. Until then, services must continue.

C. Other Discharge issues:

1. Clients are re-assessed according to the Assessment policies for Youth and Adult. At that time, recommendations can be made for additional treatment, maintenance, or preparation for discharge. If the case is co-managed by community partners, a consultation occurs prior to discharge.

2. As a client has reached their goals for treatment and is managing their symptoms well, the treatment staff needs to shift from providing treatment to arranging for more support systems in preparation for eventual termination from services. This can include arrangements for medication management, housing, support groups, socialization activities, building a social support network including peer support, encouraging pre-vocational involvement, hobbies and/or volunteer work.

3. Upon termination of County Behavioral Health services, information is given to clients and families on how to contact Behavioral Health for future need.

    a. When a client has been referred to community partners and no longer receives County Behavioral Health Services, staff shall provide consultation to the community partners when needed to ensure successful service provision (if allowed by HIPAA and with a proper Authorization to Disclose and/or Consent to Release Information). This may include re-opening the client to County Behavioral Health Services on a short-term basis until client is stabilized and ready to return to the community partners.

4. When a client fails to show for a scheduled appointment and/or has dropped out of

treatment, attempts are to be made to re-engage the client. These attempts at re-engagement must be documented.

a. Outreach and Discharge for Mental Health Services:

   i. Treatment staff will make at least one attempt weekly to contact a client who has stopped attending and scheduling treatment services. The purpose of the outreach call is to attempt to re-engage the client in services.

   ii. After attempts to re-engage, and no response from the client, the treatment staff in collaboration with the treatment team, including staff Psychiatrist (if the client is on medication(s)), writes a termination letter thus initiating the termination process (see attached Sample Termination Letter). At the point that a client has not had contact with treatment staff for more than **30-days**, staff will send a termination letter along with an NOABD Termination letter (in one mailing). The termination letter shall ask the client to respond within 2-weeks (**14-days**). The NOABD Termination letter shall also ask the client to respond within 2-weeks (**14-days**, 10 business days). At this time if there is not a response from the client, the case will be closed.

   iii. In instances when contact has been made with the client during outreach efforts, the contact must include a service that was provided by face-to-face, telehealth, or telephone. The contact with the client must be clinically significant to keep the treatment episode open. For example, a call with the client to schedule a service without other treatment services/interventions that take place shall not be considered a contact in which to cease the timeline for case closure.

b. Outreach and Discharge from Substance Use Disorder Treatment Services:

   i. Treatment staff will complete outreach calls at a frequency of a minimum of one to two outreach calls per week in which a client is absent from services. This will be done for a period no shorter than **2-weeks**. The purpose of the outreach call is to attempt to re-engage the client in services.

   ii. Another outreach attempt is made in writing, by mail, to the client by sending a Notice of Adverse Benefit Determination Termination letter. The NOABD Termination letter shall ask the client to respond within 2-weeks (**14-days**, 10 business days). At this time if there is not a response from the client, the case will be closed.

   iii. The client must be discharged/closed from treatment within **30-days**

of the last treatment service, case management service, or other contact with the client.

iv. In instances when contact has been made with the client during outreach efforts, the contact must include a service that was provided by face-to-face, telehealth, or telephone. The contact with the client must be clinically significant to keep the treatment episode open.

5. For procedures for completing the Mental Health Outpatient Discharge Summary please refer to the Mental Health Documentation Guidelines. For procedures for completing the Drug & Alcohol Services Outpatient Discharge Summary/Plan please refer to the DMC-ODS Documentation Guidelines.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 01/02/2018 | All | Formatting |
| 08/03/2022 | All | Revised to create an integrated MH & DAS policy. |
| Prior Approval dates: | | |
| 08/19/2011 | | |

| *E-Signature on file* | | *08/03/2022* |
|---|---|---|
| Approved by: | Behavioral Health Administrator (AR) | Date |

**COUNTY OF SAN LUIS OBISPO HEALTH AGENCY**
**BEHAVIORAL HEALTH DEPARTMENT**

**Penny Borenstein, MD, MPH,** *Interim Health Agency Director*
**Anne Robin, LMFT** *Behavioral Health Director*

Date of Letter

Dear (client),

I hope you are well. I have not seen you since (date). We had scheduled an appointment on (date), which you missed and did not return my call.

Please give me a call at (xxx-xxx-xxxx) to schedule an appointment so we can discuss your progress to date and current needs. If I don't hear from you by (date-give client 2 weeks), I will assume that you are doing well and no longer need our services. In that case, your chart will be closed. However, you can call us at 1- 800-838-1381 to access services at any time.

I wish you the best.

Sincerely,

Staff Name/Title

**AGENCIA DE SALUD DEL CONDADO DE SAN LUIS OBISPO**
**DEPARTAMENTO DE SALUD & BIENESTAR**

**Penny Borenstein, MD, MPH,** *Directora Interina de la Agencia de Salud*
**Anne Robin, LMFT** *Directora del Departamento de Salud & Bienestar*

Fecha de Carta

Estimado/a (cliente),

Espero se encuentre bien. No le he visto desde (fecha). Habíamos programado una llamada el (fecha), que se perdió y no me devolvió la llamada.

Llámeme al (xxx-xxx-xxxx) para programar una cita para que podamos analizar su progreso hasta la fecha y sus necesidades actuales. Si no tengo noticias suyas antes de (fecha: dé al cliente 2 semanas), asumiré que le está yendo bien y que ya no necesita nuestros servicios. En ese caso, su expediente se cerrará. Sin embargo, puede llamarnos al 1-800-838-1381 para acceder a los servicios en cualquier momento.

Le deseo lo mejor.

Sinceramente,

Nombre/título del personal

# 5.03 No Shows, Outreach, and Client Engagement Attempts/Efforts

## I. PURPOSE

Outreach and client engagement efforts will take place for clients that are absent from services for the purposes of monitoring client welfare and attempting to engage/re-engage client in services.

## II. POLICY

It is the policy of County of San Luis Obispo Behavioral Health Department (SLOBHD) to complete outreach efforts to clients that miss scheduled services or appear to be absent from ongoing Behavioral Health Services.

## III. REFERENCE(S)

- DHCS DMC-ODS Intergovernmental Agreement Exhibit A. Section III.G. Coordination of Care & Section III.PP.17 Discharge.
- MHP Contract with DHCS, Exhibit A, Attachment 9

## IV. PROCEDURE

A. Outreach and Engagement Efforts:

1. When a client fails to show for a scheduled service (face-to-face, telehealth, telephone), including group counseling services, and does not contact their assigned Specialist/Clinician/LPT, it is required for the staff member to complete an outreach phone call on the day of the missed service. For individual services, the outreach call shall be placed within 15 minutes of the start time of the scheduled service. For group services, the Specialist/Clinician/LPT will complete an outreach after the group session (or the following day, if necessary, when a group session takes place in the evening).

    a. For psychiatry appointments, the prescriber will inform an AA, designee, or scribe of the missed appointment. The AA, designee, or the scribe will place an outreach call to the client within 1-day of the missed service.
    b. For telehealth assessment appointments that are scheduled by Managed Care, the Clinician will contact the client at the time of the appointment and again within 15 minutes after the start of the appointment. The Clinician will leave information on how to reach the provider.
    c. In some situations, it may be appropriate to text the client after having attempted to reach the client by telephone or telehealth. Text messages must be sent from County issued mobile phones with an appropriate text message consent.

2. If the client does not answer the phone call, the staff member will leave a message for the client and document this in the client service entry appointment associated with the missed scheduled appointment.

3. If the client answers the phone call, the staff member has several options:

    a. Offer to provide the service by telephone or telehealth, if appropriate for the service type. If a service is provided by telephone or telehealth, then the appointment type and location must be changed to telephone or telehealth in the progress note information. The service time should reflect the accurate minutes of the service.
    b. Provide an alternate service. Example: client missed a scheduled counseling or therapy session, but the staff member ended up providing a case management service when they contacted the client by telephone. If a different service is provided, then the appointment must be updated to include the correct service description, and the appointment type and location must be changed to telephone in the progress note information. The service time should also reflect the accurate minutes of the service.
    c. If the client is not available to participate in a service by telephone or telephone, document this in the client service entry appointment associated with the missed scheduled appointment. Reschedule the missed appointment.

4. If the client does not answer the phone call, leave a message regarding the missed appointment, and request a return phone call to reschedule the appointment. If the phone is shared message line (ex. home phone), leave a general message to protect confidentiality. Example, "This message is for Susan. Susan, this is Tina, and I am calling about our missed appointment today. Please call me at XXX-XXX-XXXX to reschedule. I look forward to hearing from you."

5. When a client stops attending treatment (multiple services), it is important to conduct outreach and to document outreach attempts. Staff will document a minimum of three outreach attempts prior to closing a case. Complete outreach calls on different days of the week, at different times of day, over a 2–3-week period.

6. If the client did not attend a scheduled post hospitalization/post psychiatric health facility discharge appointment and was not open to a SLOBHD program prior to their discharge, and the client has not responded to outreach attempts, staff will work with their program's Health Information Technician to mail an outreach letter to the client (see Appendix A for sample outreach letter).

B. Documentation of Missed Appointments:

1. When a client does not show or fails to show (FTS) for a scheduled appointment, this missed scheduled appointment must be resolved in the Electronic Health Record (EHR). The appointment shall not be deleted. This documentation of the missed appointment is an important record of a service that was offered and scheduled, but

that the client did not attend.

2. In the narrative portion of the progress note, while documenting "No Show" or "FTS," it is required to document an outreach attempt. Examples:

   a. "Client failed to show (FTS). This Specialist left client a phone message to follow-up on his absence today."
   b. "April FTS for the third time this week. The specialist left a second phone message to outreach April to encourage her return to services. Specialist also contacted the CWS Social Worker and left a message to coordinate case management."
   c. "FTS for 4 services. Due to Howard's homelessness and no cell phone, Clinician is not able to call him or send a letter."

3. When a client stops attending treatment, and staff have completed and documented at least three outreach attempts, a Discharge Summary might state:

   a. "Clinician attempted outreach calls on 3 occasions (see progress notes). Client has not been in contact with Clinician for 30 days and therefore case will be closed. Probation notified xx/xx/xx."

C. Engagement Efforts for completion of full assessment for services:

1. When a client is in the intake and assessment phase of contact with behavioral health services and does not attend the assessment appointment, it is best practice that the assigned Clinician make efforts to reschedule the missed appointment in order to complete the assessment. These efforts include:

   a. Outreach phone call on the day of the missed service. The phone should be made within 15 minutes of the missed/late appointment so that the client can be provided with a reminder and assistance can be provided, if needed, to help the client locate the clinic.
   b. Coordinating with other team members that are providing services to the client (ex. case manager) to develop a plan for a scheduled assessment appointment.
   c. Meeting with the client to complete the assessment in lieu of another service the client was scheduled for (ex. client was scheduled for a group counseling session, however Clinician utilizes the time the client present in a clinic to complete the assessment).

D. Specialist/Clinician/LPT service time suggestions:

1. When a client does not show for a scheduled service, and the staff member cannot reach the client by telephone, the following are suggestions for how staff can use their available clinical service time:

   a. Provide a case management/care coordination service for another client that needs a referral and connection to a physical health, mental health, or a

community resource service.

b. Provide a case management/care coordination service on behalf of the client by completing necessary communications with other treatment providers (care coordination) or other agencies (ex. CWS, Probation).
c. Review another client's medical record in preparation for another service that is scheduled.
d. Complete progress notes and any assessments that are pending completion.
e. Review caseload and close clients that are not active in treatment (refer to 5.02 Outpatient Discharge Planning).

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 3/27/2024 | | Adopted |
| Prior Approval dates: | | |
| | | |

| *E-Signature on file* | | 3/27/2024 |
|---|---|---|
| Approved by: | Behavioral Health Administrator (SG) | Date |

**COUNTY OF SAN LUIS OBISPO HEALTH AGENCY**
**BEHAVIORAL HEALTH DEPARTMENT**
**Nicholas Drews,** *Health Agency Director*
**Star Graber, PhD, LMFT,** *Behavioral Health Director*

Date of Letter

NAME
ADDRESS
CITY, CA ZIP

Dear (client),

Recently you missed your follow-up appointment you had scheduled on (date), at (clinic name + clinic address). I hope this indicates that things are going better for you, but if they are not and you are still interested in our services, please call Central Access at 1-800-838-1381. This is the same number you can call if you are in crisis.

Sincerely,

Staff Name/Title

# 5.05 Tobacco Cessation Policy

## I. PURPOSE

Individuals with behavioral health are more than twice as likely to smoke cigarettes as a person without a behavioral health condition and are more likely to die from a smoking-related illness than from their behavioral health condition. San Luis Obispo Behavioral Health Department (SLOBHD) strives to reduce barriers to tobacco use disorder treatment to eliminate tobacco-related health disparities among persons with behavioral health conditions.

## II. POLICY

staff and contracted providers will assess each member for use of all tobacco products.

## III. REFERENCE(S)

- Behavioral Health Information Notice 22-024
- Assembly Bill 541, Chapter 150
- Business and Professions Code Section 22950.5

## IV. PROCEDURE

A. SLOBHD staff and contracted providers shall:
   1. Conduct an assessment of tobacco use at the time of initial intake
   2. Provide information to the member on how continued use of tobacco products could affect their long-term success in recovery from their substance use disorder (SUD)
   3. Recommend treatment for tobacco use disorder
   4. Offer either treatment or a referral for treatment for tobacco use disorder

###

## V. REVISION HISTORY

| Effective/Revision Date: | Sections Revised | Status: Initial/ Revised/Archived Description of Revisions |
|---|---|---|
| 11/1/2024 | Entire Policy | Initial Release for Behavioral Health Director approval/signature |
| Prior Approval dates: | | |
| | | |

| | | |
|---|---|---|
| *Signature on file* | | *10/30/2024* |
| Approved by: | Star Graber, PhD. Behavioral Health Director | Date |

# 5.10 Children's Assessment of Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC)

## I. PURPOSE

To describe the County of San Luis Obispo Behavioral Health Department (SLOBHD) procedure for collecting outcome measures as required by the Department of Health Care Services (DHCS)

## II. SCOPE

- The policy applies to all youth who receive Specialty Mental Health Services provided by SLOBHD and all contract providers
- Children's Assessment of Needs and Strengths (CANS) will be collected for all youth aged six (6) through twenty (20), regardless of program of service
- Pediatric Symptom Checklist (PSC) will be collected for all youth aged (3) three through eighteen (18) when a caregiver is available, regardless of program of service

## III. BACKGROUND

A. DHCS identified the CANS and the PSC as required outcome measures for youth. CANS is an open domain tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS was developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. For more information, visit praedfoundation.org The CANS is easy to learn and is well liked by parents, providers and other partners in the services system because it is easy to understand. CANS has been shown to be both a valid and reliable measure. SLOBHD and contractor staff must complete training and initial certification to administer the CANS and must annually recertify to use the tool; training and certification is the Praed Foundations strategy to ensure consistent and competent application of the tool.

B. PSC is a thirty-five-item rating tool that SLOBHD will administer to parents and caregivers, when available, to help gather important clinical information from a parents' perspective.

## IV. POLICY

SLOBHD staff and contract providers will collect the CANS and PSC outcome measures and will report the results to DHCS as required. Measures will be collected at initial intake and repeat measures will be collected every six(6) months thereafter and at

closing. SLOBHD staff will complete regular reporting of CANS and PSC to DHCS as required by our contract.

V. PROCEDURE

A. CANS

1. CANS certification
   a. SLOBHD clinical staff and contractor clinical staff will maintain current CANS credential
   b. Online at praedfoundation.org and periodic face-to-face training will be available
2. SLOBHD implementation of the CANS
   a. SLOBHD integrated the CANS into several different clinical assessment tools
   b. The CANS will be collected on the assessment described in the table below. When a youth continues in treatment beyond two years, all six-month ratings will be obtained by alternating the BH CANS Youth five (5) + six (6) month and the BH CANS 50 Youth five (5) + (Update) tools.
   c. Please note that the BH CANS 50 Youth five (5) + (Update) tool contains additional clinical information and a clinician may substitute it for the BH CANS Youth five (5) + six (6) month at any review period. It is required annually after initial assessment.

| Type of Assessment | Intake | 6 mo | 1 yr | 1.5 yrs | 2 yrs | Closing |
|---|---|---|---|---|---|---|
| BH CANS 50 Youth 5+ (Full) | X | | | | | |
| BH CANS 50 Youth 5+ (6 month) | | X | | X | | |
| BH CANS 50 Youth 5+ (Update) | | | X | | X | |
| BH CANS 50 Youth 5+ OP DC Summary | | | | | | X |
| Pediatric Symptom Checklist | X | X | X | X | X | X |

   d. While the goal is to complete the CANS at six-month intervals, a CANS completed between four and eight months after the previous rating will be captured for reporting. Please note that the schedule for future CANS completion will continue to be based on the initial CANS, not the most recent CANS. In other words, if a client's intake was 1/1/2019, the CANS will always be due in July and January until closing.

3. Clinical use of CANS
   a. SLOBHD staff will involve the youth and family to arrive at a consensus rating score utilizing Child and Family Teams whenever possible
   b. SLOBHD staff will utilize the CANS to identify strengths that may be used in treatment and areas of clinical need to address in treatment
   c. When available, SLOBHD staff will utilize summary communication tools to communicate strengths and needs with the youth/family

4. Reporting of CANS results to DHCS
    a. SLOBHD will develop reporting capability that will allow periodic reporting as directed by DHCS
    b. Managed Care and Quality Support Team staff will prepare and upload the report to DHCS

B. PSC

1. SLOBHD will collect PSC from caregivers at intake, every six-months thereafter, and at closing.
2. The PSC is a paper form that will be offered to parents and other caregivers to complete to help SLOBHD collect important clinical information. The PSC will not be an assessment (form) in Anasazi, but the results will be scanned into the EHR as an attachment.
3. When a caregiver is unavailable, refuses to complete, or does not turn in a PSC, clinical staff will complete the top and bottom sections for the PSC, mark 35 items, "No Response", and submit the PSC for processing.
4. Clinical use of the PSC:
    a. When a caregiver is available to complete the PSC, SLOBHD clinical and front office staff will encourage regular completion so that the caregiver's perspective is included in treatment planning
    b. Administrative Assistant (AA) and Health Information Technician (HIT) staff will collect and scan the PSC into the EHR and will place a copy in a shared drive for DHCS reporting
5. Reporting of PSC results to DHCS
    a. Clinic support staff will upload scanned PSCs into a shared drive folder
    b. Contractor staff will securely forward completed PSCs to SLOBHD Managed Care
    c. Managed Care staff will enter the PSC data into the proper format for submission to DHCS. Quality Support Team staff will prepare and upload the report to DHCS.

C. Client Action Schedules

1. HIT staff will set Client Action Schedules for the CANS in the Electronic Health Record to provide notifications to clinical staff when the next CANS will be due. PSC will not have a Client Action Schedule because it is not an Anasazi assessment.
2. Clinical staff will regularly review Notifications and complete CANS according to the schedule. PSCs will always be due at the same time as the CANS.

## VI. APPLICABLE STANDARDS/REGULATIONS

- DHCS MHSUDS Information Notice **18-048**
- DHCS MHSUDS Information Notice **18-029**
- DHCS MHSUDS Information Notice **17-052**

VII. ATTACHMENTS

- CANS/PSC Business Rules

VIII. DOCUMENT HISTORY

The Document History table is located at the end of the document and should include a short description of revisons made to the policy.

| **Effective/Revision Date:** | **Sections Revised** | **Author** | **Status: Initial/ Revised/Archived Description of Revisions** |
|---|---|---|---|
| 02/01/2019 | Entire Policy | Greg Vickery, LMFT<br>BH Division Manager<br>Quality Support | Initial Release |
| Prior Approval dates: | | | |
| | | | |

| | | |
|---|---|---|
| *Signature on file* | | *02/01/2019* |
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

ATTACHMENT A

**CANS/PSC Business Rules:**

1. The CANS/PSC at case opening after 7/1/18 MUST be "Initial"
2. If you previously submitted a "Discharge" or an "Administrative Close" CANS/PSC and closed the case, there are two choices – pick the one that fits best clinically for the client:
   a. Reassess (Assessment Update or comprehensive assessment) and open again using assessment type "Initial" for the CANS/PSC. A new six-month cycle starts based on the new "Initial" date. This is the only choice if the client was out of service for more than 90 days and is optional for clients closed less than 90 days.
   b. Email Managed Care staff to request that the "Discharge" or an "Administrative Close" CANS/PSC be DELETED. Resume the previous six-month submission cycle. Complete an Assessment Update; CANS/PSC will be "Urgent" unless it falls in the four (4) to eight (8) month window for a "Reassessment". This is an option for clients closed less than 90 days.
3. A "Reassessment" CANS/PSC MUST be completed between four (4) and eight (8) months of the previous CANS/PSC, ideally at six (6) months.
4. If completed sooner than four (4) months following a previous CANS/PSC, the type MUST be "Urgent" if ongoing care will occur
5. "Urgent" CANS/PSC does NOT reset the six-month clock and the next "Reassessment" is due six months from the most recent "Initial" or "Reassessment"
6. At closing, if a caregiver completes a PSC, the assessment type MUST be "Discharge" on both the CANS and the PSC and the clinician MUST update the CANS.
7. When closing following client/family withdrawal from treatment, CANS/PSC assessment type MUST be "Administrative Close". Neither the CANS nor the PSC are rated, but both MUST be submitted (the CANS as part of the OP Discharge Summary – choose Assessment Type "Administrative Close" and don't re-rate; the PSC by filling in Date Today, Child's Name, DOB, Client Name/Number in the footer, and For Staff Use Only section. All answers are "No Response")
8. If a client "ages in" (for example, turns three (3) during treatment), the first PSC is "Initial"; there won't be a CANS. If the case closes, select assessment type "Discharge" if the caregiver re-rates the PSC; select "Administrative Close" if they do not. Collaborate with the caregiver about whether to obtain a new PSC if the "Initial" was obtained very recently. It is acceptable to select "Administrative Close" and not get another PSC.

9. If the client turns five (5) during treatment, we will already have PSCs in the system and thus a six-month cycle already established. The best choice is to complete an Assessment Update (and CANS) during the four (4) to eight (8) month PSC "Reassessment" window to sync the CANs and the PSC reassessment cycles. The PSC will be assessment type "Reassessment", but the CANS will be "Initial".
10. If you are closing a client within the four (4) to eight (8) month "Reassessment" window and you have NOT completed the "Reassessment", just select the CANS/PSC assessment type "Discharge" or "Administrative Close" instead. Complete the Discharge Summary as usual. You do not have to complete both a "Reassessment" and a "Discharge" / "Administrative Close" if they are both due at the same time. If you already submitted the "Reassessment", then you may:
    a. Complete the "Discharge" or "Administrative Close", too (see rule #s six (6) and seven (7) above)
    b. Email Managed Care staff to request that the submitted "Reassessment" CANS/PSC be REPLACED with assessment types "Discharge" or "Administrative Close"

# Section 6

# Specialized Programs and Services

# 6.00 Access and Referrals to Services at Martha's Place

I. PURPOSE

To clarify how youth ages birth to five receive services at Martha's Place.

II. POLICY

In accordance with Access Standards for Specialty Mental Health Services, Martha's Place provides all necessary services for eligible Medi-Cal Beneficiaries, ages birth to five years of age, determined to be at risk of mental health issues and that meet medical necessity in an amount, duration, and scope sufficient to reasonably achieve symptom reduction or improvement in functioning.

Non-Medi-Cal clients will receive services based on medical necessity and to the extent resources are available.

III. REFERENCE

- Title 9, Article 4, Section 1810.405
- Contract with DHCS, Exhibit A, Attachment 1, and W&I Code Section 5600.2

IV. PROCEDURE

A. Referrals for services at Martha's Place are received from families, social workers, educators, community agencies, Mental Health clinic sites, and the Central Access office at Mental Health Services.

B. If the referral is from a Mental Health clinic site (e.g. Youth Services), Martha's Place's Reporting Unit is used for any services billed.

C. After the completion of necessary paperwork (e.g. referral form, authorizations to disclose Protected Health Information, 300 dependent court order, and Ages and Stages Questionnaire (ASQ) an appointment is scheduled for a Mental Health Assessment and a Pediatric Assessment.

D. The Pediatric Assessment is performed by a Pediatrician and a Public Health Nurse who assess the development of the child. Depending on the results of the assessment, subsequent referrals may be made to address any delays in a child's development including, but not limited to:

1. Occupational Therapy
2. Tri-Counties Regional Center services
3. Specialty Medical Services

.

E. A Pediatric and Behavioral Health Evaluation Summary is completed by the assessing therapist and the pediatrician (in some cases only a Pediatric Evaluation Summary or only a Behavioral Health Evaluation Summary is completed). The legal guardian is given a copy of this report. If there are other parties, the legal guardian requests the report to be given to, Authorizations to Disclose Information are obtained and the report is sent to those parties.

F. As soon as it is determined that a referral for Specialty Mental Health Services at a SLO County Mental Health Services is needed, the following steps are taken:

G. A Service Request Form is initiated by the Administrative Assistant, and completed by the Public Health Nurse or program supervisor.

H. Depending upon availability of resources, the special needs and the age of the client, or other relevant factors, the client is either scheduled for an assessment with an appropriately licensed clinician at Martha's Place, or referred to Central Access for an assessment appointment at another clinic site.

I. Treatment recommendations made by the assessing clinician are reviewed by the Site Approval Team (SAT). If the client meets medical necessity, the client will be provided with appropriate services and referrals.

J. Referrals to Other Resources

1. If SAT recommends that a client receive additional mental health services (i.e., therapy, rehab), the client may receive these services at Martha's Place, through the Network Provider Panel, another mental health clinic site, or other community resources by referral when appropriate.

2. When the case is transferred to another clinic site for services, the Martha's Place Reporting Unit will remain open until the Pediatric and Behavioral Health Evaluation Summary is completed coordination of services by the Martha's Place staff is completed.

3. If SAT recommends that client be evaluated by a psychiatrist, the lead coordinator contacts the mental health clinic in the client's area of residence to schedule an appointment with the psychiatrist.

4. When Martha's Place staff recommends referral to a Network Provider panel member for services:

    a. The staff member may call the NWP directly to ask about the NWP's availability, but should clearly indicate that the call does not constitute a referral or an authorization for services.

b. The Martha's Place staff member then completes a Network Provider Referral, which will be signed by the staff member and the Martha's Place Program Supervisor or designee.

c. The Martha's Place HIT will forward the chart (or shadow chart if the client will continue to receive services at Martha's Place) and referral to Managed Care.

d. Managed Care staff will contact the NWP to make the referral and authorize appropriate services. The start date for services by the NWP is the date Managed Care generates the authorization.

5. Access to treatment at Mental Health continues until medical necessity is no longer met or the client wishes to terminate services.

6. If client is does not meet criteria for medical necessity, client may be referred to CenCal for Non-Specialty Mental Health Services (see current Documentation Guidelines, Appendix G for information on referring clients to Holman Group.)

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/01/2015 | All | Minor Language, information on referring to CenCal |
| 01/02/2018 | All | Formatting |
| Prior Approval dates: | | |
| 11/16/2010 | | |

| *Signature on file* | | *11/17/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 6.01 Referrals from Forensic Re-Entry Services to Mental Health

## I. PURPOSE

To provide direction for providing services to individuals being released from County jail who have a Primary Mental Health Diagnosis and/or co-occurring disorder.

## II. POLICY

The Forensic Re-entry Service (FRS) is a community outreach program within the Mental Health Services Act, which provides brief services to individuals being released from County Jail who have a primary mental health diagnosis and/or co-occurring disorder. The goal is to provide a "bridge" service to help connect individuals to appropriate and necessary community services.

## III. REFERENCE(S)

## IV. PROCEDURE

A. Referrals to FRS are made by the Jail Psychiatric Services after the inmate has been identified as meeting target population criteria.
B. FRS services are voluntary.
C. Referred individuals are seen in the Jail by FRS staff prior to their release date to develop an individualized "Release Plan" which includes the services and goals intended to help connect the individual to community supportive and/or treatment services.
D. FRS staff will assist the person in acquiring medical care, mental health follow-up, housing, food, income benefits, medications, drug and alcohol services, etc. when the individual's release date is known.
    1. To assist individual who would like to begin receiving Specialty Mental Health Services upon their release, the FRS staff will contact Central Access to request a comprehensive Mental Health Assessment.
    2. If the individual has been receiving medication services while incarcerated or is now receptive to taking medication voluntarily to avoid risk of hospitalization, an urgent services appointment may be requested to ensure consistent availability of medication. See Mental Health Policy and Procedure 3.00 for information regarding how to access Urgent Services.
    3. To assist individuals who were receiving services prior to their arrest, FRS staff will contact the appropriate clinic to assist in scheduling a follow-up appointment.
E. FRS staff work with the individual until they have ongoing and stable connections to supportive services, typically no more than 90 days.

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## V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 3/12/2012 | Original Procedure | |
| 04/27/2015 | D | Adding description of how urgent services can be accessed. |
| 01/02/2018 | All | Formatting |
| Prior Approval dates: | | |
| 03/12/2012, 5/15/2013 | | |

| | | |
|---|---|---|
| *Signature on file* | | *05/15/2013* |
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 6.03 Day Treatment for Children Placed in SLO County Day Treatment Program

## I. PURPOSE

To provide direction for authorizing, documenting, claiming, and monitoring Day Treatment Services to youth who are receiving Day Treatment Services.

## II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will authorize Day Treatment Intensive services for youth when the youth meet medical necessity criteria for day treatment. SLOBHD will monitor Day Treatment program documentation to ensure documentation and program components meet regulatory requirements.

## III. REFERENCE

- California Code of Regulations, Title 9, §§ 1810 – 1840
- SLOBHD contract with DHCS, Exhibit A, Attachment I
- Department of Mental Health (DHCS) Informational Notice 02-06, Attachment A
- Department of Mental Health (DHCS) Letter 08-10

## IV. PROCEDURE

### A. Referral Process

1. The Local Education Agency (LEA) will send a referral packet to both Special Education Local Plan Area (SELPA) and the Coordinator of the Elementary or Adolescent Day Treatment Program.

2. The Day Treatment Coordinator, in consultation with the Youth Services Program Supervisor, will determine that:

    a. The client meets medical necessity for Specialty Mental Health Services (SMHS), Day Treatment Intensive (DTI) services and eligibility for Educationally Related Mental Health Services (ERMHS)

    b. Additional DTI medical necessity requirements are:

        i. Youth requires a structured, multi-disciplinary program of therapy (one or more):
            - As an alternative to hospitalization
            - To avoid placement in a more restrictive environment
            - To maintain in a community setting

ii. A less intensive intervention would not ameliorate, or has not ameliorated, the functional impairments that have interfered with the youth's ability to benefit from education.

3. At the next Advisory Committee Meeting for the referred Program, the referral will be discussed and reviewed. The committee will prioritize the referral and discuss alternative educational and treatment options when the DTI program is at capacity.

4. When the committee determines that the client needs to be admitted into the Intensive Day Treatment Program, an Individual Education Plan meeting (IEP) will be scheduled to add the Day Treatment Intensive services on the IEP.

B. Service Component Requirements

1. DMH Informational Notice 02-06 and 02-06 Attachment A describe the specific service component types and duration necessary for claiming DTI services. Progress Notes and Daily Schedule will clearly document the provision of these required elements for the required duration to be eligible for reimbursement.

2. Therapeutic Milieu (must average at least 3 hours/day for full day and 2 hours/day for half day programs)

- Community Meeting (at least daily)
- Skill Building Groups (as scheduled)
- Process Groups (as scheduled)
- Adjunctive Therapies (as scheduled)
- Psychotherapy provided by licensed, registered, or waivered staff practicing within their scope of practice (as scheduled)

3. Collateral Contacts (at least monthly, outside regular program hours)

C. Treatment Plan Requirements

1. Day Treatment Intensive will be a five day per week program authorized in 90 calendar day blocks.

2. The SAI will start the DTI Treatment Plan (TP) on the first day the student is to start DTI services.

3. The TP will be developed in collaboration with the client, family/legal guardian, and school within 30 days of the start date of the plan. See current Treatment Plan and Documentation Guidelines for content requirements.

4. The SAI will route the DTI TP to the Youth Services Program Supervisor or designee for authorization within 30 days of the start of services. This initial plan will be

approved for the remainder of the 90-day period

5. The SAI or designee will document the DTI service on the day treatment daily and weekly summary templates.

D. Progress Notes:

1. Progress Note frequency: DTI requires Daily Notes and a Weekly Summary, which may be separate notes or an integrated note.

2. Progress Note Timeliness: Refer to SLOBHD's Treatment Plans and Documentation Guidelines for detail.

3. Progress Note Signature requirements

    a. Signature (or electronic equivalent) of staff providing the service

    b. If Psychotherapy is documented, the staff who provided the service must sign the note and psychotherapy must be within the provider's scope of practice

    c. DTI weekly summary: The weekly clinical summary must be reviewed and signed by a Physician, a Psychologist, LCSW, LMFT, LPCC or a waivered/ Registered Intern of these disciplines or a Registered Nurse. The reviewer must be staff in the DTI Program or the person directing the services. The signature must be obtained within 14 days of the last day of the week for which services are claimed.

    d. Daily Note content:

        i. Date of service

        ii. Arrival time/departure time or total minutes client actually attended the program. If the client is unavoidably absent for all or part of the day, the reason for the absence must be clearly documented.

        iii. A brief summary of each component that occurred on the day of service, including, for each component:

            - The name of the component (Community Meeting, Skill Building Group, Process Group, Adjunctive Therapy or Psychotherapy) and topic discussed
            - The name and professional degree, licensure or job title of the staff who facilitated
            - At least one intervention by staff
            - The client's response to the intervention(s)

e. Weekly Note content

i. Dates of the service

ii. State the client's attendance for the week (days and total minutes attended each day) if not already documented in a Daily Note

- ✓ Summarize:
- ✓ Client behaviors
- ✓ Staff interventions/clinical decisions
- ✓ Client responses to the program or to specific interventions
- ✓ Progress toward treatment plan goals this week

E. Written Daily Schedule

The Written Daily Schedule will be completed in enough detail to verify that staffing, required components and hours of operation are consistent with regulations. Refer to Department of Mental Health (DHCS) Informational Notice 02-06 and 02-06 Attachment A for detail.

F. Re-Authorization

The SAI will collaborate with the client, family/legal guardian and school, and then "Reviews" the DTI TP and then will route the TP to the Youth Services Program Supervisor or Designee for reauthorization of DTI services prior to the end of the previous 90-day period

G. Service Discontinuation

1. When the client receiving DTI services achieves a level of functioning and symptom improvement which no longer require a DTI level of intervention, the SAI collaborates with the client, family/legal guardian and appropriate LEA to arrange an IEP to review treatment progress and determine the most appropriate education setting and Mental Health Services. Adjustment to the individual's Treatment Plan is made in collaboration with the client, family/legal guardian and IEP representative, when appropriate.

2. The SAI follows the MHP's most recent TP and Documentation Guidelines to document the recommendation of further services and or connection to other appropriate services in collaboration with the client, family/guardian and schools if appropriate.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 09/22/14 | Updated for CJ | Added 2B, C, D and 4B |
| 11/23/15 | All | Revised and reformatted |
| 01/02/2018 | All | Reformatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *12/01/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 6.04 Day Treatment for Youth Placed in Out-of-County Day Treatment Programs

## I. PURPOSE

To provide direction for authorizing, documenting, claiming, and monitoring Day Treatment Services to youth who have been placed out-of-county and are receiving Day Treatment Services.

## II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will authorize Day Treatment Intensive and Day Treatment Rehabilitative services for youth with SLO Medi-Cal when the youth are placed out-of-county and meet medical necessity criteria for day treatment. SLOBHD will monitor Day Treatment program documentation to ensure documentation and program components meet regulatory requirements.

## III. REFERENCE

- California Code of Regulations, Title 9, §§ 1810 – 1840
- SLOBHD contract with DHCS, Exhibit A, Attachment I
- Department of Mental Health (DHCS) Informational Notice 02-06, Attachment A
- Department of Mental Health (DHCS) Letter 08-10

## IV. PROCEDURE

A. Referral Process and Initial Authorization:

1. The Mental Health Case Manager will ensure that the youth in out-of-county placement meets medical necessity for Specialty Mental Health Services (SMHS) and for Day Treatment Intensive (DTI) or Day Rehabilitative (DR).

2. The Mental Health Case Manager will complete the “Out-of-County Service” form for each location where the client is going to receive SMHS and DTI or DR, and will provide the form to the Quality Support Team (QST) Certification Specialist.

3. The Youth Services Program Supervisor will confer with the QST Certification Specialist to ensure that the proposed DT site is certified as a Medi-Cal provider.

4. The Youth Services Program Supervisor or designee will confer with the Behavioral Health Fiscal/Contracts/Administrator to arrange a purchase order or confirm a current contract.

5. The Youth Services Program Supervisor or designee will send the provider the "Day Treatment Authorization and Documentation Requirements" procedure, which will clarify documentation and billing processes.

B. Medical Necessity Requirements

1. In order to be eligible to receive Day Treatment Intensive (DTI) or Day Rehabilitative (DR) services, each client must meet medical necessity criteria for Specialty Mental Health Services, plus either 1 or 2 below. DTI and DR documentation must clearly establish medical necessity for the specific service claimed to be eligible for reimbursement.

2. DTI: Additional Medical Necessity Criteria

    a. Youth requires a structured, multi-disciplinary program of therapy (one or more):
        - As an alternative to hospitalization
        - To avoid placement in a more restrictive environment
        - To maintain in a community setting

3. DR: Additional Medical Necessity Criteria
   Youth requires a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning

C. Treatment Plan Requirements

1. A Client or Treatment Plan is required for DTI and DR services. The plan may be either separate or part of an integrated plan that includes other Specialty Mental Health Services. Each plan must be completed at least annually or when there are significant changes in the client's condition. Services claimed against a client plan missing required elements or required signatures will be denied.

2. Required Treatment Plan elements:

    a. Goals/Objectives which are:
        - Specific, observable and/or quantifiable
        - Related to the client's mental health needs and functional impairments which result from the client's mental health diagnosis

    b. Interventions, which must:
        - Be identified by type/modality (i.e., Day Treatment Intensive, Family Therapy, Medication Support, etc.)
        - Specify frequency/duration (i.e., number of days per week and minutes per day)

- Describe how the intervention will help the client by reducing functional impairment, improving coping and/or treating the mental health disorder
- Specify frequency/duration (i.e., number of days per week and minutes per day)
- Describe how the intervention will help the client by reducing functional impairment, improving coping and/or treating the mental health disorder
- Describe how the services are consistent with/linked to the goals/objectives

c. Signatures:
   - Documentation of the client's participation in and agreement with the plan, usually in the form of client signature.
   - Signature of the Legally Responsible Person. For dependents of the court (WIC 300), this is the signature of the placing agency Social Worker.

D. Service Component Requirements

1. DMH Informational Notice 02-06 and 02-06 Attachment A describe the specific service component types and duration necessary for claiming DTI or DR services. Progress Notes and Daily Schedule must clearly document the provision of these required elements for the required duration to be eligible for reimbursement.

2. Therapeutic Milieu (Must average at least 3 hours/day for full day and 2 hours/day for half day programs)

   - Community Meeting (at least daily)
   - Skill Building Groups (as scheduled)
   - Process Groups (as scheduled)
   - Adjunctive Therapies (as scheduled)
   - Psychotherapy (DTI) provided by licensed, registered, or waivered staff practicing within their scope of practice (as scheduled)

3. Collateral Contacts (at least monthly, outside regular program hours)

E. Documentation Requirements

1. Progress Notes:

   a. Progress Note frequency:
   DTI requires Daily Notes and a Weekly Summary, which may be separate notes or an integrated note (See the SB 785 Day Treatment Intensive Progress Note template for an example of an integrated note). DR requires a Weekly Summary.

   b. Progress Note Timeliness:
   Generally, Progress Notes must be completed and signed within one (1) business day of the date of service. Progress Notes are considered late, but are billable, if

completed and signed more than one but less than fourteen (14) days of the date of service. Progress Notes which are completed and/or signed more than 14 days after the date of service are not billable. For additional information, refer to SLOBHD's *Treatment Plans and Documentation Guidelines*.

c. Progress Note Signature requirements

- Signature (or electronic equivalent) of staff providing the service and date signed
- If Psychotherapy is documented, the staff who provided the service must sign the note and psychotherapy must be within the provider's scope of practice
- DTI weekly summary: The weekly clinical summary must be reviewed and signed by a physician, a Psychologist, LCSW, LMFT, LPCC or a waivered/ registered Intern of these disciplines or a Registered Nurse. The reviewer must be staff in the day treatment intensive program or the person directing the services. The signature must be obtained within 14 days of the last day of the week for which services are claimed.
- Electronic signatures must conform to the security requirements set forth in Department of Mental Health (DHCS) Informational Notice 08-10.

2. Daily Note content (DTI only):

a. Date of service
b. Arrival time/departure time or total minutes client actually attended the program. If the client is unavoidably absent for all or part of the day, the reason for the absence must be clearly documented.
c. A brief summary of each component that occurred on the day of service, including, for each component:
   - The name of the component (Community Meeting, Skill Building Group, Process Group, Adjunctive Therapy or Psychotherapy) and topic discussed
   - The name and professional degree, licensure or job title of the staff who facilitated
   - At least one intervention by staff
   - The client's response to the intervention(s)

3. Weekly Note content (DTI and DR)

a. Dates of the service
b. State the client's attendance for the week (days and total minutes attended each day) if not already documented in a Daily Note
c. For DR only (DTI programs document this detail in Daily Notes):
   - List the program components and dates/duration of each
   - See the SB 785 Day Rehabilitation Progress Note for an example of a table that documents the components effectively.

d. For DTI and DR summarize:
   - Client behaviors
   - Staff interventions/clinical decisions
   - Client responses to the program or to specific interventions
   - Progress toward treatment plan goals this week

4. Written Daily Schedule
   When documentation and billing are submitted, the DTI or DR program must provide the Written Daily Schedule completed in enough detail that SLO Behavioral Health staff can verify that staffing, required components and hours of operation were consistent with regulations. Refer to Department of Mental Health (DHCS) Informational Notice 02-06 and 02-06 Attachment A for detail.

F. Out of County DTI/DR Authorization and Billing Requirements

1. An Anasazi Staff ID Application form (current Version) must be completed for each staff member who provides services. This allows SLO BH to bill Medi-Cal for contracted services.

2. Contract Provider is responsible to verify the NPI # and Taxonomy codes on the staff ID application.

3. Contract Provider is responsible for completing monthly checks of the Office of Inspector General's List of Excluded Individuals/Entities, the Excluded parties List System and the Medi-Cal Suspended and Ineligible Provider List to ensure that program staff are not listed. SLO BH's Verification of Excluded List Status policy is available for review.

4. Claims must include the following:

   a. SLO Service Code or a clear description of the service and the date(s) of service
   b. SLO server ID # for each staff member providing the service
   c. The total time of each service (in minutes for DTI and DR)

5. Use the SB 785 State approved forms (or electronic equivalent) for documentation and for authorization/ reauthorization. SB 785 forms include:

   a. Service Authorization Request (SAR)
   b. Client Plan
   c. Initial Assessment
   d. Assessment Update

6. The DTI or DR program is responsible for obtaining required signatures on Client Plan/ Treatment Plan. Services claimed against Client Plans which are missing required signatures will be denied. Required signatures include:

a. Social Worker or parent/ legal guardian's signature, depending on legal status
b. Client's signature if client is 12 years of age or over
c. Signature of an "approved category" of staff representing the day service program. This includes any: Physician, licensed/waivered Psychologist, LMFT/LCSW/LPCC (or registered intern of these disciplines), or Registered Nurse.

7. Authorization and Documentation Timelines:

   a. For DTI or DR programs that are more than 5 days per week:
      - SAR is required prior to the start of services
      - Client Plan is due within 20 days after initial placement date
      - Initial Assessment is due within 30 days after placement date

   b. For DTI or DR programs that are 5 days per week:
      - SAR is required within 20 days after initial placement date
      - Client Plan is due within 20 days after initial placement date
      - Initial Assessment is due within 30 days after placement date

   c. Reauthorization:
      - The SAR is due 10 days prior to the expiration of the previous SAR
      - DTI services must be reauthorized at least every three months
      - DR services must be reauthorized at least every six months
      - Authorization for other specialty mental health services provided concurrently with DTI or DR, excluding crisis services, must be authorized at the same frequency as the respective day service

   d. Comments:
      - It is the responsibility of the placement to submit completed paperwork with all required signatures
      - Always address progress towards previous goals
      - If there has been no progress during a review period, provide a clinical rationale for requesting additional services

   e. Submit Progress Notes and monthly contractor's invoice for services (billing statement) to:
      Amy Olson, Administrative Services Officer,
      2180 Johnson Ave., Room 227
      San Luis Obispo, CA 93401

   f. Fax SARs and Client Plans to:
      SLO BH Managed Care
      (805) 781-1177
      Attention: Amanda Getten, LMFT
      Managed Care Program Supervisor

G. Service Discontinuation:

1. When the individual receiving DT services achieves a level of function and symptom improvement, which no longer require a Day Treatment level of intervention, the SAI recommends an appropriate level of service to the placing agency.

2. If the client is returning to San Luis Obispo County to access mental health services, the SAI (out of county case manager) facilitates a Transfer of services per the SLO Mental Health Services Treatment Plans and Documentation Guidelines.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/23/2015 | All | Reformatted, added I and IV B-G |
| 02/01/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *12/01/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 6.05 Mental Health Assessment for Youth at Juvenile Hall

## I. PURPOSE

The County of San Luis Obispo Behavioral Department (SLOBHD) screen all youth for mental health and substance-use issues when admitted to the Juvenile Hall (JH). Elective mental health services are offered to all youth while at the Juvenile Hall and youth may request to speak with the Mental Health Therapist (MHT) via the Youth's Request Form. Those youth identified as seriously emotionally disturbed who, as the result of a mental disorder demonstrate, or are at risk of developing, substantial impairments in functioning and are likely to benefit from Mental Health services are provided a Mental Health assessment for ongoing mental health services.

## II. POLICY

Mental Health Therapists provide mental health assessment services to youth detained in the Juvenile Hall. ***Note:*** regarding on-going mental health services at the Juvenile Hall see SLO Youth Services Procedures Manual, Juvenile Hall Services.

## III. REFERENCE(S)

## IV. PROCEDURE

A. If it is determined that a youth requires Mental Health Services while in the Juvenile Hall, the staff proceeds with scheduling and completing an intake assessment per policy 5.0 Outpatient Mental Health Assessment.

B. For clients in the Juvenile Hall, authorization decisions must be made as expeditiously as the client's condition requires but no longer than seven (7) working days from the initial face-to-face contact. (See Policy 3.0 Access to Services for further information regarding timelines for services.)

C. Authorization of Services and Re-authorizations:

- See policy 3.20 Authorization of Services and Medical Necessity
- See the most current Treatment Plans and Documentation Guidelines

D. For Medi-Cal beneficiaries who do not have an open Mental Health Case:

1. After the JH Mental Health Therapist receives a copy of a JH in Custody Awaiting Placement Form (MC-250) confirming the adjudication of the minor and awaiting placement status, a determination is made as to whether the minor requires Mental Health Services while detained at the Juvenile Hall.

2. If it is determined that the minor requires Mental Health Services while in the Juvenile Hall, the staff proceeds with scheduling and completing the intake per policy 5.0 Outpatient Mental Health Assessment. A copy of the MC-250 (JSC In Custody Awaiting Placement Court Order) confirming the adjudication of the minor should be included in the client's record.
3. If the minor is not a SLO Medi-Cal beneficiary, see policy 3.21 Authorization, Documentation, Billing Process for Out of Plan Services.

E. Timelines:

1. For clients in the Juvenile Hall, authorization decisions must be made as expeditiously as the client's condition requires but no longer than 7 working days from the initial face-to-face contact.
2. See Policy 3.00 Access to Services for further information regarding timelines for services.

F. Authorization of Services and Re-authorizations

1. See policy 3.20 Authorization of Services and Medical Necessity
2. See the most current Treatment Plans and Documentation Guidelines

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 02/01/2015 | | Adopted |
| 01/02/2018 | All | Formatting |
| Prior Approval dates: | | |
| 05/30/2009, 11/25/2014 | | |

| *Signature on file* | | *02/01/2015* |
|---|---|---|
| Approved by: | Daisy Ilano, MD, Medical Director | Date |

# 6.06 Therapeutic Behavioral Health Services Authorization

## I. PURPOSE

To give direction on authorizing and providing Therapeutic Behavioral Services

## II. POLICY

County of San Luis Obispo Behavioral Health Department (SLOBHD) will provide medically necessary Therapeutic Behavioral Services (TBS) as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental Specialty Mental Health Service (SMHS) to all full scope SLO County Medi-Cal beneficiaries who are under the age of 21

## III. REFERENCE

- California Code of Regulations, Title 9, §1810.405, §1810.410
- Title 9, CCR, Section 1810.215; Title 22, Section 51184(c) and 51340(e-f);
- DMH Informational Notices 08-38 and 09-10
- TBS Documentation Manual, Version 2.0 (October, 2009)
- TBS Coordination of Care Best Practices Manual, Version 1.0 (July, 2010)
- Policy 2.13 EPSDT and TBS: Distribution of State Notices
- Contract between MHP and State Dept. of Health Care Services (DHCS), Exhibit B
- MHP's Current Treatment Plans and Documentation Guidelines

## IV. PROCEDURE

### A. Definition:

TBS are intensive one-to-one outpatient mental health services available to youth under the age 21 with serious emotional disturbances (SED) and their families. TBS are designed to help youth and their parents/caregivers (when available) manage behaviors utilizing short-term, behavioral interventions targeting measurable goals that are based on the youth's and family's needs. TBS are interventions are based on behavior modification and skill development principles. (Adapted from the TBS Documentation Manual and the Contract

B. Eligibility

| **TBS Eligibility Checklist** (Adapted from the *TBS Documentation Manual.* Items 1-6 must be "Yes" to be eligible for TBS.) | | | |
|---|---|---|---|
| **Item** | **Criteria** | **Yes** | **No** |
| 1 | Under age 21? | | |
| 2 | Full scope Medi-Cal? *(SLO County or with authorization from responsible County)* | | |
| 3 | Meets Medical Necessity[1] or EPSDT[2] criteria for Specialty Mental Health Services (SMHS)? | | |
| 4 | Meets Class Inclusion Criteria? *(One or more of the following must apply)* | | |
| | a. Currently placed in a Group Home RCL 12-14, Short Term Residential Treatment Program (STRTP), or a locked treatment facility for the treatment of mental health needs. | | |
| | b. Being considered for placement in a Group Home RCL 12-14 or a STRTP.[3] | | |
| | c. Had at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months | | |
| | d. At risk of emergency psychiatric hospitalization related to their current presenting disability.[4] | | |
| | e. Previously received TBS due to one of a through d above | | |
| 5 | Currently receives other specialty mental health services? | | |
| 6 | Meets Clinical Need Criteria? *(One or more of the following must apply)* | | |
| | a. Will require placement out of home in a higher level of residential care or emergency psychiatric hospitalization due to youth's behaviors or symptoms, which jeopardize current placement | | |
| | b. Will be unable to transition home with family, to a foster home, or to a lower level of residential care.[5] | | |

[1] *See Policy 4.00, titled Authorization and Approval of Services for the definition of Medical Necessity*

[2] *A minor may be eligible under EPSDT when specialty mental health services are needed to correct or ameliorate a defect, mental illness, or condition even if Medical Necessity criteria are not met.*

[3] *Note: "Considered for" means RCL 12-14 placement is one option being considered as part of a set of solutions to address the youth's needs. A youth also meets this requirement if his/her behavior could (reasonably) result in RCL 12-14 or STRTP placement.*

[4] *Note: "At risk of" means hospital placement is one option being considered as part of a set of solutions to address the youth's needs. A youth also meets this requirement if his/her behavior could (reasonably) result in hospitalization.*

[5] *Note: Although the youth may be stable in the current placement, a change in behavior is expected and TBS are needed to stabilize the youth in the new environment. The SAI must document the basis for the expectation of that the behavior will change.*

C. TBS shall NOT be provided

1. Unless it is necessary to prevent a client's placement in a group home at Rate Classification Level (RCL) 12-14 or STRTP; or a locked facility for the treatment of mental health needs; or to enable a transition from any of those levels to a lower level of residential care; or for a client who has undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months

2. Solely for the convenience of the family or other caregivers, physician, or teacher.

3. To provide supervision or to ensure adherence with terms and conditions of probation.

4. To ensure the child/youth's physical safety or the safety of others (e.g. suicide watch).

5. To address conditions not a part of the child's mental health condition.

6. For youth who can sustain non-impulsive self-directed behavior; handle themselves appropriately in social situations with peers, and who are able to appropriately handle transitions during the day.

7. For children/youth who will never be able to sustain non-impulsive self-directed behavior and engage in appropriate community activities without full-time supervision; or when the beneficiary is an inpatient of a hospital, psychiatric health facility, nursing facility, Institutions for Mental Diseases (IMD), or crisis residential program.

8. When youth does not receive other Specialty Mental Health Services (SMHS).

D. Referral Procedure

1. <u>Referral for TBS from External Agencies:</u>
In an effort to coordinate care, reduce barriers and ensure access to TBS for eligible class members, Mental Health Managed Care acts as a single point of entry for TBS referrals from external agencies. See MHP's most recent Documentation Guidelines and Attachment A for detail.

2. <u>Referral for TBS from within Mental Health (open case):</u>
For youth with an open case, the Single Accountable Individual (SAI) completes the TBS Criteria Form to determine eligibility whenever TBS are requested. See MHP's most recent Documentation Guidelines and Attachment B to this policy for detail.

E. Authorization Procedure

1. TBS must be pre-authorized, but every effort is made to streamline the process and reduce barriers to access. An authorization decision must be made:

   a. Within 14 days of receipt of referral for a routine request
   b. Within three (3) workdays of receipt of referral for an emergency request[6] (may be extended by up to 14 calendar days if the beneficiary requests an extension). See MHP's most recent documentation guidelines for a detailed description of emergency TBS documentation requirements.

   [6] *Note: A Behavioral Health Program Supervisor may conditionally authorize the provision of TBS for a maximum of 30 calendar days when class membership cannot be established for a youth. This may be done:*

   - *Up to 30 days or until class membership is established, whichever comes first.*
     *AND*
   - *When the child/youth presents with urgent or emergency conditions that jeopardize his/her current living arrangement.*

   *Documentation must include evidence that TBS was medically necessary and the most appropriate level of service available to address the child/youth's mental health condition.*

F. Assessment and Treatment Plan

1. The TBS Assessment and Treatment Plan establishes baseline behavioral data and the specific intervention plan to reduce the targeted behaviors.[7]

   [7] *Note: Medical Necessity and/or EPSDT qualification for SMHS must be established separately by comprehensive MH assessment.*

2. An initial TBS Assessment and Treatment Plan must be completed prior to direct or collateral TBS interventions. It authorizes TBS for up to 90 days.

3. If TBS continue to be medically necessary, an additional 90 days of TBS may be authorized by each subsequent TBS Assessment and Treatment Plan review.

4. Changes to the content of a TBS Assessment and Treatment Plan, but not the authorization period, are accomplished when the plan is revised, which may occur:
   a. At any time during the TBS treatment period to modify the plan (add or change target behaviors or interventions; increase or decrease hours of service, etc.).
   b. At anytime during TBS to document significant changes in behavior.
   c. Whenever progress is not occurring or is not reasonably expected to occur.

5. Signature Requirements:

    a. Initial plans and reviews to authorize subsequent TBS episodes:

    - Client (if over 12 and mature enough)
    - Parent/Legally Responsible Person
    - Staff member completing the assessment/plan (usually the SAI)
    - Licensed/Registered staff member (if different than above)
    - TBS staff (if different than above)
    - Behavioral Health Program Supervisor
    - Health Information Technician

    b. TBS Assessment and Treatment Plan revisions to modify the plan:

    - Client (if over 12 and mature enough)
    - Parent/Legally Responsible Person
    - Staff member completing the assessment/plan (usually the SAI)
    - Licensed/Registered staff member (if different than above)
    - Behavioral Health Program Supervisor (only above are not BH staff)
    - Health Information Technician

G. Tapering and Termination of TBS

    a. One of the core elements of TBS is transfer of skills to the youth and parent/caregiver to promote self-efficacy and the use of natural supports. As a youth reaches benchmarks and goals, service hours gradually decrease and the focus may change from skill development to relapse prevention/management. A schedule to taper services shall be built into the plan and termination of TBS should be discussed at every treatment team meeting.

    b. TBS will end when one or more of the following is met:

    - The client reaches his/her objectives.
    - When reasonable progress towards goals/benchmarks is made.
    - If progress is not occurring, despite adjustments to the TBS plan.
    - When client is not likely to improve.
    - If client or family chose to end services.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 07/13/2017 | All | Add STRTP, Registered Intern, new attachments |
| 01/25/2018 | All | Formatting |
| Prior Approval dates: | | |
| 05/30/2009, 09/21/2012 | | |

| *Signature on file* | | *07/13/2017* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 6.07 MHSA Community Planning Process

## I. PURPOSE

To provide direction on the Community Program Planning Process.

## II. POLICY

In accordance with regulations, the San Luis Obispo County Behavioral Health Department (SLOBHD) includes the participation of stakeholders (Reference 2) in its Mental Health Services Act (MHSA) Community Program Planning Process and provides evidence of this procedure.

In addition, MHSA staff provide training (Reference 3) as needed to SLOBHD staff and stakeholders, clients, and when appropriate, the client's family who are participating in the Community Program Planning Process.

## III. REFERENCE(S)

- CCR, Title 9, Chapter 14, Section 3200.270 (b)(4)
- CCR Title 9, Chapter 14, Section 3300(b) (1)(2)(3)
- CCR Title 9, Chapter 14, Section 3300
- CCR Title 9, Chapter 14, Section 3320
- CCR Title 9, Chapter 14, Section 3310

## IV. PROCEDURE

A. SLOBHD (Reference 4) has adopted the following standards in planning implementing and evaluating the programs and/or services provided with Mental Health Services Act (MHSA) funds. The planning, implementation and evaluation process includes, but is not limited to, the Community Program Planning Process; development of the Three-Year Program and Expenditure Plans and updates (Reference 5) and the manner in which the SLOBHD delivers services and evaluates service delivery.

B. The standards are as follows:

1. Community Collaboration
2. Cultural Competence
3. Client Driven
4. Family Driven
5. Wellness, Recovery and Resilience Focused
6. Integrated Service Experiences for clients and their families.

C. The Three-Year Program and Expenditure Plans shall address each of the following components (Reference 5):

1. Community Services and Supports for Children and Youth, Transitional Age Youth, Adults and Older Adults.
2. Capital Facilities and Technological Needs
3. Education and Training
4. Prevention and Early Intervention
5. Innovative Programs
6. The SLOBHD updates the Three-Year Program and Expenditure Plans at least annually and develops the Three-Year Program Expenditure Plans and updates in collaboration with stakeholders through the Community Program Planning Process, as specified in CCR Section 3300.

D. SLOBHD MHSA Components:

1. SLOBHD, the stakeholder committee is known as the MHSA Advisory Council (MAC). The MAC, through the Community Planning Process as defined in (Reference 2) have given their input and recommendations of the following programs within each of the above 5 Components:

2. Community Services and Supports (CSS) Work Plans #1 through #9:

    a. Youth Full Service Partnership (FSP)
    b. Transitional Age Youth (TAY) FSP
    c. Adult FSP including MHSA Housing Program
    d. Older Adult FSP
    e. Client and Family Wellness Supports
    f. Latino Outreach Program
    g. Enhanced Crisis Response and Aftercare
    h. Behavioral Health Treatment Court
    i. Community School Mental Health Services Program

3. Prevention/Early Intervention (PEI) Projects #1 through #5:

    a. Mental Health Awareness and Stigma Projects
    b. Campus Initiative
    c. Family Education and Support
    d. Early Care and Support for Underserved Populations
    e. Community Wellness

4. Workforce Education and Training (WET) Action #1 through #9

    a. WET Coordination
    b. Peer Advisory/Advocacy Team
    c. E-Learning
    d. Law Enforcement & First Responders
    e. Cultural and Linguistic Competency

f. Workforce Training in Co-Occurring Disorders
g. Psychosocial Rehabilitation Certification
h. Internship Program
i. Stipends and Scholarships

5. Capital/Facilities

a. Information Technology (IT)
b. Behavioral Health Electronic Health Record (BHEHR)
c. Innovation (INN) (Component is currently in the planning stages).

E. Community Program Planning Process Procedure:

1. A stakeholder is defined (Reference 1) as individuals or entities with an interest in mental health services in the State of California, to include, but is not limited to:

a. individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical care and/or social services
b. educators and/or representatives of education representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness and/or serious emotional disturbance and or their families.

2. It is important that stakeholders that reflect the diversity of the demographics of the County of San Luis Obispo (including but not limited to geographic location, age, gender and race/ethnicity) can participate in the Community Program Planning Process.

F. Recruitment and retention of stakeholders that meet the above stated definitions are involved in various events/activities and meetings throughout SLOBHD.

1. Consumers with severe mental illness and their families have been involved in discussions to plan MHSA programs from the beginning.
2. The current MHSA Advisory Council as well as the Mental Health Board, has members that have been recipients of mental health treatment or have had family members in treatment.
3. Consumers have been involved in every community planning effort and activity for each of the first three (3) components under MHSA, from needs assessments and surveys to focus groups and planning meetings.
4. We are developing plans to expand the involvement of consumers into the focus groups for the Innovation component's community planning process.

G. Consumers as stakeholders are gathered from the following community resources:

1. Local consumer-based chapter organizations such as National Alliance for the Mentally Ill (NAMI)
2. Community-Based Organizations (CBO)
3. Self-referral of consumer and/or family member of consumer.
4. SLOBHD Mental Health staff such as therapists, social workers, psychiatrists, psychologists, licensed psychiatric technicians, Patient Rights Advocate, interns and administration.
5. Private sector Health Agencies, physicians and other private practitioners.
6. Peer Advisory/Advocacy Team (PAAT) and the People Empowering People (PEP)Center – Transitions Mental Health Association

H. Evidence of stakeholder representation at meetings/forums is gathered in the form of:
   1. Invitations
   2. Sign-in sheets at stakeholder meetings.
   3. Copies of announcements of public meetings
   4. Meeting minutes
   5. SLOBHD provided responses to comments

I. Evidence of SLOBHD training provided to staff and offered to clients is provided from the following:
   1. SLOBHD distributed flyers or announcements
   2. Agendas and/or sign-in sheets
   3. Curricula or other similar documents and reports

J. As an appropriate adjunct to the goal of increasing client participation in all aspects of community activities, Transitions Mental Health Association (T-MHA) is considered the local Community-Based Organization (CBO) leader for consumer-run activities.

K. T-MHA'S newly formed Peer Advisory/Advocacy Team (PAAT), is involved in providing stakeholder training and participation in a wide range of activities promoting self-advocacy, including MHSA's Community Program Planning Process.

   1. PAAT's Mission Statement includes:

      a. Advocate and educate the community about mental health and recovery
      b. Eliminate the stigma attached to mental illness
      c. Advocate and educate the mental health system about the valuable workforce contributions to be made by the individuals it serves.
      d. Educate individuals served and family members about their rights and responsibilities in the mental health system
      e. Provide support to peer employees and other leaders of the peer movement to ensure that they have the tools they need to achieve and maintain success and job satisfaction
      f. Promote the concept of wellness versus illness and focus attention on personal responsibility and a balanced life, grounded in wholeness

L. In collaboration with the SLOBHD, T-MHA provides as evidence of training to support staff and clients/family members the following through announcements, agendas, sign-in sheets, curricula, meeting minutes and other related documents.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 05/30/2009 | All | Adopted |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file (KB)* | | *05/30/2009* |
|---|---|---|
| Approved by: | Behavioral Health Administrator | Date |

# 6.08 MHSA Peer and Family Support Services

I. PURPOSE

To give direction for establishing Peer Support and Family Education Support Services.

II. POLICY

The Mental Health Services Act (MHSA) of County of San Luis Obispo Behavioral Health Department (SLOBHD) establishes Peer support and family education support services and expand these services to meet the needs and preferences of clients and/or family members.

III. REFERENCE(S)

- Title 9, Chapter 14, Section 3610(b)

IV. PROCEDURE

A. Transitions Mental Health Association (T-MHA) is the leading local Community-Based Organization (CBO) responsible for consumer-based activities in San Luis Obispo County. MHSA funds the following consumer-based activities run by T-MHA which aims at providing a forum for advocacy, education, promotion of Wellness and Recovery, and striving to eliminate stigma:

1. Supportive employment and vocational training is provided through employment readiness classes and job placement.

2. Client and family-run support, mentoring and educational groups is conducted through the following programs overseen by a community-based organization.

3. Peer to Peer is a 9-week experiential education course on recovery that is free to any person with a mental illness. It is taught by a team of 3 to 4 peer teachers who are experienced at living well with mental illness.

4. Family to Family is a 12-week educational course for families of individuals with severe mental illness. It provides up to date information on the diseases, causes and treatments, as well as coping tools for family members who are also caregivers. A team of 2 family members teach the class.

5. The Peers Empowering Peers (PEP) Center is a consumer driven Wellness Center in the northern region of the county. Support groups and socialization activities as well as NAMI –sponsored educational activities are conducted here.

6. Client & Family Partners act as advocates, to provide day-to-day, hands on assistance, link people to resources, provide support and help to "navigate the system." This strategy will also include a flexible fund that can be utilized for individual and family needs such as uncovered health care, food, short-term housing, transportation, education, and support services.

7. Peer Advisory/Advocacy Team (PAAT) Advocates and educates the community about mental health and recovery. Goals include: Eliminate the stigma attached to mental illness. Advocate and educate the mental health system about the valuable workforce contributions to be made by the individuals it serves. Educate individuals served and family members about their rights and responsibilities in the mental health system. Provide support to peer employees and other leaders of the peer movement to ensure that they have the tools they need to achieve and maintain success and job satisfaction. Promote the concept of wellness versus illness and focus attention on personal responsibility and a balanced life, grounded in wholeness.

B. Evidence that the SLOBHD, in collaboration with T-MHA, has established ongoing peer support and family education support services, as well as expanded these services will be provided in the form of:

1. Announcements and flyers of the aforementioned programs.
2. Agendas and sign-in sheets
3. Brochures and newsletters
4. Meeting minutes
5. Curricula or similar documents that reflect that peer support services and family education support services are available or offered.
6. Records of statistics for required DMH reports will also be available.

## V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 05/30/2009 | All | Adopted |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *05/30/2009* |
|---|---|---|
| Approved by: | Behavioral Health Administrator (KB) | Date |

# 6.09 MHSA 24/7 Support Services

## I. PURPOSE

To give direction for providing 24-hour, 7 days a week support line to clients and partners enrolled in FSP.

## II. POLICY

Mental Health Services Act – Full Service Partnership Program provides a 24-hour, 7-days a week Support Line to clients / partners enrolled in the FSP program.

## III. REFERENCE(S)

- CCR, Title 9, Chapter 14, Section 3620(f)(1)(i)

## IV. PROCEDURE

A. Calls received during business hours. During regular business hours Monday through Friday, an assigned Full-Service Partnership (FSP) team responds to each client / partner. This team ensures that their client / partners are introduced to all FSP staff who is assigned to the FSP Support Line. The goal is to foster a trusting relationship between FSP staff and clients / partners, and one way to accomplish this will be to schedule ongoing social events.
B. Calls received after hours. After hours, week-ends, and holidays a member of one of the FSP teams (not necessarily an assigned team member to a particular client) responds to after hour calls. FSP team members are on a rotating schedule to provide 24-7 support line services to client/partners and family, or other supportive individuals known to the client / partner as deemed necessary.
C. The assigned on-call FSP staff member determines whether the situation requires the intervention of Mobile Crisis, law enforcement, or another appropriate contract provider for on-site crisis intervention in the field.
D. On-call FSP staff address serious issues with client / partner when receiving a crisis call. If upon further assessment the client / partner are considered to be at risk of harm to self or others, the on-call staff ascertain the best course of action whether to contact Mobile Crisis team, or other appropriate community resources i.e. 911, law enforcement, etc.
E. A log is kept of all calls to the support line. Pertinent information is documented and reviewed with the assigned therapist the following business day. The regularly assigned team then contact the client / partner as soon as possible and document these contacts as appropriate.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 05/30/2009 | All | Adopted |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *05/30/2009* |
|---|---|---|
| Approved by: | Behavioral Health Administrator (KB) | Date |

# 6.10 Telehealth Service Delivery

## I. PURPOSE

To provide timely and appropriate telehealth services and improve accessibility of services to improve a client's health by permitting two-way, real time interactive audio and video communication between the client and the healthcare provider.

## II. POLICY

In accordance with HIPAA Privacy Rule 45 CFR Parts 410.78, 160, 162 and 164, County of San Luis Obispo Behavioral Health Department (SLOBHD) may provide telehealth services to clients of the Department to augment face-to-face medical services.

## III. DEFINITIONS

- Telehealth: the use of a two-way, real time interactive audio and video communication between the client and healthcare provider
- Distant, Hub site or remote site – site at which the healthcare provider delivering the service is located at the time the service is provided
- Originating or spoke site – location of the client at the time the service is being provided. This could be a room at the clinic site or at a place where the client can be seen privately via video streaming.

## IV. REFERENCE

- HIPAA Privacy Rule 45 CFR Parts 410.78, 160, 162 and 164
- Business and Professions Code 2290.5
- Telehealth FAQ (ca.gov) (dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx#Cov)
- County of San Luis Obispo Health Agency *Health Information Privacy and Security Policy and Procedure Suite*

## V. PROCEDURE

A. Licensed and non-licensed staff may provide telehealth services within their scope of practice and as determined appropriate by the San Luis Obispo County Behavioral Health Department (SLOBHD).

B. Consents
   1. A written, signed Telehealth Informed Consent (Attachment 1) will be obtained from the client/legally responsible person by designated staff at the Originating site. Staff at the Originating site will educate the client about the service delivery process.
   2. All consents, written or verbal, for treatment and other procedures applicable to face-to-face office visit will be obtained at the Originating site.

C. Staff may provide and claim for medically necessary telehealth services delivered to clients who are temporarily outside of the state of California.
D. Clinic originating site set up
    1. Designated telehealth room will be well lit, as close as possible to daylight.
    2. The office will be of sufficient size to allow the gaze angle to be as small as possible.
    3. Video teleconferencing equipment will be set at an optimal distance and as close as possible to eye level of the observer.
E. Remote site set up
        a. Professional background – The healthcare provider will minimize distraction during the video teleconferencing encounters to facilitate trust and rapport with the client and/or family. A non-distracting and coherent neutral background should be used. Any décor appearing in the background should be professional and unobtrusive. If it is not possible to create a professional background while providing services, an appropriate, neutral virtual background may be used.
    1. Appropriate lighting – Staff should be clearly visible to the client/legally responsible person.
    2. Noise/Sound – Staff should be in a quite space without distracting background noise.
    3. Comfort – Staff space should be comfortable and follow ergonomic guidelines whenever possible.
    4. Isolation/Privacy – Services should be provided in an isolated, private location to ensure client privacy is safeguarded.
F. Technical Knowledge and Requirements
    1. Telehealth services will be provided using an approved, secure, HIPAA compliant platform.
    2. Before initiating a telehealth service all technical connections should be checked to avoid technical problems during the service. Staff should have a clear understanding of the telehealth platform being used and be able to assist the client/legally responsible person with any issues that may arise while using the telehealth platform.
    3. If a technical issue arises while providing telehealth services the staff should have an alternative form of contact to reach their client/legally responsible person, such as a phone number or email address.
G. All persons in the Originating site and distant site will be identified by name and role to all persons present prior to the delivery of the service.
H. Documentation
    1. All documentation requirements, which apply to face-to-face encounters and telephone calls, will also apply to Telepsychiatry services.
    2. Exchange or transmission of information between the distant site and the Originating site shall be done in a secure manner and in compliance with the State and Federal regulations. Electronic transmission of any clinical documents will be permissible. The exchange or transmission shall occur within 24 hours of the Telepsychiatry service.
H. Treatment Delivery
    1. The healthcare provider will be reasonably available to treatment team for consultation and planning regarding any specific evaluative or treatment services rendered during the Telehealth encounter but may not be immediately available on

an ongoing basis to the treatment team.

2. The client who will participate in Telehealth services will be assessed for appropriate psychological, physiological and medical stability.
3. Appropriate candidates will be:
   a. Sufficiently alert and oriented to participate
   b. Non-violent
   c. Free of physical restraints during the provision of Telehealth service
   d. Determined to have sufficient impulse control to remain safely in the room with the telehealth equipment. The designated staff assigned to provide support to the healthcare provider will assess the client's impulse control prior to each visit.
4. Originating site staff, if applicable, will be present or immediately be available in case the client is no longer able to remain safely in the room.
5. Originating site staff, if applicable, will make relevant psychiatric, developmental, social, medical and substance abuse histories available to the healthcare provider prior to the visit.
6. Originating site staff, if applicable, will be available to perform and transmit results of routine vital signs including heart rate, respiration, standing or sitting blood pressure and temperature (if needed) to the telehealth healthcare provider.
7. The healthcare provider will have access to all laboratory examinations and results necessary for the assessment of the client.
8. Based on the healthcare provider's orders, sample medications may be available and dispensed at the Originating site where the client is being seen (Refer to Policy # 7.03 Medication Procurement, Storage, Administration, and Dispensing).

I. Responsibility and workflow requirements of staff
   1. Distant site
      a. The healthcare provider will speak the preferred language of the client/legally responsible person and/or family whenever possible. When not possible, an interpreter will be utilized in the same manner as those used in face-to-face encounter.
      b. The healthcare provider will participate in the treatment planning and consultation regarding clients with the members of the treatment team to the same extent as their colleagues who provide face-to-face services at clinic sites.
      c. If medication is prescribed, the psychiatrist/psychiatric nurse practitioner will ensure timely transmission of prescriptions and verbal orders to the pharmacies and/or staff at the Originating site or input the prescription directly into the EHR.
   2. Originating site
      a. Designated staff, when applicable, will escort the client and/or family to and from the Telehealth room.
      b. Designated staff will be available to the healthcare provider by phone call before, during and after the visit.
      c. Designated staff will serve as the primary contact for the client and the healthcare provider.

d. Licensed medical staff will be available at the Originating site, when applicable, to assist the psychiatrist/psychiatric nurse practitioner during any of the following circumstances:
   1. When an adequate assessment of the physical signs and symptoms require an onsite licensed medical staff
   2. When a significant degree of physiologic instability is present
   3. When an immediate administration of medication requiring subsequent onsite monitoring is required
   4. When there is a significant change in the client's mental status that is of uncertain origin
e. If it is determined by the licensed medical staff at the Originating site that the client needs emergency medical care, the staff will facilitate the transfer of the client to the nearest medical facility.

###

VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 04/26/2016 | All | Origination and Formatting |
| 04/15/2020 | All | policy that now applies to a variety of services and provider types, changed patient to "client" and language under purpose revised. |
| 6/29/2021 | All | Updated for expansion of telehealth providers and services |
| 8/28/2023 | V. | Updated for consistency with our new EHR Consent for Telehealth |
| 09/05/2024 | V.C. | Added provision that services may be provided to clients temporarily located out of state |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *09/10/2024* |
|---|---|---|
| Approved by: | Star Graber, PhD, LMFT, Behavioral Health Administrator | Date |

# CONSENT FOR TELEPSYCHIATRY SERVICES

I,_____(Name of patient/Legal Guardian/Conservator), hereby consent for myself/my child/Conservatee to engaging in telepsychiatry as part of my treatment, in which Mental Health staff appropriate to my needs is not immediately available at my clinic. I understand that telepsychiatry includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communication. I understand that telepsychiatry also involves the communication of my medical/mental information, both orally and visually, to healthcare practitioners located in California or outside California.

I understand that I have the following rights with respect to telepsychiatry:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to telepsychiatry. As such, I understand that the information disclosed by me during the course of my treatment is confidential. However, there are mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse reporting threats of violence toward identifiable victim(s); and where I make my mental or emotional state an issue in a legal proceeding.

3. My video telepsychiatry will not be recorded. All identifying information in the interaction will be kept secure in the same manner as any other private medical information.

4. I understand that there are risks and consequences from telepsychiatry, including, but not limited to, the possibility, despite reasonable efforts on the part of my healthcare provider, that the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted or accessed by unauthorized persons.

5. In addition, I understand that telepsychiatry based services and care may not be as complete as face-to-face services.

6. I understand that I may benefit from telepsychiatry, but the results cannot be guaranteed or assured.

7. I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

8. I understand that by consenting to telepsychiatry, my healthcare provider will communicate medical information concerning me to physicians and other healthcare providers such as Primary Care Physician.

| Signature of Patient | Signature of Witness | Date |
|---|---|---|

| Signature of Legal Guardian/Parent | Relationship to Patient | Date |
|---|---|---|

☐ Patient is willing to accept Telepsychiatry Services, but unwilling to sign the Consent

| Signature of Staff | Date |
|---|---|

A copy of this consent ☐ was given ☐ was declined on_____ by _____
Date Initial

# CONSENTIMIENTO PARA LOS SERVICIOS DE TELEPSYCHIATRY

Yo,_____(Nombre de Paciente/Guardian Legal/ Conservador), doy consentimiento para mí / mi hijo / Conservador a participar en la tele psiquiatría como parte de mi tratamiento, en el que el personal de Salud Mental, de acuerdo con mis necesidades, no está inmediatamente disponible en mi clínica. Entiendo que la tele psiquiatría incluye la práctica de la prestación de atención médica, diagnóstico, consulta, tratamiento, transferencia de datos médicos y educación mediante audio interactivo, video o comunicación de datos. Entiendo que la tele psiquiatría también implica la comunicación de mi información médica/mental, tanto oral como visualmente, a profesionales de la salud ubicados en California o fuera de California.

Entiendo que tengo los siguientes derechos con respecto a la tele psiquiatría:

1. Tengo derecho a retener o retirar el consentimiento en cualquier momento sin afectar mi derecho a la atención o tratamiento futuro.

2. Las leyes que protegen la confidencialidad de mi información médica también se aplican a la tele psiquiatría. Como tal, entiendo que la información divulgada por mí durante el curso de mi tratamiento es confidencial. Sin embargo, hay excepciones obligatorias y permisivas a la confidencialidad, incluyendo, pero no limitado a denunciar el abuso de niños, ancianos y adultos dependientes; denunciar amenazas de violencia hacia víctimas identificables; y donde hago de mi estado mental o emocional un problema en un procedimiento legal.

3. Mi tele psiquiatría de video no será grabada. Toda la información de identificación en la interacción se mantendrá segura de la misma manera que cualquier otra información médica privada.

4. Entiendo que hay riesgos y consecuencias de la tele psiquiatría, incluyendo, pero no limitado a, la posibilidad, a pesar de los esfuerzos razonables por parte de mi proveedor de atención médica, de que la transmisión de mi información médica podría ser interrumpida o distorsionada por fallas técnicas; la transmisión de mi información médica podría ser interrumpida o accedida por personas no autorizadas.

5. Además, entiendo que los servicios y la atención basados en tele psiquiatría pueden no ser tan completos como los servicios presenciales.

6. Entiendo que puedo beneficiarme de la tele psiquiatría, pero los resultados no pueden ser garantizados o garantizados.

7. Entiendo que tengo derecho a acceder a mi información médica y copias de los registros médicos de acuerdo con la ley de California.

8. Entiendo que al consentir la tele psiquiatría, mi proveedor de atención médica comunicará información médica que le concierne a los médicos y otros proveedores de atención médica como a mi Médico de Cabecera.

| | | | |
|---|---|---|---|
| Firma de Paciente | Firma de Testigo | Fecha | Fecha |
| Firma del Tutor Legal/Padre | Relación al Paciente | Fecha | Fecha |

☐ El paciente está dispuesto a aceptar los Servicios de Tele psiquiatría, pero no está dispuesto a firmar el Consentimiento

| | |
|---|---|
| Firma de Personal | Fecha |

Copia de consentimiento ☐ se dio ☐ fue declinado en _____ por _____
Fecha Inicial

# 6.11 Continuum of Care Reform/Pathways to Wellbeing: Subclass, Model, and Services

## I. PURPOSE

To describe mechanisms for:

- Referring, screening, and assessing the mental health needs of Child Welfare Services (CWS) referred youth
- Identifying and tracking Katie A subclass members
- Tracking MHP implementation of the Core Practice Model (CPM), especially SLOBHD staff participation in Child and Family Team (CFT) meetings
- Promoting the delivery of Specialty Mental Health Services (SMHS) and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, including Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC), to all eligible Medi-Cal beneficiaries, when medically necessary
- Providing initial and annual Mental Health program approval and site certification for contracted Short-Term Residential Therapeutic Programs (STRTPs)

## II. POLICY

San Luis Obispo Behavioral Health Department (SLOBHD) will provide all medically necessary SMHS and EPSDT supplemental services, including ICC, IHBS and TFC, to all Medi-Cal beneficiaries who meet medical necessity and eligibility criteria.

Additionally, SLOBHD will collaborate with County of San Luis Obispo Department of Social Services (SLO DSS) to identify, screen, assess and provide medically necessary SMHS to youth who have an open Child Welfare case and will certify and provide the mental health program approval for STRTPs utilized by SLO DSS and County of San Luis Obispo Probation Department.

SLOBHD will report Katie A service data to Department of Health Care Services (DHCS) as required by contract.

## III. REFERENCE(S)

- Welfare & Institutions Code §§ 11400 – 11469; 16501 – 16519.5; 18987.7
- Family Code § 7911
- DHCS Informational Notices 18-022, 17-016, 17-009, 16-84, 16-049, 16-031E, 16-002, 14-36, 14-010, 13-19, 13-11, and 13-10
- U.S. Code, Title 42, Chapter 7, Subchapter XIX, § 1396
- California Code of Regulations, Title 9, Chapter 11, §1830.205
- Katie A. etc., et al. v Bonta, etc. et al., Class Action Settlement Agreement
- The California Integrated Core Practice Model for Children, Youth, and Families (2018)

- Integrated Training Guide (2018
- Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC) for Medi-Cal Beneficiaries
- Contract between MHP and DHCS, Exhibit B
- MHP's Current Documentation Guidelines

IV. PROCEDURE

*See most current Katie A procedure for additional detail regarding processes and forms*

A. SLO DSS/CWS Screening and Referral:

1. CWS Social Worker will screen all children entering the CWS system utilizing the appropriate MH Screening Tool (Birth to 5 or 6 to Adult).

2. CWS Social Worker will complete a MH Referral Eligibility Assessment on the DSS.net (a shared database between the SLO DSS and SLOBHD). The referral generates an automatic email notification to SLOBHD Managed Care.

3. CWS Social Worker will upload relevant case information, screening tool, MH intake paperwork, and court orders into DSS.net

B. SLOBHD Assessment and subclass tracking

1. SLOBHD Managed Care staff will review the information provided by CWS and will arrange a comprehensive mental health assessment within the SLOBHD timeliness standard or provide appropriate referrals to the client's Medi-Cal Managed Care Plan.

2. SLOBHD clinical staff will complete a comprehensive assessment, which will document whether medical necessity criteria for SMHS and Katie A subclass eligibility are met. The comprehensive assessment will contain a Katie A eligibility tracking question. See Attachment for an example.

3. SLOBHD Health Information staff will assign Katie A subclass eligible youth to a "Client Category" in SLOBHD's electronic health record to facilitate tracking and required reporting.

4. Every effort will be made to synchronize the eligibility information in DSS.net and the SLOBHD medical record.

C. Provision of services must follow the CPM and will utilize a CFT

1. When a placing agency such as DSS or Probation are involved, the placing agency, if

applicable, will initiate and facilitate the CFT; SLOBHD staff will be strongly encouraged to participate actively in the CFT process when involved in a youth's care.

2. Youth and families who are not part of the DSS or Probation systems of care also benefit from the CPM model; in those cases, the "Single Accountable Individual" (SAI) identified in Cerner will function as the ICC Coordinator. This individual may be a SLOBHD staff or CBO staff, and will be responsible for scheduling and leading CFT meetings and coordination of care.

3. SLOBHD staff will ensure that all necessary services, including ICC and IHBS, are part of the youth's Treatment Plan, whether or not the youth meets subclass criteria

4. SLOBHD staff will document attendance and participation in all CFT meetings in a Progress Note, typically using the ICC service code and "Child and Family Team" to indicate who received the service ("Provided to" in Cerner). This applies equally to Katie A Subclass clients and all other clients who have an active CFT attended by Mental Health staff. See Attachment 1 for an example.

D. SLOBHD will report ICC, IHBS and TFC service data to DHCS as required by contract using the required service code set up and other methods as determined by DHCS.

E. ICC,IHBS, and TFC contract development and monitoring

1. SLOBHD will maintain a written contract with Family Care Network to provide ICC, IHBS, and TFC services. The contract will specify the scope of services needed to ensure network adequacy, including the capacity to provide culturally and linguistically appropriate services.

2. SLOBHD Fiscal and Quality Support Team (QST) staff will monitor compliance with provisions of the contract by conducting regular contract meetings, regular record and utilization review activities, and by site certification monitoring.

F. STRTP Contracts, Certification and Program Approval

1. SLOBHD will maintain a written contract with Transitions Mental Health Association (TMHA) and other entities as needed to provide STRTP level of care. The contract(s) will specify the scope of services needed to ensure network adequacy.

2. SLOBHD Quality Support Team Staff will conduct initial and renewal site certification and Mental Health program approval as needed for STRTPs in SLO County.

3. SLOBHD Fiscal and Quality Support Team (QST) staff will monitor compliance with provisions of the contract by conducting regular contract meetings, regular record

and utilization review activities, and by site certification monitoring.

G. KATIE A. SUBCLASS Criteria

1. The Katie A. v Bonta settlement agreement establishes a class and subclass of youth who are eligible to receive services as described in the reference documents listed. Katie A class or subclass membership is not a prerequisite for ICC, IHBS, or TFC.

2. Katie A subclass criteria are:

   a. Under 21 years old, and
   b. Have full scope Medi-Cal eligibility, and
   c. Meet medical necessity criteria for SMHS, and
   d. Have an open CWS case, and
   e. Currently receiving or being staffed for:
      - Wraparound services
      - Therapeutic Foster Care
      - Therapeutic Behavioral Services
      - Crisis Stabilization
      - Other intensive EPSDT Services (i.e. Day Treatment)
      - Full Service Partnership
      - Eligible for specialized care rate due to behavioral health needs
      - Placed in a group home (Rate Classification Level 10 or above), a psychiatric hospital or 24 hour mental health treatment facility, and/or has experienced three or more placements within 24 months due to behavioral health needs

H. DEFINITIONS

- Core Practice Model (CPM) is a transformative model of coordinated service delivery that mandates the use of a Child and Family Team to make treatment and related decisions.

- Child and Family Team (CFT) is a team of people comprised of the youth and family and all of the ancillary individuals who are working with them toward their mental health goals and their successful transition out of the child welfare system. Mental Health and placing agency staff will work together to facilitate CFT meetings, which will be held at minimum every 90 days when a youth receives ICC or IHBS. When a youth is placed in a STRTP, the placing agency will facilitate CFT meetings.

- Intensive Care Coordination (ICC) is a Medi-Cal-covered, EPSDT service that is similar to Targeted Case Management (TCM) and includes components such as facilitating assessment, care planning and coordination of services, including urgent services for children/youth. The difference between ICC and the more traditional TCM service functions is that ICC must be delivered using a CFT and is intended for children and youth whose treatment requires cross-agency collaboration. For

additional information please see the Medi-Cal Manual on ICC, IHBS & TFC.

- Intensive Home Based Services (IHBS) are intensive, individualized, strength-based, and needs-driven intervention activities that support the engagement and participation of the child or youth and his/her significant support persons and to help the child or youth develop skills and achieve the goals and objectives of the plan. IHBS will be predominantly delivered outside an office setting and in the home, school, or community.

- Short Term Residential Therapeutic Program (STRTP) is an intensive residential placement which provides a variety of treatment resources to allow youth to return to a home-like environment quickly. Replaces the Rate Classification Level system for Group Homes and residential centers paid for by AFDC.

- Therapeutic Foster Care (TFC), also known as Treatment Foster Care and Therapeutic Family Care, consists of intensive and highly coordinated mental health and support services provided to a youth placed with a resource family (formerly called foster parent) or caregiver. In the TFC model, the caregiver who provides and documents TFC receives specialized training and is an integral part of the youth's treatment team.

V. REVISION HISTORY

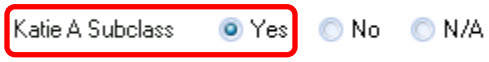
| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/01/2015 | All | Added purpose, reformatted, added F |
| 08/17/2017 | All | Reformatted, New CCR Language |
| 04/30/2018 | All | Updated language |
| 09/22/2018 | All | Reformatted & Updated Language |
| Prior Approval dates: | | |
| 05/30/2009, 06/05/2010, 10/12/2012 | | |

| *Signature on file* | | *10/10/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

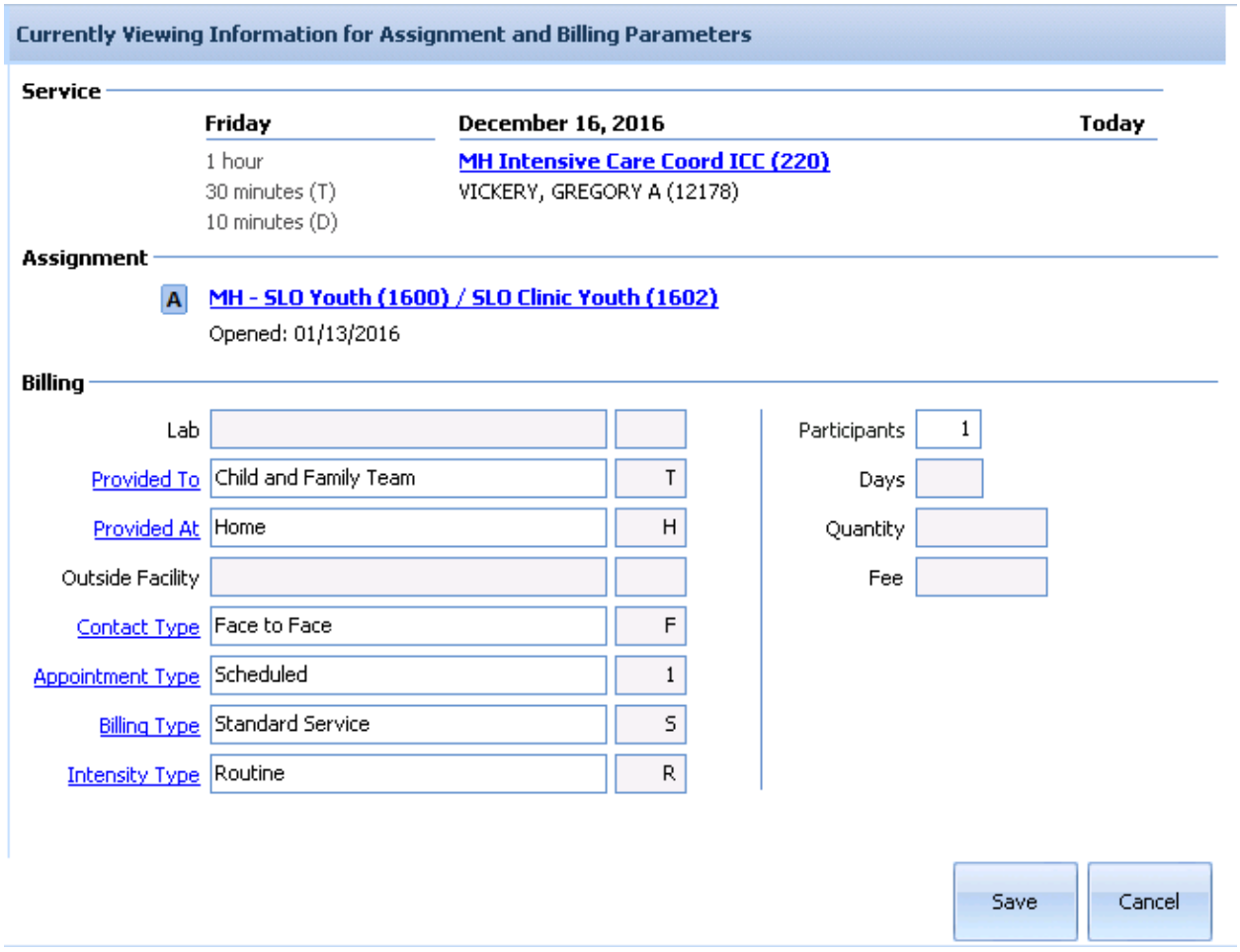
**Attachment 1**

Tracking examples:

1. Katie A Subclass question must be marked “Yes” if subclass criteria are met!




2. Example of Mental Health staff documentation of CFT attendance in the billing ribbon of a Progress Note. In most situations, ICC is the correct service code.



# 6.15 Monitoring LPS Conservatees

## (Out of County)

I. PURPOSE

To describe the County of San Luis Obispo Behavioral Health Department's (SLOBHD) rationale and standards for monitoring the individualized treatment, supervision, and placement provided to LPS conservatees who are placed in an out-of-County Board & Care, state hospital, mental health rehabilitation center, Institute for Mental Disease (IMD), or other approved housing.

II. BACKGROUND

The Lanterman Petris Short (LPS) Act (Welfare and Institutions Code (WIC) Division 5, Part 1, §§5000-5556) describes legislative intent to "…end the inappropriate, indefinite, and involuntary commitment" of persons with mental health disorders. WIC §5350.1 states, "The purpose of (LPS) conservatorship… is to provide individualized treatment, supervision, and placement" for individuals who are gravely disabled as a result of a mental health disorder.

To accomplish this, LPS conservatorships are time limited, involve safeguards to protect conservatees, and require coordination between the conservator (often the Public Guardian) and the County Mental Health Plan, which retains responsibility for coordinating care for a conserved person.

III. POLICY

SLOBHD staff will monitor LPS conservatees placed out-of-County by the Public Guardian's Office to ensure that conservatees receive high quality care at the lowest level of care necessary for their wellbeing. Staff will continually assess the level of care needs of LPS conservatees and will work collaboratively with the Public Guardian to return LPS conservatees to the County of San Luis Obispo whenever possible.

IV. REFERENCE(S)

- California Code of Regulations (CCR) Title 9, §1810.405 and §1850.405(c)(3)(B)
- Welfare & Institutions Code (WIC) Division 5, Part 1 (LPS Act) §§5000-5556
- WIC §5350
- SLOBHD Documentation Guidelines

V. PROCEDURE

A. Centralized Caseload: To facilitate coordination with the Public Guardian and with out-

of-County placements, SLOBHD will assign all LPS conserved clients to one clinical staff person, who will be the Single Accountable Individual for the clients on this specialized caseload.

B. Service Level Expectations:
   1. The assigned staff member will:
      a. Ensure that the conservatee, Public Guardian, and placement staff are able contact the staff member by phone, mail, or email regarding any quality of care, treatment, or any other concerns.
      b. Provide a face-to-face Targeted Case Management (TCM) or other Specialty Mental Health Service (SMHS) with the conservatee and with placement staff on at least a quarterly basis either via telehealth or in person by traveling to the placement.
      c. Inform the LPS conservatee of the behavioral expectations required for the conservatee to transition to a lower level of care.
      d. Conduct a monthly review of service plans, MD progress notes and documentation updates from all facilities.
      e. Maintain a valid Treatment Plan and complete Annual Assessment Updates in SLOBHD's Electronic Health Record (EHR).
      f. Document each TCM or other SMHS to LPS conservatees in the EHR consistent with SLOBHD's current Documentation Guidelines (i.e., each service must be documented in the record in a timely manner).
      g. Coordinate transportation to the PHF for LPS conservatees requiring a psychiatric admission for stabilization.
      h. Consult with the Patients' Rights Advocate (PRA) and forward any grievances or concerns from the conservatee to the PRA.
      i. Coordinate with other SLOBHD programs, which may include:
         i. Attendance at the PHF Inter-disciplinary Team meetings to coordinate regarding LPS conservatees and other high-risk individuals who are or may be considered for conservatorship in the future
         ii. Exploring placement or treatment options for those high-risk clients as necessary, in conjunction with PHF staff and the FSP Coordinator.

C. Coordination with the Public Guardian
   1. The assigned staff member will:
      a. Attend the weekly Public Guardian staff meeting with Health Agency Fiscal staff to coordinate care.
      b. Keep the Public Guardian apprised of the conservatee's treatment progress.
      c. Obtain the Public Guardian's signature on Treatment Plans, Authorizations, and related SLOBHD documentation as needed.
      d. Collaborate with the Public Guardian regarding needed changes in level of care, whether to a more restrictive or less restrictive setting.

###

VI. REVISION HISTORY

| Effective/Revision Date: | Sections Revised | Status: Initial/ Revised/Archived Description of Revisions |
|---|---|---|
| 05/29/2020 | Entire Policy | Initial Release |
| 12/30/2020 | Procedure | Removed B1c |

| *Signature on file* | | *12/30/2020* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# Section 7

# Medication Related

# 7.00 Responsibility of Psychiatrist to Treatment Staff

## I. PURPOSE

To ensure that psychiatrists or Nurse Practitioners provide consultation and direction in medical-psychiatric matters in all treatment programs, and to outline the frequency of psychiatric services.

## II. POLICY

Staff providing services in all treatment programs receive consultation and directions in medical-psychiatric matters from psychiatrists. All staff are responsible for seeking the assistance of the psychiatrist in regard to the known or potential medical needs of their caseload. The psychiatrist determines the frequency of contact based on clinical assessment and in consideration of the size of the Psychiatrists' treatment case load, the staff members' clinical experience, and the client's needs.

When a nurse practitioner is employed, he or she assumes the same responsibilities of a psychiatrist with appropriate supervision. (See policy 7.08 Standard Procedures for Nurse Practitioners).

## III. REFERENCE(S)

- Mental Health Plan Contract with DHCS

## IV. PROCEDURE

A. Consultation: Staff in each program receives consultation from a psychiatrist, and consultation is provided for direct treatment, program planning and staff development.

B. Direct Treatment

1. Each client at the onset of treatment has "Interim Recommendations" approved by the psychiatrist on the Assessment form, which is documented in the record.
2. The psychiatrist is available on the premises a specified number of hours for medication evaluation, psychiatric evaluation, case consultation, and immediate needs as requested by staff.
3. The psychiatrist is also available on the premises for assessment for special accommodation based on the client's educational needs such as Home and Hospital Instruction. A "Physician's Request for Home and Hospital Instruction" form (Attachment A) is completed and submitted to the school for review and approval.

C. Program Planning
   1. The Program Supervisor works with the psychiatrist in all phases of program planning.
   2. The Program Supervisor meets with the psychiatrist a minimum of once a week for this purpose.
   3. The psychiatrist meets with all program staff on a weekly basis.
   4. The Program Supervisor works with the psychiatrist in all phases of staff and program development.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 02/01/2015 | Policy<br><br><br>B Direct Treatment | Changed "*Program Supervisor* will determine frequency of contacts" to *Psychiatrist* will determine frequency of contacts"<br>Added section on Home and Hospital Instruction and added Attachment "A". |
| 04/01/2018 | All | Formatting |
| Prior Approval dates: | | |
| 04/30/2009, 10/16/2009 | | |

| *Signature on file* | | *03/12/2015* |
|---|---|---|
| Approved by: | Daisy Ilano, MD, Medical Director | Date |

| *Signature on file* | | *03/12/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

**ATTACHMENT A**

**SAN LUIS OBISPO COUNTY HEALTH AGENCY**
2178 Johnson Avenue
San Luis Obispo, CA 93401-4535
(805) 781-4719 Fax (805) 781-1273
www.slocounty.ca.gov

*Jeff Hamm*
*Health Agency Director*

*Anne Robin, LMFT*
*Behavioral Health Administrator*

**BEHAVIORAL HEALTH**

## PHYSICIAN'S REQUEST FOR HOME AND HOSPITAL INSTRUCTION

Student's Name _____ _____ _____
*Last Name* *First Name* *Middle Initial*

Date of Birth: _____ Name of School: _____

Grade Level: _____ Teacher or Home Room: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

1. Description of the Disability (DSM Description/ICD Code/As it pertains to the request for Home and Hospital Instruction):_____
_____

2. Treatment/Therapeutic Plan:_____
_____

3. Plan for school re-entry:_____

4. Date of last evaluation: _____

5. Nature of the illness: Infectious Contagious Not applicable

6. It is recommended that _____ be placed on Home and Hospital
*(Name of student)*

Instruction from _____through _____(min of 5 days not to exceed 45 days)
*(Month/Day/Yr)* *(Month/Day/Yr*

_____ _____
Name of Physician Signature of Physician

_____ _____
CA License # Date

*County of San Luis Obispo – Physician's Request for Home and Hospital Instruction: Revised 02/2015*

# 7.01 Medication Support Visits

## I. PURPOSE

To ensure that Medication Support Services are provided by currently licensed medical staff within the scope of practice of their profession, to provide direction on documentation and frequency of visits, and to provide the safest possible medication support within the standard of care to clients who are mentally and possibly physically incapacitated.

## II. POLICY

Medication Support Services include monitoring and dispensing of psychiatric or addiction medications necessary to alleviate the symptoms of mental illness and substance use disorders.

## III. REFERENCE(S)

- California Code of Regulations, Title 9, Title 9 § 1840.372

## IV. PROCEDURE

A. Medication Support visits are documented as outlined in the latest version of the Department's Documentation Guidelines, and includes monitoring of the following:

1. Medication dosage and frequency
2. Adherence to medication regimen
3. Response to medications
4. Presence of side effects
5. Reported symptoms and impairments
6. Plan for future contact

B. Medication Support Services may be either face-to-face or by telephone with the client or significant support person(s), and must include therapeutic intervention to reduce the level of documented impairment, prevent decompensation and maintain stability.

C. If two Medication Support Services are provided for a client in the same day, both should be documented accurately in separate Progress Notes if provided by different providers. A maximum of four hours of Medication Support Services can be billed in a 24 hour period (Title 9 § 1840.372); Anasazi is set up to limit claims for Medication Support to the maximum amount.

D. Every client receiving medication is seen at least every three months by the treating psychiatrist/nurse practitioner (depending upon availability of psychiatrist/nurse

practitioner) and at least every two months by the medication manager monitoring the medications, or as suggested by the treating psychiatrist/nurse practitioner. If the client cannot come to the clinic to see the medication manager, a well-documented telephone conversation may be alternated with the face-to-face contact.

E. Missed Appointments:

1. If a client has not been seen by the treating psychiatrist/nurse practitioner for more than three months because of the psychiatrist's change of schedule (e.g. illness), an appointment is scheduled and refills may be given until then at the discretion of the psychiatrist/nurse practitioner.

2. If a client fails to keep 2 consecutive scheduled appointments with the psychiatrist/nurse practitioner, the client must be seen face to face by the assigned medication manager on the earliest available appointment. Enough refills will be given to last until the appointment with the med manager and the client will be informed that the case will be closed if the appointment is missed again.

3. If the delay has been due to the client's change of schedule, an appointment is scheduled as soon as possible and refills are provided until then at the discretion of the psychiatrist. However, if the client cancels or fails to show for the second time, the psychiatrist must consult, however feasible, with the Medical Director or another staff psychiatrist prior to providing additional refills.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 01/01/2015 | Purpose<br>#E<br>#C | Added Purpose<br>Added detail<br>Added instruction for 2 Med Support visits in one day |
| 09/08/2017 | Scope | BH, not MH policy |
| 04/01/2018 | All | Formatting |
| Prior Approval dates: | | |
| 04/30/2009, 05/18/2012 | | |

| *Signature on file* | | *09/08/2017* |
|---|---|---|
| Approved by: | Daisy Ilano, MD, Medical Director | Date |

| *Signature on file* | | *09/08/2017* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 7.02 Informed Consent for Medications (Oral and Injectable)

I. PURPOSE

- To ensure that the staff physician/nurse practitioner informs patients of dosage, use and indication, risks and benefits, side effects and alternative medications available for each psychotropic medication prescribed.
- To ensure that the patient is an informed participant in his/her healthcare decision making
- To ensure that the patient is competent to make a voluntary choice to accept or refuse the medication(s) being prescribed and administered
- To ensure that the patient consent is documented by the prescribing physician/nurse practitioner prior to prescribing.

II. SCOPE

Applies to psychotropic medication(s) prescribed in outpatient clinics of Mental Health and Substance Use Disorder treatment programs.

III. POLICY

It is the policy of the County of San Luis Obispo Behavioral Health Department (SLOBHD) that the attending staff physician/nurse practitioner (MD/DO/NP) shall obtain Informed Consent for Psychotropic/Medication Assisted Treatment (MAT) Medication(s) prior to prescribing or administering psychotropic/MAT medication(s), including injectable medications. This occurs in the context of the discussion between the prescribing physician or nurse practitioner and the patient and or/legally responsible person.

IV. REFERENCE

- Welfare and Institutions Code (W&I Code) §§5325.3
- California Code or Regulations (CCR), Title 9, §§850-851
- W&I Code §§300 – 369.5
- California Rules of Court , Title 5, Rule 5.640
- Education Code §49423
- Senate Bill (SB) 184, Chapter 47, Statutes of 2022

V. PROCEDURE

## A. ADULTS, CHILDREN AND ADOLESCENTS

1. The MD/DO/NP prescribing the psychotropic/MAT medication(s) discusses the information on each psychotropic/MAT medication with the patient and/or legally responsible person and provides supplemental written educational material. The

discussion will include, but is not limited to, the following information:

a. Name and type of psychotropic/MAT medication(s)
b. Reason for taking psychotropic/MAT medication(s) (i.e., the condition that the psychotropic/MAT medication(s) will treat) and the likelihood of improving (or not) with the psychotropic/MAT medication(s)
c. Reasonable alternative treatments available, including the right to refuse treatment
d. Whether use is approved for the intended purpose or is prescribed "off label"
e. Directions for use and storage, including medication or food interactions
f. Dosage, frequency, and route of administration
g. How long the patient can expect to take the psychotropic/MAT medication(s)
h. Probable short-term side effects known to commonly occur and any side effects likely to occur with the particular patient
i. Possible side effects if taken long term (more than three (3) months), including, when applicable, that such side effects may include persistent involuntary movement of the hands and feet that may be potentially irreversible and may appear after the psychotropic/MAT medications have been discontinued
j. Warnings regarding operation of vehicles, machinery, or taking psychotropic/MAT medication(s) with alcohol
k. Controlled Substance Utilization Review and Evaluation System (CURES) website will be checked for any other controlled substances prescribed by other healthcare provider at least every visit. This ensures that our prescribers have the most current information on the patient(s) medication profile.
l. That consent may be withdrawn at any time

2. If the patient and/or legally responsible person is agreeable to the initiation of the psychotropic/MAT medication(s), the prescribing physician or nurse practitioner completes the Informed Consent for Medication in the patient's identified language and obtains verbal consent for the medication OR the provider can have the patient sign an electronic consent. MD/DO/NP and the patient or legally responsible person will sign the form. In addition to the information discussed with the patient in A1 above, the form will document:
   a. Name of the psychotropic/MAT medication(s) prescribed
   b. Dosage range of the psychotropic/MAT medication(s) as allowed by FDA
   c. Name of the prescribing physician or nurse practitioner
   d. Signature of the prescribing physician or nurse practitioner
   e. Verbal consent or electronic signature of the patient and/or legally responsible person
   f. Date of the signature(s)
   g. Off label use/Indication, if applicable
   h. Method of administration
   i. Duration of treatment
   j. Proof that patient was offered a copy of the consent

k. Proof that the patient was provided with educational materials about medication(s) prescribed.

3. The MD/DO/NP documents the following in a Progress Note:
   a. All current medications the patient is taking
   b. The discussion with the patient and/or legally responsible person regarding the psychotropic/MAT medication(s)
   c. The willingness of the patient and/or legally responsible person to sign the Informed Consent for Medication and Informed Consent for Injection Therapy (if applicable)
   d. A statement that supplemental written educational material and a copy of the Informed Consent(s) were offered and provided or was declined.
   e. If the patient consents to receiving the medication and refuses to sign the Medication Consent document, the prescribing physician/nurse practitioner will document the client's verbal consent and reason for declining to sign the Medication Consent document.

4. The consent is valid from the date of signature from both the prescribing physician /nurse practitioner until consent is withdrawn by the patient and/or legally responsible person or the case is closed. The patient and/or legally responsible person can withdraw consent at any time, either verbally or in writing.

5. A new Informed Consent for medication must be completed when:
   a. A new psychotropic/MAT medication is prescribed after the Initial consent form has been signed and dated.
   b. A case has been closed but is then re-opened.
   c. The patient consents for psychotropic/MAT medication(s) after previously withdrawing consent
   d. The patient consents for psychotropic/MAT Medication(s) after previously discontinued by the prescriber
   e. A copy of the Informed Consent for Medication and/or and Informed Consent for Injection Therapy (if applicable) will be offered and provided to the patient upon request or declined.

**B. W&I CODE 300 DEPENDENTS OF THE COURT**

1. When a minor is a W&I Code 300 Dependent of the Court and is living in an out-of-home placement, the following forms are required to be completed (see JV220(A)/(B) Procedure for additional information):
   f. JV-220 form (Application Regarding Psychotropic Medication)
   g. JV-220(A) (Prescribing Physician's Statement—Attachment)
   h. JV-221 (Proof of Notice: Application Regarding Psychotropic Medication)
   i. JV-222 (Opposition to Application Regarding Psychotropic Medication)
   j. JV-223 (Order Regarding Application for Psychotropic Medication)
2. SLOBHD licensed medical staff will complete the above forms in collaboration with

the assigned social worker from Department of Social Services.

3. The JV-220 forms do not replace an Informed Consent for Medication unless the MD/DO/NP specifically writes the route of administration and any side possible side effects if taken long term (more than 3 months) on the JV-220(A). This will include, when applicable, that side effects may include persistent involuntary movement of the hands and feet that may be potentially irreversible and may appear after medications have been discontinued.
4. A Health Information Technician or other designated staff will scan a copy of the fully executed JV-220 forms into the record.
5. The JV-220 will specifically identify the psychotropic medication(s) authorized by the Court for the minor. Any medication not on the fully executed forms medication(s) will require a new set of JV-220 forms.
6. If the same psychotropic medication needs to be continued beyond 180 days, a new set of JV-220 forms will be completed for approval by the Court.
7. If the minor is to be transferred to another facility or treatment program, a copy of the fully executed JV-220 forms and all attachments will be sent to the accepting facility.
8. No psychotropic medication(s) can or will be administered to a dependent minor until the JV-220 and other attachments are fully approved by the Court.

**C. LPS CONSERVATEE(S)**

1. In accordance with W&I Code 5358, the Public Guardian's Office will be notified via telephone that the MD/DO/NP intends to start the patient on specific psychotropic/MAT medication(s) and obtain a verbal consent. Such discussion will be documented in the progress note. The Public Guardian will sign the Medication Consent document within 24 hours of the verbal consent, excluding holidays and weekends.
2. A written or verbal consent will be obtained from the Office of the Public Guardian before the Conservatee is prescribed a new psychotropic/MAT medication(s).
3. The Public Guardian can be reached at (805) 781-5845 during normal business hours. For after hours or weekends, Chief Deputy Public Guardian, can be contacted at (805) 801-0928 for any consent forms that need to be signed.

VI. DOCUMENT HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 12/05/14 | A., B, C, D | Added B, C, D, and expanded A to include more detail |
| 11/10/15 | B | Minor revisions to section B |
| 09/08/17 | Added scope | Reformatted, updated information |
| 09/19/18 | All | Formatted made HA policy - 6.02 PHF is hyperlinked to 7.02 Outpatient (original). |
| 09/10/19 | All | Revised for all HA staff, added DAS Medication Assisted Treatment (MAT), removed psychotropic |

| | | |
|---|---|---|
| | | 7.02 Outpatient (original) – PHF 6.02 (copy) |
| 10/29/2020 | All | Revised protocols (oral and injectable) |
| 11/17/2023 | All | Updated to align with SB 184 |
| 12/15/2023 | All | Revised and removed PHF related protocols. |
| 03/06/2024 | V.A. | Revised to include direction for obtaining verbal consent |
| Prior Approval dates: | | |
| | | |

| | | |
|---|---|---|
| *E-Signature on File* | | *03/06/2024* |
| Approved by: | Siddarth Puri, Interim MD, Medical Director | Date |

| | | |
|---|---|---|
| *E-Signature on file* | | *12/15/2023* |
| Approved by: | Star Graber, PhD. Behavioral Health Director | Date |

**San Luis Obispo County Behavioral Health Services**

**INFORMED CONSENT FOR INJECTION THERAPY**

The purpose of this informed consent form is to provide written documentation that a discussion transpired between you and your prescriber and his/her designated licensed medical staff regarding risks, benefits and alternatives to the Injection Therapy so that you can make an educated decision as to whether you will accept this injection .

Your attending doctor/nurse practitioner has recommended that you be treated with the following injectable medication(s):

- o Sublocade
- o Vivitrol
- o Invega Sustenna
- o Invega Trinza
- o Abilify Maintena
- o Risperdal Consta
- o Perseris
- o Other _____

Your doctor/nurse practitioner and his/her designated licensed medical staff has discussed the following information with me:

- All injection treatments are accompanied by possible risks
- In almost all cases, injection therapy is considered safe, minimally invasive with minimal risk of complications.
- All injection treatments have the possibility of experiencing any of the following:
  - o Discomfort
  - o Bruising, redness, swelling or irritation on the injection site
  - o Temporary pain or numbness around the injection site
  - o Inflammation, infection, allergic reaction, weakness, or paralysis
  - o Dizziness, lightheadedness feeling, fainting may also occur during or after the injection
  - o Bleeding, blisters, skin rash
  - o Area may feel hard
  - o Injury to nerves, muscles, or blood vessels at or around the injection site
  - o Fainting or loss of consciousness during the procedure
  - o Rarely, an allergic reaction

You have also been made aware that other unforeseeable complications may occur but you do not expect the doctor/nurse practitioner and his/her designated licensed medical staff to be able to anticipate and/or explain all risks and possible complications.

You rely on your doctor/nurse practitioner and his/her designated licensed medical staff to exercise good judgment during the course of treatment with regards to receiving this injection.

## ATTESTATION

I have read or have been read to me the above consent. My doctor/nurse practitioner and/or his/her designated licensed medical staff has adequately explained the procedure to me so that I fully understand it. No guarantee of successful injection procedure has been implied.

I understand that I have the right to consent to, refuse this injection prior to its administration or retract my consent at any given time during my treatment. .

I understand that I am entitled to a copy of this consent form upon request.

I acknowledge that I have been given the opportunity to discuss the nature and purpose of the treatment, alternate methods of treatment; and the risks, complications and consequences associated with the administration of the injection.

I further acknowledge that any questions I have regarding the procedure have been answered to my satisfaction and that I have been further told that any additional questions I may have would be answered.

My signature on this form affirms that I give permission for my doctor/nurse practitioner and his/her designated licensed medical staff to give the injection as he/she feels it is needed and I have given consent to receive this injection.

_____ _____

Patient Name and Signature Date

_____ _____

Prescriber's Name and Signature Date

_____ _____

Licensed Medical Staff's Name and Signature Date

# 7.03 Medication Procurement, Storage, Administration, and Dispensing

## I. PURPOSE

To clarify the Mental Health Plan's (MHP) access procedures.

## II. POLICY

Medication services include procuring, prescribing, dispensing, administration, disposing and monitoring of psychiatric medications used to treat symptoms of mental illness. These services are provided by Mental Health staff within their scope of professional practice. All medications stored and/or used in each clinic site are documented to identify the source of the medication, the method of storage of medications, and the use or disposal of all medications as required by law, and regulatory agencies.

The Medical Director requires each psychiatrist and nurse practitioner who obtains samples of any medication to be dispensed at a Mental Health Clinic to ensure that the documentation maintained includes the source of the medication, the name of the medication, the expiration date, the dosage, the original quantity and the lot number of the medication, name of the intended recipient, and signature of the dispensing psychiatrist or nurse practitioner. The Program Supervisor of each clinic institutes a system to monitor inventory of medications on a monthly basis by an assigned licensed medical staff to ensure that all medications brought into the clinic, whether client prescriptions or samples, are logged in when they are received, stored, dispensed, administered, and/or disposed of per San Luis Obispo County Mental Health Policies and Procedures. Any failure to follow policies and procedures will be documented in an Incident Report within 24 hours and reported by the Program Supervisor to the Medical Director no later than three (3) business days from the date of the Incident Report is written.

## III. REFERENCE

- California Code of Regulations, Title 9, §1810.405, §1810.410

## IV. PROCEDURE

### A. Procurement

1. Medications can include either samples obtained from pharmaceutical companies by psychiatrists or nurse practitioner, or clients' own prescription bottles.

2. Immediately upon receipt of Pharmaceutical Samples, the following information will be documented on the Pharmaceutical Sample Medication Log (Attachment A):

a. Date received
b. Name of medication
c. Strength of medication
d. Lot number/Vial number
e. Quantity received (number of tabs, caps, or volume) for each lot number
f. Expiration date
g. Form

3. Immediately upon receipt of Clients' own prescription bottles, the following information will be documented on the Patient's Prescription Log (Attachment B):

a. Patient Name and Medical Record number
b. Medication name, strength and quantity
c. Expiration date
d. Date ordered
e. Date received
f. Issuing pharmacy and prescription number
g. Prescriber
h. Source
i. Form
j. Lot/Vial #

4. All medications will be stored according to the procedure in the "Storage" section of this policy.

5. The Medication Logs shall be retained for three years and kept in a binder in the designated medication room. The binder shall be available for review and inspection by all authorized personnel for audit or in the event of a drug recall.

B. Storage

1. Each Mental Health Clinic site has a designated room for the storage of medications. This Medication Room is locked at all times and access to the space is restricted to medical personnel authorized to prescribe, dispense or administer medication.

a. If a medication is to be transported from the main Mental Health Clinic site to a satellite clinic by a licensed medical staff using a locked bag, such medication will be immediately stored in a locked file cabinet designated for medications only upon arrival at the site. Only a designated licensed medical staff shall have access to the locked file cabinet. Any unused medication(s) shall be transported back to the main Mental Health Clinic site by the licensed medical staff at the end of the day using a locked bag.

2. Medications stored are clearly marked and remain in their original containers. No alterations of the original label may be made.

3. Medications that look alike or sound alike and hazardous medications are stored in separate areas in the Medication Room.

4. All medications intended for external-use-only are stored separately.

5. The Program Supervisor assigns a licensed medical staff to check all stored medications, including the temperature of the designated refrigerator, on a monthly basis. Outdated medications or contaminated medications are discarded according to Policy 7.05 Disposal of Medications.

6. The Medical Director or designee will routinely perform routine on-site audits of the dedicated medication rooms and Medication Logs of each clinic.

7. The temperature of the Medication Room is kept between 59ºF – 86ºF. Temperature is checked daily and logged in a separate sheet and kept in a binder to be retained for 3 years.

C. Dispensing

1. Dispense means the furnishing of drugs upon a prescription from a physician or upon an order to furnish drugs or transmit a prescription from a nurse practitioner, physician assistant, or the furnishing of drugs directly to a patient by a physician, nurse practitioner or physician assistant. (Business & Professions Code Section 4024)

2. The dispensing of medications from the clinic is, by law, permitted only by pharmacists, psychiatrists or nurse practitioners. No other person shall give the client a supply of medication; the psychiatrist or nurse practitioner is responsible for handing the medication directly to the client. However, in the event that the psychiatrist or nurse practitioner is unavailable, a telephone/verbal order to hand out the medication samples may be given by a psychiatrist to a licensed medical staff on site for the benefit of the client to prevent decompensation due to the client leaving without medication(s). Such verbal order for handing out the sample is documented in the client's chart. Samples of medications that have been ordered by the psychiatrist can be left in the possession of any other clinic staff provided they are in a sealed envelope or box and appropriately labeled with client's name so they can be returned to the licensed medical staff at the end of the day and stored in the Medication Room if they are not picked up.

3. Psychiatrists or Nurse Practitioners may dispense sample medications for the following reasons:

a. On an emergency basis
b. For clients without financial means to obtain them
c. In small quantities as a temporary measure during periods of financial need, or to evaluate the effectiveness of a medication prior to prescribing it.

4. When a psychiatrist or nurse practitioner dispenses sample medication to a client, he/she must complete the information on the Pharmaceutical Sample Medication Log (Attachment A) that contains the following information:

   a. Date prescribed
   b. Number dispensed
   c. Time dispensed
   d. Total remaining
   e. Name of Patient
   f. Signature of dispensing Physician/Nurse Practitioner

5. The container must be labeled with the following information:

   a. Manufacturer's name and name of medication
   b. Directions for use of the medication
   c. Name of client
   d. Name of MD/NP prescribing the medication
   e. Strength of the medication (dose per unit of drug)
   f. Date of issue (to the client)
   g. Name and address of the Mental Health Clinic issuing the medication
   h. Quantity of medication dispensed
   i. Expiration date of the medication

6. Whenever a new medication is prescribed or dispensed, the psychiatrist or nurse practitioner is responsible for obtaining informed consent from the client in their preferred language. Obtaining informed consent is documented in the client's record according to Policy 7.02 Medication Consent.

D. Medication Administration

1. Administration of medication means the direct application of a drug or device to the body of a client by injection, inhalation, ingestion, or other means. (Business & Professions Code Section 4016)

2. Administration of medications may be done by a psychiatrist, NP, RN, LVN or LPT and only upon the order of a psychiatrist or NP. This order may be written or verbal and must be countersigned by the ordering psychiatrist or nurse practitioner, and documented in the client's record. The order includes the name of the medication ordered, the dose to be given, the route of administration, and the time(s) it is to be given.

3. When administering any medication from a multi-dose vial, the following steps are followed:

    a. Upon receiving a multi-dose medication vial, compare the label placed on the vial by the pharmacy with the psychiatrist's order.
    b. Prior to opening the vial, check the expiration date.
    c. Note on the vial the date it was opened and initial the vial.
    d. Vials are to be disposed of after 28 days of opening it
    e. If the vial is past the expiration date, or appears to be contaminated, follow the procedure for medication disposal.
    f. A consent form is signed for each medication administered.

4. When medication is administered to a client the following must be logged on the Patient's Prescription Log (Attachment B):

    a. Date of administration
    b. Number of Tabs/Caps/Vials Administered
    c. Time Administered
    d. Number of Tabs/Caps/Vials Remaining
    e. Signature of staff administering medication

E. Transporting client medication bottles

Occasionally legally dispensed medications are transported to the client's new clinic site using inter-county mail. The medication(s) must be placed in a sealed envelope, addressed to the appropriate licensed medical staff at the client's new clinic, and transported in the locked/sealed inter-county envelope. The client's name can be written on or attached to the medication box, but not on the outside of the envelope.

F. Disposal of Meds
Please see Policy 7.05 Disposal of Medications for more information.

###

V. REVISION HISTORY

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| 4/29/2014 | Storage, 2, 5, 6<br>Added: Transporting client medication bottles | 2. Separate look alike meds; 5. Record temp of refrigerator; 6. Medical Director to perform audits |
| 9/22/2014 | Storage 1a | Added transfer of meds from locked bag to locked cabinet upon arrival when transporting meds. |
| | Procurement | Log will be kept in a binder and not in the bag |
| | Attachment A | Added time dispensed |
| | Attachment B | Added time dispensed/administered and vial/lot# |
| 10/16/2014 | Medication Administration | Added list of items to log when administering meds and dispensing meds (separate the lists) |
| 11/2014 | Medication Dispensing and Administration | Added lists of all information included on attachments and rearranged text slightly to create better flow |
| 02/28/2018 | All | Formatting |
| Prior Approval dates: | | |
| 04/30/2009, 01/24/2011 | | |

| | | |
|---|---|---|
| *Signature on file* | | *11/17/2014* |
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 7.04 Ordering of Diagnostic Procedure and Results

I. PURPOSE

- To provide guidance for ordering screening and diagnostic procedures for both Inpatient and Outpatient such as Urine Toxicology Screen, Radiological procedures and other diagnostic procedures
- To ensure continuity, efficiency and appropriateness of patient care with a clear evidence-based rationale for each procedure ordered
- To ensure that the results are appropriately processed and acted upon in a timely manner for optimal patient care
- To ensure that test results are appropriately evaluated to assess the risks for drug interactions that would contraindicate prescribing of medications
- To minimize the risk of misdiagnosis, failure or delay in diagnosis to improve outcomes and quality of care

II. POLICY

County of San Luis Obispo Behavioral Health Services establishes this policy for all areas of the Inpatient and Outpatient services to standardize the delivery of services as it relates to pharmacological management of psychiatric conditions and substance use disorders.

III. REFERENCE(S)

42 CFR § 410.32 - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

IV. PROCEDURE

A. All Diagnostic and screening procedures must be ordered by a licensed physician or nurse practitioner.
B. The physician or nurse practitioner who orders the tests must maintain documentation of medical necessity in the patient's medical records.
C. Any tests may be completed by any laboratory or entity that accepts the patient's insurance coverage or a contracted entity with the County if the patient is uninsured.
D. Any blood tests ordered shall follow the Medication Monitoring Guidelines for prescribing psychotropic medications.
E. Lab slips or any ordering forms will be provided to the patient and presented to the laboratory or entity of choice as long as the entity accepts the patient's insurance coverage.
F. If a test Is performed onsite such as Urine Toxicology screen, the staff who collects and tests the sample will immediately document the time and date that sample was taken in order to provide an accurate baseline.

1. Universal Precautions shall be practiced to ensure safety
2. Collection cups, gloves and other materials used shall be disposed of in a designated receptacle.

G. The staff who performed the test shall then document the result using the appropriate forms in the electronic health records.
H. Staff will complete the Diagnostic Procedures form in the patient's electronic health records as a means to inform the ordering/covering physician/nurse practitioner of the results and make comments on any abnormalities.
I. All diagnostic and screening tests results performed by the staff or outside entities shall be evaluated by the ordering physician/nurse practitioner or any covering physician/nurse practitioner in a timely manner to ensure proper management and to take action accordingly.
J. Critical results must be communicated to the ordering physician/nurse practitioner and addressed within 1 business day of receipt of the results.
K. Screening and diagnostic tests are all voluntary, however, the ordering physician/nurse practitioner may have the option to withhold prescribing of medications if clinically contraindicated without support of the tests requested due to the following:
    3. As part of the Medication Treatment Agreement (Attachment 1) and patient is not in compliance.
    4. When there is a suspicion that a patient may be at risk for toxic drug interaction from unknown substances thereby contraindicating further prescribing.
    5. When a patient's current appearance suggests current or ongoing substance abuse.
L. All staff shall have knowledge and be trained on proper use of supplies for onsite tests such as Urine Toxicology Screen, breathalyzer, glucometer). Should there be a therapeutic issue, an exemption shall be made after the direct supervisor is consulted.

V. REVISION HISTORY

| **Effective/Revision Date:** | **Sections Revised** | **Status: Initial/ Revised/Archived Description of Revisions** |
|---|---|---|
| 09/10/2021 | Entire Policy | Initial Release |

| *E-Signature on file* | | *09/16/2021* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

**COUNTY OF SAN LUIS OBISPO**
**HEALTH AGENCY**

# MEDICATION TREATMENT AGREEMENT

**Patient Name (print)** _____ **Date** _____

You have agreed to receive the following prescribed medications for short-term treatment. It is important that you have an understanding of the risks and responsibilities that go along with this treatment.

| | Generic Name | Brand Name |
|---|---|---|
| | Alprazolam | Xanax, Niravan |
| | Armodafinil | Nuvigil |
| | Chloralhydrate | |
| | Chlordiazepoxide | Librium |
| | Clonazepam | Klonopin |
| | Clorazepate | Tranxene |
| | Dexmethylphenidate | Focalin |
| | Dextroamphetamine | Dexedrine, Dextrostat, Desoxyn |
| | Dextroamphetamine & Amphetamine Salts | Adderall |
| | Diazepam | Valium |
| | Estazolam | Prosom |
| | Eszopiclone | Lunesta |
| | Antabuse | |
| | Buprenorphine | Suboxone, Sublocade |
| | Naloxone | Narcan |

| | Generic Name | Brand Name |
|---|---|---|
| | Flurazepam | Dalmane |
| | Lisdexamfetamine | Vyvanse |
| | Lorazepam | Ativan |
| | Methamphetamine | Desoxyn |
| | Methylphenidate | Ritalin, Metadate, Concerta Daytrana, Methylin, Quillivrant XR |
| | Modafinil | Provigil |
| | Oxazepam | Seraz |
| | Temazepam | Restoril |
| | Triazolam | Halcion |
| | Flurazepam | Dalmane |
| | Zaleplon | Sonata |
| | Zolpidem | Ambien |
| | Naltrexone (Long Acting) | Vivitrol |
| | Acamprosate | Campral |

In order to provide appropriate and effective medication management, it is important to determine if there is also a substance use disorder which may impact mental health symptoms and problems. This is necessary, because active use of any alcohol or drugs, may be unsafe with prescribed medications. And therefore, we may not be able to prescribe medication.

As a participant in Outpatient Behavioral Health Clinic Services, I freely and voluntarily agree to abide by this treatment contract as follows:

1. This agreement is necessary for the trust and confidence necessary in a doctor-patient relationship. My psychiatrist/prescriber will provide treatment based on this agreement.
2. I am aware that the use of this medication has a high potential for abuse and has a certain risk associated with it, including, but not limited to: tolerance, physical & psychological dependence, withdrawal symptoms, confusion, memory loss, and an increased risk of dementia.
3. I agree to take my medication as my psychiatrist/prescriber has instructed, and not to alter the way I take my medication, without first consulting my psychiatrist/prescriber.
4. I agree not to obtain psychiatric medications from any other doctors, pharmacies, or other sources without telling my treating physician.
5. I agree to keep my scheduled appointments and to be on time to all of my scheduled appointments. If I frequently miss appointments, the psychiatrist/prescriber may require that I come to the clinic to be seen before authorizing refills.
6. The prescribed medication is strictly monitored by the Patient Activity Report from the Controlled Substance Utilization Review and Evaluation system database (CURES).
7. No prescriptions will be refilled early.

8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place, out of the reach of children. I agree that lost medication may not be replaced regardless of why it was lost.
9. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and will result in my treatment being terminated without any recourse for appeal.
10. I agree not to deal, steal, or conduct any illegal or exhibit disruptive activities in the outpatient clinic.
11. I understand that if dealing or stealing or if any illegal or exhibiting disruptive activities are observed or suspected by employees of the pharmacy where my psychiatric medications are filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated. However, if I feel that my services were terminated inappropriately, I may file an appeal.
12. I understand that mixing psychiatric medications with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous. I also recognize that several deaths have occurred among persons mixing psychiatric medications including benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses) with other medications or illicit drugs.
13. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in additional treatment services and wellness activities as discussed and agreed upon with my doctor and specified in my treatment plan.
14. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances.
15. If you have both symptoms of a mental disorder and a substance use disorders, the following steps will be taken:
    a. I agree to provide random urine samples upon request and have my doctor test my blood alcohol level to ensure safety in prescribing ongoing medications.
    b. Medications may be postponed for short periods of time, depending on the assessment and decision of the treatment team including the psychiatrist.
    c. Medications may be withheld or discontinued for the following reasons:
        i. Persistent substance use (alcohol/drug) in which the risks outweigh the benefits of continuing psychotropic medications
        ii. Refusal to consistently participate in treatment services
        iii. Non- compliance with the medication plan

**I agree to follow this medication Treatment Agreement. I understand that violations of the above may be grounds for termination of treatment.**

_____Date _____

Patient Signature

_____

Physician/Nurse Practitioner *Printed* Name & Title

_____Date_____

Physician/Nurse Practitioner Signature

# 7.05 DISPOSITION OF DRUGS

I. PURPOSE

- To establish a system on how to dispose of medications, both controlled and non-controlled substances, in a safe and appropriate manner in compliance with Department of Justice and State Regulations.
- To establish proper supervision and oversight of medication disposal

II. POLICY

County of San Luis Obispo Behavioral Health Department will establish a standard procedure for proper disposition of medications.

III. REFERENCE

MHP Contract, Exhibit A, & Attachment 1, Appendix D, Item 10A-F

IV. PROCEDURE

A. Accountability : The Program Supervisor, in consultation with the Medical Director, and in accordance with procedures, oversees and monitors that the medication disposal procedures are carried out safely at the clinic site. Individual and specific accountability is assumed by licensed medical staff at each clinic site that have access to the medication room of their clinic site. Licensed medical staff are responsible for carrying out all Mental Health Services medication policies and procedures.

B. When to dispose of medication?
1. Medications are disposed of when they are no longer considered safe to administer to clients. Medications are disposed of when:
   a. The label is incorrect, unreadable or in any way unclear.
   b. The expiration date for the medication has passed.
   c. A multi-dose vial has been opened for 180 days or more.
   d. The medication appears to be possibly contaminated.
   e. The medication has been discontinued and the client gives the remainder of the prescription to a staff person or abandons it at the clinic in storage. A prescribed medication is considered abandoned by the client if it is no longer prescribed and/or the client does not claim it within four (4) weeks.

C. Who can dispose of Medications and how are medications disposed of?
1. Medications may be disposed of only by a licensed medical staff.
2. If a therapist's client relinquishes a medication to the therapist, the therapist immediately following the session with the client, delivers the medication to a licensed medical staff in the clinic.

3. The licensed medical staff person receiving the medication that is to be disposed of, takes the prescription bottles to the dedicated medication room, counts the number of pills left in the bottle in the presence of another licensed staff and logs it in the appropriate Medication Disposal Log.
4. The medication is then disposed of immediately by pouring in the pills into the approved drug disposal system. Both licensed medical staff will sign the Medical Disposal Log in the appropriate column stating that the medications have been destroyed.
5. Medications listed in Schedules II, III, and IV of the Federal Comprehensive Drug Abuse prevention and Control Act of 1970, Title 21, United States Code, Section 801 et. Seq. shall be destroyed as scheduled by facility licensed medical staff in the presence of a pharmacist and a licensed registered nurse employed by the facility. The name of the patient (if applicable), the name and strength of the medication, the prescription number (if applicable), the amount destroyed, the date of destruction and the signature of the witnesses required above shall be recorded on the Medication Disposal Log (Controlled Substance- Attachment A). Such log shall be retained for at least three years and kept in a binder in the Medication Room.
6. It is highly recommended that any controlled drugs be returned to the client for their own disposal such as returning them to the dispensing pharmacy by using a self-sealed envelope provided by the pharmacy.
7. Medications not listed under Schedules II, III, and IV of the above Act shall be destroyed as scheduled by licensed medical staff in the presence of a pharmacist or another licensed medical staff. The name of the patient (if applicable), the name and strength of the medication, the prescription number (if applicable), the amount destroyed, the date of destruction and the signature of the person named above and one other licensed medical staff shall be recorded on the Medication Disposal Log (Non-Controlled Substance) (Attachment B). Such log shall be retained for at least three years and kept in a binder in the Medication Room.

D. Documenting Disposal of Medications
   1. Medication Disposal Logs (Attachments A and B) are maintained for three (3) years to ensure the clinic site disposes of expired, contaminated, deteriorated and abandoned medications in a manner consistent with State and Federal laws. This includes disposal of client's prescriptions as well as pharmaceutical samples. The following information shall be recorded on the log(s).
      a. Name of the medication and strength
      b. Medical Record Number (when applicable)
      c. Date logged in (when applicable)
      d. Lot #/expiration date
      e. Date medications were destroyed
      f. Number of tablets/capsules received and destroyed
      g. Name of licensed medical staff who received the medication to be destroyed
      h. Name of the witnessing licensed medical staff, registered nurse or registered pharmacist

## V. **DOCUMENT HISTORY**

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/14/2017 | All | Procedure and formatting |
| 10/24/2019 | All | Procedure and made HA policy – hyperlinked to outpatient 6.13 (7.05 is original). |
| | | |
| Prior Approval dates: | | |
| 04/30/2009, 01/24/2011 | | |

| *Signature on file* | | *10/24/2019* |
|---|---|---|
| Approved by: | Daisy Ilano, MD, Medical Director | Date |

| *Signature on file* | | *10/24/2019* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 7.06 Prescription Pad Security

I. PURPOSE

- To ensure that all staff involved in the handling of the prescription pads and other prescription pad related activity follow the correct processes of ordering, storing, and transporting prescription pads to minimize the risk of fraud and prevent illegal drug diversion
- To ensure that a system is in place for immediate reporting of any loss or theft of prescription pads

II. POLICY

County of San Luis Obispo Behavioral Health Department will establish a protocol on handling of prescription pads at each clinic site and ensures that the ordering, storage and transport of prescription pads follow the established procedure.

III. REFERENCE(S)

- Health & Safety Code, Sections 11161.5 and 11162.1 et. seq
- Tamper-Resistant Prescription Law (Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007)
- DEA Practitioner's Manual

IV. PROCEDURE

A. Ordering
1. When a new licensed prescriber is hired, the Health Agency (HA) Human Resources staff informs MH Billing Department Supervisor and/or the MH Billing Department designated staff and provides the following information necessary in ordering of the prescription pads:
   a. Copies of California medical license
   b. DEA certificate
   c. Address of the assigned clinic
   d. Telephone and Fax number of the assigned clinic/inpatient unit
2. Prescription pads are ordered by the Mental Health (MH) Billing Department designated staff and logged into inventory upon receipt of the order by both the MH Billing Department Supervisor and the MH Billing Department designated staff
3. Prescription pads are provided to the prescriber on the first day of work. The provider may contact the Billing Office (805) 781-4775 to request more prescription pads as needed.

B. Storage at Health Campus
   1. Prescription pads are stored in a locked file cabinet in the Mental Health Billing Department.
   2. Access is restricted to the Medical Director, MH Billing Department Supervisor, and the MH Billing Department designated staff.
   3. Staff is to log (in binder) each time prescription pads are picked up from the MH Billing Department.

C. Picking Up
   1. Prescription Pads are not delivered to the site by County Mail, but must be picked up in person from the Billing Office by the prescriber, the Division Manager or the Program Supervisor.
   2. An authorized staff may also pick up and transport the prescription pads to the outpatient clinic/inpatient unit with written approval (email or hard copy, Attachment A) from the prescriber only. The authorized staff will be provided with a written receipt of the prescription pad (Attachment B) with the serial number(s) that will in turn be given to the requesting prescriber with the prescription pads. A copy of the receipt will be kept in MH Billing Department (in a binder).

D. Storage at Clinic Sites
   1. Prescription pads are stored in a locking cabinet, safe or lock box at clinic sites, in the prescriber's office or in the inpatient unit.
   2. The prescriber is fully responsible for the safety and security of the prescription pads in their possession.
   3. Prescription pads are not to be unattended at any time and at any place.

E. Loss or Theft
   1. In the event of loss or theft of prescription pads, the staff member who discovers the event immediately:
      a. Notifies the Medical Director
      b. Completes an Incident Report and sends it to Quality Support Team, 2nd Floor, Health Campus.

F. Disposal
   1. When a prescriber is no longer employed or contracted by the County, the Program Supervisor or the prescriber returns the remaining prescription pads to the Billing Office in person.
   2. Prescription pads are logged in by MH Billing Department Supervisor or designated staff as received and scheduled to be shredded.
   3. If other names of prescribers are printed on the prescription pads, such prescription pads may be reassigned to the other prescriber(s)) and added to the inventory.
   4. Prescription pads are shredded in the presence of MH Billing Department Supervisor and designated staff. The MH Billing Department Supervisor documents in the inventory logbook that the prescription pads have been destroyed.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 04/29/2014 | Procedure Section III | 1. Allows for authorized staff to pick up prescription pads<br>2. Changed "MH Accounts Payable" to "MH Billing Department" |
| 11/14/2017 | All | Purpose, procedure and formatting |
| Prior Approval dates: | | |
| 09/20/2010 | | |

| *Signature on file* | | *04/29/2014* |
|---|---|---|
| Approved by: | Daisy Ilano, MD, Medical Director | Date |

| *Signature on file* | | *04/29/2014* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 7.07 Network Provider Requests for Medication Evaluations

I. PURPOSE

- To establish a guidelines and direction for processing Network Providers' requests for psychiatric evaluation for medication management of clients who are under their psychiatric care.
- To ensure a timely evaluation after the referral has been processed

II. POLICY

County of San Luis Obispo Behavioral Health Department will establish a referral process for a client who is under the psychiatric care of a Network Provider to obtain a psychiatric evaluation for pharmacological management in addition to psychotherapy. When a Network Provider requests Medication Support Services for a client, the Managed Care Program Supervisor or designee will consult with the Behavioral Health Medical Director to initiate an appropriate plan of action as needed to determine the appropriate level of care.

III. REFERENCE(S)

- 3.21 Mental Health Plan Contract with DHCS
- 3.22 Welfare & Institutions Code 5600.4 -5600.7

IV. PROCEDURE

A. Closed Case:
   1. The Network Provider initiates a request for medication services by completing a Medication Evaluation Request form (Attachment A) and faxes it to Managed Care.
   2. The Managed Care Program Supervisor or designee consults with the Behavioral Health Medical Director as needed to recommend an initial level of care. The consumer is either referred to his/her Primary Care Physician (PCP) or opened to a Mental Health clinic for medication evaluation. See Policy 8.01 Referrals between Community Health Centers and Mental Health for more details.

B. Open Case to any Mental Health Clinic:
   1. The clinic-based Single Accountable Individual (SAI) schedules a medication evaluation for the client with the psychiatrist/psychiatric nurse practitioner.
   2. Managed Care staff forward information from the Network provider to the SAI (e.g., Medication Evaluation Request, Care Coordination Report, or Treatment Plan) to the clinic-based SAI as needed to facilitate the evaluation.

C. Post Evaluation Follow-Up

1. The medication evaluation can result in any of the following recommendations by the Mental Health Staff Psychiatrist:

| SCENARIO | REFERENCE | ACTION REQUIRED |
|---|---|---|
| Client's condition requires ongoing Medication Support at Mental Health | ▪ Policy titled *Medication Support Visits*<br>▪ MHP's most recent *Treatment Plans and Documentation Guidelines* for detail. | SAI arranges ongoing care and treatment planning at Mental Health. |
| Client's medication needs can be met by a PCP. | Policy titled *Referrals between Community Health Centers and Mental Health*. | The SAI arranges for follow up by the PCP in a manner consistent with this Policy. |
| Client does not require medication at this time. | | The psychiatrist and/or SAI discuss this decision with the client and make other referrals. |

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/14/2017 | All | Consumer changed to client, Policy statement added, purpose added |
| Prior Approval dates: | | |
| 03/30/2009,09/21/2012 | | |

| *Signature on file* | | *02/01/2018* |
|---|---|---|
| Approved by: | Daisy Ilano, MD, Medical Director | Date |

| *Signature on file* | | *02/01/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 7.08 STANDARDIZED PROCEDURES FOR Nurse Practitioners

***IN COLLABORATION***
***WITH***
**San Luis Obispo County**
**Behavioral Health Department**

## I. TABLE OF CONTENTS

## II. INTRODUCTION TO STANDARDIZED PROCEDURES

A. The purpose of these standardized procedures is to define the scope of practice for Nurse Practitioners (NP) in collaboration with **San Luis Obispo County Behavioral Health Department** in order to meet the legal requirements set forth in the California State Board of Registered Nursing Business and Professional Code, Nursing Practice Act Section 2725 and further clarified in Title 16, California Code of Regulation, Division 14, Article 7, § 1470-1474 and § 1480-1485 These requirements are established to assist all health care providers with an understanding of the role and scope of practice of the nurse practitioners, both mental health and primary care and to provide safeguards so that providers and patients alike may be assured of the best health care possible.

B. In order to provide the highest standard of care, these Standardized Procedures incorporate the following:

1. ADAPTABILITY (to allow for the unique needs of individual patients)
2. FLEXIBILITY, to accommodate the rapidly changing and complex nature of health care, and to acknowledge that medicine is not an exact science
3. PRACTICALITY, to be useful in settings that must incorporate a variety of educational backgrounds and personal management styles
4. SPECIFICITY, to address the intent of the Board of Registered Nursing's Standardized Procedures

C. The Standardized Procedures consist of the following:

1. GENERAL POLICIES to define the general conditions of and give authorization to the nurse practitioners to implement the Procedures.
2. BEHAVIORAL HEALTH CARE AND PRIMARY CARE MANAGEMENT STANDARDIZED PROCEDURES to delineate the functions requiring a Standardized Procedure and, policies and protocols, define the circumstances and requirements for the implementation by the nurse practitioner.

## III. REFERENCES

- Business & Professions Code – Sections 2725, 2834-2836, 2863.1
- Title 16, California Code of Regulations, Division 14, Article 7, Sections 1470-1474, 1480-1485
- Medical Board of California, Title 16, CCR, Section 1379
- Health & Safety Code 11056

## IV. APPROVAL AND AGREEMENT

A. STATEMENT OF APPROVAL AND AGREEMENT

1. All NPs and supervising physicians will signify agreement to the Standardized Procedures by signing this agreement. Signature implies approval of all the policies and protocols in this document, the intent to abide by the Standardized Procedures, and the willingness to maintain a collegial and collaborative relationship with all the parties. NPs and physicians who join the Department or who cover the practice must also signify approval of the Standardized Procedures.

2. By signing this Statement of Approval and Agreement, I

   - Approve the Standardized Procedures and all the policies and protocols contained in this document.
   - Agree to maintain a collaborative agreement and collegial relationship.
   - Agree to abide by the Standardized Procedures in theory and practice.

| Printed Name and Title | Signature | Date |
|---|---|---|

B. STANDARDIZED PROCEDURE AS APPROVED BY

| | |
|---|---|
| *signature on file* | *03/28/19* |
| Daisy Ilano, MD, Medical Director | Date |
| *signature on file* | *03/28/19* |
| Greg Vickery, LMFT, Division Manager, Quality Support Team | Date |
| *signature on file* | *03/28/19* |
| Anne Robin, LMFT, Behavioral Health Administrator | Date |

C. STANDARDIZED PROCEDURE AS REVISED AND APPROVED BY

| | |
|---|---|
| *signature on file* | *03/28/19* |
| Daisy Ilano, MD, Medical Director | Date |
| *signature on file* | *03/28/19* |
| Greg Vickery, LMFT, Division Manager, Quality Support Team | Date |
| *signature on file* | *03/28/19* |
| Anne Robin, LMFT, Behavioral Health Administrator | Date |

## V. GENERAL POLICIES AND DEFINITIONS

**A.** It is not the intent of this document to have the NP independently diagnose, treat, or manage **ALL** the patient conditions they may encounter, but rather to utilize their assessment and mental health/physical health care management skills in conjunction with the Standardized Procedures and the supervising physician /NP relationship to meet the health care needs (both behavioral and physical health) of the patients.

**B.** Standardized Procedure is a term specified in the California Nursing Practice Act that refers to the legal mechanism designed to allow the nurse practitioners to perform functions which would otherwise be considered the practice of medicine under the Medical Practice Act.

**C.** However, it is the intent of this document to recognize the existence of overlapping and interdependent functions between the physicians (psychiatrists, primary care physicians and internists) and NPs, to permit additional sharing, and to provide clear legal authority for those functions and procedures which have common acceptance.

**D.** Each Standardized Procedure shall:

1. Be in writing, dated and signed by the organized healthcare system personnel authorized to approve it.
2. Specify which standardized procedure functions each nurse practitioner may perform and under what circumstances.
3. Specify any requirements that are to be followed by the nurse practitioner in performing the standardized procedure functions.
4. Specify any experience, training and/or education requirements in performing the standardized procedure.

5. Establish a method for initial and continuing evaluation of the competence of those nurse practitioners authorized to perform standardized procedure functions.
6. Provide a method of maintaining a written record of NP authorized to perform the standardized procedure functions.
7. Specify the level of supervision required for the performance of the standardized procedure functions (i.e. record review, peer review).
8. Set forth any special circumstances under which the NP must be immediately reported/communicated with the patient's psychiatrist.
9. State the limitations on setting, if any, in which standardized procedure functions may be performed.
10. Specify patient record keeping requirement
11. Provide a method of periodic review of the standardized procedure.

## E. DEVELOPMENT, REVISION AND REVIEW

The Standardized Procedures have been developed collaboratively and will be reviewed, and revised as practice changes by nursing, medicine and administration of San Luis Obispo County Behavioral Health Department. Changes made are reviewed by the Quality Support Team (QST) and approved by the Medical Director. This changes and approval are reflected in the dated and signed approval and agreement sheet.

## F. SETTING

The NP will perform these Standardized Procedures at all clinic sites and the Psychiatric Health Facility of San Luis Obispo County Behavioral Health Department. The Standardized Procedures may also be performed by telephone or electronic means and other settings as part of nurse practitioner practice.

## G. EDUCATION AND TRAINING

1. The NP(s) must possess at least 4 of the following:

    i. A valid and current California license as a Registered Nurse
    ii. A certification from the California Board of Registered Nursing as a Nurse Practitioner
    iii. A certification as a Family, Adult, or Psychiatric, Gerontological Nurse Practitioner from the American Academy of Nurse Practitioners or the American Nurses Credentialing Center.
    iv. Must be a graduate of a certified Adult Mental Health Nurse Practitioner Program, if hired as an MHNP
    v. Must possess a current furnishing number

## H. SUPERVISION and EVALUATION OF CLINICAL CARE

1. The Standardized Procedure is a physician-directed procedure; however, other disciplines are involved in the development to provide recommendations for the utmost care that can be afforded to the patients. It can be implemented without direct supervision or immediate observation, or approval of the supervising physician, except as may be specified on individual Health Care Management Standardized Procedure. However, consultation must be available at all times, either on site or by any electronic means that comply with the Privacy Rule.
2. Supervision and evaluation of NP's performance of standardized procedure functions will be done in conjunction with the existing performance appraisal and peer review policies, and according to the following:

    i. NPs must receive at least one hour or more hours of supervision from a designated supervising physician as arranged between the two (2) parties.
    ii. Areas needing increased skills as determined by the initial or routine evaluation will be re-evaluated by the Medical Director at appropriate intervals until acceptable skill level is achieved within a previously determined probationary period.
    iii. A physician may only supervise up to four (4) NPs
    iv. Supervising physicians and Program Supervisors must provide the Medical Director with written evaluations/written or verbal report and/or feedback of all NP's performance at six (6) months and twelve (12) months in the first year of employment and yearly thereafter.
    v. Utilization review of cases being managed by the NPs must take place at least every six (6) months - twelve (12) months.
    vi. Arrangements for alternative supervision for the NP will be made with another physician in the event that the current supervising physician is/will not be available.

## I. PATIENT RECORDS

The NP will be responsible for the preparation of a complete medical record for each patient visit that meets the documentation criteria for San Luis Obispo County Behavioral Health Department.

## J. CONSULTATION

1. The NP will be managing Simple, Complex, Emergent care conditions as outlined in this document. In general, however, communication (in person or by electronic means) with a physician will be sought for all the following situations and any

others that may be deemed appropriate (whenever a physician is consulted, the NP will document the details of the consultation including the physician's name and outcome of the consultation in the patient's medical record).

i. Whenever a situation arises which is beyond the intent of the Standardized Procedures or the competence, scope of practice, or experience of the NP
ii. Whenever patients' conditions fail to respond to the management plan in an appropriate time
iii. Any rare or unstable patient condition.
iv. Any patient conditions which do not fit the commonly accepted diagnostic patterns for a disease or disorder (both physical and mental).
v. Any unexplained phenomenon or historical findings.
vi. At a patient's, legal spokesperson, the NP's or physician's request
vii. All emergency situations after stabilizing care have been initiated

## VI. BEHAVIORAL/PHYSICAL HEALTH CARE MANAGEMENT

A. SIMPLE MANAGEMENT:

1. POLICY

i. Simple behavioral health/physical health care conditions are common, chronic, uncomplicated, stable psychiatric/primary care conditions and maintenance health care. These simple care conditions may include common psychiatric/primary care disease states such as, but not limited to uncomplicated mood, anxiety, psychotic, personality, acne, iron deficiency anemia, constipation, conjunctivitis, diarrhea, eczema, ingrown toenail URI, UTI, Pediculosis, minor wounds and sleep disorders.

ii. The NP is authorized to diagnose care conditions, which involve the assessment and evaluation of chronic psychiatrically ill patients under this protocol. For the purposes of this policy, the NP is able to perform an intake assessment, determine a diagnosis(es) and to manage the simple mental health/physical health care condition(s) and/or request a medical/psychiatric consult. In addition, the NP assigned to the Drug & Alcohol Division is authorized to treat patients requesting assistance with detoxification of substance including methamphetamine, alcohol, and opiates. Patients that meet the parameters defined in Level I as described in the Drug & Alcohol Services Detox Policy & Procedures manual will be treated according to the guidelines found in Simple Mental Health care management.

iii. Primary interventions include furnishing of formulary-approved medications, relationship-based cognitive-behavioral interventions, crisis intervention,

mental and preventive health care education, referrals to primary care physicians, medication reviews and updates monitoring ongoing progress of patient.

2. PROTOCOLS

   i. A treatment plan of care is developed as appropriate for patient condition
   ii. "Psychiatric Assessment" individual plan of care for general mental health referrals
   iii. Treatment plan for opiate withdrawal (if applicable)
   iv. "Psychiatric Assessment" (County Mental Health for Cd952) individual plan of care for methamphetamine withdrawal
   v. Treatment plan for alcohol withdrawal
   vi. If treatment plan fails after reasonable due diligence or a complex mental health care condition exists, the supervising psychiatrist will be consulted according to the guidelines below for complex mental health care conditions.

B. COMPLEX MANAGEMENT

1. POLICY: Complex care conditions are defined as unfamiliar, uncommon, unstable, complex conditions or detoxification condition(s) that meet the criteria for Level II as described in the Drug & Alcohol Services Detox Policy & Procedure Manual. Complex care conditions include any condition associated with a co-morbid unstable medical condition. Other complex care conditions may include abnormal lab results, significant change in diagnosis or presentation, or significant and unexpected relapse of illness. The NP is authorized to diagnose and evaluate these secondary care conditions and co-manage these conditions with the supervising physician according to the protocol below.

2. PROTOCOLS

   i. A physician is communicated with regarding the evaluation, diagnosis and/or treatment plan.
   ii. Management of the patient is either in conjunction with a physician or by complete referral to a physician or secondary treatment facility and documented thereof.
   iii. The physician is notified if his/her name is used on a referral
   iv. The consultation or referral is noted in the progress note including the name of the physician.
   v. All other policies and procedures of this document are adhered to by the nurse practitioner

C. EMERGENT CARE

1. Policy
   i. **Emergent care** conditions are emergency medical/psychiatric conditions caused by a sudden illness or a serious exacerbation of symptoms of an existing disorder that can be acute and life threatening. The emergent care conditions require immediate stabilization and referral to a physician/psychiatrist. Emergent conditions include acute, life-threatening conditions such as cardiac/respiratory arrest, suicide attempt, acute hospitalization, acute psychiatric decompensation, and involuntary hospitalization (5150's).
   ii. The NP is authorized to evaluate Emergent Care conditions under the following protocols:

2. PROTOCOLS
   i. Initial evaluation and stabilization of the patient may be performed with the concomitant and direct communication with the psychiatrist or physician.
   ii. If the physician cannot be contacted, the NP may initiate emergency treatment as deemed necessary, such as BLS and/or initiation of the EMS system and/or Mental Health Crisis Intervention.
   iii. The communication and initial treatment is noted in the progress note including the name of the psychiatrist, physician, and emergency destination/outside medical facility.

3. FOR ALL PATIENT INTERACTION, THE NP WILL ADHERE TO THE GENERAL POLICIES AND PROTOCOLS OF THIS DOCUMENT, AS WELL AS REGULATORY AND POLICES AND PROCEDURES OF SAN LUIS OBISPO COUNTY BEHAVIORAL HEALTH SERVICES (when applicable).

D. HISTORY & PHYSICAL EXAMINATIONS (Policy and Protocols)

1. The NP is authorized to:
   i. Perform History and Physical Examinations within 24 hours of admission to the Psychiatric Health Facility (PHF)
   ii. Diagnose care conditions, which involve the assessment and evaluation of chronic psychiatrically ill patients under this protocol, mainly focusing on the physical health/ailments
   iii. Perform physical assessment, determine a diagnosis(es) and to manage the simple physical healthcare condition(s).
   iv. Request a medical/psychiatric consult, when necessary, with the supervising psychiatrist or contracted internist for more complicated and medically compromised patients.

2. Primary interventions include:
   i. Furnishing of formulary-approved medications
   ii. Preventive health care education
   iii. Referrals to primary care physicians
   iv. Medication reviews and updates monitoring ongoing progress of patient.

3. The NP will inform the attending physician of any concerns regarding the patient's physical condition and assist the PHF staff in transferring a patient to the nearest emergency room, when necessary. On occasion, when a patient is unable to cooperate in giving history and/or examination, the history and physical examination may be deferred until the patient is able to cooperate. In these instances, appropriate documentation as to why examination is deferred shall be made on Physician's Medical Progress Notes.

E. LAB WORK AND DIAGNOSTIC STUDIES

1. POLICY: The NP is authorized to collect order and/or interpret lab work and diagnostic studies appropriate to the individual plan of care as described above and per County Mental Health Medication Monitoring Guidelines.

2. PROTOCOLS
   i. Routine lab work such as CBC, chemistry panel, urinalysis, throat cultures, x-ray, etc., may be ordered as needed for Disease Management as outlined in this document.
   ii. Other advanced studies may also be ordered, such as ultrasound, CT scan, in consultation with a physician.
   iii. All other applicable Standardized Procedures in this document are followed during patient care management.
   iv. All General Protocols regarding Review, Approval, Setting, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

F. FURNISHING DRUGS

1. POLICY: The NP may independently furnish medications or devices by prescription, orders written on a facility Physician's order sheet, verbal order, or facsimile transmission under the following protocols:

   i. The NP has met all the requirements of the California State Board of Nursing and the Business and Professional Code and therefore possesses a valid furnishing number (DEA license for controlled substances-optional).

ii. The drugs and/or devices are incidental to the provision of routine health care as outlined under the Medication Management Section of this agreement and per establish plan of care.
iii. All drugs and devices are furnished per the formulary listed in this document; or are recommended after consultation with the collaborating or consulting physician and documented thereof.
iv. A physician must be available at all times in person, by phone, or by electronic means.
v. Ability to furnish is included in the annual review of this agreement.

G. PROTOCOL: MEDICATION MANAGEMENT

1. The NP may also independently initiate, discontinue, and/or renew orders or prescriptions according to the developed plan of care under the following protocols:
2. All of the protocols under "Furnishing Drugs and Devices" in this agreement are met.
3. Medication history has been obtained: other medications being taken, medication and food allergies, any contraindications for the individual patient, as well as contraindications with other medications, prior medications used for current condition.
4. The drug or device is appropriate to the condition being treated:
   i. The lowest dosage effective per pharmaceutical references is used.
   ii. Not to exceed upper limit dosage per pharmaceutical references.
   iii. Generic medication is ordered, when appropriate
5. A follow-up assessment is written in the progress note.
6. Patient education regarding the medication is given and documented in the progress note. Patient will be informed of potential side effects and changes to be monitored as well as potential benefits of medications.
7. Consultation with a physician or pharmacy consultant is documented in the progress note, when applicable.
8. The formulary in Appendix "A" will be used, unless otherwise approved by the Medical Director.
9. The order will include name of the drug, strength, route of administration, frequency of administration, and prn guidelines.
10. The NP will re-assess with appropriate frequency (hourly, daily, weekly, etc.) for the circumstances (acute vs. chronic, reduction of symptoms, change of condition, adverse effects) and adjust regimen to achieve optimal relief of symptoms
11. The NP may dispense sample medications provided all of the above has been met and the applicable documentation has taken place (lot number, expiration date, number dispensed).

H. GENERAL MANAGEMENT OF ACUTE AND CHRONIC HEALTH CONDITIONS

1. DEFINITION: These procedure and protocols as described in the general policy are designed to assist nurse practitioners in the appropriate protocol for health assessment, acute illness or procedure as needed for managing various health conditions. The nurse practitioner will evaluate the database which will include but not be limited to as appropriate:

2. DATABASE:
   i. General health
   ii. Current complaint, if any
   iii. Review of systems
   iv. Past medical history
   v. Past surgical history
   vi. Family history
   vii. Immunizations
   viii. Current medications and allergies
   ix. An appropriate physical exam will be conducted
   x. Appropriate studies will be obtained

3. ASSESSMENT: The nurse practitioner will assess a working diagnosis based on history and physical.

4. PLAN: A plan will be implemented to include but not be limited to:
   i. New orders for new treatment
   ii. Evaluation of old treatments
   iii. Further diagnostic tests as indicated
   iv. Appropriate referral to other health services
   v. Appropriate education based on age, conditions and individual needs and interests of the patient
   vi. Develop appropriate follow up
   vii. Charting and communication to other members of the health team

I. DISEASE MANAGEMENT – PRIMARY CARE

1. POLICY: Primary care problems are common acute conditions such as pharyngitis, otitis media, etc. OR chronic stable conditions such as hypertension, hypothyroidism, irritable bowel syndrome, etc. The Nurse Practitioner is authorized to diagnose and treat primary care problems under the following protocols:

2. PROTOCOLS

    i. A medical treatment plan is developed based on the resources listed in this document.
    ii. All other applicable Standardized Procedures in this document are followed during patient care management.
    iii. All General Protocols regarding Review, Approval, Setting, Education, Evaluation, Patient records, Supervision, and Consultation in these Standardized Procedures are in force.
    iv. Primary care conditions do not require physician signature on notes and orders.
    v. Admission evaluation physicals, while classified as primary care conditions, do require counter signature by physician, unless medically cleared through Hospital Emergency Department.

J. DISEASE MANAGEMENT – SECONDARY CARE

1. POLICY: Secondary problems are unfamiliar, uncommon or unstable conditions such as acute abdominal pain, unstable sprain, diabetes with complications, etc. The Nurse Practitioner is authorized to perform an initial evaluation. Any of these cases may be referred to the Emergency Department.

2. PROTOCOLS
    i. Transfer for emergency care shall be initiated, when necessary.
    ii. Evaluation and referral shall be documented in the medical record.
    iii. All other applicable Standardized Procedures in this document are followed during patient care management.
    iv. All General Protocols regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

K. DISEASE MANAGEMENT – TERTIARY CARE

1. POLICY: Tertiary care problems are acute, life-threatening conditions such as respiratory arrest, cardiac arrest, major trauma, etc. Emergency Services are to be notified by calling 911 immediately. A physician is to be notified immediately. The Nurse Practitioner is authorized to evaluate tertiary care problems under the following protocols:
2. PROTOCOLS
    i. Initial evaluation and stabilization of the patient may be performed with the concomitant notification of and immediate management by a physician.

ii. The referral is noted in the patient's chart including the name of the physician or agency referred to.
iii. All other applicable Standardized Procedures in this document are followed during patient care management.
iv. All General Protocols regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.
v. Certified nurse practitioners or other health care providers may initiate BLAS and AED.

**VII.RESOURCES**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- Minor Emergencies. Buttaravoli & Stair. Mossy.

- Mosby's Diagnostic and Laboratory Test Reference (5th edition) Pagana

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- Pocket Guide to Diagnostic Tests (3rd edition) Nicoll, McPhee, Pignone, Detmer, & Chou (2001)

- Prescribers Letter. Therapeutic Research Group

- Principles of Trauma Therapy A Guide to Symptoms, Evaluation, and Treatment (Chapter 11, pages 185- 229) Briere, J., Scott, C. Sage Publications (2006)

- Short Term Opioid Withdrawal Using Buprenorphine NIDA/SAMHSA www.nattc.org/aboutUs/blendingInitiative/BupDetox/Detoxfinal.ppt

- Standing Orders for Alcohol Withdrawal Protocol, San Luis Obispo County Mental Health Services. (August 2003)
- Swift, R. M. (1999). Medications and Alcohol Craving Alcohol Research and Health ,vol 23, No.3, 207-214.

- The Sanford Guide to Antimicrobial Therapy, 2018

- Up To Date. 2018 Wolters Kluwer

**VIII.** Other medications/devices may be used based upon consultation with the attending physician and/or pharmacy consultant and availability in the Medication Dispense machine.

## APPENDIX "A"

**ANTI-DEPRESSANTS**
Anafranil (Clomipramine)
Brintellix (Vortioxetine)
Celexa (citalopram)
Cymbalta (duloxetine)
Desyrel (trazodone)
Effexor (venlafaxine)
Elavil (amitriptyline)
Fetzima (Levomilnacipran)
Lexapro (escitalopram)
Luvox (fluovoxamine)
Norpramin (desipramine)
Pamelor (Nortriptyline)
Paxil (paroxetine)
Prozac (fluoxetine)
Remeron (mirtazapine)
Sinequan (doxepin)
Tofranil (imipramine)
Viibryd (Vilazodone)
Wellbutrin (bupropion)
Zoloft (sertraline)

**MOOD STABILIZERS**
Depakote (valproate)
Lamictal (lamotrigine)
Latuda (Lurasidone)
Lithium
Neurontin (gabapentin)(off label use)
Saphris (Asenapine)
Tegretol (carbamazepine)
Topamax (topiramate) (off label use)
Trileptal (oxycarbazepine)

**ANTI-DIARRHEAL**
Immodium (loperamide)
Kaopectate (bismuth subsalicylate)

**OTHERS**
Artane ((triheyphenidyl)
Clonidine (off label for opiate withdrawal)
Cogentin (benzotropine)
Strattera (atomoxetine)
Suboxone (Buprenorphine and Naloxone)
Symmetrel (amantadine)

**ANTI-ANXIETY/WITHDRAWAL**
Ativan (lorazepam)
Buspar (buspirone)
Klonopin (clonazepam)
Librium (chlordiazepoxide)
Valium (diazepam)
Vistaril (hydroxyzine)
Xanax (alprazolam)

**SLEEP AIDS**
Ambien (zolpidem)
Benadryl (off label use)
Dalmane (flurazepam)
Desyrel (trazodone) (off label use)
Restoril (temazepam)

**ANTI-CRAVING**
Antabuse
Campral (acamprosate)
Naltrexone

**ANTI-PSYCHOTICS**
Abilify (aripiprazole)
Clozaril (clozapine)
Geodon (ziprasidone)
Haldol (haloperidol)
Invega (Paliperidone)
Latuda (Lurasidone)
Mellaril (thioridazine)
Navane (thiothixene)
Prolixin (fluphenazine)
Risperdal (risperidone)
Seroquel (quetiapine)
Stelazine ((trifluoperazine)
Thorazine (chlorpromazine)
Trilafon (perphenazine)
Zyprexa/Zydis (olanzapine)

**PAIN**
Acetaminophen
Acetaminophen w/codeine elixir
Ibuprofen
Ultram (Tramadol)

**Revision History**

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| 11/2014 | Section added | Added History & Physical Examinations |
| | Lab Work | Added protocols |
| | General Management of | Added break down of management of care |
| 08/01/2018 | Entire Policy | Formatting |
| 01/29/2019 | Entire Policy | Revised protocols and updated resources |
| Prior Approval dates: | | |
| 4/29/2014 | | |

# 7.09 SYRINGE DISPOSAL

## I. POLICY

County of San Luis Obispo Behavioral Health Department shall establish a policy on proper disposal of all used needles, syringes and other medical devices that have been used by licensed medical staff.

## II. PURPOSE

1. To ensure the safety of staff and patients and prevent injuries caused by contaminated objects that can penetrate the skin
2. To comply with OSHA standards in accordance with 29 CFR 1910.1030
3. To comply with FDA Safe Disposal of Needles and other Sharps

## III. REFERENCES

- 29 CFR 1910.1030
- Food and Drug Administration (www.fda.gov/safesharpsdisposal)

## IV. PROCEDURE

1. Used sharps and needles shall be disposed of immediately and placed by the user in appropriate safety containers for disposal of used needles and syringes called sharps containers.

2. Sharps disposal containers must:

    a. Be puncture-resistant and leak-proof
    b. Visible and easily accessible by the users
    c. Located as close as feasible to the area where sharps will be used.
    d. Clearly marked with the word “Biohazard”

3. When administering any injectable medications, only safety lock syringes are used. After giving the injection, the syringe, with safety shield over needle, is placed in the appropriate Sharps Container located in the medication room.

4. When the Sharps Container is ¾ full, the container will be snapped shut by pressing down simultaneously on the two top tabs and pushing in the hinged, plastic tray. NO CONTAINER IS TO BE OVER ¾ FULL.

5. The contracted Waste Disposal Company will be contacted by the Program Supervisor or designee for pick up at the scheduled date and time.

6. Contaminated sharps are never allowed in trash bags or liners and must never be sheared or broken. Recapping, bending, or removing needles is permissible only if there is no feasible alternatives or if such actions are required for a specific medical procedure.

I. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 02/01/2018 | All | Updated and Formatting |
| Prior Approval dates: | | |
| 02/04, and 11/07 | | |

| *Signature on file* | | *02/28/2018* |
|---|---|---|
| Approved by: | Daisy Ilano, MD, Medical Director | Date |

| *Signature on file* | | *02/28/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 7.10 Pharmaceutical Services General Information

## I. POLICY

County of San Luis Obispo Behavioral Health Department (SLOBHD) shall have a plan to ensure that inventory, supply, provision and oversight of pharmaceutical services are conducted in accordance with the state pharmacy laws and professional practice regulations.

## II. PURPOSE

- To establish proper supervision and oversight responsibilities of all pharmaceutical services provided at the SLOBHD.
- To ensure that the medications are administered to all patients, including admitted patients to the Psychiatric Health Facility (PHF) in a safe and uniform manner by licensed medical staff.
- To minimize harm from the use of medications through development and implementation of appropriate policies and trainings.

## III. REFERENCE

- California Code of Regulations, Title 22, Division 5, Chapter 9, Article 3, §77079.1-77079.13
- Business and Professions Code 4000 et seq.
- California Code of Regulations Title 16, Section 1700 et seq.
- Health and Safety Code 11000 et seq.

## IV. PROCEDURE

A. GENERAL PRINCIPLES

1. Arrangements shall be made with the contracted pharmacies for a consultant pharmacist licensed by the California Board of Pharmacy to assure that pharmaceutical services (prescribed drugs and biologicals) are available and provided to all patients.

2. The Consultant pharmacist assumes the following responsibilities:

   a. Overall responsibility of PHF pharmacy services, including the monthly review and inspection of the PHF Medication Room and Quarterly inspection of outpatient clinic medication rooms.
   b. Oversight of all records of drugs procured, administered, transferred, distributed, dispensed to all patients
   c. Oversight of medication destruction and removal of unwanted or outdated drugs, including controlled substances, as required by laws and regulations

d. Assist in development and revisions of pharmacy services policies and procedures to establish a system for control and accountability of pharmaceuticals
e. Provide in-service education and training to licensed medical staff, when applicable
f. On-site review of charts and documentation as required by laws and regulations

B. AUTOMATED PATIENT MEDICATION DISPENSE SYSTEM (PHF ONLY)

1. Immediately upon receipt of pharmaceutical supplies ordered from contracted pharmacies, these supplies are stored in a locked cabinet to be used to replenish the Med Dispense system as needed or on scheduled days. Patient's own medications ordered under their names will be kept in a locked cabinet, in a personal box clearly marked with the patient's name.
2. If any ordered medication is not available, the prescriber will be notified immediately, and the order will be modified. If the ordered medication is the prescriber's preference, the medication may be ordered from the contracted pharmacy provided that it is covered by the patient's insurance. If the mediation is not covered, the prescriber will be given a list of alternative medications.
3. The medication room has some stock medication for use as needed. All medications will be pulled from the automated medication dispense system and supply will be replenished as needed from stock supply. All multiple dose vials are labeled with date opened and are to be disposed of after 28 days of opening. A report will be generated daily at the end of the NOC shift of a list of patient names with medications dispensed in the last 24 hours. The daily report will be placed in the designated binder and be retained for at least one (1) year.
4. All medications used, including stock and patient's own medication supply, must be logged out through the automated Med-Dispense® system.
5. An eMAR is generated using the electronic health record each time a medication is ordered and noted by the licensed medical staff. A copy of the eMAR is printed at the end of each day for record keeping, in the event that the electronic health record system is inoperable. An updated copy will be printed when changes occur.
6. When a patient is discharged, licensed medical staff will remove the patient's name from the automated medication dispense system and all medications ordered on the eMAR will be discontinued.
7. Liquid medications will not be used if there is a change of color, odor, or consistency. Unused liquid medications are NEVER returned to container.
8. If special tests are ordered such as medication blood levels, the licensed medical staff assigned to the Drug Room will check to see if medications are to be given or held. This will be noted on the eMAR.

C. SCHEDULE II NARCOTICS WILL BE ORDERED AND OBTAINED AS FOLLOWS:

1. Every a.m. shift, a PAR (restock) level report is generated and printed by licensed medical staff which reflects all medications in the automated medication dispense system needing to be restocked.
2. To order a Schedule II medication, a 222 form must be filled out completely and sent to the contracted pharmacy. Licensed medical staff will follow the established protocol for completing the 222 form. The protocol is located in a labelled Schedule II Narcotic binder and forms are located in a locked safe.
3. The licensed medical staff will then restock the automated medication dispense system drawer with the ordered Schedule II narcotic.
4. The tracking of administered medications will be done by generating a report from the Med-Dispense® machine and filed in appropriate binder in med room. Records will be retained for two years.
5. Outpatient Clinics shall not have any Schedule II narcotics kept at any clinic sites at any given time.

D. PATIENT'S PERSONAL MEDICATIONS

1. Patient's personal medications can only be administered to the patient whose name is on the label of the prescription bottle even though the medications may be the same.
2. Personal medications of patients admitted to the PHF may be either sent home with family or kept in a locked cabinet on the unit for safekeeping when not in use. All other personal medications will be listed, the property bag is signed off, sealed, copy to chart and placed in the medication safe that is accessible to all licensed medical staff.
3. If the staff psychiatrist chooses to use patient's own medications, an order shall be written, and a log of patient's medications shall be kept and tracked using Patient's Prescription log. Outpatient licensed medical staff may also track patient's own medications using the same form (see Outpatient Policy # 7.03)
4. All personal Controlled Substances brought in by a patient that cannot be sent home with family shall have the following done (PHF Only):
   a. A licensed medical staff will fill out the property bag with the name, dosage and amount of each Controlled Substance.
   b. A second licensed medical staff will review the medications and information documented on the property bag and cosign.
   c. The patient will then electronically sign the PHF Property List which includes list of medications with amount and retained the patients EHR.
   d. The bottles of medications are placed in the property bag.
   e. Both licensed medical staff will then seal the property bag and place in the medication safe that is accessed by the licensed medical staff only.
   f. The patients name will be added to the count board for safe.

g. Contents counted and initialed each shift by the Lead.
h. The double initialed property bag will be stored in the medication safe and kept until the patient is discharged or when the medications are returned to the family, with patient's permission. A final count will be made at the time of discharge and returned to the patient provided that the medications are still current.

## V. **DOCUMENT HISTORY**

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| 03/24/2017 | I. Policy<br>IV. Procedure | I. added "and oversight"<br>IV.<br>B2. Added "immediately"<br>B3. Replaced "bottles" with "vials" and added are to be disposed of after 28 days of opening.<br>B4. Added "and patient's own medication supply"<br>3H. added "and kept until the patient is discharged or when the medications are returned to the family, with patient's permission. A final count will be made at the time of discharge and returned to the patient provided that the medications are still current" |
| 02/01/2018 | 1. Policy<br><br><br><br>IV. Procedure | Entire Policy amended for a SLOBHD policy (both inpatient and outpatient) 6.03 is original/PHF 7.10 is hyperlinked<br>Entire Policy: Medication envelope replaced with property bag (entire policy).<br>D3 Paragraph added |
| 08/15/2018 | All | Reformatting |
| Prior Approval dates: | | |
| 01/17 | | |

| *Signature on file* | | *02/27/2018* |
|---|---|---|
| Approved by: | Daisy Ilano, MD, Medical Director | Date |

| *Signature on file* | | *02/27/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 7.11 Prescribing of Controlled Substances

I. PURPOSE

- To ensure safe prescribing of Benzodiazepines and stimulants
- To clarify when short-term prescribing may be indicated
- To confirm that long-term use of Benzodiazepines and stimulants is rarely, if ever, indicated
- To aid Primary Care and Behavioral Health Providers in managing patients who are prescribed or who request controlled substances
- To provide appropriate directions and recommendations on discontinuing these medications

II. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) will establish parameters for the safe and appropriate use of psychoactive medications. Particular care will be used when prescribing controlled substances, especially Benzodiazepines and stimulants, to patients who have (or who are at risk of developing) substance-related disorders or who have commonly associated comorbid general medical conditions.

Key elements of SLOBHD's practice parameters will include:

1. Benzodiazepines and stimulants will be used as short-term agents during the implementation of a long-term treatment plan.
2. Patients who request or who are considered as candidates for prescription of Benzodiazepines and stimulants will be evaluated on an individual basis, taking into consideration their past psychiatric history, medical history, substance use disorder history, and medical treatment received, including the past use of Benzodiazepines and stimulants. Patients already taking Benzodiazepines and stimulants will be assessed with sensitivity to their prior medication treatment plans.
3. It is understood that the prescribing guidelines and protocols are not absolute, and the clinical condition of the patient ultimately dictates the course of action to be followed by SLOBHD prescribers. However, specific reason(s) for deviation from any guidelines or protocols will be clearly documented in the patient's medical record.
4. Careful documentation of a thorough discussion with each patient of the risks and benefits of any medication regimen is a standard expectation of all SLOBHD prescribers as part of the Informed Consent for Medication. This careful documentation of risks and benefits is especially crucial when controlled substances are part of the treatment plan.
5. There is no guarantee that the medication previously prescribed by outside providers or be a previous SLOBHD provider will be continued by SLOBHD medical staff.

III. REFERENCE(S)

- Title 21, Code of Federal Regulations (CFR) Part 1300 et seq.
- Title 42 CFR, Part 8
- Title 22 California Code of Regulations (CCR), Sections 51341.1, 51490.1 and 51516.1
- Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq.
- Title 22, CCR, Division 3, Chapter 3, Sections 51000 et seq.

IV. PROCEDURE

A. PRESCRIBING CONSIDERATIONS:

1. Long-term use is defined as duration of treatment beyond six (6) weeks. Long-term use of a Benzodiazepine is not recommended. The prescriber will be explicitly explain this limit to the patient prior to initiating short-term treatment.
2. Risks and side effects will be reviewed with the patient, including the risk of dependence.
3. Some patients will have difficulty discontinuing the medication at the end of acute treatment. Discuss exit strategies, such as short tapering or switching to alternative treatments.
4. Discuss alternative treatments:
   a. Antidepressants
   b. Psychotherapy
   c. Serotonergic agents for anxiety
   d. Anticonvulsants for restless legs
   e. Adjunctive symptomatic medications *(see Table 1 on page 5)*
5. The patient and the health care provider will agree on one provider to be the prescriber for the Benzodiazepine and/or the stimulant. This designated prescriber must coordinate care with the prescriber of other CNS stimulants and narcotics that are not psychiatrically related.

B. CONTRAINDICATIONS

1. Active or history of Substance Use Disorder
2. Pregnancy or risk of pregnancy
3. Treatment with opioids for chronic pain or replacement therapy for narcotic addiction
4. Medical and mental health problems that may be aggravated with Benzodiazepines and stimulants (such as fibromyalgia, chronic fatigue syndrome, somatization disorders, depression, Bipolar Disorders (except for urgent sedation in acute mania)).
5. Cardiopulmonary disorders such as asthma, sleep apnea, COPD, CHF and other cardiopulmonary disorder, since Benzodiazepines and stimulants may worsen hypoxia, hypoventilation, and any cardiac disorders. stimulants
6. All patients will be encouraged to discontinue long-term use of Benzodiazepines and

stimulants. Prescribers will create a treatment plan to help patients with tapering and discontinuation.

7. For those patients who do not want to stop using Benzodiazepines or stimulants, set the expectation of revisiting the topic and initiation of the tapering off schedule on the next visit or no later than one month, whichever comes first. Patient will be informed of a referral back to the original prescriber for continued treatment if the patient prefers not to discontinue the medications.

C. TAPERING AND DISCONTINUATION

1. Tapering Considerations
   a. Assess the patient's underlying condition for which the medications were originally prescribed; discuss alternative treatments as needed
   b. Assess the patient for readiness/suitability to taper off. Patients are considered suitable if they:
      - Are willing and committed, with adequate social support
      - Have no previous history of complicated drug withdrawal
   c. Therapy should be available to assist with the withdrawal process and help the patient deal with rebound anxiety
   d. Consider referral to a specialist for patients who have:
      - history of substance use disorder
      - have a concurrent severe medical or psychiatric disorder
      - are on a high dose of Benzodiazepines
      - are taking amphetamines or opiates concurrently
      - have a history of drug withdrawal seizures

2. Gradual Tapering
   a. The most effective strategy to manage discontinuation and prevent adverse outcomes associated with the development of severe withdrawal is a gradual taper.
   b. Consider converting patients to a longer acting preparation
   c. Tapering will be guided by individual choices and severity of withdrawal symptoms. Medication discontinuation may take up to 3 months or longer but it is best to set a target date upon initiation of the tapering schedule.
   d. Review the patient's progress frequently to detect and manage problems early and to provide advice and encouragement during and after tapering.
   e. Emphasize that any reduction in use is beneficial

3. Clinical indications for rapid discontinuation
   a. Urine drug screen is positive for other substances of abuse
   b. Patient's behavior suggests possible misuse or diversion of medication. Such behaviors might include:
      - Selling prescription drugs

- Forging prescriptions
- Stealing or borrowing drugs
- Frequently losing prescriptions
- Aggressive demand for drugs
- Self-adjustment of dose with escalation to a higher dose
- Concurrent use of illicit drugs
- Obtaining drugs from multiple prescribers
- Recurring emergency department visits

D. TREATMENT TEAM AND TREATMENT AGREEMENT

1. All members of the treatment will coordinate any changes in the treatment plan
2. The prescriber reviews the Medication Treatment Agreement (Attachment A) with the patient
3. A Medication Treatment Agreement is signed by all members of the Treatment Team and the patient and a copy is given to the patient
4. The Medication Treatment Agreement can be revised as needed with the approval of all members of the Treatment Team
5. Any revisions will be discussed by the prescriber with the patient and signed by the patient
6. The Medication Treatment Agreement describes the conditions under which the controlled drugs are prescribed and highlights the responsibilities of the prescriber and the patient

E. MONITORING

1. A Patient Activity Report from the Controlled Substance Utilization Review and Evaluations System database (CURES) will be run at least each visit and prior to prescribing any controlled drug.
2. Suspicious activity noted in CURES will be documented in the medical record along with the appropriate intervention(s).
3. Limiting refills to ”zero (0) ” is strongly recommended.
4. Set expectations for frequency of visits and consider discontinuation of the controlled drug if a pattern of missed appointment occurs.
5. A urine toxicology screen will be ordered at each visit or at the discretion of the prescriber.

###

# TABLE 1

| Symptom | Medication | Dosing |
|---|---|---|
| Seizure prevention | Carbamazepine [1] | Start 200 mg twice daily, adjust dose weekly up to 400 mg twice daily. Continue for 2–4 weeks after stopping benzodiazepines and then taper anticonvulsant. |
| | Valproic acid [1, 2] or Divalproex sodium EC [1, 2] | Start 500 mg twice daily, adjust dose weekly up to 2,000 mg daily. Continue for 2–4 weeks after stopping benzodiazepines and then taper anticonvulsant. |
| Tachycardia, hypertension, tremors, sweats, anxiety, restlessness | Propranolol | 10 mg three times daily as needed for 3 days |
| Hypertension, tremors, sweats, anxiety, restlessness | Clonidine | 0.1 mg three times daily as needed for 3 days |
| Anxiety, restlessness | Hydroxyzine [3] or Diphenhydramine [3] | 25 mg every 6 hours as needed |
| Insomnia [4] | Hydroxyzine [3] or Diphenhydramine [3] | 25–50 mg daily before bed as needed |
| Nausea | Promethazine [3] | 25 mg every 6 hours as needed |
| | Metoclopramide | 10 mg every 6 hours as needed |
| Dyspepsia | Calcium carbonate | 500 mg 1–2 tabs every 8 hours as needed |
| | Mylanta, Milk of Magnesia | Follow package instructions. |
| Pain, fever | Acetaminophen | 500 mg every 4 hours as needed, not to exceed 3,000 mg in 24 hours |
| | Ibuprofen | 600 mg every 6 hours as needed |

[1] In patients with liver impairment, consider topiramate, gabapentin or levetiracetam. Check CBC and liver function tests at baseline.
[2] Check CBC and liver function tests at baseline and every 3 months during treatment.
[3] These are high-risk medications for the elderly. Please consider alternatives for patients aged 64 and older.
[4] Patients with chronic insomnia or worsening anxiety during the taper often do better with cognitive behavioral therapy to address these symptoms during the taper. Refer these patients to Behavioral Health Access for this specific therapy.

###

## V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| July 2018 | | Adopted & HA Policy – Hyperlinked with PHF 6.18 (Outpatient 7.11 is the original) |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *08/08/2018* |
|---|---|---|
| Approved by: | Daisy Ilano, MD, Medical Director | Date |

| *Signature on file* | | *08/08/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

**COUNTY OF SAN LUIS OBISPO**
**HEALTH AGENCY**

ATTACHMENT A

# MEDICATION TREATMENT AGREEMENT

**Patient Name (print)** _____ **Date** _____

You have agreed to receive the following prescribed medications for short-term treatment. It is important that you have an understanding of the risks and responsibilities that go along with this treatment.

| Generic Name | Brand Name | Generic Name | Brand Name |
|---|---|---|---|
| ☐ Alprazolam | Xanax, Niravam | ☐ Flurazepam | Dalmane |
| ☐ Armodafinil | Nuvigil | ☐ Lisdexamfetamine | Vyvanse |
| ☐ Chloral Hydrate | | ☐ Lorazepam | Ativan |
| ☐ Chlordiazepoxide | Librium | ☐ Methamphetamine | Desoxyn |
| ☐ Clonazepam | Klonopin | ☐ Methylphenidate | Ritalin, Metadate, Concerta, Daytrana, Methylin, Quillivant XR |
| ☐ Clorazepate | Tranxene | ☐ Modafinil | Provigil |
| ☐ Dexmethylphenidate | Focalin | ☐ Oxazepam | Serax |
| ☐ Dextroamphetamine | Dexedrine, Dextrostat, Desoxyn, ProCentra | ☐ Temazepam | Restoril |
| ☐ Dextroamphetamine & Amphetamine Salts | Adderall | ☐ Triazolam | Halcion |
| ☐ Diazepam | Valium | ☐ Zaleplon | Sonata |
| ☐ Estazolam | Prosom | ☐ Zolpidem | Intermezzo, Ambien, Zolpimist |
| ☐ Eszopiclone | Lunesta | ☐ Other: _____ | |



In order to provide appropriate and effective medication management, it is important to determine if there is also an alcohol or drug problem which may impact mental health symptoms and problems. This is necessary because active use of any alcohol or drugs may cause it to be unsafe to prescribe medications.

As a participant in Outpatient Clinic Services, I freely and voluntarily agree to accept this treatment contract as follows:

1. This agreement is necessary to the trust and confidence necessary in a doctor-patient relationship. My psychiatrist/prescriber will provide treatment based on this agreement.
2. I am aware that the use of this medication has a high potential for abuse and has a certain risk associated with it, including, but not limited to: tolerance, physical & psychological dependence, withdrawal symptoms, confusion, memory loss, and an increasing risk of dementia.
3. I agree to take my medication as my psychiatrist/prescriber has instructed and not to alter the way I take my medication without first consulting my psychiatrist/prescriber.
4. I agree not to obtain psychiatric medications from any doctors, pharmacies, or other sources without telling my treating physician.
5. I agree to keep and be on time to all my scheduled appointments. If a pattern of frequent missed appointments emerges, the psychiatrist/prescriber may require that I come to the clinic before authorizing refills.

6. The prescribed medication is strictly monitored by obtaining Patient Activity Report from the Controlled Substance Utilization Review and Evaluation system database (CURES).
7. No prescriptions will be refilled early.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication may not be replaced regardless of why it was lost.
9. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
10. My treating provider and I both agree to conduct myself in a courteous manner in the doctor's office.
11. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
12. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my psychiatric medications are filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
13. I understand that mixing psychiatric medications with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous. I also recognize that several deaths have occurred among persons mixing psychiatric medications including benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses) with other medications or illicit drugs.
14. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
15. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances.
16. If you have both symptoms of a mental disorder and alcohol or other drug problem the following steps will be taken:

a. I agree to provide random urine samples and have my doctor test my blood alcohol level to ensure safety in prescribing ongoing medications.
b. Medications may be postponed for short periods of time depending on the assessment and decision of the treatment team including the psychiatrist.
c. Medications may be withheld or discontinued for the following reasons
    i. persistent alcohol/drug use in which the risks outweigh the benefits of continuing psychotropic medications
    ii. refusal to consistently participate in treatment services
    iii. non- compliance with the medication plan



**I agree to follow this medication Treatment Agreement. I understand that violations of the above may be grounds for termination of treatment.**

_____Date _____

Patient Signature

_____

Physician/Nurse Practitioner *Printed* Name & Title

_____Date_____

Physician/Nurse Practitioner Signature

# 7.12 Medication Monotoring and Queuing Up of Medications

I. PURPOSE

To outline the responsibilities and guidelines for medication managers at San Luis Obispo Behavioral Health to ensure accurate and safe medication management for patients.

II. SCOPE

Applies to psychotropic medication(s) prescribed in outpatient clinics of Mental Health and Substance Use Disorder treatment programs

III. POLICY

This policy specifically focuses on the process of queuing up medications for prescribers, while considering important factors such as the last provider note, side effects, worsening symptoms, patient compliance, and scheduled follow-up appointments.

IV. REFERENCE

- Welfare and Institutions Code (W&I Code) §14456.5
- California Code or Regulations (CCR), Title 9, §1810.225

V. PROCEDURE

A. Ensuring last provider note's medications are being queued up for the prescriber and the note was signed. SmartCare permits the ability for the Medication Manager to send medication directly to the pharmacy. Our County Policy on refilling medication currently prohibits this. All medication refills will be sent directly to the prescriber for final approval.

B. Medication Managers will follow the following steps to queue up medication prescriptions for approval of the prescribing physician/nurse practitioner:
   1. Review the last provider note to identify the medications prescribed by the healthcare provider. The note should include details such as medication names, dosages, frequencies, and any specific instructions or changes.
   2. Cross-check the medications listed in the last provider note with the medications currently queued up for administration. This can be done by reviewing the medication queue or electronic health record system.
   3. Ensure the provider's signature is on the last provider note. If there are any doubts, consult with the healthcare provider for clarification.
   4. If the medications listed in the last provider note are confirmed to be accurate, medication managers should update the medication queue accordingly. Remove

any medications that are no longer prescribed and add any new medications that were prescribed in the last note.
5. Maintain clear communication with the healthcare team, including the prescribing provider, regarding any concerns or questions regarding the medications. Seek clarification if needed.

C. Medication Managers will follow the following steps to ensure there are no reported side effects and no worsening symptoms of the patient's psychiatric condition:
1. Assess the patient's overall well-being, including physical and mental health through a phone call, in person or a virtual visit. Patient's will be evaluated if stable at least once every two months by the Medication Manager and once every 3 months by the prescriber. More often if needed.
2. Build open and effective communication channels with the patient, encouraging them to report any side effects or worsening symptoms they may be experiencing. Create a safe and non-judgmental environment for the patient to express their concerns.
3. Provide thorough education to the patient regarding potential side effects and symptoms related to their prescribed psychiatric medication. Explain what to expect and encourage them to reach out if they experience any adverse effects or worsening symptoms.
4. Utilize standardized monitoring tools to psychiatric medications to track the patient's progress, identify any side effects, and monitor changes in symptoms over time.
5. Collaborate closely with the patient's healthcare team, including psychiatrists, therapists, and other relevant professionals. Share information, discuss concerns, and seek guidance when needed.
6. Schedule regular follow-up appointments with the patient to assess their medication response and evaluate any reported side effects or worsening symptoms.
7. Encourage patients and healthcare providers to report any suspected side effects or adverse events to the appropriate regulatory authority, such as the FDA's MedWatch program, to ensure drug safety monitoring.

D. Medication Managers will take the following steps to ensuring patient compliance with medication:
1. Review the patient's medication records to check for a history of consistently filling prescriptions and refilling them on time. Use electronic health record systems or pharmacy records for this purpose.
2. Assess if the patient is using medication adherence tools such as pill organizers, medication reminder apps, or electronic monitoring devices.
3. Conduct medication reconciliation by comparing the patient's self-reported medication list with the prescribed medications in their records to identify any discrepancies. Determine if the patient is taking all their prescribed medications or if they are omitting any.

4. Establish open and honest communication with the patient to understand their experiences, challenges, and barriers to medication adherence.
5. Monitor the patient's clinical outcomes, such as symptom improvement or disease progression, to gain insights into their medication compliance. Positive outcomes may indicate adherence to the medication regimen.
6. Collaborate with the healthcare team, including the prescribing provider, to gather additional information and perspectives regarding the patient's medication compliance.

E. Medication Manager will take the following steps to ensuring the patient has a scheduled follow-up with the provider:
1. Review the patient's medical records to check for any upcoming appointments or follow-up instructions from the provider. Utilize electronic health record systems or any documentation provided by the provider.
2. Maintain open communication with the healthcare team, including the provider, to inquire about scheduled follow-up appointments and ensure awareness of the details.
3. Update the patient's medication schedule to align with the scheduled follow-up appointment, if necessary. Adjust medication administration times accordingly.
4. Remind the patient about their scheduled follow-up appointment. Provide verbal reminders during medication administration or written reminders.
5. Coordinate with the patient's caregiver or family, if needed, to arrange transportation and support for the follow-up appointment.

## VI. DOCUMENT HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 12/15/2023 | All | Adopted |
| | | |
| | | |
| | | |
| Prior Approval dates: | | |
| | | |

| *E-Signature on File* | | *12/15/2023* |
|---|---|---|
| Approved by: | Siddarth Puri, MD, Interim Medical Director | Date |

| *E-Signature on file* | | *12/15/2023* |
|---|---|---|
| Approved by: | Star Graber, PhD, LMFT, Behavioral Health Administrator | Date |

# 7.20 Medication Assisted Treatment

I. MISSION STATEMENT

To provide comprehensive medications for addiction and withdrawal management services to empower residents of San Luis Obispo County seeking sustained recovery from substance use disorders. Through our programs, we promote harm reduction strategies, fostering physical and emotional well-being, self-sufficiency, and prosocial behaviors thereby improving both individual and community health.

II. GOAL STATMENT

The goal of the Medication for Addiction Treatment (MAT) Team is to provide tailored medication interventions aimed at minimizing the adverse effects of ongoing substance use on individuals and the community. Our objective is to support individuals in achieving sustained health and well-being by promoting harm reduction strategies and facilitating the path towards abstinence from substances. SLO DAS provides outpatient MAT services in an office setting by trained clinicians who provide medically supervised evaluations, withdrawal management, and referral services according to a predetermined schedule. All clients admitted prior to BHIN 23-054 will receive verbal updates on MAT policies and procedures from their clinicians and MAT team that highlights improvements and changes to the MAT program. They will be provided the policy and procedure upon request.

## III. PROCEDURE: MAT WORKFLOW

A. PROVIDING PATIENTS INFORMATION ABOUT MEDICATIONS FOR ADDICTION TREATMENT {MAT}

1. San Luis Obispo County provides patients and any adult collateral contacts (including but not limited to adult family members) with information about addiction medications at intake, during treatment, and at discharge in accordance with the patient's plan of care. The information provided is specific to each type of addiction medication that is clinically effective for treating that patient's specific SUD(s). Patients who are not actively being treated with addiction medications will continue to be offered addiction medications, as clinically appropriate, in accordance with the patient's plan of care.
2. An active client caseload will be maintained by the MAT Team by MD/DO/NP/PA (herein "prescriber"), LPT/LVN/RN (herein "medication manager") and case managers and include withdrawal management, initiation and continuing of addiction medications including Buprenorphine, Naltrexone, Acamprosate, Antabuse, and other medications with data to support their use in reducing substance use, cravings, or withdrawal symptoms among SUD patients. Prescribers

and support staff will review client's health status and substance use history with the client at intake.

3. Prescribers and support staff will review requests and assess appropriateness for admitting clients to medications for addiction treatment. SLO will provide patients with information using written and online materials about medications for addiction treatment that clearly explain the benefits of addiction medications and the risks of not accepting addiction medications. The provider will document specifically which MAT information was provided to patients_, the patient's response upon receiving this information, and all medication services offered to the patient, including a description of the patient's clinical history and prior use of addiction medications when applicable.
4. During the intake process, prescribers will discuss options for MAT services if they are appropriate for the patient and the patient is amenable. If the patient is actively withdrawing and requires a higher level of medical attention, the patient will either be directed to the closest emergency room or 911 will be called to transport the patient. If patients are not amenable to MAT, they will continue to offer individualized MAT options for patients.
5. Prescribers will provide continuous assessment and review of signs and symptoms of medication compliance, relief of cravings, and/or other recovery needs to determine if medications are adequately addressing client's needs.
6. Prescribers and support staff will provide education to clients and their designated support persons to assist the client through effective substance use disorder treatment including support and prevention services for medical complications during the withdrawal management process.
7. Psychiatric, medical, and case management referrals will be provided during and after treatment.
8. Clients will be required to attend concurrent treatment groups or other recovery support services while receiving MAT services.
9. Clients in early remission may engage in Recovery Support Services (RSS) if determined appropriate by the MAT provider.
10. Referrals will be provided to those who are unable to enter outpatient medication addiction treatment due to exclusion criteria or being unable to meet their immediate needs.

B. CLINICAL SUPPORT FOR THE MAT TEAM

1. The Medical Director for the County of San Luis Obispo Behavioral Health Department (SLOBHD) or designee will serve as the supervising physician of the Medication Addiction Treatment Team.
2. The clients and/or their support person will be referred to primary and emergency medical care services as needed and appropriate. No primary or emergency medical care will be provided onsite by Drug and Alcohol Services staff. Clients will be responsible for the cost of any recommended medical services and will be advised as such.

C. MAT STAFF RESPONSIBILITES

1. Clients seeking help for substance use disorders may have a heightened sensitivity to the perceived judgments of others. Staff members must address the clients with nonjudgemental, non-stigmatizing language, empathy and respect as well as reinforcing self-esteem and supporting client's goals of treatment.
2. Staff must observe client-staff boundary guidelines in accordance with the SLOBDH policiesl4.07 Social Relations with Clients and 14.05 Gifts, Donations and Loans

D. DAS STAFF TRAINING AND MAT STAFF TRAININGS:

1. The medical director (addiction medicine/psychiatry board certified physician), designated provider (LPT, RN, LVN), or division manager of DAS with experience in discussing MAT for high-risk populations will lead quarterly meetings and trainings to all DAS staff (clinicians, providers, LPTs, RNs, LVNs) that will cover:
   a. The risks and benefits of MAT
   b. Updates on MAT services
   c. Skill building exercises to discuss MAT with patients and their families.
2. The training shall be specific to all types of MAT that are available in SLO County, including Buprenorphine, Methadone, Naltrexone, Acamprosate, Disulfiram, and others as they become available, and FDA approved.
3. The training shall include the pharmacological properties and physiological effects of the common substances people use, as well as the clinical evidence of the efficacy, safety profiles and treatment outcomes for MAT.
4. There will be quarterly office hours by the medical director to discuss MAT concerns, challenging cases, and ways to improve MAT delivery services.
   a. All new staff shal1 be required to take the MAT training within the first 45 days of starting their employment with the MAT Team/SLO County DAS.
   b. SLO DAS programs shall receive MAT, overdose prevention education and naloxone training from qualified staff1 including prescribers and other LPHA.
   c. All medical and clinical staff working at SLOBHD DAS program shall be required to take the MAT training. This includes prescribers, medication managers, clinicians, and case managers.
   d. All training records shall be maintained in personnel files at the program location by supervisors.
5. Training shall also be provided to all staff about the MAT team structure and referral process-including review of policies and guidelines related to MAT.
   a. A review of all MAT Team Policies and Procedures and Guidelines shall be performed by the program supervisor at each program with all new staff at the time of hire or transfer into an MAT Team within the first 45 days of start date.
   b. The MAT Team policy shall be reviewed with all medical and clinical staff referring or providing MAT services, including prescribers, medication managers, clinicians, and case managers.

E. DIRECT PROVISION OF MAT SERVICES ON SITE:

1. All referrals will be directed to the regional clinic MAT team staff. All potential clients must have attended either the walk-in clinic or be an active treatment or recovery client of the DAS Division with a tentative diagnosis of substance use disorder. Screening for admission to MAT services can be completed by the prescriber or medication manager. If a patient presents in acute withdrawal and requires immediate medical attention, they will be triaged to determine if they can be medically stabilized with outpatient withdrawal management protocols (see MAT Medication Policy Guidelines for treatment algorithms). If they are deemed too acute for withdrawal management services, they will be referred to the closest emergency room for services or 911 will be called for emergency transportation.
2. SLO offers the following MAT at the DAS clinics: Buprenorphine, Buprenorphine/naloxone (oral, injectable), Naltrexone (oral, injectable), Acamprosate, and Disulfiram. SLO maintains a current list of which addiction medications are available directly via practitioners providing on-site services, including when these medications are prescribed, covered by Medi-Cal Rx, and provided to our patients through coordination with an offsite pharmacy.
3. SLO ensures that initial and follow-up addiction medication service appointments are arranged in accordance with the patient's individualized plan of care. Patients are required to see their providers at least once every 30 days for continuation of MAT. SLO maintains sufficient medical staffing operating within the scope of practice of their license (licensed prescribing clinician) to meet patient demand for addiction medication services, which includes employment of, or contracts with, prescribing clinicians and arranging coordination of telehealth medication services if applicable.
4. If the MAT Team receives a request for withdrawal management services with medications that are not available at SLO DAS, the client will be given appropriate referral(s) [see directly below]. DAS staff will facilitate a phone call or engagement with these alternative providers. However, If the client needs immediate medical attention, they will be referred to the nearest medical facility and will be provided with transportation, if necessary. If they are medically unstable, the MAT team will call 911 to get the client the closest emergency medical facility.

F. REFERRAL FOR MAT THROUGH EXTERNAL PARTNERS:

1. If the client is found to be ineligible or requires MAT that is not available (only methadone) an appropriate referral will be made to another agency and an attempt will be made to facilitate treatment linkage. Other agencies may include, but are not limited to:
   a. Aegis for Narcotic Treatment Program (NTP) services
      1551 Bishop St STE 520,
      San Luis Obispo, CA 93401.
      Phone: (805) 461-5212

2. SLO ensures that at least one external partner that offers each remaining required MAT is identified.
3. SLO maintains procedures for client transportation to/from these external partners.

## IV. SCREENING PROCESS

A. ELIGIBILITY CRITERIA FOR MAT TEAM AND ENGAGEMENT WITH MAT/WITHDRAWAL MANAGEMENT:

1. A potential client will be interviewed to determine eligibility for the program based on the following criteria.
   a. An expressed desire to stop using or reducing their substance use.
   b. Substance use within the past 12 months that has resulted in at least 3 of the following:
      i. Substance is often taken in larger amounts or over a longer period than intended. This criterion refers to unsuccessful attempts to cut down or control substance use.
      ii. Persistent desire or unsuccessful efforts to cut down or control substance use. This includes persistent desire or unsuccessful efforts to cut down or control substance use.
      iii. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects - This can include spending significant time obtaining drugs, using them or recovering from their effects.
      iv. Craving, or a strong desire or urge to use the substance - This refers to an intense desire or urge to use the substance.
      v. Recurrent use resulting in failure to fulfill major role obligations at work, school, or home. This criterion involves continued substance use despite its interference with important responsibilities.
      vi. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance. This refers to continued substance use despite negative consequences in relationships or social situations.
      vii. Important social, occupational, or recreational activities are given up or reduced because of substance use - This involves giving up or reducing important activities due to substance use.
      viii. Recurrent use in situations where it is physically hazardous. This includes using substances in situations that are physically risky or dangerous.
      ix. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance. This involves continued substance use despite awareness of physical or psychological problems related to its use.
      x. Tolerance, as defined by either needing increased amounts of the substance to achieve the desired effect or experiencing reduced effect with continued use of the same amount. Tolerance refers to needing more of the substance

to achieve the desired effect or experiencing reduced effects with the same amount.

xi. Withdrawal, as manifested by either characteristic withdrawal syndrome for the substance or using the substance to relieve or avoid withdrawal symptoms - Withdrawal involves experiencing characteristic withdrawal symptoms when substance use is reduced or stopped or using the substance to relieve or avoid withdrawal symptoms.

2. Minimum age of 16 years old; or approval by the Medical Director. A referral to an alternate treatment program/facility will be made for any person under the age of 16 years (Senate Bill 184).
3. Has the ability to understand and voluntarily accept the plan of care.
4. Absence of severe and unstable medical/psychological conditions that would preclude participation in individual or groups processes.
5. Clients shall never be denied access to services at DAS for participating in MAT services and shall be permitted to use their preferred MAT medication if the prescribing provider and the client determine the medication is clinically beneficial.
6. Clients shall not be required to change MAT medications in order to receive treatment services. Clients who wish to continue to receive their preferred MAT medications shall be supported, if the prescribing prescriber and the client determine the medication is clinically beneficial.
7. Clients shall not be compelled to taper, discontinue, decrease dosage, or abstain from medications provided as part of MAT or as a condition of entering or remaining in treatment in any DAS program.
8. Clients shall not be denied access to MAT regardless of their choice to participate in all services offered by the DAS program.
9. Clients shall not be denied access to MAT when clinically appropriate, based on their substance use or misuse.

B. MEDICAL CONDITIONS OF EXCLUSIONS:

1. The following conditions could make the potential client ineligible for admission into the Medication Assisted Treatment Program: buprenorphine due to the increased possibility of complications:
   a. Active infectious cutaneous disease
   b. Unstable angina
   c. Uncontrolled hypertension
   d. History of recurrent seizure disorder within last two years with the last episode within the past week and without anti-seizure medication
   e. Head trauma within past 6 weeks that has not been worked up and cleared by a medical provider.
   f. Significant recent exposure to extreme environmental temperature change
   g. Unstable diabetes mellitus with recent hypoglycemic episodes, diabetic ketoacidosis, blood sugars over 400
   h. Active or chronic homicidal ideation and attempts including violent behavior or threats to staff

i. Methadone dosage of greater than 40 mg a day*.
j. Significant /Severe psychiatric comorbidity rendering client unable to provide informed consent and manage their health care needs independently
k. Active suicide ideation
l. Client experiencing:
    i. Vomiting more than 5 times in 24 hours / unable to keep fluids down
    ii. Labored breathing
    iii. Intractable diarrhea
    iv. Decrease in urination despite adequate hydration

2. The conditions listed above do not automatically disqualify an individual from receiving MAT services, the MAT prescriber will assess each referred individual for medical necessity, access criteria, and appropriateness for MAT services.

**All clients who are using greater than 40 mg of methadone will be referred to a methadone clinic for methadone treatment; high levels of opioid use may be referred to a methadone*

C. PAYMENT FOR WITHDRAWAL MANAGEMENT AND MAT SERVICES
In accordance with the DAS fee policy, all clients will be required to comply with the current cost of the MAT program. The payment will be based on a sliding fee scale according to gross monthly income and family size. Medi-Cal will be accepted per SLOBHD Policy and Procedures.

## V. ADMISSION PROCESS

A. INTAKE

1. After the walk-in has been completed and the DAS clinician and/or case manager has approved the referral, the client will be triaged by the MAT team prescriber (see DAS general policy and procedure for details regarding walk-in clinic process).
2. MAT staff, either prescribers, or their designee shall gather a history of all prescribed, over the counter, and supplemental medications the client is currently taking, including controlled substances using the CURES system (Controlled Substances Utilization Review and Evaluation Systems). The results will guide MAT staff regarding recent prescribed opioids or other medication as related to admission to MAT services: buprenorphine, referral to another provider, or discussion regarding status of medical interventions/pain management.

B. EVIDENCE-BASED ASSESSMENTS:

1. The following evidence-based assessments for severity, withdrawal and cravings were selected by the MAT Treatment Team and Medical Director based on recommendations from DHCS and appropriateness for the treatment programs

and may be used at intake to determine the patient's current state.

a. The Drug Abuse Screening Test (DAST) consists of 10 "Yes/No" questions related to how much and how often an individual uses substance. This instrument shall be used with all substances other than alcohol. (Severity)
b. The Alcohol Use Disorders Identification Test (AUDIT-C) is a screening tool that detects high risk and harmful drinking patterns for alcohol. (Severity)
c. The Prediction of Alcohol Withdrawal Severity Scale (PAWSS) consists of three parts:
    i. The threshold criteria, whether the patient consumed alcohol during the 30 days prior to admission and/or had a positive blood alcohol level on admission, followed by a series of 10 "Yes/No" questions
    ii. Patient interview
    iii. Clinical evidence, assessing risk factors for alcohol withdrawal.
d. The Subjective Opiate Withdrawal Scale (SOWS) is a self-administered scale for rating opioid withdrawal symptoms. (Opioid Withdrawal)
e. Brief Substance Craving Scale is a self-report instrument that assesses cravings for substances over a 24-hour period. (Cravings for Alcohol and Opioids)
f. The process for conducting the assessment shall include, at minimum:
    i. The evidence-based assessment shall be performed by prescriber, medication manager or clinician within twenty-four (24) hours of admission. All clients shall receive the DAST or AUDIT-C to assess for symptom severity which will then indicate if the assessments for cravings and withdrawal also need to be administered.
    ii. If the evidence-based assessments indicate that MAT services could be beneficial for the client, the client shall be scheduled with the prescribing provider within 48 hours of admission. The prescribing provider shall determine if MAT medications are appropriate and prescribe the medications as clinically indicated and in accordance with any relevant program policies and procedures or guidelines.

C. MAT DISCUSSION:

1. The risks, benefits and alternatives of MAT shall be discussed by the prescribing provider at the first medication services appointment. This information shall be presented both by verbal discussion and on a Medication Consent Form that is reviewed and signed by the provider and the client. Details shall include common side effects, risks of combining the medication with other substances and documentation of alternative options for treatment. Information shall be specific to each type of medication prescribed for treatment of a SUD.
2. For those clients who initially decline MAT services, medication mangers, clinicians, and case managers shall revisit the availability of MAT services throughout the duration of care for a client enrolled in services at DAS. A client can be referred or re-referred to the MAT prescribing provider at any time during care for assessment for MAT.

3. The risks, benefits, and alternatives for the use of MAT shall be discussed in detail on the Medication Consent Form and for clients on buprenorphine.
4. All clinical staff, including medication managers, and clinicians, shall be enabled to discuss the availability of MAT services with clients whose substance use (opioids and alcohol) may be appropriate for MAT services. A summary of MAT program parameters (including standard frequency of visits and urine testing) is listed on the Referral Checklist and shall be reviewed with all clients who may be interested in MAT for Opioid Use Disorder (OUD). However, details on the clinical mechanism of action, side effects and the risks, benefits and alternatives for use of MAT are reserved for direct discussion between the prescribing provider and the client.
5. Upon acceptance into MAT services: Buprenorphine program, clients will be advised to cease opioid use immediately in anticipation of starting buprenorphine. Prescribers will send a prescription directly to a pharmacy that carries buprenorphine for the patient and will instruct the patient to pick up the medications. DAS does not store buprenorphine on site but ensures that local pharmacies carry and have buprenorphine available for same-day prescriptions.
6. Should a client present with active opioid use, the client will be offered MAT services comfort medication protocol OR an urgent in-person or telehealth appointment with prescriber for evaluation and treatment to initiate buprenorphine.
7. Admissions for the current week are not available on Fridays unless the client has experience with buprenorphine and/or is currently on MAT.
8. The DAS Assessment Coordinator (AC) /Specialist will be notified of the client's acceptance to the program, if applicable.

D. PROCEDURE FOR TREATMENT WITH BUPRENORPHINE:

1. **To be completed by prescriber or medication manager.**
2. Patients with opioid use disorder are informed about the scientific evidence base, effectiveness, associated risks and benefits, and clinical considerations for treatment with buprenorphine. All patients with opioid use disorder who are not currently receiving medication for opioid use disorder are offered a referral and care coordination for addiction medication services through external partners where treatment with buprenorphine is available. SLO coordinates continuing clinically beneficial treatment with buprenorphine on intake, throughout the admission, and at discharge. This includes the coordination of medication services arranged prior to discharge to ensure that a sufficient supply of buprenorphine is available until the next scheduled follow-up appointment.
    a. Induction appointment starts with a discussion regarding client's commitment to full participation in the program, including cessation of all opioids and participation in group therapy and/or individual counseling (as deemed

necessary due to client's mental health status).
b. Obtain baseline urine screen for drugs of abuse.
c. Obtain a urine pregnancy test for women.
d. Per industry accepted standards, the Clinical Opioid Withdrawal Scale (COWS) will guide induction to buprenorphine therapy. However, the team will also recognize that patients are able to discuss their withdrawal symptoms and can describe how intense they are. We respect and understand that patients know themselves and their symptoms best.
e. COWS scores equal to or great than 12 will be inducted to buprenorphine treatment either in the clinic or patients will be given a short prescription and a home dosing guideline.
f. COWS scores less than 12, the client will be invited to return for re-assessment if they request at the next available appointment or will be given a short prescription and home guideline to start Buprenorphine at home.
g. If client is able to understand risk of precipitated withdrawal, client may be prescribed buprenorphine and provided education on home start.
h. Complete the Health Questionnaire and Medical Conditions Review.
i. Inquire about HIV and Hepatitis C status; refer for testing as appropriate.
j. Assess physical health and recent physical exam and refer as appropriate.
k. Refer for immediate Primary Care intervention for immediate medical need as determined by above assessment.
l. The following forms will be signed by the client and witnessed by the 1V1AT program staff prior to admission to the program (See Appendix):
    i. Client Treatment Agreement
    ii. Pharmacy Consent
    iii. Medication Consent
    iv. Criminal justice release to jail medical staff if client has legal history

E. DOCUMENTATION REQUIREMENTS

1. Health Evaluations: All clients will have their current Health Questionnaire reviewed by the MAT prescriber or medication manager prior to or during the course of treatment in the program. The evaluation will include:
    a. Current health conditions
    b. Current mental status
    c. History of primary health conditions
        i. Clients' physical exam history will be reviewed encouraged and referred to get a physical exam if over 12 months have passed
        ii. Clients with active outstanding medical conditions will be referred for primary care evaluation and treatment
    d. History of mental health conditions

F. MAT SERVICES

1. Medication Consent, signed by both the prescribing provider and the client.

2. Initial Biopsychosocial Assessment completed by the prescribing provider.
3. Medication Services prescriber Progress Notes completed by the prescribing provider.
4. Drug Testing Result Forms performed by a medication manager, case manager, or designated staff.
5. Assessment based on American Society of Addiction Medicine (ASAM) criteria completed by medication manager or clinician.
6. Progress notes, documented by medication manager, clinician, or case manager.

G. CASE MANAGEMENT

1. All MAT clients taking MAT will be offered and encouraged to utilize case management services by either MAT staff or per clinic case managers. The purpose of case management is to create the optimal environment for reaching their goals by supporting a client's needs in addition to recovery support.
2. Although case management and substance use disorder treatment are presented as separate and distinct aspects of the treatment continuum, in reality, they are complementary and, at times thoroughly blended.
3. Case management principles as applied to substance use disorders are as follows:
   a. Case management offers the client a single point of contact with the health and social service systems.
   b. Case management is client-driven and driven by client need.
   c. Case management is grounded in an understanding of clients' experiences and the world they inhabit, the nature of addiction and the problems it causes, and other problems with which clients struggle.
   d. Case management involves advocacy and is community-based.

H. MEDICAL INTERVENTION

1. The following parameters are to be observed for each client in the program:
   a. In the event the client requires immediate or emergency medical care during the withdrawal management process, the MAT staff will make every effort to assist the client in obtaining medical or psychiatric care.
   b. If the client is in distress during clinic hours, the MAT staff will attempt to facilitate linkage with a medical or psychiatric care facility. If the distress occurs outside of clinic hours, the client may leave a message on the staff’s voice mail regarding the distress and their attempts to remedy the situation. A follow-up call will then be carried out as to the disposition of the client's care.
   c. The Medical Director or designee may be asked to determine the client's eligibility to continue with the MAT based on the physical status of the client.

I. DISCHARGE/TRANSFER FROM THE MAT PROGRAM

1. After buprenorphine therapy is completed or stabilized, the client will be encouraged to remain an active treatment client. However, the client may be dis-

enrolled from the MAT program for any of the following reasons, only after the MAT team has met with and discussed the clients' goals:

a. Client completes the MAT program and wishes to be discharged.
b. Client is medically/psychologically unable to continue per previous parameters.
c. Client is absent for multiple appointments without prior notification.
d. Client does not participate in the second assessment appointment to complete Medi-Cal admission process.
e. Client does not attend the required treatment groups on a consistent basis.
f. If Client continues to use illicit drugs as evidenced by two or more positive drug urine testing or by client self-report, then MAT team will discuss their goals to determine if they are in a place where they are ready/willing/able to reduce their substance use. If not, they will be provided harm reduction education and supplies and told they will be able to return to the MAT Program in the future.
g. Client admits or is found to be diverting the medication prescribed. Or client does not test positive for buprenorphine which would indicate the client has not taken their medication as prescribed for two or more drug test results and/or 14 days.
h. All discharges, voluntary or otherwise, will require sending client a Notice of Adverse Beneficiary Determination per BH policy 3.30 Notice of Adverse Benefit Determination

2. No client will be left to experience opioid/suboxone withdrawal when they are involuntarily discharged from the MAT program. The client will be referred toa community provider and given a prescription that will continue their therapy without interruption. If possible, the MAT staff will assist the client in making their appointment to ensure the client leaves the program with continued care in place.

J. PROCEDURES FOR CLIENTS TO ACCESS NARCOTIC TREATMENT PROGRAM (NTP) MEDICATIONS FOR OPIOID USE DISORDER (MOUD), INCLUDING METHADONE.

1. Methadone is not currently provided by the MAT Team or through SLO County DAS Clinics.
2. DAS MAT Team will discuss methadone with a patient upon their request to ensure they understand the risks, benefits and alternatives to methadone and engage in shared decision-making to ensure this is the best treatment option for the patient.
3. If a client requests methadone for MAT, or the prescribing provider on the MAT Treatment team program deems methadone is the best course of treatment, the client shall be referred to the NTP providers in SLO below:
   a. Aegis for Narcotic Treatment Program (NTP) services
      1551 Bishop St STE 520,
      San Luis Obispo, CA 93401.
      Phone: (805) 461-5212

4. Care Coordination with NTP:
    a. DAS Staff will call the NTP program within 24 hours to provide a warm hand-off about the patient who is requesting methadone treatment.
    b. DAS staff will ensure that they have the appropriate releases to discuss the patient's case with the NTP with regards to coordination of access to NTP, sufficient medication, and an understanding of the current follow-up schedule.
    c. SLO County will discuss and ensure transportation support for patients who will need to receive methadone dosing and are enrolled in the DAS program.
    d. DAS will not provide safe storage for methadone take home but will work with the NTP and the patient to ensure that the patient has a safe and secure space in their residence for their take home methadone. SLO will provide any necessary clinical information to the NTP if the patient requests exception to take-home limits.
    e. DAS will continue to have scheduled case coordination calls with the NTP at regular intervals to ensure quality care.
    f. If a DAS patient receiving methadone from an NTP decides to discharge from DAS, DAS staff will make attempts to coordinate ongoing methadone treatment with the NTP for the patient.
    g. Patients will be continued on their choice of MOUD in coordination with the NTP as long as it is clinically appropriate. DAS staff will assess the patient's suitability for MOUD based on clinical guidelines and individual health status and will obtain informed consent, discuss the benefits, risks, and alternatives of MOUD.

## VI. APPENDIX

- Client Handbook: COUNTY OF SAN LUIS OBISPO BEHAVIORAL HEALTH <ca.gov)
- Health Questionnaire: HEALTH QUESTIONNAIRE (ca.gov)
- Entire intake packet: bh-application English 0I 25 2022 bh-application-Spanish 01 25 2022
- MAT Program Treatment Agreement treatment-program-agreement (ca.gov)
- Clinical Opiate Withdrawal Scale (nib.gov)
- CIWAASAM
- SOWS ASAM
- Informational Sheets: Home Buprenorphine Start Patient Guide

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VII. REVISION HISTORY

| Effective/Revision Date: | Sections Revised | Status: Initial/ Revised/Archived Description of Revisions |
|---|---|---|
| November 1997 | Entire Policy | Initial Release |
| August 2001 | Entire Policy | First Revision |
| December 2007 | Entire Policy | Second Revision |
| April 2008 | Entire Policy | Third Revision |
| April 2009 | Entire Policy | Fourth Revision |
| November 2013 | Entire Policy | Fifth Revision |
| December 2015 | Entire Policy | Sixth Revision |
| September 2016 | Entire Policy | Seventh Revision |
| July 2024 | Entire Policy | Eighth Revision |
| | | |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *07/12/2024* |
|---|---|---|
| Approved by: | Star Graber, PhD.<br>Behavioral Health Department Administrator | Date |

| *Signature on file* | | *07/12/2024* |
|---|---|---|
| Approved by: | Siddarth Puri, M.D.<br>Behavioral Health Department Medical Director | Date |

# 7.21 Medication for Addiction Treatment (MAT) Medication

I. PURPOSE

To provide comprehensive medications for addiction and withdrawal management services to empower residents of San Luis Obispo County seeking sustained recovery from substance use disorders. Through our programs, we promote harm reduction strategies, fostering physical and emotional well-being, self-sufficiency, and prosocial behaviors thereby improving both individual and community health.

II. POLICY

To cover prescribing guidelines for MAT including buprenorphine, naltrexone, acamprosate, and disulfiram.

## III. BUPRENORPHINE PRESCRIBING GUIDELINES

A. Information on accessing buprenorphine MAT:
- Standard of Care for Opioid Use Disorder _Medications for Addiction Treatment (MAT) and Medications for Opioid Use Disorder (MOUD) are the accepted standard of care for individuals who have been taking opioids daily, regardless of route, for more than two years and/or to extent of experiencing opioid withdrawal.
- Buprenorphine is used to promote opioid addiction recovery by decreasing/ceasing opioid addiction related symptoms.
- For individuals taking opioids who experience withdrawal symptom when they cease their use, buprenorphine is provided to ease/cease those symptoms.
- If a client had been an opioid user, longer than two years per ASAM level of care, they are offered MAT/MOUD regardless of time opioid free.
- Buprenorphine is used to decrease/cease opioid craving that are severe enough to negatively impact a client's life goals and potential for remaining abstinent from illicit opioids.

B. The following procedures will be followed and are detailed below:
1. Clients shall be scheduled with the prescribing provider for an in-person assessment face-to-face or via telehealth.
2. The prescribing provider shall review and complete the SUD Biopsychosocial, the Buprenorphine Treatment Agreement, the Medication Consent and order baseline labs as appropriate
3. Access to naloxone and overdose prevention education shall be provided to the client.
4. For long-acting injectable buprenorphine, medication shall be delivered to the clinic and administered by the RN.

5. For oral forms of buprenorphine, the prescribing provider shall send the prescription electronically to a pharmacy for direct pick-up by the client. Inductions of buprenorphine may be performed in-office or with detailed home instructions provided by the prescriber.
6. Follow-up appointments shall be scheduled with the client on timelines that are clinically appropriate.
7. Transportation resources shall be provided for clients as needed.

## IV. MAT STAFF WALK-IN SCREENING

A. All clients are admitted to DAS via walk-in screening process-see DAS Policy and Procedure for details:
B. Medication Manager Role
   1. All clients actively or recently using opioids, including buprenorphine, will speak with MAT staff for potential admission to MAT: Buprenorphine program
   2. If client is actively in withdrawal, they will be scheduled to see a prescriber the same day as available
      - If a prescriber is unable to see client in medically timely and appropriate interval, client will be referred to closest or preferred emergency room (ER) or will call DAS Medical Director for potential Quick-Start Buprenorphine with follow-up at the next available appointment.
      - If client referred to ER, efforts will be made to coordinate care with ER staff to facilitate prescribing of appropriate medications, including buprenorphine
   3. If client is under the influence of opioids, they will be provided preliminary education on self-induction and comfort medication protocol
   4. All opioid using clients will be offered and trained on Narcan; will be provided a sample and Kloxxado prescription; or verified that Narcan is in their possession.
   5. All opioid use clients will be offered and trained on using Fentanyl Test Strips (FTS)
   6. Clients that are new to buprenorphine, unknown to MAT staff, have unusual presentation, or the medication manager is uncomfortable with triaging admission, the prescriber will be consulted with prior to scheduling any MAT intervention.

## V. WITHDRAWAL MANAGEMENT AND MAINTENANCE THERAPY

A. Withdrawal Management: Buprenorphine Initiation:
   1. After the client has completed the walk-in process, been assessed as appropriate, and agrees to requirements of MAT services, clients may begin buprenorphine therapy.
      a) Short Acting Opioids: If a client is using a short acting opioid such as heroin or norco and their COWS score is 12 or greater (see index for form), they will be offered buprenorphine therapy.
      b) Long-Acting Opioid: If a client has been taking a methadone dose of 40 mg for equal to or longer than 10 days, has been methadone free for 72 hours or more, and their COWS score is 12 or greater (see index for form), they will be offered

buprenorphine therapy.

c) Fentanyl: If a client is actively using fentanyl, they will be offered either a combination of only comfort medications or buprenorphine and comfort medications. This will be dependent on client presentation, goals, and level of comfort with treatment recommendations.

2. The first prescription of buprenorphine is provided. The lowest possible dosage will be used to achieve desired clinical effect. Factors that contribute to dosage choice include:
   a) length of time addicted to opioids,
   b) past buprenorphine usage and dosing (including illicit use),
   c) route of administration,
   d) street value of daily usage,
   e) other factors as appropriate.
3. Dosages will be based on client current opioid tolerance. Clients will be given no more than 10 days of buprenorphine at one time during buprenorphine initiation, unless specified longer for situation unique to client, prescriber, and/or clinic needs to monitor for:
   a) adverse effects,
   b) for positive efficacy,
   c) to verify client has completed their follow up treatment recommendations
   d) to decrease potential for diversion,
   e) to verify and/or coordinate group participation.

## VI. BUPRENORPHINE INITIATION DOSING GUIDE EXAMPLE:

A. Pre-Administration:
   - Confirm the patient has abstained from opioids for at least 12-24 hours and is experiencing withdrawal symptoms.
   - Ensure the patient is in a comfortable setting with home instructions to initiate buprenorphine.

B. Day 1:
   - Initial Dose: Administer 8 mg of buprenorphine sublingually. This dose may be increased or decreased based on specific client presentation.
   - Observation Period: Wait for 1-2 hours and reassess withdrawal symptoms using the COWS.
   - If symptoms persist or worsen, administer an additional 8 mg.
   - Maximum Dose: Do not exceed 24 mg on the first day.

C. Day 2:
   - Morning Dose: Administer a dose based on the total amount taken on Day 1 (usually 16-24 mg).
   - Titration: Monitor and adjust the dose by 4-8 mg increments as needed, ensuring the patient is comfortable and withdrawal symptoms are managed.
   - Maximum Dose: Do not exceed 32 mg on the second day.

D. Day 3 and Beyond:
   - Stabilization Dose: Adjust the dose based on patient response, typically between 16-

32 mg/day.
- Monitor and Adjust: Continue to monitor for withdrawal symptoms and side effects. Adjust the dose as necessary to maintain comfort and prevent withdrawal or cravings.
- Maximum Dose: Do not exceed 48 mg/day during the maintenance phase.

E. Maintenance Phase
- Target Dose: Most patients stabilize on a dose of 16-32 mg/day. Some may require up to 48 mg/day.

## VII. COMFORT MEDICATION PROTOCOL

A. Rationale: As it has been determined most clients using fentanyl cannot self-induct for a period longer than 24-36 hours, non-opioid medication is offered to assist the client in the up to 7 days wait to safely induct to buprenorphine. As fentanyl using clients will experience severe withdrawal symptoms but are at high risk of precipitated withdrawal should they self-induct prematurely, symptom specific medication are offered.
1. Prescriber will review:
   a) length of time using fentanyl,
   b) past buprenorphine usage and dosing (including illicit use),
   c) route of administration,
   d) street value of daily usage,
   e) other factors as appropriate
2. Prescriber will provide education on current understanding of length of time before self- induction to buprenorphine may safely incur. Prescriber will also provide education on risk of precipitated withdrawal should client take buprenorphine "too early"
3. Prescriber will review comfort medication protocol per client history with use, efficacy, allergies, any other pertinent history: gabapentin, clonidine, ibuprofen, hydroxyzine, loperamide. Other medications the client may request will be reviewed for appropriacy except benzodiazepine class-which will not be prescribed with this protocol. Prescriber will provide education on which medication to take for specific withdrawal symptoms and will encourage client to not take all at once but to wait for appropriate matching of medication to withdrawal symptoms.
4. Prescriber will prescribe the following medications with client per associated symptom relief for 3 days of therapy:
   - Clonidine 0.1 mg take #1 TID #9 (Blood Pressure taken pm)
   - Gabapentin 300 mg #1 TID #9
   - Ibuprofen 800 mg #1 TID #9 pm for pain.
   - Hydroxyzine 25 mg #1-2 pm am and hs #12
   - Loperamide 2 mg #1 up to QID pm for diarrhea
5. Any of above medication already being prescribed will be modified or eliminated from protocol.
6. Client will be educated on self-induction guidelines using self-scoring COWS assessment. Prescriber will review each element of symptoms in COWS scoring and discuss corresponding symptom escalation and appropriate scoring. Client will be

educated that a COWS score above 12 **may** reflect readiness to self-induct to buprenorphine therapy.

7. Prescriber will educate client on use of buprenorphine in small amounts to evaluate if client can safely self-induct. Client will be given following instructions as found on education sheet "Guide For Starting Buprenorphine (Suboxone)"(see Attachment A):
   - "Use your other medications starting on day 2 when your withdrawal symptoms are moderate. Take each medication as needed for symptoms of anxiety: gabapentin, hydroxyzine; restlessness: clonidine, gabapentin; diarrhea: loperamide; headache: ibuprofen- take with food.
8. The Clinical Opioid Withdrawal Scale matches symptoms with level of withdrawal severity. Rate your withdrawal symptoms per matching number.
9. If your total reaches 12 or more, you MAY be ready to take buprenorphine (Suboxone). Following is a guide for starting:
   - Take a small test dose, 2 mg or less.
   - If you feel slightly better after 60-90 minutes, try another small dose, 2 mg or less.
   - If both doses are helping, try 4 mg 60-90 minutes after the 2nd small dose.
   - If 4 mg helps, then you will most likely not go into precipitated withdrawal and may proceed to taking 12 mg twice a day approximately 12 hours apart
   - If you take a small dose and you do not feel better or feel worse, do not take more at this time. Wait for another 12 to 24 hours and try the process again.

**B. <u>Do not rely on number of days since you have last used to start buprenorphine (Suboxone)</u>**

C. BUPRENORPHINE USE IN COMFORT PROTOCOL:
   1. Prescriber will provide very short course of buprenorphine without naloxone, usually 3 days up to 24mg, to allow client to self-induct. Enough buprenorphine will be prescribed to last until clients next MAT appointment.

D. FOLLOW-UP ON COMFORT PROTOCOL:
   1. MAT staff, prescriber or other, will meet with client 3-7 days post comfort protocol initiation to review success or difficulties. Client may meet with a medication manager 2-3 days into protocol initiation should prescriber feel mid-protocol visit would increase success of induction. After client has successfully self-inducted to buprenorphine therapy, client will continue to "Buprenorphine Stabilization Phase" as found below.
   2. Should a client not be successful with self-induction, prescriber will assess need for further intervention such as: additional days of comfort medication and education, referral to methadone therapy, and/or Residential Treatment placement to provide more structure and support for induction. The latter is facilitated through treatment staff and may require re- assessment for level of care recommendation.

## VIII. BUPRENORPHINE MAINTENANCE THERAPY:

A. Rationale: Opioid replacement therapy is offered to all clients assessed at being at high risk for relapse to potentially deadly opioids. A client is at highest risk for death by overdose if opioid naïve and relapse to a full agonist. Replacement therapy is designed to attenuate/alleviate cravings for opioids, allowing the individual to focus on

developing their recovery skills and to lower the risk or likelihood of relapse, overdose, and or death.

B. If a client is opioid naive for longer than two months, they will start with 0.25-0.5 mg and will be titrated up according to clinical response, usual indicator is severity of craving for opioids. At the start of treatment, replacement therapy clients will be seen weekly to gauge clinical response. At weekly intervals, the client's dosage will be increased by an appropriate percentage to their current dose, not to exceed an increase of 16 mg a visit.

## IX. BUPRENORPHINE MAINTENANCE PHASE:

A. The goal of the Maintenance Phase is to prevent emergence of opioid withdrawal symptoms and to suppress the client's cravings for opioids,

B. Once the client is considered in the Maintenance Phase, they will be seen minimally every 30 days by the medication manager and minimally every 90 days by MAT provider. Should a client return to substance use, the frequency of the MAT visit will be increased until restabilized in recovery. Upon graduation from DAS program, the client will be offered continued MAT services unless precluded due to DAS policy. The client will be expected to continue with random urine screens and remain other substance free-including THC and alcohol. After sufficient time has elapsed and client has continued to comply with random urine testing, at the discretion of MAT provider client will be offered at-visit urine screens.

C. Should the client request discontinuation of services, they will be given referrals to outside buprenorphine providers for continued treatment. Once the transfer to an outside provider has been completed, the case may be closed for MAT services.

## X. BUPRENORPHINE STABILIZATION PHASE:

A. When the client experiences no withdrawal symptoms, no uncontrollable opioid cravings, minimal side effects, and is not using additional opioids, then the client's dose can be considered stabilized.

B. The primary goal of Stabilization is to find the minimum dose needed to achieve the desired clinical effect. Withdrawal management clients will have minimal opioid withdrawal symptoms and replacement therapy clients will have craving reduced to manageable levels.

C. The MAT staff will continue to monitor the client and evaluate the client's progress and medical/mental health status during buprenorphine treatment.

D. Monitoring by the MAT staff will consist of assessment of:
   1. Buprenorphine response
   2. Compliance with plan of care
   3. Group attendance, individual counseling, or recovery support services
   4. Cravings
   5. Review of common side effects:
      a) Constipation-less than daily bowel movement:
         i. Treatment with Colace and/or MiraLAX will be initiated.

ii. Should above medication not be sufficient, alternative medications will be offered as covered by insurance
iii. Client will be provided education on food and fluid recommendations to prevent constipation

b) Urinary hesitancy
i. Alleviated only by dose decrease

c) Sexual dysfunction
ii. If male, referred for evaluation and treatment of low testosterone level as long-term opioid use, including buprenorphine, may result in lower-than-normal testosterone level
iii. If female, refer to pcp and/or women's health for evaluation and treatment.

E. The MAT staff will work in conjunction with the appropriate DAS treatment staff to monitor the clients' compliance with their respective programs. When stabilized, frequency of visits will be dictated by participation in treatment, urine screen results, and attendance of MAT appointments. Substance use urine testing, including buprenorphine, is performed at treatment appropriate intervals using dip test. This allows the immediate option of discussing the results with the client. The medication manager is responsible for monitoring random urine screen results and communicating unfavorable results to prescriber. Breathalyzer is used as clinically appropriate.

## XI. BUPRENORPHINE TAPERING/DISCONTINUATION PROCESS:

A. TAPER
1. A taper should only be considered once a successful treatment period is completed and agreed upon by provider and client, when a client has demonstrated nonadherence to medication, or when a client requests a taper. Buprenorphine treatment is designed to suppress cravings and withdrawal so a client can have the opportunity to make changes in behavior, routine, living situation and thinking without chronic and often debilitating cravings. If this is not done first, the taper will likely be shortly followed by relapse and return to opioid use.
2. The purpose of a taper is to gradually reduce tolerance, thus minimizing withdrawal symptoms. This slow process minimizes the discomfort experienced on any single day. Every client's taper will be individualized according to their needs, desires, and tolerance. The taper will be adjusted to the body's ability to adapt to each decrease, as measured by opioid withdrawal symptoms. Dose decreases of 25% separated by at least 10 days, or 2 mg per 7 days are examples of tolerable taper schedules.
3. Starting from greater than 8 mg, given the half-life of buprenorphine, a 2 mg per 7-14 days taper of often tolerated. Between 8 and 4 mg, a dosage decrease of 1 mg per 7-14 days is scheduled depending on client urgency to discontinue therapy. When dosage is 2 mg, the taper schedule is even more individualized per client tolerance of discomfort with a dose decrease of 0.5 mg per 7-14 days. At 0.25 to 0.5 mg the last step in tapering, if needed, is to add hours to the time of day taken until 72 hours is reached. By 72 hours after last minimal buprenorphine dose if the client is withdrawal symptom free, they will most likely remain as thus. If withdrawal symptoms emerge and are not tolerable, take 0.5 mg to 1 mg and wait another 72

hours; repeat this process until all symptoms are resolved.

B. PROTRACTED WITHDRAWAL
   1. As defined by SAMHSA, a protracted withdrawal is strictly defined as the presence of substance-specific signs and symptoms common to acute withdrawal but persisting beyond the generally expected acute withdrawal timeframes. A broader definition of protracted withdrawal is defined as experiencing of the above symptoms and of non-substance-specific signs and symptoms that persist, evolve, or appear well past the expected timeframe for acute withdrawal. This includes the cessation of buprenorphine as daily opioid replacement therapy. Education should be provided to the client who intends to, or has already, tapered off buprenorphine therapy. MAT staff will improve the client's chances for long-term recovery by normalizing the probability of experiencing protracted withdrawal and help them develop realistic attitudes toward recovery.
   2. Symptoms of protracted withdrawal include:
      a) Anhedonia/decreased ability to experience pleasure*
      b) Anxiety*
      c) Dysphoria (i.e., feeling down or emotionally blunted)*
      d) Insomnia
      e) Fatigue
      f) Difficulty concentrating
      g) Impaired executive control (e.g., impulse control, solving problems)
      h) Cravings

         *very high frequency
   3. The MAT staff will support a client's recovery process by offering support and understanding, monitoring them regularly, and intervening early when a client appears to be heading for relapse.
   4. Interventions include:
      a) Assess for co-occurring disorders and either provide direct psychiatric services or refer for care.
      b) Ask about sleep problems; make a differential diagnosis to determine whether a client's sleep problems likely stem from protracted withdrawal or are the result of other causes.
      c) Prescribe medications as needed to control symptoms past the acute withdrawal stage
      d) Advise clients to be active; physical and mental exercises, which improve sleep, promote positive emotional states, reduce stress and nervousness, help clients avoid triggers, and distract clients' attention from symptoms.
      e) Advise clients to be patient; healing can be slow but progresses every day of recovery.
      f) Encourage clients to join mutual support groups and increase healthy social interactions.

## XII. NALTREXONE PRESCRIBING GUIDELINES:

A. Naltrexone, an FDA-approved opioid antagonist, will be used to treat clients with

alcohol use disorder and opioid use disorder under a defined set of policies and procedures to ensure safety, efficacy, and compliance with medical standards. Providers will select an individualized approach for planning therapy based on medical history and physical exam findings.

B. Providers will apply best practices when treating and monitoring patients with opioid or alcohol use disorders with naltrexone. Naltrexone is indicated for patients who do not want to be on any opioids. Providers are not required to have an x-waiver to prescribe naltrexone LAI, and patients will not experience withdrawal symptoms on discontinuation of the medication.
   1. Patient has been opioid free for at least seven days from short-acting opioids and fourteen days from long-acting opioids
      - Naltrexone is contraindicated in anyone who has taken opioids over the past week, who is likely to require opioid pharmacotherapy, or who is actively in opioid withdrawal. Naltrexone can be prescribed if the patient has been verified, by self-report and CURES collateral and, if available, toxicology, to be free from short acting opioids (such as morphine, oxycodone, hydrocodone, and hydromorphone) for at least seven days, extended release opioids (such as morphine sulfate extended-release or oxycodone extended-release) for at least ten days, and long-acting opioids (such as methadone and buprenorphine) for at least 14 days.
   2. Patient has failed or has contraindications to buprenorphine containing regimen (buprenorphine or buprenorphine/naloxone), such as an allergic reaction, worsened opioid use while taking buprenorphine, or history of significant diversion or non-adherence to buprenorphine
      - Relative contraindications for naltrexone LAI include BMI >40 (injection unable to reach gluteal muscle) and severe coagulopathy or thrombocytopenia (risk of injection site hematoma).

**C. Oral Naltrexone**
   1. Pre-Administration:
      - Ensure the patient is not currently using opioids.
      - Obtain a thorough patient history and conduct a liver function test within the first 6 months of initiation. It is not required to initiate Naltrexone.
   2. Initial Dose:
      - Day 1: Administer 25 mg of oral naltrexone.
   3. Subsequent Doses:
      - If no adverse reactions occur, administer 50 mg daily starting on Day 2.
      - Continue with a daily dose of 50 mg.

**D. Extended-Release Naltrexone (Vivitrol)**
   1. Pre-Administration: Provider will order Vivitrol through a pharmacy that will deliver the medication to the DAS Clinic:
      - Ensure the patient has been opioid-free for at least 7-10 days if there's a history of opioid use.
      - Confirm the absence of opioids via a urine toxicology screen, if clinically appropriate.
   2. Initial Dose:

- Administer a 380 mg injection of extended-release naltrexone intramuscularly into alternating gluteal muscles once every 4 weeks (28 days).
- A licensed nurse or provider administers the IM dorso gluteal injection in clinic in a sterile approach and monitors the patient for 10 minutes after the injection for any adverse effects.
- A return appointment for repeat injection in the contralateral gluteus should be scheduled 1 month afterwards.

## XIII. DISULFIRAM (ANTABUSE):

A. Disulfiram is an FDA-approved medication used to support the treatment of alcohol use disorder by producing an acute sensitivity to ethanol. It acts as a deterrent to drinking by causing unpleasant effects when alcohol is consumed. Disulfiram inhibits the enzyme acetaldehyde dehydrogenase, leading to an accumulation of acetaldehyde when alcohol is consumed. This causes unpleasant effects such as flushing, nausea, vomiting, and headaches, discouraging the patient from drinking alcohol. Before prescribing this, the provider will ensure that the patient meets the indications for use including alcohol use disorder. The provider will ensure there are no current absolute contraindications:
   - Concurrent use of alcohol or metronidazole.
   - Severe myocardial disease or coronary occlusion.
   - Hypersensitivity to disulfiram or any of its components.
   - Psychosis.

B. Or any relative contraindications:
   - Diabetes mellitus, epilepsy, thyroid disorders.
   - Hepatic cirrhosis or insufficiency.
   - Severe renal impairment.

C. Pre-Administration:
   1. Confirm that the patient has abstained from alcohol for at least 12 hours.
   2. Conduct a thorough patient history and baseline liver function test that should be completed within the first 3 months.

D. Initial dose:
   1. Day 1: Administer 250 mg of disulfiram orally once daily for 1-2 weeks

E. Maintenance Dose:
   1. After the initial period, continue the dose of 250 mg to increase to 500 mg if necessary.

F. Prescriptions will be sent to the patients preferred pharmacy. Note that Disulfiram has shown to be most effective when the medication has been observed when taken. Disulfiram should be taken in the morning. If it causes drowsiness, it may be taken in the evening.

G. Providers will share the following information with patients:
   1. Medication Adherence: Take Antabuse exactly as prescribed. Do not stop taking it without consulting your healthcare provider.
   2. Avoid Alcohol: Do not consume alcohol in any form, including in sauces, vinegars, and medications containing alcohol.

3. Reaction with Alcohol: Drinking alcohol while on Antabuse will cause severe reactions including flushing, nausea, vomiting, chest pain, dizziness, and headache.
4. Dietary and Lifestyle Restrictions: Be aware of hidden alcohol in foods, beverages, and other products like cough syrups, tonics, and mouthwashes.
5. Side Effects: Common side effects include drowsiness, tiredness, headache, acne, and metallic/garlic-like taste in the mouth. Serious side effects include liver problems (yellowing skin/eyes, dark urine), vision changes, mood/mental changes, and numbness/tingling of arms/legs.

H. Monitoring and Follow-Up:
1. Regular Check-Ups:
- Schedule regular follow-up appointments to monitor the patient's progress, adherence, and side effects.
- Liver Function Tests:
- Perform baseline and periodic liver function tests due to the risk of hepatotoxicity.

## XIV. ACAMPROSATE:

A. Acamprosate (Campral) is an FDA-approved medication used to help individuals with alcohol use disorder maintain abstinence from alcohol. It is believed to work by restoring the balance of neurotransmitters in the brain that are disrupted by chronic alcohol use. Acamprosate does not prevent withdrawal symptoms but helps reduce cravings for alcohol and supports abstinence. Before prescribing Acamprosate, the provider will ensure that the patient has no clear contraindications:
- Hypersensitivity: Patients with known hypersensitivity to acamprosate or any of its components should not be prescribed this medication.
- Severe Renal Impairment: Acamprosate is contraindicated in patients with severe renal impairment (creatinine clearance :S 30 mL/min).
- Pregnancy and Lactation: Acamprosate should be used with caution in pregnant or breastfeeding women due to limited data on safety in these populations.

B. The provider will follow the following dosing guide: The recommended dose for adults is 666 mg (two 333 mg tablets) taken three times daily.
C. Initial Dose:
1. Day 1: Administer 666 mg (two 333 mg tablets) orally three times daily
2. Maintenance Dose: Continue with 666 mg three times daily.
3. Adjust the dose in patients with moderate renal impairment (creatinine clearance 30- 50 mL/min) to 333 mg three times daily. Avoid use in patients with severe renal impairment (creatinine clearance <30 mL/min).
4. Administration: Acamprosate should be taken orally with or without food. It is essential that patients start acamprosate treatment as soon as possible after achieving abstinence from alcohol and maintain treatment even if a relapse occurs.

D. Providers will share the following information with patients:

1. Acamprosate helps reduce the desire to drink alcohol and supports maintaining abstinence. Possible Side Effects: Include diarrhea, nausea, depression, and anxiety.
2. Adherence to Therapy:
   a. It is crucial for patients to take acamprosate regularly as prescribed, even if they feel better or believe they no longer need the medication.
   b. Missing doses can reduce the effectiveness of the treatment.
3. Alcohol Consumption:
   a) Patients should be advised that acamprosate is not a cure for alcohol dependence and should be used as part of a comprehensive treatment plan that includes abstaining from alcohol.
   b) Patients should avoid consuming alcohol while taking acamprosate. Pregnancy and Breastfeeding:
   c) Women who are pregnant, planning to become pregnant, or breastfeeding should discuss the risks and benefits of acamprosate with their healthcare provider.

E. Monitoring and Follow-Up:
- Initial Assessment: Perform a comprehensive assessment of the patient's medical history, and renal function.
- Regular Monitoring: Schedule follow-up visits to monitor the patient's adherence tothe medication, assess for side effects, and evaluate the effectiveness of the treatment. Periodic renal function tests may be necessary for patients with renal impairment.

## XV. STORAGE AND MANAGEMENT OF MEDICATION AT DAS CLINICS

A. Policy: The storage and management of medication at DAS clinics will be conducted in a secure and compliant manner to ensure patient safety and regulatory adherence. Only authorized MAT staff will handle and administer medications. This policy applies to all DAS clinics and staff involved in the storage, handling, and administration of medications, specifically injectable MAT medications such as Vivitrol, Sublocade, and Brixadi.

B. Medication Storage:
1. Medication Rooms:
   - Each of the four DAS clinics has a designated medication room.
   - Access to these rooms is restricted to MAT staff only.
   - MAT staff are issued keys to the medication rooms, ensuring controlled access.
2. Security Measures:
   - Medication rooms feature double-lock security:
   - A locked refrigerator is situated behind a locked door.
   - Injectable MAT medications (Vivitrol, Sublocade, Brixadi) are stored in these secure rooms.

C. Medication Delivery and Handling:
1. Pharmacy Coordination:

- When a patient is prescribed an injectable MAT, DAS staff coordinate with a partnering pharmacy.
- The pharmacy delivers the medication to the clinic, where it is securely stored until the patient arrives.

2. Tracking and Logging:
   a) Upon delivery, DAS staff log the following details:
      - Name of the medication
      - Lot number
      - Expiration date
      - Date of administration
      - A second staff signature for compliance verification

D. Medication Administration:
   1. Licensed Providers: Injections are administered by a licensed provider, which may include
      - Medical Doctor (MD)
      - Nurse Practitioner (NP)
      - Registered Nurse (RN)
      - Licensed Psychiatric Technician (LPT)
   2. Administration Guidelines: Medications are administered per the insert guidelines to ensure proper dosage and safety.

E. Monitoring and Compliance:
   1. Monthly Audits:
      a) Medication rooms are audited monthly by an independent pharmacy contractor.
      b) Audits ensure that:
         - Medications are not expired.
         - Medications are appropriately stored.
         - Administration logs are accurate and up to date.

F. Medication Disposal:
   1. Expired Medications: If a patient does not show up for an appointment and the medications expire, disposal procedures are followed.
   2. Disposal Procedure:
      a) Patient's medications supplied by prescription which have been expired or discontinued by the prescriber or and those which remain in the facility after discharge of the patient, shall be destroyed by the facility in the following manner:
         i. Medications listed in Schedules II, III, and IV of the Federal Comprehensive Drug Abuse prevention and Control Act of 1970, Title 21, United States Code, Section 801 et. Seq. shall be destroyed as scheduled by facility licensed medical staff in the presence of a pharmacist and a licensed registered nurse employed by the facility.
         ii. The name of the patient (if applicable), the name and strength of the medication, the prescription number (if applicable), the amount destroyed, the date of destruction and the signature of the witnesses

required above shall be recorded on the Medication Disposal Log (Controlled Substance) (Attachment B).

iii. If the medications were received from Outpatient Clinic for destruction, the source will be identified on the log form. Signature will be obtained from the outpatient licensed medical staff and be counted as one of the two (2) licensed medical staff logging the medication in and by placing medication(s) into a numbered bag.

iv. Such log shall be retained for at least three years and kept in a binder in the Medication Room.

b) Medications not listed under Schedules II, III, and IV of the above

i. Shall be destroyed as scheduled by licensed medical staff in the presence of a pharmacist or another licensed medical staff.

ii. The name of the patient (if applicable), the name and strength of the medication, the prescription number (if applicable), the amount destroyed, the date of destruction and the signature of the person named above, and one other person shall be recorded on the medication disposal log (non-controlled substance) (Attachment C).

iii. Such log shall be retained for at least three years and kept in a binder in the medication room.

c) Destruction of expired or unused medications will utilize an FDA-approved drug disposal system that meets DEA non-Retrievable standard, irreversible and eco- friendly.

i. Injectable medications may include LAI that come with separate syringes and vials of medications that will need to be reconstituted or preloaded syringes.

ii. If these medications need to be disposed of, they will follow the instructions above.

iii. If there are preloaded syringes, they will be disposed of in the sharps container.

iv. If there is a separate syringe and medication vial, the syringe will be disposed of in the sharps container and the vial will follow instructions above to be placed in an FDA-approved drug disposal system that meets DEA non-Retrievable standard, irreversible and eco-friendly.

## XVI. MEDICATION DISPOSAL PROCEDURE FOR UNIDENTIFIED SUBSTANCES LEFT AT DAS

A. Staff will follow these procedures when unidentified pills or substances found/left at DAS require disposal and safe and secure monitoring:

1. Identify and secure MAT or unidentified substance:

a) When unidentified substances are discovered left behind by patients at the substance use clinic, staff will immediately secure the items.

b) Staff will equip themselves with gloves, or other necessary PPE before interacting with the substance.

c) Staff members will place the unidentified substances in a designated

locked safe located in a secure closet within the clinic premises, including FDA-approved drug disposal system that meets DEA non-Retrievable standard, irreversible and eco-friendly, which can also be used to dispose of illicit substances.

2. Safe Storage and Access
   a) Access to the locked container containing the unidentified substances will be restricted to authorized MAT staff only and those with the appropriate key for the medication room.
3. Notification of Law Enforcement
   a) Upon discovery and secure storage of the unidentified substances, designated administrative staff will promptly contact local law enforcement on the same day.
   b) Staff will inform law enforcement that a patient has left unidentified substances behind at the clinic and request immediate pickup and disposal by authorized authorities.
4. Documentation and Record-Keeping
   a) All incidents involving the discovery, storage, and disposal of unidentified substances will be documented in the clinic's records.
   b) Documentation will include details such as the type and quantity of substances, date and time of discovery, actions taken, and communication with law enforcement.
5. Compliance and Legal Consideration
   a) This medication disposal policy complies with all relevant federal, state, and local laws and regulations pertaining to the handling and disposal of controlled substances.
   b) The clinic will maintain adherence to established protocols and guidelines for the safe handling and disposal of medications and substances left behind by patients.
6. Staff Training and Awareness
   a) All clinic staff members will receive training and education on the proper procedures for handling and disposing of medications and substances left behind by patients.
   b) Training will emphasize the importance of maintaining security and confidentiality in the handling of unidentified substances to ensure compliance and safety.

## XVII. OUTPATIENT WITHDRAWAL MANAGEMENT FOR ALCOHOL USE DISORDER:

A. Management of Alcohol Withdrawal in Ambulatory Settings:

**1. STEP I:**

a) Diagnose and determine severity of alcohol withdrawal syndrome in patients with clinically significant alcohol consumption where the patient is currently experiencing, or likely to experience, alcohol withdrawal syndrome. If unfamiliar with evaluating alcohol withdrawal (see the Attachment D and Attachment E). A formal SAWS or CIWA does not need to be administered or

completed prior to offering patients alcohol / sedative withdrawal management if mild to moderate withdrawal is confirmed by the clinical history.

b) The clinical interview should assess for the quantity of alcohol intake, duration of alcohol use, time since last drink, previous episodes of alcohol withdrawals including medical complication from those withdrawal episodes, presence of concurrent medical or psychiatric conditions, and use of other intoxicants. The physical exam should assess for complicating medical conditions, including arrhythmias, congestive heart failure, coronary artery disease, gastrointestinal bleeding, infections, liver disease, nervous system impairment, and pancreatitis.

c) These are the indications to refer patients to the emergency room for a higher level of care:
   - History of delirium tremens or withdrawal seizures
   - Acute illness
   - Severe cognitive impairment (acute or chronic) that prevents ability of patient to take medications or follow instructions
   - Inability to take oral medications because of vomiting or swallowing issues
   - Serious psychiatric condition requiring a higher level of care
   - Pregnancy - unless directed by high-risk obstetrics team
   - Severe alcohol withdrawal symptoms (SAWS > 16 or CIWA-Ar ≥20 if using scales)
   - **If any of the above are present, refer to the nearest emergency room for a higher level of care.**

2. **STEP 2:**
   a) Order the following labs at the same time medication (Step 3) is started:
      - Urine drug screen (Urine Drug Toxicology Screen), based on clinical judgment.
      - Complete blood count (CBC), based on clinical judgment.
      - Comprehensive metabolic panel (CMP), based on clinical judgment
   b) Do not hold medications for the results of these tests unless there is a history of or obvious signs of renal compromise (for gabapentin) or liver compromise (for carbamazepine) where the expected findings would change management.
   c) Patients who are found to have profound derangements in laboratory studies should be considered for a higher level of medical care.

3. **STEP 3:**
   a) Initiate pharmacotherapy for alcohol withdrawal
   b) Gabapentin is the first line agent; carbamazepine can be used in patients who experience gabapentin- induced sedation, dizziness, edema, or GI intolerance.
   c) Escalate to a higher level of care if the patient has worsening withdrawal

symptoms despite gabapentin treatment.

d) Gabapentin is renally cleared so avoid if CrCl is ≤30 mL/minute and dose adjusted if CrCl is ≤ 60 mL/min.

e) Patients in alcohol withdrawal without adequate dietary intake should be prescribed thiamine 100mg daily and folate 1mg daily for ≥ 30 days to diminish the likelihood of developing encephalopathy.

f) Gabapentin is dosed as 600mg PO TID plus an additional 600mg pm once daily for the first week, followed by a 300mg taper after the first week.

g)

| DAYS | Gababentin Monotherapy (fixed schedule dosing) |
|---|---|
| 1 | |
| 2-7 | 600mg TID plus 600mg x1 PRN |
| 8 | 300mg TID |
| 9 | 300mg BID |
| 10 | 300mg qHS |

h) How to write the gabapentin prescription:

- Rx: Gabapentin 600mg tabs, take as directed, #30, NR Verbalized or printed instructions for the patient:
  - Day 1: Take 2 tabs twice daily plus an additional 2 tabs if needed the first day
  - Days 2-7: Take 1 tab three times daily plus an additional 1 tabs if needed
  - Day 8: Take½ tab three times daily
  - Day 9: Take ½ tab twice daily
  - Day 10: Take½ tab once at bedtime

4. In patients who do not tolerate gabapentin:

a) Carbamazepine is dosed 200mg PO QID x 3 days followed by a 200mg reduction every 3 days

b)

| DAYS | Carbamazepine Monotherapy (fixed schedule dosing) |
|---|---|
| 1-3 | 200mg QID |
| 4-6 | 200mg TID |
| 7-9 | 200mg BID |
| 10-11 | 200mg qHS |

c) How to write the carbamazepine prescription:

- Rx Carbamazepine 200mg tabs, take 1 QID x3d, then 1 TIDx3d, then 1 BID x3d, then 1 qHS x3d, #30, NR
  - Verbalized or printed instructions for the patient:
  - Days 1-3: Take 1 four times throughout the day
  - Days 4-6: Take 1 three times throughout the day

  - Days 7-9: Take 1 twice a day
  - Days 10-11: Take 1 at bedtime
- Monitor for gabapentin / carbamazepine intolerance.
- Patients should be monitored based on symptom severity and patient factors (support-system, availability of transportation).
- Whether the patient should follow up over the phone or in person is left to the provider's discretion based upon what is both clinically appropriate and feasible.
- Symptoms should resolve within seven days of abstinence from alcohol.
- Development of seizures, altered sensorium, or worsening of symptoms are indications for referral to a higher level of care.

**B. Benzodiazepines**

1. Despite their proven usefulness in the management of alcohol withdrawal seizures and delirium tremens, the use of benzodiazepines for alcohol withdrawal in ambulatory settings is fraught with potential complications, which include high risk of the medication being diverted, high risk of benzodiazepines being taken by the patient in ways other than as prescribed, blunted cognition, respiratory and cognitive interactions with other central nervous system depressants such as alcohol, increased alcohol cravings, and psychomotor retardation including ataxia.
2. If a provider determines that the benefits of benzodiazepine treatment for alcohol withdrawal syndrome outweigh these risks for specific patients in the ambulatory setting, this risk- benefit analysis must be documented and a fixed dose (not symptom triggered) regimen of a long-acting benzodiazepine should be prescribed, and the patient should be assessed daily for response.
3. **STEP 4:** Treat alcohol use disorder concurrently with medications for withdrawal management.
4. **STEP 5:** Engage patient in specialty SUD Services including a follow-up appointment within 24 hours to determine if patient's withdrawal symptoms are controlled on the prescribed medications.

## XVIII. ATTACHMENT(S)

A. Guide for starting buprenorphine (suboxone)
B. Medication disposal log (controlled substance)
C. Medication disposal log (non-controlled substance)
D. SAWS - Outpatient withdrawal management for alcohol use disorder:
E. CIWA - Clinical institute withdrawal assessment for alcohol, revised (ciwa-ar)

## XIX. REVISION HISTORY

| Effective/Revision Date: | Sections Revised | Status: Initial/ Revised/Archived Description of Revisions |
|---|---|---|
| November 1997 | Entire Policy | Initial Release |
| August 2001 | Entire Policy | First Revision |
| December 2007 | Entire Policy | Second Revision |
| April 2008 | Entire Policy | Third Revision |
| April 2009 | Entire Policy | Fourth Revision |
| November 2013 | Entire Policy | Fifth Revision |
| December 2015 | Entire Policy | Sixth Revision |
| September 2016 | Entire Policy | Seventh Revision |
| July 2024 | Entire Policy | Eighth Revision |
| | | |
| Prior Approval dates: | | |
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| | | |
|---|---|---|
| *Signature on file* | | *07/12/2024* |
| Approved by: | Star Graber, PhD.<br>Behavioral Health Department Administrator | Date |

| | | |
|---|---|---|
| *Signature on file* | | *07/12/2024* |
| Approved by: | Siddarth Puri, M.D.<br>Behavioral Health Department Medical Director | Date |

**San Luis Obispo County Mental Health**
**Medication Disposal Log (Controlled Substances)**

ATTACHMENT B

| Date Logged In | Patient Name (if applicable) | Lot # /Expiration Date | Medication/ Strength/ Prescription # | # of Pills | Signature Licensed Medical Staff | Signature Licensed Medical Staff | Date Disposed | Signature Licensed Medical Staff | Signature Registered Nurse or Registered Pharmacist |
|---|---|---|---|---|---|---|---|---|---|
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- ✓ If Meds are returned to the patient, document on the log form under Medication/Strength Column.
- ✓ Outpatient staff bringing meds to be disposed of shall empty the meds into the medication disposal bin witnessed by the Registered nurse or pharmacist.

**San Luis Obispo County Mental Health**

**Medication Disposal Log (Non-Controlled Substances)**

ATTACHMENT C

| Date Logged In | Patient Name (if applicable) | Lot # /Expiration Date | Name of Medication/ Strength/ Prescription # | # of Pills | Signature # 1 Licensed Medical Staff | Signature # 2 Licensed Medical Staff | Date Disposed | Signature # 1 Licensed Medical Staff | Signature #2 Licensed Medical Staff |
|---|---|---|---|---|---|---|---|---|---|
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- ✓ If Meds are returned to the patient, document on the log form under Medication/Strength Column.
- ✓ Outpatient staff bringing meds to be disposed of shall empty the meds into the medication disposal bin witnessed by a second Licensed Medical Staff, Registered nurse or Pharmacist.

ATTACHMENT D

# SAWS

## (Short Alcohol Withdrawal Scale)

## OUTPATIENT WITHDRAWAL MANAGEMENT FOR ALCOHOL USE DISORDER

- SAWS (see below) is a patient-administered questionnaire wit 10 items. It can be administered over the phone.
  - < 12 points indicates mild withdrawal
  - ≥12 points indicates moderate to severe withdrawal.
  - >16 points indicates severe withdrawal*
- CIWA-Ar (see below) is a clinician-administered scale with 10 items.
  - 10-15 points indicates mild withdrawal
  - 16-20 points indicates moderate withdrawal
  - >20 points indicates severe withdrawal*

| Item | None (0 points) | Mild (1 point) | Moderate (2 points) | Severe (3 points) |
|---|---|---|---|---|
| Anxious | | | | |
| Feeling confused | | | | |
| Restless | | | | |
| Miserable | | | | |
| Memory problems | | | | |
| Tremor (shakes) | | | | |
| Nausea | | | | |
| Heart pounding | | | | |
| Sleep disturbance | | | | |
| Sweating | | | | |

ATTACHMENT E

# Clinical Insitutue Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ Blood pressure:_____

**NAUSEA AND VOMITING** — Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

**TREMOR** — Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

**PAROXYSMAL SWEATS** — Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

**ANXIETY** — Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

**AGITATION** — Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

**TACTILE DISTURBANCES** — Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning ornumbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

**AUDITORY DISTURBANCES** — Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

**VISUAL DISTURBANCES** — Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

**HEADACHE, FULLNESS IN HEAD** — Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 no present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

**ORIENTATION AND CLOUDING OF SENSORIUM** — Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person




Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction* 84:1353-1357, 1989.

Patients scoring less than 10 do not usually need additional medication for withdrawal.

Total CIWA-Ar Score _____

Rater's Initials _____

Maximum Possible Score 67

# ADDICTION MEDICINE ESSENTIALS

## Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Many quantification instruments have been developed for monitoring alcohol withdrawal (Guthrie, 1989; Sullivan et al, 1989; Sellers and Naranjo, 1983). No single instrument is significantly superior to the others. What is clear is that there are significant clinical advantages to quantifying the alcohol withdrawal syndrome. Quantification is key to preventing excess morbidity and mortality in a group of patients who are at risk for alcohol withdrawal. Such instruments help clinical personnel recognize the process of withdrawal before it progresses to more advanced stages, such as *delirium tremens*. By intervening with appropriate pharmacotherapy in those patients who require it, while sparing the majority of patients whose syndromes do not progress to that point, the clinician can prevent over- and undertreatment of the alcohol withdrawal syndrome. Finally, by quantifying and monitoring the withdrawal process, the treatment regimen can be modified as needed.

The best known and most extensively studied scale is the Clinical Institute Withdrawal Assessment - Alcohol (CIWA-A) and a shortened version, the CIWA-A revised (CIWA-Ar). This scale has well-documented reliability, reproducibility and validity, based on comparison to ratings by expert clinicians (Knott, et al, 1981; Wiehl, et al 1994; Sullivan, et al, 1989). From 30 signs and symptoms, the scale has been carefully refined to a list of 10 signs and symptoms in the CIWA-Ar (Wiehl, et al, 1994). It is thus easy to use and has been shown to be feasible to use in a variety of clinical settings, including detoxification units (Naranjo, et al, 1983; Hoey, et al, 1994), psychiatry units (Heinala, et al, 1990), and general medical/surgical wards (Young, et al, 1987; Katta, 1991). The CIWA-Ar has added usefulness because high scores, in addition to indicating severe withdrawal, are also predictive of the development of seizures and delirium (Naranjo, et al, 1983; Young, et al, 1987).

The CIWA-Ar scale can measure 10 symptoms. Scores of less than 8 to 10 indicate minimal to mild withdrawal. Scores of 8 to 15 indicate moderate withdrawal (marked autonomic arousal); and scores of 15 or more indicate severe withdrawal (impending *delirium tremens*). The assessment requires 2 minutes to perform (Sullivan, et al, 1989).

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CIWA-Ar categories, with the range of scores in each category, are as follows:

| | |
|---|---|
| Agitation | (0-7) |
| Anxiety | (0-7) |
| Auditory disturbances | (0-7) |
| Clouding of Sensorium | (0-4) |
| Headache | (0-7) |
| Nausea/Vomiting | (0-7) |
| Paroxysmal Sweats | (0-7) |
| Tactile disturbances | (0-7) |
| Tremor | (0-7) |
| Visual disturbances | (0-7) |

The instrument also has been adapted for benzodiazepine withdrawal assessment (Clinical Institute Withdrawal Assessment-Benzodiazepine).

A study of the revised version of the CIWA predicted that those with a score of >15 were at increased risk for severe alcohol withdrawal (RR 3.72;95% confidence interval 2.85-4.85); the higher the score, the greater the risk. Some patients (6.4%) still suffered complications, despite low scores, if left untreated (Foy, et al, 1988).



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# 7.22 Withdrawl Managment

I. PURPOSE

The goal of the Medication for Addiction Treatment (MAT) Team is to provide tailored medication interventions aimed at minimizing the adverse effects of ongoing substance use on individuals and the community. Our objective is to support individuals in achieving sustained health and well-being by promoting harm reduction strategies and facilitating the path towards abstinence from substances. SLO DAS provides outpatient withdrawal management services (detox) and MAT services in an office setting by trained clinicians who provide medically supervised evaluations, withdrawal management, and referral services according to a predetermined schedule. SLO DAS will provide a structured and safe approach for managing withdrawal symptoms in individuals with substance use disorders.

II. POLICY

To provide comprehensive medications for addiction and withdrawal management services to empower residents of San Luis Obispo County seeking sustained recovery from substance use disorders. Through our programs, we promote harm reduction strategies, fostering physical and emotional well-being, self-sufficiency, and prosocial behaviors thereby improving both individual and community health.

## III. AMBULATORY WITHDRAWAL MANAGEMENT (WM):

A. Withdrawal Management, also known as detoxification, is a set of treatment interventions aimed at managing acute intoxication and withdrawal from alcohol and other substances. The goal of WM is to provide the appropriate level of support to allow the person served safety during the withdrawal period, which then allows the person served and provider to work together to determine the optimal ongoing treatment strategy. While WM may be an opportunity to initiate lasting abstinence from alcohol and/or other drugs, the primary goal is to minimize the health risks associated with withdrawal, not long-term abstinence. As such, WM should not be withheld from persons served due to provider uncertainty about their commitment to long-term abstinence.
B. All SUD persons served, particularly those with alcohol and opioid use disorders, should be considered for WM and be offered access to these essential treatment services. WM alone does not constitute adequate treatment for addiction but will increase the likelihood that a person served will complete withdrawal successfully in order to transition to the next stage in the recovery treatment process. Person served who receive WM should be connected with ongoing treatment services. Persons served who are eligible for both residential services and WM services are monitored during the detoxification process.

C. Additionally, the person served shall be provided medically necessary habilitative and rehabilitative services in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber.
D. SLO ambulatory services are provided in outpatient settings for persons served with mild to moderate withdrawals symptoms. Services in this setting should require daily or less than daily outpatient supervision.

## IV. CLINICAL SUPPORT FOR THE MAT TEAM

A. The Medical Director for the County of San Luis Obispo Behavioral Health Department (SLOBHD) or designee will serve as the supervising physician of the Medication Addiction Treatment Team.
B. The clients and/or their support person will be referred to primary and emergency medical care services as needed and appropriate. No primary or emergency medical care will be provided onsite by Drug and Alcohol Services staff. Clients will be responsible for the cost of any recommended medical services and will be advised as such.

## V. MAT STAFF RESPONSIBILITIES:

A. Clients seeking help for substance use disorders may have a heightened sensitivity to the perceived judgments of others. Staff members must address the clients with nonjudgemental, non-stigmatizing language, empathy and respect as well as reinforcing self-esteem and supporting client's goals of treatment.
B. Staff must observe client-staff boundary guidelines in accordance with the SLOBDH policies14.07 Social Relations with Clients and 14.05 Gifts, Donations and Loans

## VI. MAT STAFF TRAINING:

A. DAS Regular training sessions will include information on withdrawal management protocols, emergency procedures, and the use of assessment scales including the CIWA, COWS, and SOWS. Trainings will also include how to provide patients about the withdrawal process, their care plan, and available support services.

## VII. AMBULATORY WITHDRAWAL MANAGEMENT SERVICES ON SITE:

A. All referrals will be directed to the regional clinic MAT team staff. All potential clients must have attended either the walk-in clinic or be an active treatment or recovery client of the DAS Division with a tentative diagnosis of substance use disorder. Screening for admission to MAT services can be completed by the prescriber or medication manager. If a patient presents in acute withdrawal and requires immediate medical attention, they will be triaged to determine if they can be medically stabilized with outpatient withdrawal management protocols (see MAT Medication Policy Guidelines for treatment algorithms). If they are deemed too acute for withdrawal management

services, they will be referred to the closest emergency room for services or 911 will be called for emergency transportation.

**B. Eligibility Criteria for Withdrawal Management**

1. Initial Screening
   a) Brief Screening: DAS staff will conduct a comprehensive screening to determine the necessity for withdrawal management services. This process involves identifying the type and severity of substance use, recent usage patterns, and any immediate health concerns. Staff will be vigilant in noting any severe symptoms, as listed below, which may necessitate a transfer to a medical emergency room for closely monitored withdrawal management services. Standardized screening tools will be employed to quantify withdrawal symptoms, including the CIWA and PAWSS for alcohol withdrawal, and the COWS and/or SOWS for opioid withdrawal. Staff will be trained to recognize that mild and some moderate symptoms can be managed in ambulatory settings, while any severe symptoms will require immediate transfer to an emergency department.
   b) Alcohol Withdrawal Symptoms
      i. Mild: Anxiety, Insomnia, Nausea, Headaches, Palpitations, GI upset, Tremors
      ii. Moderate: Increased BP and HR, Sweating, Irritability, Confusion, Hyperthermia, Hyperreflexia
      iii. Severe: Hallucinations, Seizures, Delirium Tremens (agitation, hallucinations, fever, delirium, autonomic hyperactivity)
   c) Opioid Withdrawal Symptoms
      i. Early: Anxiety, Muscle aches, Restlessness, Insomnia, Runny nose, Sweating, Yawning
      ii. Moderate: Nausea, Vomiting, Diarrhea, Abdominal cramping, Goosebumps, Dilated pupils, Tremors
      iii. Severe: Severe cramping, Diarrhea, Vomiting, Rapid HR, High BP, Severe agitation, Intense cravings.

**C. Comprehensive Assessment**

1. **Medical History:** DAS staff will document the patient's medical history, including any chronic conditions, medications, and previous withdrawal experiences.
2. **Psychological Assessment:** DAS staff will evaluate the patient's mental health status, including any co-occurring psychiatric disorders.
3. **Substance Use History:** DAS staff will gather detailed information about the patient's substance use, including type, quantity, frequency, duration, and last use.
4. **Vital Signs and Urine Drug Screen:** DAS staff will complete vital signs and urine drug screen, if deemed clinically appropriate to establish a baseline for monitoring.
5. If a patient completes the screening and is deemed medically appropriate for ambulatory WM, DAS SLO staff will offer the following WM medications at the DAS clinics: Buprenorphine, Buprenorphine/naloxone (oral, injectable), Naltrexone (oral, injectable), Gabapentin, Carbamazepine. SLO maintains a current list of which addiction medications are available directly via practitioners providing on-site services, including when these medications are prescribed, covered by Medi-Cal Rx,

and provided to our patients through coordination with an offsite pharmacy.

6. SLO ensures that initial and follow-up addiction medication service appointments are arranged in accordance with the patient's individualized plan of care. SLO DAS will offer MAT to all patients who are engaged in WM services. Patients will be offered appointment with MAT providers within a maximum of 3 days of starting WM services to ensure appropriate and timely follow-up. SLO maintains sufficient medical staffing operating within the scope of practice of their license (licensed prescribing clinician) to meet patient demand for addiction medication services, which includes employment of, or contracts with, prescribing clinicians and arranging coordination of telehealth medication services if applicable.
7. If the MAT Team receives a request for withdrawal management services with medications that are not available at SLO DAS, the client will be given appropriate referral(s) [see directly below]. DAS staff will facilitate a phone call or engagement with these alternative providers. However, If the client needs immediate medical attention, they will be referred to the nearest medical facility and will be provided with transportation, if necessary. If they are medically unstable, the MAT team will call 911 to get the client the closest emergency medical facility.

## VIII. REFERRAL FOR WM THROUGH EXTERNAL PARTNERS:

A. If the client is found to be ineligible or requires WM that is not available (only methadone) an appropriate referral will be made to another agency and an attempt will be made to facilitate treatment linkage. Other agencies may include, but are not limited to:
   1. Aegis for Narcotic Treatment Program (NTP) services 1551 Bishop St STE 520, San Luis Obispo, CA 93401. Phone: (805) 461-5212
B. SLO ensures that at least one external partner that offers each remaining required WM is identified.
C. SLO maintains procedures for client transportation to/from these external partners.

## IX. ELIGIBILITY CRITERIA FOR WITHDRAWAL MANAGEMENT:

A. A potential client will be interviewed to determine eligibility for the program based on the following criteria:
   1. Clients must display the presence of physiological dependence on alcohol and other drugs and mild to moderate withdrawal symptoms. Severe withdrawal symptoms, such as the risk of seizures or delirium tremens, are not appropriate for ambulatory settings and require more intensive care and will be referred to the nearest emergency room.
   2. Clients must display psychiatric stability with no acute psychiatric conditions requiring immediate stabilization, such as suicidal ideation, homicidal ideation, or active paranoia, hallucinations or active attempts including violent behavior or threats to staff and/or peers.
   3. Minimum age of 16 years old; or approval by the Medical Director. A referral to an

alternate treatment program/facility will be made for any person under the age of 16 years (Senate Bill 184).
4. Can understand and voluntarily accept the plan of care.
5. Clients shall never be denied access to services at DAS WM for refusing MAT services and shall be permitted to use their preferred MAT medication if the prescribing provider and the client determine the medication is clinically beneficial.
6. Clients shall not be compelled to taper, discontinue, decrease dosage, or abstain from medications provided as part of MAT or as a condition of entering or remaining in treatment in current WM services.

## X. MEDICAL CONDITIONS OF EXCLUSIONS

A. The following conditions could make the potential client ineligible for admission into the ambulatory withdrawal management program:
   1. Active infectious cutaneous disease
   2. Unstable angina
   3. Uncontrolled hypertension
   4. History of recurrent seizure disorder within last two years with the last episode within the past week and without anti-seizure medication
   5. Head trauma within past 6 weeks that has not been worked up and cleared by a medical provider.
   6. Significant recent exposure to extreme environmental temperature change
   7. Unstable diabetes mellitus with recent hypoglycemic episodes, diabetic ketoacidosis, blood sugars over 400
   8. Methadone dosage of greater than 40 mg a day*.
   9. Significant /Severe psychiatric comorbidity rendering client unable to provide informed consent and manage their health care needs independently
   10. Client experiencing:
      a) vomiting more than 5 times in 24 hours / unable to keep fluids down
      b) labored breathing
      c) intractable diarrhea
      d) decrease in urination despite adequate hydration
B. Thought, the above conditions will not automatically disqualify an individual from receiving MAT services when they are medically appropriate, and their withdrawal management needs have been managed by a higher level of care.
C. *All clients who are using greater than 40 mg of methadone will be referred to a methadone clinic for methadone treatment; high levels of opioid use may be referred to a methadone clinic.

## XI. OBSERVATION:

A. Observation during ambulatory withdrawal management includes monitoring patients upon arrival, completing a comprehensive screening process, and determining the most appropriate withdrawal management medications.

B. Medications will be prescribed, and patients will be provided with paperwork outlining home withdrawal management recommendations and instructions on when to return to the clinic or emergency department. For patients who require closer observation, they will be offered the option to go to the sobering center for up to 72 hours of observation.
C. Additionally, medical managers will call the patients the day after starting their withdrawal management medications to check in and ensure their well-being.

## XII. PAYMENT FOR WITHDRAWAL MANAGEMENT SERVICES

A. In accordance with the DAS fee policy, all clients will be required to comply with the current cost of the MAT program.
B. The payment will be based on a sliding fee scale according to gross monthly income and family size. Medi-Cal will be accepted per SLOBHD Policy and Procedures.

## XIII. ADMISSION PROCESS

### A. Intake

1. After the walk-in has been completed and the DAS clinician and/or case manager has approved the referral, the client will be triaged by the MAT team prescriber for WM services. (see DAS general policy and procedure for details regarding walk-in clinic process).
2. MAT staff, either prescribers, or their designee shall gather a history of all prescribed, over the counter, and supplemental medications the client is currently taking, including controlled substances using the CURES system (Controlled Substances Utilization Review and Evaluation Systems). The results will guide MAT staff regarding recent prescribed opioids or other medication as related to admission to MAT services: buprenorphine, referral to another provider, or discussion regarding status of medical interventions/pain management.
3. Evidence-Based Assessments: The following evidence-based assessments for, withdrawal severity were selected by the MAT Treatment Team and Medical Director based on recommendations from DHCS and appropriateness for the treatment programs and may be used at intake to determine the patient's current state.
    a) CIWA: A tool for assessing and monitoring alcohol withdrawal symptoms. It evaluates ten different criteria, including nausea, tremors, sweating, anxiety, agitation, tactile disturbances, auditory disturbances, visual disturbances, headache, and orientation. Each criterion is scored on a scale, and the total score helps determine the severity of withdrawal and guide treatment decisions.
    b) The Prediction of Alcohol Withdrawal Severity Scale (PAWSS) consists of three parts:
        i. The threshold criteria, whether the patient consumed alcohol during the 30 days prior to admission and/or had a positive blood alcohol level on admission, followed by a series of 10 “Yes/No” questions
        ii. Patient interview

iii. Clinical evidence, assessing known risk factors for withdrawal. (Alcohol Withdrawal)

c) Clinical Opioid Withdrawal Scale (COWS): A standardized tool used to assess the severity of opiate withdrawal symptoms. It includes eleven criteria: resting pulse rate, sweating, restlessness, pupil size, bone or joint aches, runny nose or tearing, gastrointestinal upset, tremor, yawning, anxiety or irritability, and gooseflesh skin.

d) The Subjective Opiate Withdrawal Scale (SOWS) is a self-administered scale for rating opioid withdrawal symptoms. (Opioid Withdrawal)

B. The process for conducting the assessment shall include, at minimum:
   1. If the evidence-based assessments indicate that WM services could be beneficial for the client.
   2. The prescribing provider shall determine if MAT medications are appropriate and prescribe the medications as clinically indicated and in accordance with any relevant program policies and procedures or guidelines.

C. MAT Discussion:
   1. The risks, benefits and alternatives of MAT shall be discussed by the prescribing provider at the first medication services appointment. This information shall be presented both by verbal discussion and on a Medication Consent Form that is reviewed and signed by the provider and the client. Details shall include common side effects, risks of combining the medication with other substances and documentation of alternative options for treatment. Information shall be specific to each type of medication prescribed for treatment of a SUD.
   2. For those clients who initially decline MAT services, medication mangers, clinicians, and case managers shall revisit the availability of MAT services throughout the duration of care for a client enrolled in services at DAS. A client can be referred or re-referred to the MAT prescribing provider at any time during care for assessment for MAT.
   3. The risks, benefits, and alternatives for the use of MAT shall be discussed in detail on the Medication Consent Form and for clients on buprenorphine.
   4. All clinical staff, including medication managers, and clinicians, shall be enabled to discuss the availability of MAT services with clients whose substance use (opioids and alcohol) may be appropriate for MAT services. A summary of MAT program parameters (including standard frequency of visits and urine testing) is listed on the Referral Checklist and shall be reviewed with all clients who may be interested in MAT for Opioid Use Disorder (OUD). However, details on the clinical mechanism of action, side effects and the risks, benefits and alternatives for use of MAT are reserved for direct discussion between the prescribing provider and the client.

D. Upon acceptance into MAT services: Buprenorphine program
   1. Clients will be advised to cease opioid use immediately in anticipation of starting buprenorphine.
   2. Prescribers will send a prescription directly to a pharmacy that carries buprenorphine for the patient and will instruct the patient to pick up the medications.

3. DAS does not store buprenorphine on site but ensures that local pharmacies carry and have buprenorphine available for same-day prescriptions.

E. Should a client present with active opioid use, the client will be offered MAT services comfort medication protocol OR an urgent in-person or telehealth appointment with prescriber for evaluation and treatment to initiate buprenorphine.
F. Admissions for the current week are not available on Fridays unless the client has experience with buprenorphine and/or is currently on MAT.
G. The DAS Assessment Coordinator (AC) /Specialist will be notified of the client's acceptance to the program, if applicable

## XIV. WITHDRAWAL MANAGEMENT MEDICATION PROCEDURES:

A. Patients currently in withdrawal from either alcohol use or opioid use will be informed about the scientific evidence base, effectiveness, associated risks and benefits, and clinical considerations for treatment with withdrawal management medications.
B. All patients with alcohol use disorder and/or opioid use disorder who are not currently receiving medication are offered a referral and care coordination for addiction medication services through external partners where treatment with withdrawal management and MAT are available.

## XV.WITHDRAWAL MANAGEMENT GUIDELINES FOR ALCOHOL USE DISORDER:

A. Patients will be offered non-benzodiazepine medications for mild to moderate alcohol withdrawal including Gabapentin or Carbamazepine. In addition to that, if they meet criteria for starting Naltrexone, they will also be offered Naltrexone for MAT for Alcohol Use Disorder. If patients require benzodiazepines for alcohol withdrawal, there will be a discussion between the Medical Director and MAT prescriber to ensure that the patient can be managed in an ambulatory setting.
    1. Gabapentin 600mg tabs with instructions for the patient:
        - Day 1: Take 2 tabs twice daily plus an additional 2 tabs if needed the first day
        - Days 2-7: Take 1 tab three times daily plus an additional 1 tabs if needed
        - Day 8: Take ½ tab three times daily
        - Day 9: Take ½ tab twice daily
        - Day 10: Take ½ tab once at bedtime

    2. OR

    3. Carbamazepine 200mg tabs with instructions for the patient:
        - Days 1-3: Take 1 four times throughout the day
        - Days 4-6: Take 1 three times throughout the day
        - Days 7-9: Take 1 twice a day
        - Days 10-11: Take 1 at bedtime

## XVI. WITHDRAWAL MANAGEMENT GUIDELINES FOR OPIOID USE DISORDER WITH BUPRENORPHINE:

A. Patients will be offered buprenorphine for withdrawal management. If they do not want buprenorphine, they will be offered comfort medications (please see SLO MAT Medication Prescribing Guidelines for comfort medication protocol) or linked to AEGIS for methadone withdrawal management.

**B. Option 1: Patient in moderate withdrawal:**

1. Day 1-3: 4-8mg suboxone s/l x1 dose when patient is in mild - moderate withdrawal utilizing the COWS score (8-12) or has been free of short acting opiates/opioids 12-24 hours. Additional 4mg doses may be administered every 4 hours if the patient continues to report cravings up to 24mg total first daily dose. If precipitated withdrawal occurs or withdrawal symptoms worsen contact the MAT provider or Medical Director for guidance. The total previous daily dose administered should be given as a single dose in the morning the following day.
2. Days 3-7: 8MG - 48 MG daily, adjust dose in 4mg increments to eliminate cravings up to 48 mg maximum daily dose.

C. **Option 2: Not in withdrawal: Macro-dosing**:

1. Buprenorphine macro-dosing protocols should be used only with patients who are known to have high opioid tolerance, and this can be useful when they are not in withdrawal but are open to transitioning to buprenorphine. At doses of 24 mg or higher, there is enough buprenorphine to provide relief of withdrawal symptoms after the full-agonist opioids are displaced from the mu-receptors, whereas lower doses (2–8 mg) displace other full-agonist opioids without providing relief. Essentially, higher initial doses effectively bypass precipitated withdrawal and achieve a full therapeutic dose within hours.
   a) **Day 1:** Start with 16-24 mg SL x 1 with the patient. If the patient does not feel relief within 45 minutes, please administer another dose of 16-24 mg SL and continue to administer doses between 8-24 mg SL every 45 minutes until symptoms are manageable and less intense. Given this protocol requires a higher dose of buprenorphine on day 1, the maximum dose can be 84mg.
      i. **Consider prescribing comfort medications including gabapentin 600 mg PO TID, Baclofen 10 mg PO TID and Ativan 1 mg Q2 hours (#6) for them to utilize during the transition.**
   b) **Day 2:** Please continue with a dose that manages the patients and cravings. Generally, with fentanyl we are seeing total daily doses of 24-32 mg (divided if that is helpful or patient preference).
   c) Reference: MacrodosingPrimer.pdf (metaphi.ca)

**D. Option 3: Not in withdrawal: Microdosing:**

1. Utilizing gradually increasing doses of buprenorphine while patients continue to use their full opioid agonist:
   - Day 1: 0.5 mg once a day
   - Day 2: 0.5 mg twice a day
   - Day 3: 1 mg twice a day

- Day 4: 2 mg twice a day
- Day 5: 3 mg twice a day
- Day 6: 4 mg twice a day
- Day 7: 12 mg (stop other opioids)
- Reference: Buprenorphine–naloxone “microdosing”: an alternative induction approach for the treatment of opioid use disorder in the wake of North America’s increasingly potent illicit drug market - PMC (nih.gov)

**E. Option 4: Not in withdrawal: Rapid Overlap Initiation**

1. Utilizing gradually increasing doses of buprenorphine (or combo product) to reach therapeutic levels in 3–4 days:
   - Day 1: 0.5 mg of buprenorphine sublingually every 6 hours (total dose of 2 mg).
   - Day 2: 1 mg sublingually every 6 hours (total dose of 4 mg).
   - Day 3: 2 mg sublingually every 6 hours, (total dose of 8 mg).
   - Day 4: Take a total of 12 mg of buprenorphine in the morning and follow up with the provider.
   - Day 5 onwards: Continue to manage the patient to increase to a dose that is appropriate for their OUD with a max of 72 mg/day.
   - Reference: Rapid Overlap Initiation Protocol Using Low Dose Buprenorphine for Opioid Use Disorder Treatment in an Outpatient Setting: A Case Series - PMC (nih.gov)

F. Pregnant woman and fast metabolizers may benefit from divided dosing and the use of naloxone free buprenorphine. An adequate dose is when the patient no longer reports cravings or the desire to use. If buprenorphine does not eliminate craving or desire to use, ensure patient is ingesting medication properly or consider injectable buprenorphine or transfer to methadone maintenance protocol. Patients who discontinue or do not achieve the desired therapeutic outcomes for OUD may switch to another treatment modality/medication. Switching from buprenorphine to a different MAT modality should be planned, considered, and monitored

## XVII. WITHDRAWAL MANAGEMENT FOR SEDATIVE USE DISORDER:

A. Patients withdrawing from sedatives including benzodiazepines or Z-drugs will require close follow-up and monitoring given the high risk of prolonged withdrawal and seizure. Only patients who meet criteria for mild to moderate sedative withdrawal will be provided ambulatory withdrawal services. Benzodiazepine withdrawal is unlikely if the patient's use is intermittent or follows a binge pattern. However, more severe withdrawal is associated with abrupt cessation, the use of short-acting agents (especially alprazolam), and high doses. Benzodiazepine withdrawal can typically be managed safely as an outpatient unless there are co-existing major medical or psychiatric problems, polydrug dependence, concurrent use of other CNS depressants such as opioids, or if the patient is taking a high dose (over 50mg diazepam equivalent per day) or injects. Additionally, outpatient management is not appropriate if the patient requires stabilization of other medications, such as methadone or buprenorphine, or has a history of seizures.

B. These cases will be taken on a case-by-case basis to determine if they can be managed with a slow, controlled titration of longer acting benzodiazepines or if they will need acute treatment at a higher level of care.

## XVIII. ANCILLARY MEDICATIONS FOR WITHDRAWAL MANAGEMENT:

A. Cessation of alcohol, sedative/benzodiazepine and/or opioid use in a patient with physiological dependence may result in many withdrawal signs and/or symptoms resulting in clinically significant distress and functional impairment.
B. Ample use of ancillary medications will be utilized for withdrawal management.
   1. Nutritional deficiency – Patients will be recommended to have a daily vitamin supplementation with thiamine 100mg, Folic Acid 1mg and a MVI to address any possible nutritional deficiencies from substance misuse.
   2. Insomnia – Medications may include Melatonin 5 mg, Remeron 15mg po qHS or trazadone 50mg-100mg unless contraindicated.
   3. Anxiety – Medications may include clonidine 0.1-0.2mg PO prn, with a maximum daily dose of 1.2 mg (with cut off parameters for heart rate and blood pressure), Neurontin 100mg-600 mg every 8 hours prn may be ordered or Hydroxyzine up to a total daily dose of 150mg.
   4. Nausea and Vomiting – Zofran 4-8 mg q8h PO prn, dose may be increased based on patient need and considering risk of prolonged qTC and torsade's.
   5. Muscle pain or spasm – Patients on a withdrawal management protocol may also be prescribed baclofen 10mg q8h prn if clinically appropriate.
   6. Chronic pain - is best treated with around-the-clock medications. Depending on the etiology of the pain multiple medications may be utilized in addition to Tylenol and NSAIDS. Other effective pain management ancillary medications include the judicious use of Neurontin (titrated to a maximum dose 1200mg 30 every 8 hours)
   7. Fever – Tylenol 650mg q6h will be ordered prn as a first line medication after assessment by medical provider. Ibuprofen 200-400mg q6h prn will be offered as a second line medication or by patient preference.
   8. Indigestion/GERD/Heartburn – Mylanta, a magnesium containing medication, can be prescribed in addition to Proton pump inhibitors and other medications can be prescribed.
   9. Constipation – Milk of Magnesia (MOM), another magnesium containing medication will be ordered as first line medication, Senna 2 tablets bid prn and Citroma 300mg po q48 will also be ordered if MOM not effective.
   10. Diarrhea – Medications ordered may include Pepto Bismal 30ml po q6h prn or Loperamide 2mg po q2h if Pepto Bismal not effective (or patient preference).

## XIX. DOCUMENTATION REQUIREMENTS

### A. Health Evaluations:

1. All clients will have their current Health Questionnaire reviewed by the MAT prescriber or medication manager prior to administering withdrawal management

medications.

2. The evaluation will include:
   a) Current health conditions
   b) Current mental status
   c) History of primary health conditions
      i. Clients' physical exam history will be reviewed encouraged and referred to get a physical exam if over 12 months have passed
      ii. Clients with active outstanding medical conditions will be referred for primary care evaluation and treatment
   d) History of mental health conditions

B. In addition to Withdrawal Management, Client will be offered MAT Services. If clients agree to MAT services, they will complete the following steps:
   1. Medication Consent, signed by both the prescribing provider and the client.
   2. Initial Biopsychosocial Assessment completed by the prescribing provider.
   3. Medication Services prescriber Progress Notes completed by the prescribing provider.
   4. Drug Testing Result Forms performed by a medication manager, case manager, or designated staff.
   5. Assessment based on American Society of Addiction Medicine (ASAM) criteria completed by medication manager or clinician.
   6. Progress notes, documented by medication manager, clinician, or case manager.

**C. Health Referrals:**

1. Client will be given appropriate referrals, as guided by the Health Questionnaire, for medical treatment and laboratory tests in order to bring them current on health issues. This includes, but is not limited to:
   a) Physical exam with yearly lab work
   b) PPD/chest X-ray if at risk for having current or latent TB or recent exposure to TB
   c) Pregnancy test
   d) Communicable disease assessment, treatment, and/or vaccination as appropriate
   e) Mental health assessment
   f) Pap smear/birth control/mammogram as appropriate
2. These will be tracked in our assessments and continued to be monitored in the monthly progress notes.

## XX. CASE MANAGEMENT

A. All WM clients taking medications will be offered and encouraged to utilize case management services by either MAT staff or per clinic case managers. The purpose of case management is to create the optimal environment for reaching their goals by supporting a client's needs in addition to recovery support.

B. Although case management and substance use disorder treatment are presented as separate and distinct aspects of the treatment continuum, in reality, they are complementary and, at times, thoroughly blended.

C. Case management principles as applied to substance use disorders are as follows:
   1. Case management offers the client a single point of contact with the health and social service systems.
   2. Case management is client-driven and driven by client need.
   3. Case management is grounded in an understanding of clients' experiences and the world they inhabit, the nature of addiction and the problems it causes, and other problems with which clients struggle.
   4. Case management involves advocacy and is community-based,

## XXI. MEDICAL INTERVENTION

A. The following parameters are to be observed for each client in the program:
   1. In the event the client requires immediate or emergency medical care during the withdrawal management process, the MAT staff will make every effort to assist the client in obtaining medical or psychiatric care.
   2. If the client is in distress during clinic hours, the MAT staff will attempt to facilitate linkage with a medical or psychiatric care facility. If the distress occurs outside of clinic hours, the client may leave a message on the staff's voice mail regarding the distress and their attempts to remedy the situation. A follow-up call will then be carried out as to the disposition of the client's care.
   3. The Medical Director or designee may be asked to determine the client's eligibility to continue with the WM program based on the physical status of the client.

## XXII. TRANSFER TO THE MAT PROGRAM

A. After withdrawal management therapy is completed or stabilized, the client will be encouraged to remain an active treatment client in the MAT clinic. Clients will be encouraged to remain within the MAT clinic to receive ongoing support services.
B. However, the client may be dis-enrolled from the MAT program for any of the following reasons, only after the MAT team has met with and discussed the clients' goals:
   1. Client completes the MAT program and wishes to be discharged.
   2. Client is medically/psychologically unable to continue per previous parameters.
   3. All discharges, voluntary or otherwise, will require sending client a Notice of Adverse Beneficiary Determination per BH policy 3.30 Notice of Adverse Benefit Determination
C. No client will be left to experience opioid/suboxone withdrawal when they are involuntarily discharged from the MAT program. The client will be referred to a community provider and given a prescription that will continue their therapy without interruption. If possible, the MAT staff will assist the client in making their appointment to ensure the client leaves the program with continued care in place.

## XXIII. PROCEDURES FOR CLIENTS TO ACCESS NARCOTIC TREATMENT PROGRAM (NTP)

A. Medications for opioid use disorder (MOUD), including methadone.

1. If a client needs withdrawal management with methadone, the following steps will be followed:
   a) Methadone is not currently provided by the MAT Team or through SLO County DAS Clinics.
   b) DAS MAT Team will discuss methadone with a patient upon their request to ensure they understand the risks, benefits and alternatives to methadone and engage in shared decision-making to ensure this is the best treatment option for the patient.
   c) If a client requests methadone for MAT, or the prescribing provider on the MAT Treatment team program deems methadone is the best course of treatment, the client shall be referred to the NTP providers in SLO below:
      i. Aegis for Narcotic Treatment Program (NTP) services 1551 Bishop St STE 520, San Luis Obispo, CA 93401. Phone: (805) 461-5212
2. Care Coordination with NTP:
   a) DAS Staff will call the NTP program within 24 hours to provide a warm hand-off about the patient who is requesting methadone treatment.
   b) DAS staff will ensure that they have the appropriate releases to discuss the patient's case with the NTP with regards to coordination of access to NTP, sufficient medication, and an understanding of the current follow-up schedule.
   c) SLO County will discuss and ensure transportation support for patients who will need to receive methadone dosing and are enrolled in the DAS program.
   d) DAS will not provide safe storage for methadone take home but will work with the NTP and the patient to ensure that the patient has a safe and secure space in their residence for their take home methadone. SLO will provide any necessary clinical information to the NTP if the patient requests exception to take-home limits.
   e) DAS will continue to have scheduled case coordination calls with the NTP at regular intervals to ensure quality care.
   f) If a DAS patient receiving methadone from an NTP decides to discharge from DAS, DAS staff will make attempts to coordinate ongoing methadone treatment with the NTP for the patient.
   g) Patients will be continued on their choice of MOUD in coordination with the NTP. DAS staff will assess the patient's suitability for MOUD based on clinical guidelines and individual health status and will obtain informed consent, discuss the benefits, risks, and alternatives of MOUD.

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XXIV. REVISION HISTORY

| Effective/Revision Date: | Sections Revised | Status: Initial/ Revised/Archived Description of Revisions |
|---|---|---|
| November 1997 | Entire Policy | Initial Release |
| August 2001 | Entire Policy | First Revision |
| December 2007 | Entire Policy | Second Revision |
| April 2008 | Entire Policy | Third Revision |
| April 2009 | Entire Policy | Fourth Revision |
| November 2013 | Entire Policy | Fifth Revision |
| December 2015 | Entire Policy | Sixth Revision |
| September 2016 | Entire Policy | Seventh Revision |
| July 2024 | Entire Policy | Eighth Revision |
| | | |
| Prior Approval dates: | | |
| | | |

| | | |
|---|---|---|
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| Approved by: | Star Graber, PhD.<br>Behavioral Health Department Administrator | Date |

| | | |
|---|---|---|
| *E-Signature on file* | | 09/11/2024 |
| Approved by: | Siddarth Puri, M.D.<br>Behavioral Health Department Medical Director | Date |

# Section 8

# Interface with Physical Healthcare

# 8.00 Coordination of Care with CenCal

I. PURPOSE

To provide direction for County of San Luis Obispo Behavioral Health Department (SLOBHD) staff to complete closed-loop referrals to increase successful connections to services for Medi-Cal members.

II. POLICY

SLOBHD will assess clients' needs and provide closed-loop referrals for Medi-Cal members to support access to care and connect members with services that can address identified needs across settings and delivery systems.

III. REFERENCE

- Code of Federal Regulations (CFR), Title 42, §438.208 and §438.62
- California Code of Regulations (CCR), Title 9, §1810.415 (a)-(d)
- CFR, Title 45, Part 164, §§164.500-164.534 (HIPAA)
- CFR, Title 42, Part 2, §§2.1-2.35
- California Civil Code, Part 2.6 §§56.10-56.16
- Department of Health Care Services (DHCS) Contract with SLOBHD (Mental Health Plan), Exhibit A, Attachment 10, Coordination and Continuity of Care
- DHCS Contract with SLOBHD (DMC-ODS Waiver)
- Memoranda of Understanding between SLOBHD and CenCal Health
- SLOHA Health Information Privacy and Security Policy & Procedure Suite

IV. PROCEDURE

A. CenCal beneficiaries will be referred to CenCal Health for non-specialty mental health services (SMHS) by SLOBHD as a result of a completed Adult or Youth Screening or Transition of Care Tool (see SLOBHD policy 3.05 for more details).

B. SLOBHD Central Access Line staff will log each referral received from the CenCal Health Access Line or healthcare providers and offer the referred individual an initial service within current timely access standards (see SLOBHD policies 3.00, 3.02 and 3.23 for more details).

C. Tracking Member Referrals

1. Data timeliness
    a. SLOBHD will conduct weekly tracking of referral status
    b. SLOBHD will review referral and access data in monthly leadership meetings with CenCal Health to identify any barriers to access and improve procedures as needed to ensure successful coordination of care.
2. Minimum member data elements to be included on each referral and tracked
    - Last, first name
    - Medi-Cal client index number
    - Date of birth
    - Primary phone number

- Address
- Legal guardian/parent name and relationship
- Legal guardian/parent phone number
- Date of referral
- Reason for referral (Screening Tool, Transition of Care)
- Requested services
- Referring program name
- Referring program phone number

3. Referral processing – the following elements will be tracked on the shared referral tracking log:
    - Date referral received
    - Description of contact with member
    - Date of first scheduled service, including provider's name and contact information
    - Referral disposition

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 09/09/2024 | All | Adopted |
| | | |
| Prior Approval dates: | | |

| *Signature on file* | | *09/10/2024* |
|---|---|---|
| Approved by: | Star Graber, PhD, LMFT, Behavioral Health Administrator | Date |

# 8.01 Referrals Between CHC and MH

I. PURPOSE

II. POLICY

In accordance with the terms of the contract with Community Health Center (CHC) and existing policies and procedures of the Mental Health Plan (Access to Services, Authorization/Approval of Services), San Luis Obispo County Behavioral Health Department (SLOBHD) evaluates referrals between CHC and SLOBHD.

SLOBHD recognizes the importance of coordination of care with primary healthcare professionals and providing clinical consultation and training, including consultation and training on medications, to primary care healthcare professionals. SLOBHD also ensures that the exchange of medical records information maintains confidentiality in accordance with applicable State and federal laws and regulations.

III. REFERENCE(S)

IV. PROCEDURE(S):

**A. REFERRALS FROM CHC STAFF:**

1. Clients are referred to SLOBHD for assessment to determine if they are eligible for Specialty Mental Health Services due to one or more of the following:

    a. The client's psychiatric symptoms have increased and are not responsive to the interventions of a physical health care provider.
    b. The client has moderate to severe functional impairments due to a mental illness.
    c. The client has had a psychiatric hospitalization within the last two (2) months, or is at risk of psychiatric hospitalization and may need specialty mental health services for stabilization.

2. When a CHC staff wishes to refer a client to SLOBHD, the CHC staff follows these steps:

3. Fax the following forms to the SLOBHD Central Access fax number (805-781-1177):

    - A completed CHC Referral for SLOBHD Services Form
    - (Attachment A). This form may also include the results of consultation between CHC's primary care physician and CHC consulting psychiatrist, if available.

- Legible copies of relevant medical notes (lab results, etc.) will also be included with the referral
- A completed Authorization to Disclose Protected Health Information (PHI), when needed.

4. After completing the referral form, the CHC staff directs the client to call SLOBHD Central Access (800-838-1381) to request services.

5. When the referred client contacts Central Access, the Managed Care licensed clinician gathers information to complete an initial request for services (using the most current form and process). If the client meets the criteria set forth in policy titled Access to Services, an appointment for assessment is given.

6. Central Access staff informs CHC about the outcome of the referral to SLOBHD. Central Access staff completes and faxes the CHC Referral Response Form (Attachment B) to CHC.

7. Clients are advised of their rights including appeal of decisions.

**B. DIRECT REQUESTS FOR SERVICES FROM CHC CLIENTS: WHEN A CHC CLIENT INITIATES A CALL TO CENTRAL ACCESS TO REQUEST SERVICES, THE FOLLOWING STEPS ARE FOLLOWED:**

1. Client's request is evaluated in accordance with the SLOBHD's policy titled Access to Services. Any Medi-Cal beneficiary who requests a mental health evaluation is offered an assessment appointment. Non-Medi-Cal beneficiaries' requests are screened by Managed Care staff, and an appointment may be given based on the availability of resources and severity of reported symptoms and impairment.

2. If the CHC client is given an assessment appointment, the assessment clinician obtains the client's Authorization to Disclose PHI and requests more information from CHC.

**C. REFERRALS FROM SLOBHD TO CHC**

1. Referral of Stabilized Clients to CHC

   a. SLOBHD Services may refer psychiatrically stable clients to CHC for ongoing medication management. A psychiatrically stable client is defined as someone who no longer requires specialized psychiatric mental health treatment, or who has been stable on medication for six months (i.e. no significant medication changes). In general, clients needing Clozaril, injectables, those with chronic suicidal ideations, or those who have used Crisis Services (Mobile Crisis or clinic crisis) and Inpatient Unit within the last six (6) months are not referred to CHC.

b. When SLOBHD Services considers referring a client to CHC, the following are completed:

i. The treatment team discusses the transfer of care to CHC, and with the psychiatrist's approval, the SAI discusses this plan with the client.
ii. The SAI meets with the client and calls CHC to make an appointment with a physician for the client.
iii. The SAI faxes the following information to CHC (fax 542-6791):

- A completed MD Referral Letter to CHC (Attachment C), making reference to the appointment date already set for the client. Letter must specify that the client is psychiatrically stable.
- The last three psychiatrist's Progress Notes.
- Authorization to Disclose PHI, when needed
- Copy of Psychiatric Assessment

2. SLOBHD, when approved by the Site Approval Team (SAT), will be available to provide case management services and clinical consultation for more complex cases during the transition period up to six (6) months to ensure smooth transition and transfer of the client's care to CHC provider.

**D. REFERRAL OF NEW CLIENTS TO CHC**

1. SLOBHD staff may refer a client who has not been seen by a psychiatrist at SLOBHD Services to CHC. Such referral is done after a comprehensive mental health assessment is done and the Site Approval Team (SAT) finds that the client is not meeting Medical Necessity Criteria as set forth by Specialty Mental Health Services Guidelines. SAT then recommends that the psychiatric needs of the client can be met by the CHC physicians.

2. When referring new clients to CHC, the following steps are followed:

3. The SLOBHD staff assigned to coordinate the care of the client reviews the SAT's recommendation with the client and directs the client to make an appointment with CHC.

4. The SLOBHD staff faxes the following documents to CHC (542-6791):

- A completed New Client CHC Referral Letter. Letter must specify that the client is new and state whether the client needs psychiatric care or ongoing physical healthcare at CHC (Attachment D).
- Authorization to Disclose PHI, when needed
- Copy of Assessment (intake).

**E. REFERRAL OF NEW CLIENTS FROM CENTRAL ACCESS**

1. A client may be referred to CHC after initial screening by Central Access clinician for any of the following reasons.

    a. Client does not have an included mental health diagnosis.
    b. Client has an included diagnosis but lacks a significant functional impairment.
    c. Client's mental health needs can be met by a primary medical care provider.
    d. Client already participates in a CHC-administered program.
    e. Client is actively engaged in treatment at CHC and is not being referred by CHC staff.

2. In such a case, the client will be asked to follow up with CHC, and no supporting documentation is faxed to CHC.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| 01/20/2012 (KB) | | |

| | | |
|---|---|---|
| *Signature on file* | | *01/20/2012* |
| Approved by: | Behavioral Health Administrator | Date |

# Section 9

# Fiscal Policies

# Section 10

# Provider Relations and Contracting

# 10.01 Outpatient Clinic Physical Environment

## I. POLICY

County of San Luis Obispo Behavioral Health Department (SLOBHD) will provide program facilities that are clean, safe, sanitary, and in good repair at all times for the safety and well-being of clients, employees, and visitors.

- Each department is required to appoint a Departmental Safety Representative and maintain an Operations Manual with safety information.
- Program staff will report up to their immediate Supervisor or another available Program Supervisor any issues related to the physical environment. Facility issues which are hazardous to clients, staff, and visitors shall be reported and addressed immediately.

County-operated facilities will be ADA compliant. Should a client require accommodation for a physical disability, SLOBHD will provide necessary accommodations or refer the client to a provider who can so that the client receives proper treatment. The MHP will maintain written/electronic log of all initial requests for outpatient SMHS and monitors timeliness of access as part of a continuous quality improvement effort.

## II. REFERENCE(S)

- DHCS Information Notice 17-017, Alcohol and/or Other Drug Certification Standards, Sec 20000 & 200010
- http://www.dhcs.ca.gov/provgovpart/Documents/MHSUDS_Information_Notice_17-017_AOD_Certification_Standards.pdf
- The Americans with Disabilities Act (ADA) of 1990
- County of San Luis Obispo Health Agency Non-discrimination and Language Access Plan
- County of San Luis Obispo ADA Compliance Policy and Grievance Policy
- 15.01 Fire and Disaster Plan
- 3.01 Services for Clients with Impaired Hearing and Vision
- County of San Luis Obispo Injury and Illness Prevention Program Policy and Procedures Manual (Rev. 7/2017)
- County of San Luis Obispo Emergency Action Plan: An Information Source for County Employees (Rev. 2/2014).
- County of San Luis Obispo Safety Guide: Risk Management (2014)

III. PROCEDURE

A. The program facilities shall be free from the following: broken glass, filth, litter, or debris; flies, insects, or other vermin; toxic chemicals or noxious fumes and odors, exposed electrical wiring; other health or safety hazards.
B. Program facilities will ensure that all carpets and floors are free from filth, holes, cracks, tears, broken tiles, or other safety hazards.
C. Program facilities shall safely dispose of contaminated water and chemicals used for cleaning purposes.
D. All clients shall be protected against hazards within the program through provision of protective devices including, but not limited to, nonslip material on rugs, smoke alarms, and fire extinguishers.
E. All outdoor and indoor passageways, stairways, inclines, ramps, open porches and other areas of potential hazard shall be kept free of obstruction and lighted for the visibility and safety of all clients.
F. Program equipment and supplies shall be stored in an appropriate space and shall not be stored in a space designated for other activities.
G. The program shall maintain a valid fire clearance. Program facilities will have an annual fire inspection and obtain a fire clearance. The QST division is responsible for making the request to the appropriate fire agency for fire clearance review. Fire clearance will be kept at each program facility. Fire extinguishers are inspected by General Services. In leased County facilities, the QST division will contact Real Property Management regarding fire extinguishers who act as a liaison between the County and landlord/tenant.
H. Emergencies, such as a fire or disaster, staff will follow Policy 15.01 Fire and Disaster Plan

IV. REVISION HISTORY

| **Effective/Revision Date:** | **Sections Revised** | **Status: Initial/ Revised/Archived Description of Revisions** |
|---|---|---|
| 06/18/2018 | Entire Policy | Initial Release |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *06/18/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT Behavioral Health Director | Date |

# 10.02 No Weapons Policy

## I. PURPOSE

For the safety of staff and clients, no weapons are permitted to be present in Behavioral Health Clinics or during behavioral health services that take place in the community.

## II. POLICY

San Luis Obispo Behavioral Health Department has a no weapons policy. This includes guns, knives (other than kitchen utensils), or other weapons (except for law enforcement officers, or security guards acting in the line of duty) at the program site. The safety of our staff, clients, public, and clinics are of paramount importance and must be given proper attention at all times.

## III. REFERENCE(S)

- California Code of Regulations, Title 9, §1810.435 (b)(2)(c)(5)
- DHCS Certification Standards for Substance Use Disorder Treatment Programs Section 20000(a)(4)
- County of San Luis Obispo Workplace Violence Policy Section III

## IV. PROCEDURE

A. The No Weapons policy shall be posted in the lobby of each certified outpatient treatment program.
B. Any staff who observes a weapon or becomes aware of a weapon at the program/clinic shall immediately notify the Program Supervisor or designee.
C. The Program Supervisor (and/or the Specialist/Clinician) shall ask the client to leave the premises with the weapon. At the discretion of the Program Supervisor, the client may return to program/clinic without the weapon.
D. Should a client bring work tools or other objects (carried independently or carried in a work bag) that can also be used as or considered to be a weapon, the Program Supervisor (and/or Specialist/Clinician) will ask the client to secure all items in question outside of the program/clinic building in a locked vehicle.

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V. REVISION HISTORY

| Effective/Revision Date: | Sections Revised | Status: Initial/ Revised/Archived Description of Revisions |
|---|---|---|
| 10/9/2024 | Entire Policy | Initial Release for Behavioral Health Director approval/signature |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *10/28/2024* |
|---|---|---|
| Approved by: | Star Graber, PhD. Behavioral Health Director | Date |

# 10.03 Network Provider Referral

## I. PURPOSE

To ensure that each County of San Luis Obispo Medi-Cal beneficiary who qualifies for Specialty Mental Health Services (SMHS) or Substance Use Disorder Services (SUDS) receives access to services in a timely manner and at a level of care appropriate for the beneficiary's treatment needs.

## II. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) shall offer a range of SMHS and SUDS that is adequate for the anticipated number of clients served, including a panel of independent individual Network Providers (NWP). The NWP panel shall be sufficient in number, mix, and geographic distribution to meet the needs of clients who require medically necessary treatment services outside a clinic setting.

## III. REFERENCE(S)

- California Code of Regulations, Title 9, Chapter 11, §1810.310(a)(5)(A)(B)
- SLOBHD Policy 3.00 *Access to Services*
- SLOBHD Policy 3.20 *Authorization of Services and Medical Necessity*
- SLOBHD Policy 3.23 *Availability, Timeliness, Network Adequacy, and Array of Services*
- SLOBHD Policy 10.14 *Monitoring and Authorizing Network Provider Services*

## IV. PROCEDURE

### A. NWP Treatment Modality

SLOBHD utilizes a brief therapy model for NWP services. MC staff authorize up to 18 individual, group, family, or collateral therapy sessions. When a provider documents a need for additional treatment, MC staff review and provide authorization on a case-by-case basis. Refer to *Monitoring and Authorizing Network Provider Services* for additional detail. NWP service may stand-alone or may be part of a recovery program that includes other services, such as medication support, case management, rehabilitation, wellness, or recovery support groups at a Behavioral Health clinic or Wellness Center.

### B. Documentation Requirements

1. Prior to referral to Managed Care (MC) for assignment to a NWP, clinic staff and Program Supervisor shall review the record to verify the presence of the following:

    a. A current (within the last 12 months) comprehensive assessment or assessment update that addresses current functional impairments and treatment needs

b. An up-to-date Diagnostic Review with an included diagnosis
c. Evidence in a Progress Note that staff discussed the referral with the client and the client is in agreement with the referral to a NWP
d. A completed BH Referral with required staff signatures

C. Client Prerequisites for NWP level of care

1. Must have full-scope Medi-Cal with no share of cost or private insurance coverage
2. Must be motivated for treatment and likely to benefit from short-term therapy
3. Must have a history of attending scheduled appointments, with few FTS
4. Must be able to identify treatment issues and be capable of participating in therapy

D. NWP Referral Process

**1. <u>Referring staff will:</u>**

a. Ensure that the client is appropriate and eligible for NWP services (B and C above must be complete)
b. Document discussion and client's agreement with NWP referral in a billable Case Management Progress Note
c. Fully complete a BH Referral in Anasazi and obtain Program Supervisor signature.
d. The referral must document:
   i. Symptoms that result in current functional impairment
   ii. Objectives that are SMART (Specific, Measurable, Attainable, Results-oriented, Timely)
   iii. Any additional information or concerns that might be helpful to NWP

**2. <u>Clinic Health Information Technician (HIT) will:</u>**

a. Process referral to MC
   i. Obtain all required signatures for opening before sending to MC
   ii. Open subunit 1003/1004 (adult/youth) to the MC Program Supervisor, effective the date the Clinic Program Supervisor signs the referral
   iii. Fax the MEDS Lite Screen to MC HIT

b. When informed the client is assigned a NWP
   i. Modify end dates for Treatment Plans as appropriate
   ii. Check Client Action Schedules (CAS) and delete as appropriate
   iii. Close clinic subunits as appropriate
   iv. Send the record and name tab for the drop file to the MC HIT, once all items are completed and final approved

**3. <u>MC Program Supervisor or designee will:</u>**

a. Review the BH Referral to confirm that the client is appropriate for NWP

b. Sign the referral and enter comments in the "Receiving Program Comments" box
c. If the referral is accepted, assign the MC HIT to process the referral
d. If the referral is not accepted, email the clinic staff and Program Supervisor to describe the reasons the client cannot be assigned this level of care

**4. <u>MC Clinician will:</u>**

a. Contact the client to discuss availability, preferences, and requests regarding NWP
b. Contact potential NWP to discuss the referral, confirm availability to treat client in a timely manner, and document the provider's next available appointment for a new client on the BH Referral
c. Contact the client by phone and by letter after a NWP agrees to accept the referral to instruct the client about how to contact the NWP for services
d. Complete the MH NWP Authorization assessment in Anasazi and assigns the MC HIT to process the assignment
e. Write a Case Management Progress Note to document the assignment
f. If unable to reach the client in step one, will attempt to reach the client by phone twice more. If unable to reach the client by phone, will send an outreach letter
g. If the client does not respond to the outreach letter, will notify the referring clinic staff and Program Supervisor that the NWP referral cannot be completed at this time and the case will be transferred back to the clinic for review

**5. <u>MC HIT will:</u>**

a. Launch an authorization in Managed Care Module (MCO) in Anasazi
b. Send a welcome letter to the client with the NWP's name, address, and phone number instructing the client to call the NWP to schedule a first session
c. Print the following documents from Anasazi and send to the NWP:
    i. Current assessment or assessment update
    ii. Current Diagnostic Review
    iii. Current Demographic
    iv. BH Referral
    v. NWP Authorization

E. Conclusion of Therapy with NWP

1. NWP will use the authorized sessions to conclude the therapy episode with the client or will request additional sessions. Refer to *Monitoring and Authorizing Network Provider Services for additional detail*. When treatment ends, the NWP will submit a Closing Summary to MC.
2. If the client is open at a local clinic for other services, the MC Clinician will write an Informational Note to document the closing and alert the clinic Single Accountable Individual (SAI) of the closing by email
3. If the client's Behavioral Health episode of care is closing (no clinic assignments remain open), the MC Clinician will notify the MC HIT to close the case

4. The MC HIT will scan the Closing Summary into Anasazi and close assignments as needed

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 04/05/2015 | All | Procedure updates |
| 08/13/2018 | All | Revised for clarity, procedure updates |
| Prior Approval dates: | | |
| 10/01/2012 | | |

| | | |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 10.04 Fraudulent Advertising Policy

## I. PURPOSE

Individuals with behavioral health needs and their families are vulnerable and at risk of being easily victimized by fraudulent marketing practices that adversely impact the delivery of health care. This policy ensures compliance with advertising requirements for behavioral health programs licensed and certified by the California State Department of Health Care Services.

## II. POLICY

San Luis Obispo Behavioral Health Department (SLOBHD) will not use false or misleading advertisements for services.

## III. REFERENCE(S)

- Behavioral Health Information Notice 22-022
- Senate Bills 434 and 541

## IV. PROCEDURE

A. SLOBHD shall not:
   1. Make a false or misleading statement or provide false or misleading information about the entity's products, goods, services or geographical locations in its marketing, advertising materials, or media, or on SLOBHD website or on a third-party website.
   2. Include on SLOBHD website a picture, description, staff information, or location of an entity, along with false contact information that surreptitiously directs the reader to a business that does not have a contract with SLOBHD.
   3. Include on SLOBHD website false information or an electronic link that provides false information or surreptitiously directs the reader to another internet website.

B. SLOBHD clinics and contracted providers shall disclose its license and/or certification number and the date that the license is scheduled to expire in each of the following circumstances:
   1. To any person who inquires about the facility's license and or certification in writing, verbally, electronically, or by any other method of communication between the person and the facility.
   2. By posting on the SLOBHD website or the website of the contracted provider in a clear and conspicuous manner the following language and a link to the DHCS website that contains the facility's license number and expiration date: "Licensed and/or certified by the State Department of Health Care Services."
   3. Included in any print, audio, or electronic advertising or marketing of the facility in a clear and conspicuous manner.

V. REVISION HISTORY

| Effective/Revision Date: | Sections Revised | Status: Initial/ Revised/Archived Description of Revisions |
|---|---|---|
| 11/1/2024 | Entire Policy | Initial Release for Behavioral Health Director approval/signature |
| Prior Approval dates: | | |
| | | |

| | | |
|---|---|---|
| *Signature on file* | | *10/30/2024* |
| Approved by: | Star Graber, PhD. Behavioral Health Director | Date |

# 10.10 Network Provider Panel: Membership and Credentialing

I. PURPOSE

To describe the Network Provider selection, credentialing, and support processes

II. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) Managed Care staff will maintain a panel of individual Network Providers to provide Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS) for SLO Medi-Cal beneficiaries. The panel will be of sufficient size and diversity to meet the needs of beneficiaries, taking into consideration the anticipated needs of clients for professional services in their own communities.

SLOBHD will certify and re-certify Network Providers according to National Committee for Quality Assurance (NCQA) standards at least every three years.

SLOBHD will not credential or contract with any debarred, suspended or otherwise prohibited provider.

III. REFERENCE(S)

- Code of Federal Regulations, Title 42, §§ 438.12, 438.214, 438.610, 455.436, 455.104
- Welfare and Institutions Code, §§ 14043.6 and 14123
- California Code of Regulations, Title 9, §§1810.435 and 1810.436
- DHCS Contract with the MHP, Exhibit A
- DHCS DMC-ODS Contract with the SLOBHD
- SLOBHD Policy and Procedure 12.08, Monitoring and Verifying Provider Eligibility
- SLOBHD Policy and Procedure 10.14, Monitoring and Authorizing NWP Services

IV. PROCEDURE

A. Applicants will complete an Network Provider Application, which includes an attestation regarding:

1. The ability to perform the essential functions of the position
2. Lack of present illegal drug use and/or alcohol abuse
3. Any history of loss of licensure or felony convictions
4. Any history of loss or limitation of privileges or disciplinary activity
5. An attestation as to the correctness and completeness of the application

B. Upon receipt of a completed Outpatient Network Provider Application, the credentialing clerk or designee (which may be an outside contractor, such as Med Advantage) will verify provider eligibility (see SLOBHD Policy and Procedure 12.08, Monitoring and Verifying Provider Eligibility for detail.

C. Additional database searches will include the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB)

D. The Managed Care credentialing clerk or designee will verify that each applicant has:

1. A current valid California state license as a Medical Doctor, Psychiatrist, Psychologist, Licensed Clinical Social Worker, Licensed Marriage Family Therapist, Licensed Professional Clinical Counselor, or a Master's level Registered Nurse
2. A valid Drug Enforcement Agency (DEA) Certificate, if applicable
3. A diploma from an accredited professional school or highest training program applicable to the academic degree, discipline and licensure of the professional
4. Current, adequate malpractice insurance coverage and comprehensive general liability insurance in accordance with County standards
5. A history free from professional liability claims resulting in settlements or judgments paid by, or on behalf of the professional
6. Clinical privileges in good standing at the institution designated by the professional as the primary admitting facility, if applicable
7. Professional work history including, but not limited to, the last (5) years
8. Two (2) professional peer references

E. Credentialing Committee Approval Process and Selection Criteria

1. The Credentialing Committee will consist of the Managed Care Program Supervisor, the Quality Support Team Division Manager, and the Behavioral Health Administrator. Additional staff will join the committee when needed to evaluate the application of specialist providers
2. Upon completion of step D, the Credentialing Committee will review the application to make a membership determination
3. Expected utilization, geographic location (time/distance/proximity to public transportation), specialty/training/experience, service type, capacity to provide services in a timely manner, cultural/linguistic capability, willingness to accept new beneficiaries, and physical accessibility will be factors in determining panel membership
4. SLOBHD will not discriminate against providers who serve high–risk or specialized populations that require costly treatment
5. SLOBHD will not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely based on that license or certification
6. Once approved by the Credentialing Committee, the credentialing clerk or designee will send a contract to the provider for signature, notarization and return

F. Protest Procedure

1. If the Credentialing Committee elects not to contract with an applicant, the Managed Care Program Supervisor will give the affected provider written notice of the reason for its decision and information regarding SLOBHD's protest procedure
2. The applicant may challenge the Committee's decision by submitting a written protest to the SLOBHD Medical Director for review
3. SLOBHD will review the protest and respond in writing within 30 calendar days of receipt
4. If the matter is not decided in favor of the applicant or if SLOBHD fails to respond in a timely manner, then the protest shall be deemed denied and the provider may appeal the failure to DHCS

G. Post-Contract Support and Monitoring

1. Upon receipt of a signed, notarized contract, the Managed Care Program Supervisor or designated clinician will conduct a site visit to ensure that the site is clean, safe, accessible, and provides for secure storage of medical records
2. The Managed Care Program Supervisor or designated clinician will review medical necessity criteria, documentation, authorization, billing and appeal processes with the provider. The Network Provider Handbook and documentation training material will be given to the provider
3. See SLOBHD Policy and Procedure 10.14, Monitoring and Authorizing NWP Services for additional detail regarding service monitoring

H. SLOBHD will re-credential every (3) years in accordance with NCQA standards and will consider the following:

1. Member complaints
2. Quality improvement activities, including, but not limited to audits
3. Utilization management activities
4. Member satisfaction data

I. Termination/Termination Notice

1. SLOBHD will retain the right to terminate any Network Provider contract in keeping with the terms of the contract
2. SLOBHD will make every effort to provide written notification of intent to terminate a provider to any affected beneficiary at least 15 days in advance of the termination and will arrange ongoing treatment for the beneficiary

J. Network Providers will additionally comply with any DHCS Provider Enrollment Division (PED) requirements, including, but not limited to enrollment in the Provider Application and Validation for Enrollment (PAVE) database

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/23/15 | All | Reformatted, added purpose |
| 09/08/17 | All | Expanded scope to include DMC-ODS providers |
| 02/18/22 | IV.E. | Added #5 and CFR 42 reference |
| Prior Approval dates: | | |
| 05/30/09 | | |

| *E-Signature on file* | | *04/29/2022* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 10.11 Network Provider Expedited Credentialing

## I. PURPOSE

To ensure San Luis Obispo County Medi-Cal beneficiaries who qualify for Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (DUDS) are provided timely outpatient services with certifying the competency, professionalism, and appropriateness of each Network Provider serving on the San Luis Obispo County Behavioral Health Department (SLOBHD) Network Provider panel.

## II. POLICY

SLOBHD Managed Care unit will complete expedited processing of Network Provider applications when there is a high demand for services, delays of service, a Transition of Care request, or following the routine credentialing process might jeopardize the functioning of the clients served.

## III. REFERENCE(S)

- SLOBHD Policy and Procedure(s)
  - 10.10 Network Provider Panel Membership and Credentialing
  - 3.23 Availability, Timeliness, Network Adequacy and Array of Services
  - 3.50 Transition of Care
  - 12.08 Staff Eligibility Verification and Provider Credentialing

## IV. PROCEDURE

A. The Managed Care Program Supervisor gives the applicant's name to the Credentialing Technician who contacts the applicant to request the following documentation/information:

   - Professional State License
   - DEA Certificate (if applicable)
   - Provider's Professional Liability Insurance Face Sheet
   - Provider's Social Security Number
   - Date of Birth
   - Provider's mailing address, email, telephone and fax number
   - County in which professional is credentialed (if an out-of-county applicant)
   - Network Provider Application (includes a required Attestation)

B. In most cases, a Credentialing Information Request form is sent by fax and the above information is returned in the same manner.
C. After receiving the required information, the Credentialing Clerk verifies the professional's state licensure online with the proper licensing board, (i.e. California

Board of Behavioral Sciences, California Board of Psychology, Medical Board of California) to ensure that the license is current, and no pending or past disciplinary action has been taken against the professional. If any pending or past disciplinary action against license or insurance is discovered, a written explanation is required from the individual for consideration by the Credentialing Committee.

D. The Credentialing Technician verifies that the applicant is not on any excluded list (see Policy 12.08 Staff Eligibility Verification and Provider Credentialing for detail)
E. If the Network Provider applicant practices in a county other than San Luis Obispo, the Credentialing Clerk contacts the professional's County of practice for verification of current credentials.
F. Once all information has been gathered, the applicant's credentialing file is presented to the Quality Support Team Division Manager for initial review. The Division Manager then routes the file to the Behavioral Health Administrator for further review by the Credentialing Committee. The Credentialing Committee may grant provisional credentialing status in order for a particular client to be treated.
G. Once the credentialing file is returned to the Credentialing Technician, the thorough process of credentialing the applicant is completed. See Policy titled Credentialing of Private Providers.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 05/30/2009 | | Adopted |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *05/30/2009* |
|---|---|---|
| Approved by: | Behavioral Health Administrator (KB) | Date |

# 10.12 Network Providers Profile Information

## I. PURPOSE

To ensure the County of San Luis Obispo Behavioral Health Department (SLOBHD) Medi-Cal beneficiaries who qualify for Specialty Mental Health Services (SMHA) are provided a current provider list upon request and when first receiving a SMHS..

## II. POLICY

Credentialed Network Provider participants must be added to the Profile List in the Network Provider section of the Provider Payment database as well as to the County of San Luis Obispo Behavioral Health Department (SLOBHD) provider list available to the public on the SLOBHD website in both English and Spanish. Mental Health Managed Care maintains a practice profile of all Network Providers.

## III. REFERENCE(S)

## IV. PROCEDURE

A. The Network Provider applicant is required to provide a clinical profile with their Network Provider application.
B. Upon enrollment as a Network Provider, the Senior Account Clerk enters the following information in the Provider Maintenance Database fields, based upon the information outlined on the provider's clinical profile, and Network Provider application:

- Provider Type (Discipline)
- First and Last Name
- Office Location
- Mailing Address
- Telephone Number
- Email Address
- Fax Number
- Tax I.D. Number
- License Number and Expiration Date
- Professional Liability Insurance Number and Expiration Date
- Contract Start and End Date
- Re-Credentialing Date
- Assigned Staff Identification Number
- Bilingual Capabilities
- Culturally Specific Capabilities
- Clinical Specialties

C. The Managed Care Senior Account Clerk updates the fields as necessary by maintaining a regular system of tracking, and by notification from the provider.
D. The Managed Care Program Supervisor, or designated Managed Care staff, will update the SLO County Behavioral Health provider list to include the following information and direction on how to access the following information about each provider:
   1. Names of provider
   2. Office location and contact information
   3. Language capacity
   4. Scope of Practice
   5. Whether the provider is accepting new referrals
E. When the Managed Care Program Supervisor receives notification of a change in the provider's status, (i.e., bilingual/culturally specific capabilities) this information is reviewed for approval and the provider list is updated.
F. After approval by the Managed Care Program Supervisor, this information is given to the Managed Care Senior Account Clerk to update the provider's clinical profile, and Managed Care staff is informed of changes in provider status.
G. At minimum, at the time of biennial contract renewal, Network Providers are given the opportunity to update their practice profile.
H. Network Providers may update their practice profiles at any time upon request by submitting information to the Managed Care Program Supervisor or Senior Account Clerk.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 06/01/2015 | I | Purpose added |
| 08/21/2018 | All | Formatting |
| Prior Approval dates: | | |
| 05/30/2009 - Adopted | | |

| *Signature on file* | | *06/01/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 10.13 Credentialing Former Employees as Network Providers

I. PURPOSE

To ensure the competency, professionalism, and appropriateness of each Network Provider serving on the San Luis Obispo County Mental Health (SLO MH) Network Provider panel.

II. POLICY

- SLO MH carefully monitors the participation of former employees on the Network Provider panel to ensure high quality, professional care for beneficiaries.
- Employees of SLO Behavioral Health and Community Based Organizations cannot apply for Network Provider panel membership until after termination of employment.
- Former employees become eligible for Network Provider panel membership one year after terminating employment.
- Any attempt by an employee to influence Behavioral Health clients to participate in treatment activities with the employee in a private practice setting (e.g., referral to self or to a business partner) is prohibited. Evidence of improper inducement will be referred to the appropriate licensing and/or legal entity for investigation.

III. REFERENCE(S)

IV. PROCEDURE

A. Standard Credentialing:
A former employee may begin the Network Provider application process six months after leaving employment, but credentialing will not be finalized and the Network Provider contract will not be signed by the Behavioral Health Administrator until one year after the employment termination date.

B. Expedited Credentialing:
Occasionally, it is in the best interest of SLO MH to expedite credentialing of a former employee (e.g., if the Network Provider panel lacked a needed language/cultural/specialized treatment resource a former employee could provide). Requests for expedited credentialing are reviewed on a case-by-case basis by the Behavioral Health Administrator. See policy 10.11 Network Provider Expedited Credentialing for detail.

C. Waiver of the Wait Period
Occasionally, it is in the best interest of both a beneficiary and SLO MH to authorize treatment by a former employee before the standard one year wait period ends. Requests for waiver of the wait period are reviewed on a case-by-case basis by the Behavioral Health Administrator. Continuity of care, language/cultural considerations, the need for specialized treatment, beneficiary preference and other relevant factors may be considered.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 04/01/2015 | I | Purpose added |
| 08/23/2018 | All | Formatting |
| Prior Approval dates: | | |
| 05/30/2009, 12/21/2012 | | |

| | | |
|---|---|---|
| | | |
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 10.14 Monitoring and Authorizing Network Provider Services

I. PURPOSE

To ensure Client Care Plans and Progress Notes documenting services requested and provided by Network Providers are reviewed in a consistent, timely manner and are monitored for medical necessity and to confirm documentation standards are met.

II. POLICY

The Behavioral Health Managed Care Site Authorization Team (SAT) will perform quality review and authorization functions for beneficiaries whose specialty mental health services (SMHS) or substance use disorder services (SUDS) are provided by Network Provider panel members. The Managed Care SAT is composed of licensed clinicians (LMFT, LCSW, LPCC or Psychologist) and waivered/registered interns. The Behavioral Health Medical Director is available for consultation as needed.

III. LICENSED MANAGED CARE STAFF WILL:

1. Ensure that beneficiaries served by Network Providers meet medical necessity criteria for SMHS or SUDS
2. Review payment authorization requests from Network Providers and make timely authorization decisions
3. Review Client Care Plans and Progress Notes to ensure that Network Providers maintain client records in a manner that meets state, federal, and the MHP's Quality Management Program standards

IV. REFERENCES

- California Code of Regulations, Title 9, §1810.435(b)(4,5), §1830.205, §1830.210 and §1830.215
- Contract with Department of Health Care Services (DHCS), Exhibit B, Sections 1, 2, 4, 7, 11 through 14, 16
- Policy 3.20, *Authorization/Approval of Services* for information about medical necessity and the MHP's SAT process
- Policy 10.03, *Network Provider Referral* for a description of the referral process, initial determination of medical necessity, and the Network Provider brief therapy model.
- Policy 10.10, *Network Provider Credentialing* for a description of Network Provider credentialing and contracting requirements

V. PROCEDURE

A. Initial Authorization
After locating a Network Provider with a current opening and the ability to meet the beneficiary's treatment, language and cultural needs, Managed Care staff preauthorize one assessment and two therapy sessions.

B. Client Care Plan Review

1. Prior to the fourth therapy session, the Network Provider and beneficiary develop a Client Care Plan, which documents the beneficiary's strengths, current symptoms, impairments, goals and objectives.
2. The Client Care Plan must:
   a. Contain specific observable and/or quantifiable goals and objectives
   b. Identify the number and type of sessions requested
   c. Identify the proposed interventions, which must:
      i. Address the identified functional impairments which are a result of the mental health or substance use disorder
      ii. Be consistent with the client plan goal and with the qualifying diagnoses
   d. Be signed by the Network Provider, the client (age 12 and older), and, (if applicable), by the Parent/Legally Responsible Person.
3. If the plan documents medical necessity for ongoing services and contains all the necessary elements, Managed Care staff preauthorize the services requested by the Network Provider. The authorization is valid for six (6) months or until the sessions are utilized, whichever comes first. If the Client Care Plan does not meet documentation standards, Managed Care staff return it to the Network Provider for revision. If the Network Provider's request for services is modified or denied, an appropriate NOABD is sent to the provider and beneficiary. See Policy 3.30, Notices of Adverse Beneficiary Determination for detail.
4. The Network Provider completes a new Client Care Plan prior to the end of an authorization to request additional sessions. Managed Care staff review the request and make an authorization decision based on the documentation of medical necessity, the appropriateness of the interventions, the availability of other resources, and other relevant factors. If the Network Provider's request for services is modified or denied, an appropriate NOABD is sent to the provider and beneficiary.

C. Quarterly Progress Note Audits

1. Network Providers submit progress notes to match billing for services rendered in January, April, July and October each year. Managed Care staff audit a random sample of at least 10% of the progress notes using the Progress Note Audit Tool (Attachment A). Minor errors (missing license or signature of provider, inconsistent

dates, etc.) are returned to the Network Provider for correction. If a note does not meet the MHP's documentation standards, the service is voided, and a letter is sent to the Network Provider to correct the deficiency.

2. Results of the audit are reported to the Quality Support Team (QST) Committee on a quarterly basis. The results are also distributed to the Network Providers and are used to help direct training efforts.

D. Network Provider Documentation Training

1. A Client Care Plan documentation manual is distributed to each Network Provider upon initial contracting. The documentation manual is periodically updated and redistributed.
2. A periodic newsletter provides updates on documentation, feedback from progress note audits, and other relevant information.
3. Periodic Network Provider trainings review documentation issues.
4. Network Providers participate in SLOBHD trainings.

## VI. DOCUMENT HISTORY

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| 10/28/2015 | | Added purpose, reformatted |
| 10/27/2017 | | Broadened to include SUD |
| 12/19/2017 | | Broadened to include ODS Waiver |
| Prior Approval dates: | | |
| 12/21/2012, 10/28/2015 | | |

| *Signature on file* | | *12/19/2017* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

**Attachment A:** Progress Note Audit Tool

| **Progress Notes** | | | |
|---|---|---|---|
| **YES** | **NO** | **N/A** | **Note date:** **Procedure Code**: |
| | | | 1. Is the billing time reasonable for this service? |
| | | | 2. Is there documentation of client encounters including clinical decisions and interventions? |
| | | | 3. Is the focus of the intervention to address the impairment caused by the covered diagnosis (and not solely academic, vocational, recreational, socialization, transport, clerical, payee-related)? |
| | | | 4. Is the documentation legible? |
| | | | 5. Was the service billed appropriately for the setting? |
| | | | 6. Is there a signature of the staff providing the service with their professional degree, license, or job title? |
| | | | 7. If this is a group note, are the interventions individualized? |
| | | | 8. Is the note written according to Standard Progress Note format? |

# 10.15 Compliance with Charitable Choice Requirements

## I. PURPOSE

To provide guidance to ensure adherence to Charitable Choice requirements regarding nondiscrimination and institutional safeguards for religious providers.

## II. SCOPE

Applies to all County of San Luis Obispo Behavioral Health Department (SLOBHD) contracts and contracting providers.

## III. POLICY

SLOBHD contracts shall include language prohibiting discrimination against individuals on the basis of religion. In addition, religious organizations shall be equally eligible for receipt of contracts through SLOBHD.

## IV. REFERENCE

- Title 42, United States Code, Section 300x-65
- Title 42, CFR, Part 54
- Title 45, CFR, Part 96, Section 96.122
- ADP Bulletin 04-5, http://www.adp.ca.gov MHP Contract, Exhibit A, Attachment 1, Section 7
- SABG Application, Enclosure 2, III, 6

## V. PROCEDURE

A. Contracting religious organizations shall establish a referral process to a reasonably accessible program for clients who may object to the religious nature of the contractor's program, and contractors shall be required to notify clients of their rights:

   1. Protecting them from discrimination
   2. To be referred to another program if they object to the religious nature of the program at intake

B. Contractors shall not use funds for religious program content.

C. Contractors shall be required to report any referrals that were made due to the religious nature of the contractor's program to the SLOBHD Drug and Alcohol Services Division Manager or designee.

D. Referral information will be submitted to the State annually by the SLOBHD Quality Support Team (QST).

E. SLOBHD QST will monitor adherence to this requirement through annual site visits to programs and through a review of client files.

###

VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 1/30/2023 | All | Formatted |
| | | |
| Prior Approval dates: | | |
| 7/30/2007 – Adopted | | |

| *Signature on file* | | |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 10.20 Medi-Cal Certification Sites

## I. PURPOSE

To ensure that all contract organization providers and County-owned and operated providers meet Medi-Cal Certification criteria.

## II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will require that all contract organization providers and all County-owned and operated providers meet Medi-Cal certification criteria. SLOBHD's Quality Support Team (QST) will provide oversight of the certification process.

## III. REFERENCE(S)

- Code of Federal Regulations, Title 42, § 438.214
- California Code of Regulations, Title 9, §§ 1810.435 and 1810.436
- DHCS-MHP Contract, Exhibit A, Attachment I, Section 4
- DMC-ODS Contract with DHCS (Intergovernmental Agreement)
- DHCS MHSUDS Information Notice 21-075

## IV. PROCEDURE

Reimbursement for Medi-Cal claimed services may only occur if the provider has been certified as a Medi-Cal provider.

A. Certification of New County-owned and operated Mental Health sites:

1. Behavioral Health (BH) Billing must request a provider number from the Department of Health Care Services (DHCS) by submitting a Provider File Update form (MH 3829). The form will specify Modes of Service and Service Function codes that will be utilized.
2. Application packets for initial certification of county-owned and operated programs will be completed by the MHP Quality Support Team (QST) and submitted to DHCS by emailing the application along with the documents listed below to: DMHCertification@dhcs.ca.gov.
   a. Fire clearance dated within one year.
   b. Copy of the professional license of the head of service for the site.
   c. Program Description and General Operating Procedures.
3. DHCS will verify the receipt of the application packet via email back to QST, request additional information or corrections if needed, and schedule a site visit within 6 months of the receipt of the application.
4. QST staff will ensure that the site is in compliance with the most recent SD/MC

Provider Certification and Re-Certification Protocol before the site is operational and before the DHCS site visit.

B. Re-certification of County-Owned and Operated Mental Health sites:

1. Re-certification will be completed by QST staff every three years.
2. Before the certification period ends, QST staff will re-certify the County-owned and operated sites as follows:
   a. The fire clearance will be requested from Health Agencies Facilities.
   b. After the fire clearance is received, QST staff will ensure that the site is in compliance by conducting a site visit and completing the MHP Re-Certification of County-Owned or Operated Providers Self Survey Form.
   c. The completed form will be emailed to DHCS along with the fire clearance, program description, and a copy of the professional license of the head of service.
3. Exceptions:
   a. If Day Treatment is provided at a County-owned and operated site, a DHCS site visit and recertification will be required.
   b. If Day Treatment or Medication Support (involving the administration and storage of medications) are added, a MHP Re-Certification of County–Owned or Operated Providers Self Survey Form will be completed, and a DHCS site visit and recertification will be required.
   c. If a County-owned and operated site moves to a new address, a DHCS site visit and re-certification will be required at the new site.

C. Certification and re-certification of Contracted Mental Health sites:

1. Certification and re-certification of contracted Mental Health sites will be completed by QST staff as follows:
   a. The Program Supervisor will be asked to obtain a fire clearance.
   b. After the fire clearance is received, QST staff will conduct a site visit and will use SD/MC Provider Certification and Re-Certification Protocol to ensure that the site is in compliance.
   c. QST staff will complete the Medi-Cal Certification Transmittal (DHCS 1735) form and will email it to DHCS along with the fire clearance and a copy of the professional license of the head of service.
2. Re-certification of contracted Mental Health sites will be completed by QST staff every three years unless the provider moves to a new address.
   a. If the provider moves to a new address, QST staff will conduct a site visit as described above at the new site.
   b. When a new site visit takes place because of a move to a new address, the site will be considered “re-certified”, and recertification will be due three years from the date of the new certification.

D. Certifying and re-certifying Out-of-County providers (“Piggybacking”):
1. Out-of-County providers will only be certified when HA Billing Department has made

arrangements for payment and if a SLOBHD client receives services there. Out-of-County providers will not be certified in anticipation of clients possibly needing to receive services there.

2. Before a SLOBHD client receives services at an out-of-County facility, QST staff will:
   a. Contact the facilities administrative representative and ask for their County's Medi-Cal certification approval letter, Fire Clearance, and copy of professional license of head of service.
   b. Complete the Medi-Cal Certification Transmittal (DHCS 1735) form, requesting only the services listed as approved on their County's Medi-Cal Certification approval letter.
   c. Email the completed form along with the fire clearance and copy of professional license of head of service to DHCS.

*Note: The SLOBHD Medi-Cal certification period will end on the same day that the host county's certification period ends.*

E. Provider Information Management Systems (PIMS):

1. The county approver designee is responsible for:
   - Adding new providers
   - Managing existing providers
2. All providers certified by SLOBHD will be listed on the PIMS website.
3. QST staff will monitor the PIMS system on a quarterly basis to ensure sites are certified, re-certified, or terminated by accessing the PIMS website and viewing the most recent certification date, location, and service modes that have been requested and approved.

F. Certification of new County operated Drug & Alcohol clinics and contracted DMC-ODS Providers:

1. DMC-ODS Counties select the DMC-certified providers with who they contract to establish their DMC-ODS provider networks. DMC-certified providers that do not receive a DMC-ODS County contract cannot receive a direct contract with DHCS to provide services to residents of DMC-ODS Counties.
2. DMC-ODS Provider Qualifications: DMC-certified providers providing DMC-ODS services must:
   a. Be licensed, registered, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations.
   b. Abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by DHCS.
   c. Sign a provider agreement with the DMC-ODS county or counties in which DMC-ODS services will be rendered.

3. Initial Certification:
   a. The application for Medi-Cal Enrollment is completed in the DHCS PAVE database

by the provider. QST staff will be an administrator for applications and to assist with facilitation of resolving any PAVE/application issues.

G. Monitoring In-County DMC-ODS Providers:

1. Each fiscal year, QST staff will complete on-site monitoring reviews for all County-operated and contracted DMC-ODS providers located within the county. Monitoring reports include administrative, personnel, fiscal, and clinical/chart reviews. The on-site portion of the review will include a review of the facility.
   a. The fire clearance for each facility will be checked every year during the site review process. The Program Supervisor will be asked to obtain a fire clearance.
2. A monitoring report for each site/provider will consist of a site visit letter and a Corrective Action Plan (CAP), if applicable. The monitoring report is submitted to the Program Supervisor, Division Manager, and/or Program Director.
3. QST will submit the monitoring report to DHCS within 2-weeks of the date that the report was sent to the site/provider.

H. Monitoring Out-of-County DMC-ODS Contracted Providers:

1. Each fiscal year, QST Staff will request monitoring reports from the County Behavioral Health agency in the county that each contracted provider is located. QST will request that the monitoring reports include administrative, personnel, fiscal, and clinical/chart reviews.
2. QST Staff will review the monitoring reports with the aid of a monitoring tool (checklist) to assess that important safety/risk elements were monitored by the contracted provider's County (i.e., fire clearance, excluded provider database checks).
3. QST will submit the Out-of-County monitoring report to DHCS, along with the completion of the monitoring tool from SLOBHD. This will be submitted to DHCS within 2-weeks of QST Staff's review of the Out-of-County monitoring report(s). QST will also submit a cover letter to DHCS that will indicate the date the monitoring report(s) were received from the partnering County, the date that the report(s) were reviewed by QST, and the date the report(s) were submitted to DHCS.

I. Termination of a Contracted Provider:

1. QST is notified from Fiscal Department termination of a contracted provider with date of termination.
2. QST will complete the Existing Provider Information Form for Request Type of Contract Status Change to delete provider on San Luis Obispo Master Provider File Report or Out of County Referral Report for providers outside of San Luis Obispo County.
3. Existing Provider Information Form is emailed to dhcsmpf@dhcs.ca.gov
4. QST receives Master Provider File Report and Out of County Referral Log monthly to review and notify DHCS of any changes within five (5) business days to assure reports are current in the DHCS database.

## V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/23/2015 | | Renamed and updated procedure to reflect current practice |
| 08/23/2018 | All | Formatting |
| 03/30/2022 | Added F | Added section F to include certification of DMC-ODS sites and monitoring DMC-ODS providers |
| 02/03/2023 | Added I | Added Termination of Contracted Provider |
| 09/05/2024 | IV.A.2 & E | Updates made to align with current procedure |
| Prior Approval dates: | | |
| 03/21/2007 | | |

| | | |
|---|---|---|
| *Signature on file* | | *09/11/2024* |
| Approved by: | Star Graber, PhD, LMFT, Behavioral Health Administrator | Date |

# 10.21 Contracting and Monitoring of Services

I. PURPOSE

To ensure that contracts and services provided through independent contractors are monitored.

II. POLICY

Contracting for services is governed by the Government Code and the San Luis Obispo County Behavioral Health Department (SLOBHD) on Contracting for Services and Construction as adopted by the Board of Supervisors on November 9, 1981.

The authority to purchase using public funds begins with our Board of Supervisors who, by ordinance, established rules and regulations related to the purchase of materials, supplies, equipment, services and other personal property. Through the ordinance the Board has appointed a Purchasing Agent with duties and responsibilities defined within the SLOBHD Code.

- The General Services Agency Director is the appointed Purchasing Agent. County Code Section 2.36.020 Creation of the Office of the Purchasing Agent
- The purpose of section 2.36.020 is to establish the authority to purchase in the name of the County. Title 2, Chapter 2.36, section 2.36.030 sets forth the specific duties of the purchasing agent and provides for standardized procedures and provides uniform requirements for acquiring goods and services for the County.
- It can be found at: http://www.slocounty.ca.gov/clerk/County_Codes___Traffic_Codes.htm.

It is the responsibility of SLOBHD to monitor the contracts and the services provided through independent contractors. Such monitoring includes compliance with the contract and the standard of the services being provided.

III. REFERENCE(S)

- California Code of Regulations, Title 9, §1810.405, §1810.410

IV. PROCEDURE

A. Request for Proposal (RFP)

1. SLOBHD may contract for services by following State and County guidelines. http://myslo.intra/Assets/GSA/Purchasing/Forms/Contracts+101.pdf

2. For selection of contractors, the Behavioral Health Administrator may request the Purchasing Agent in Central Services to prepare and issue a Request for Proposals (RFP) when the service value exceeds $25,000.00. RFPs include services or program needs that will be incorporated during the development of the contract.
3. Responses for RFPs are reviewed by a committee formed by the Behavioral Health Administrator. Members may include, (but not limited to) representatives of the Behavioral Health Advisory Board, the County Administrator's Office, and Central Services.
4. Behavioral Health Advisory Board, the County Administrator's Office, and Central Services.
5. Upon the recommendation of the selection committee, the selected contractor will work with the SLOBHD to finalize the program description and budget to be included in the contract.
6. Contracts for services are based on funding availability and generally coincide with the SLOBHD's Fiscal Year which ends on June 30.
7. Periodically, RFPs are published to allow new contractors to submit applications for particular services, even when current contractors are performing well. Generally, this should occur at least every three to five years.

B. Contractor requirements to SLOBHD: The following procedure applies to SLOBHD contracts exceeding $25,000.00.

1. The selected contractor provides the SLOBHD with a description of the program or services, a detailed rate schedule, a signed W-9 Tax form including the contractor's Tax I.D. number, a copy of all applicable licenses, proof of authorization for two (2) signatures who have rights to enter into legally binding contracts for the contractor, and any other pertinent information necessary to draft the proposed contract.
2. Once the W-9 is received, staff will review contractor eligibility thru the Health Agency Public Ineligible Provider Search portal. Some individuals and businesses are prohibited from participation in Health Agency programs due to felony convictions or other circumstances as defined by State and Federal guidelines. If contractor is found to be ineligible, notification to contractor is required and contracting process is terminated. If contractor is eligible, process is continued below.
3. The proposed contract is then sent to the contractor for review and further negotiations. Upon mutual agreement, a final contract is submitted to contractor for the appropriate signatures.
4. After the contract has been signed by the contractor, it is submitted to the County Counsel's Office for signature after their review as to form and legal effect.
5. After approval by County Counsel, staff prepares a staff report and transmittal memo to accompany the contract which is submitted to the County Administrative Office for review and placed on the Board of Supervisors consent agenda. These actions follow the Board Agenda Policy and Manual, which is found on the SLOBHD Administrative Office intranet site.

6. The process includes:

    a. Board Memo and Transmittal Form is prepared by staff and reviewed by the Behavioral Health Chief Fiscal Officer.
    b. An Outlying Agreement Number (OAR) is requested from Central Services/Purchasing through the Behavioral Health Fiscal Division.
    c. Board Memo and Transmittal Form is sent to the Administrative Analyst of the County Administrative Office five (8) working days prior to the specified Board of Supervisors meeting via Agenda.Net.
    d. After approval by the County Administrative Office, the item is placed on the Board of Supervisors Agenda. Refer to Agenda Item Preparation Manual for details and calendar.

7. The Chair of the Board of Supervisors is the last to sign the contract. With the Chair's signature the document is considered to be a fully executed contract.

8. The executed contract is returned to the Behavioral Health Administrative Division and is distributed as follows:

    a. Original signed contract is stored in the Behavioral Health's central filing cabinet.
    b. A signed cover letter by the Behavioral Health Chief Fiscal Officer or designee is prepared regarding the executed contract and identifies the responsible contract administrator.
        i. Contract and cover letter is scanned and e-mailed to the contractor.
        ii. Scanned contract and cover letter is filed in: M:/Accounting/Contracts/
        iii. Scanned contract is also filed in:
        iv. U:/Contracts and Grants/Mental Health/
        v. A working hardcopy of each contract should be filed in the contract administrators' contracts folder.

    c. Contracts are generally awarded for one (1) year, with the term of the contract aligned to the fiscal year. There are some exceptions to this practice (Example: multiple year State contracts, individual doctors and contracts with other government agencies.) Annual contracts may be extended for additional years depending upon budgetary negotiations and successful performance by the contractor. Contract extensions should be reviewed and approved by the Behavioral Health Chief Fiscal Officer.

C. SLOBHD as Service Provider to State or other Organization

1. Department of Health Care Services, State Department of Rehabilitation, California Counties, or other organizations may contract with SLOBHD to provide services. In these instances, SLOBHD is not the initiator of the contract. The contract is drafted by the outside entity and processed according to outside entities procedures and timelines

and is the last to sign. County Counsel and Board of Supervisors approval processes remain the same.

D. Compliance issues relating to:

1. Department of Health Care Services regulations and standards concerning contracts;
2. SLOBHD policies and regulations pertaining to contract negotiations and monitoring;
3. Licensing and insurance issues as specified in individual contracts.

E. Compliance Issues:

1. The contractor is responsible for ensuring that all contract services are in compliance with the requirements of the Department of Health Care Services as contained in the Cost Reporting/Data Collection (CR/DC) Manual.
2. The contractor is responsible for ensuring that all contract services are in compliance with existing SLOBHD contract policies.
3. All contracts for services shall be reviewed by the County Counsel's Office as to form and legal effect.
4. Upon approval of the contract by the Board of Supervisors, the contractor shall provide SLOBHD with a current copy of all pertinent insurance policies and/or certificates clearly indicating the insurance to be provided and naming the SLOBHD as additional insured. Contractor shall meet all standard insurance coverage requirements in accordance with the provisions of the contract. Any exceptions to the standard insurance coverage requirements must be reviewed and approved by the SLOBHD's Risk Manager. Documentation of current insurance coverage shall be retained in SLOBHD's contract file.
5. Upon approval of the contract by the Board of Supervisors, the contractor shall provide SLOBHD a signed copy of the SLOBHD's Compliance Plan Certification and Code of Ethics.
6. Claims for payment and/or reimbursement shall be submitted to Behavioral Health Fiscal for review prior to approval for payment. All reasonable efforts will be made to process claims in a timely manner.
7. Contractors who provide Medi-Cal services shall submit an annual Cost Report as instructed by Behavioral Health Fiscal.
8. The SLOBHD may initiate a review of the contractor's records as provided for in the contract.
9. Contractors shall provide SLOBHD with all information necessary to track outcomes related to the established performance measures and financial reporting as indicated in the contract.

F. Standards for client services:

1. SLOBHD will designate a case manager to serve as a liaison for each contractor. The case manager will aid in the development of referral criteria, participate in ongoing

evaluation of the amount and the appropriateness of each service, and ensure a discharge plan is developed when the service is no longer considered required or appropriate.

2. Contractors, after consultation with SLOBHD staff are expected to develop procedures and methods for quality assurance and peer reviews. These results shall be reported to the SLOBHD Quality Support Team as a condition of contract compliance.
3. Regular meetings with each contractor, their representatives and SLOBHD staff shall be scheduled to review services and costs, while providing a venue for problem solving of clinical and fiscal issues.
4. SLOBHD's clinical, administrative, and technical staff can contact contractors for consultation and assistance throughout the year.
5. SLOBHD refers to SLOBHD Central Services Contracting for Services. Department of Health Care Services and/or SLOBHD policies, standards, and regulations have precedence and are binding to both SLOBHD and the contractor.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/17/2015 | All | Adopted |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *11/17/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 10.22 Master Provider File Review

## I. PURPOSE

- Confirm information documented in the DHCS Master Provider File (MPF) is accurate on a monthly basis for County and contracted providers
- Establish corrective action and timelines for submission of updated information

## II. POLICY

In accordance with state regulations, the County of San Luis Obispo Behavioral Health Department (SLOBHD) will review each monthly Master Provider File (MPF) issued by the California Department of Health Care Services (DHCS) to confirm the accuracy of information. Written notification of provider changes or inaccuracies in a MPF file will be submitted to DHCS MPF within five (5) business days on current approved forms. Additionally, SLOBHD will notify DHCS of any new providers subcontracted through SLOBHD to establish new records within MPF.

## III. REFERENCE

- SABG State-County Contract, Exhibit A, Attachment I A2, Part III, G

## IV. PROCEDURE

A. Existing Provider Documentation and Review:

1. MPF Report is generated by DHCS at the end of each calendar month and issued to SLOBHD Quality Support Team Administrative Services Officer (ASO).
2. ASO reviews report for inaccuracies or changes in existing providers, including contract status, relocation, closing, and changes in services provided.
3. ASO will communicate all discrepancies to DHCS for resolution. Written notification must be submitted to MPF mailbox at DHCSMPF@dhcs.ca.gov within 5 business days of issuance of MPF for any changes or corrections. Document used is "Existing Provider Request Form."

B. New Provider Documentation Submission:

1. For any new subcontractor relationships, ASO will submit "New Provider Request" Form to request six-digit provider ID for any SUD provider site that is not in the MPF database.

2. For any sub-contracted SUD provider located in a different county, ASO will submit "OOCR Request Form" to request Out-of-County Referral (OOCR) number.
3. Written documentation for new providers will be submitted to MPF mailbox at DHCSMPF@dhcs.ca.gov.

## V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 09/09/2024 | All | Formatting |
| | | |
| Prior Approval dates: | | |
| 7/1/2020 | | |

| | | |
|---|---|---|
| *Signature on file* | | *09/11/2024* |
| Approved by: | Star Graber, PhD, LMFT, Behavioral Health Administrator | Date |

# Section 11

# Quality Improvement

# 11.00 Performance Outcome Measures

## I. PURPOSE

To track and monitor quality management and quality improvement activities for San Luis Obispo County Behavioral Health Department (SLOBHD).

## II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) administers all performance outcome measures as directed by the State Department of Health Care Services (DHCS). Performance outcomes focus on the prescribed target populations including Foster Youth, Youth, Adults, Perinatal and Postnatal Women, and Older Adults as directed by the Department. Target populations include county residents, as well as clients who are residents of other counties receiving services in SLOBHD.

## III. REFERENCE(S)

- Title 42, CFR, Section 438.240 (e), (b)3
- CCR, Title 9, Chapter 11, Section 1810.440
- Contract between DHCS and SLOBHD (MHP) Exhibit A,
- Contract between DHCS and SLOBHD (DMC-ODS) Exhibit A

## IV. PROCEDURE

A. All performance outcome measure materials are handled using the same standard of confidentiality as mental health medical records. This will include using client identification numbers to protect name confidentiality when necessary.

B. The State Consumer Perception and Treatment Perception Surveys are distributed according to Department of SLOBHD's schedule to all mental health and substance use disorder clients and the results will be summarized and shared with providers, consumers, and Behavioral Health Board.

C. Aggregate results of performance outcomes are shared with SLOBHD staff, providers, and Behavioral Health Board upon their availability from state or local evaluation staff, no less than annually.

D. The results from performance outcome measures are used in the Performance and Quality Improvement process of program review on an annual basis.

E. Providers are trained in the use and interpretation of the performance outcome measures on a regular basis.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 05/30/2009 | | Adopted |
| 09/04/2018 | All | Formatting |
| 4/5/2023 | All | Described behavioral health scope |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *04/11/2023* |
|---|---|---|
| Approved by: | Behavioral Health Administrator (KB) | Date |

# 11.01 Quality Improvement /Quality Management Committee

## I. PURPOSE

Purpose of the PQI/QM Committee is to identify areas that need quality improvement, and track and monitor quality improvement activities for San Luis Obispo County Behavioral Health Department (SLOBHD).

## II. POLICY

In accordance with regulations, the Quality Support Team/Quality /Management Committee (QST/QM):

- Oversees the quality improvement activities of SLOBHD, including the implementation of the annual Quality Improvement work plan.
- Recommends policy changes.
- Reviews and evaluates the results of quality improvement activities.
- Institutes needed quality improvement actions.
- Ensures follow-up of quality improvement processes.
- Develops, implements, and evaluates the effectiveness of strategic initiatives.
- Receives reports from any QI subcommittee (e.g. Morbidity and Mortality Committee, Performance Improvement Project Committees) or from compliance officer regarding compliance activities.

## III. REFERENCE(S)

- CCR, Title 9, Chapter 11, Section 1810.440
- Title 42, CFR, Section 438.240 (e), (b)3
- Title 42, CFR, Section 438.416
- CA Evidence Code 1157.6
- Contract with Department of Health Care Services (DHCS), Exhibit B, Sections 11-12

## IV. PROCEDURE

A. Membership in the QST/QM committee is determined by Title 9 regulations and by invitation from the committee chair and the Behavioral Health Administrator. Membership is as follows:

- Division Manager of QST or designee (Chair)
- Behavioral Health Administrator
- Mental Health Compliance Officer
- Mental Health Privacy Officer
- Behavioral Health Medical Director

- Chief Fiscal Officer or designee
- Division Manager
- Program Supervisor
- Staff Psychiatrist
- Patients' Rights Advocate
- Consumer/Family Advocate
- Contracted Services Representative or designee
- PHF Services Representative (optional)
- Utilization Review Clinical Staff
- Mental Health Board Representative
- Cultural Competence Representative
- Consultants or guests by invitation

B. The QST Committee meets at least ten times per year or as frequently as needed to meet organizational needs.

C. Quorum Requirements:

1. Meetings are official QST Committee meetings when a quorum is present.
2. A quorum is defined over 50% of the members.
3. A quorum is necessary to approve Policies and Procedures.
4. Meetings at which the attendance is less than an official quorum proceed as QST Action and Review Subcommittee meetings.
5. Motions adopted in Action and Review Subcommittee meetings have the same weight as those adopted in official QST meetings except in cases of Policies and Procedures, which require a quorum to adopt.

D. Motions and Recommendations:

1. The Committee follows Robert's Rules of Order.
2. A motion may be made and seconded by any of the members.
3. The Committee Chair calls for votes of all motions.
4. Consultants and guests do not have voting rights.
5. Motions require a simple majority to be recommended as action items.
6. All Policies and Procedures require a simple majority to be recommended to the Behavioral Health Administrator for approval. Members can vote in person or electronically.

E. Responsibilities of the Committee Members

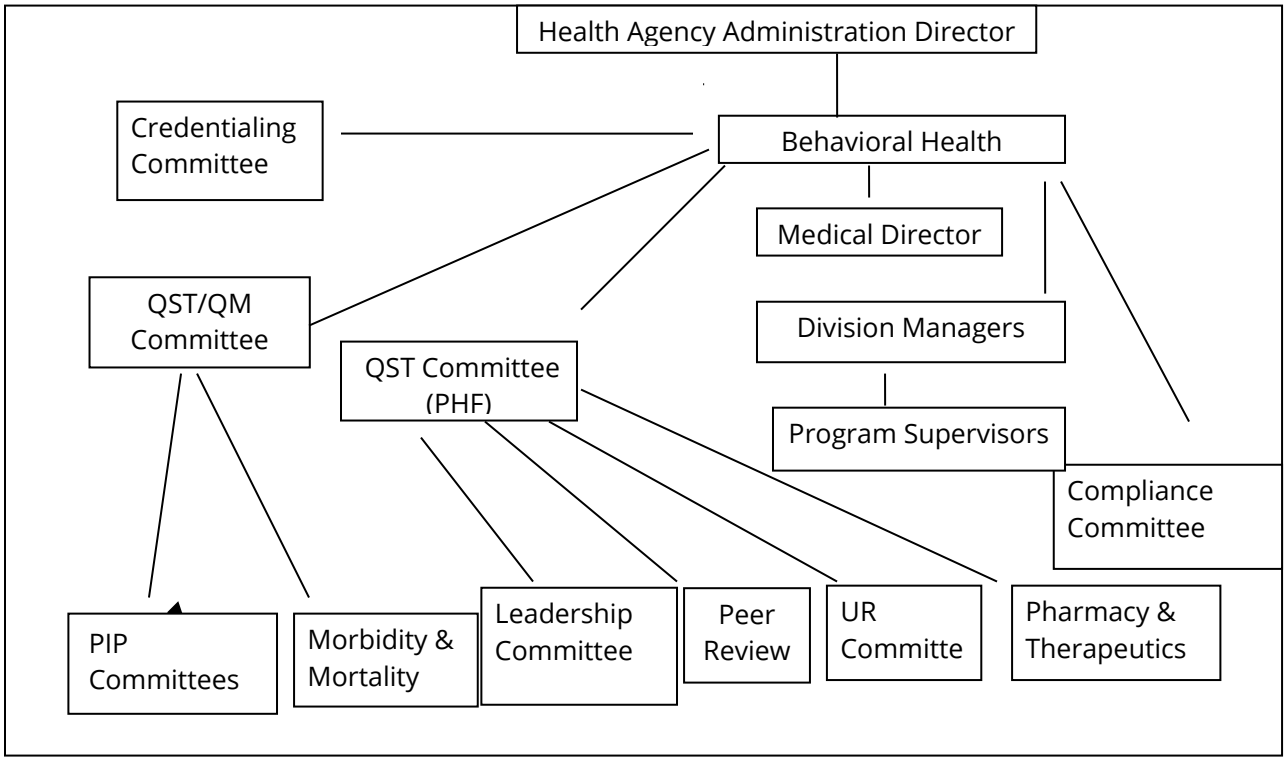
1. The proceedings of the meeting are kept confidential.
2. As representatives of various parts of the department, timely input/reports are to be provided about activities that contribute to clinical care, beneficiary service, and initiatives.

3. The relevant and identified issues are communicated to staff in collaboration with implementing the notion of quality throughout the department.
4. Members participate in the evaluation of the effectiveness of the initiatives and work plan items.

F. Billing and Documentation

1. All proceedings of the meeting are kept confidential except for data which can be shared with staff for training or feedback purposes.
2. Committee minutes are not distributed electronically to members.
3. Meeting records, including minutes, incident reports and other records are kept securely and permanently.
4. Committee's proceedings are also kept electronically in a folder on a shared drive with access restricted to key staff: M:\QST\MH Plan\QST_QM MHP COMMITTEE
5. Mental Health committee members bill their participation to QST and Utilization Review Internal Order according to the information in Attachment A. When this option is unavailable, billing to Medi-Cal Administrative Activities (MAA) should be considered.

G. Organizational Chart of QST Committee Structure



V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/01/2012 | | Adopted |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| 09/21/2012 | | |

| *Signature on file* | | *09/12/2012* |
|---|---|---|
| Approved by: | Behavioral Health Administrator (KB) | Date |

**Attachment A**: Time Card Coding Information for Participating in PQI Activities.

| | |
|---|---|
| 166R126ADUS | Arroyo Grande UR Support |
| 166R126ADSP | Arroyo Grande UR Skilled Professional |
| 166R126AUS | SLO Vicente UR Support |
| 166R126ADSP | Inpatient UR Skilled Professional |
| 166R126ADUS | Inpatient UR Support |
| 166R126ADSP | Managed Care Skilled Professional |
| 166R126ADSP | SLO Vicente UR Skilled Professional |
| 166R126ADSP | OP QI/UR Skilled Professional |
| 166R126ADUS | OP QIUR Support |
| 166R126ADSP | Compliance UR Skilled Professional |
| 166R126ADSP | SLO Johnson UR Skilled Professional |
| 166R126ADUS | SLO Johnson UR Support |
| 166R126ADSP | Atascadero UR Skilled Professional |
| 166R126ADUS | Atascadero UR Support |
| 166R310000SP | CSS OP QI/UR Skilled Professional |
| 166R310000US | CSS Outpatient QI/UR Support |

# 11.02 Change Committee

I. PURPOSE

The mission of the Change Committee is to gather information regarding the need for organizational changes in order to develop a system which is efficient, responsive, transparent, and supportive. This involves facilitating communication between staff and management, resulting in recommendations for change. The mission will be successful when staff participates in the process and when recommendations for change are implemented or addressed by management and results are disseminated to staff

II. POLICY

The Change Committee was developed in order to create a venue where direct care and line staff can communicate directly with the Behavioral Health Administrator.

III. REFERENCE(S)

IV. PROCEDURE

A. Membership in the Change Committee is comprised of the Behavioral Health Administrator, and direct care, and line staff. Each program site from Mental Health Services and Drug and Alcohol Services has a representative on the committee.

B. Responsibilities of the Committee Members and Minutes

1. Staff gather information from their co-workers at their program sites. Issues and concerns are emailed to the Committee chair to be placed on the agenda for the next meeting.
2. The members of the committee communicate to their co-workers the issues presented at the committee meetings and the response from administration.
3. Minutes are taken at each meeting and distributed electronically to all staff. The minutes are stored on the shared drive/intranet.

C. Meeting Frequency

1. This committee meets every-other month or at the discretion of the chair.

D. Suggestion Boxes

1. Each program site in Behavioral Health has received a locked suggestion box.

2. This box is for clients and staff members to make compliments, comments or suggestions.
3. Each Change Committee member will have the key to the suggestion box and will collect the comment cards on a weekly basis.
4. The comment cards will be reviewed at each Change Committee meeting.
5. Compliments or positive comments made about a specific staff member will be given to the Program Supervisor by the appropriate committee member. The Program Supervisor reviews the comment card at a staff meeting.
6. Comments containing a specific complaint about staff will be given to the Behavioral Health Administrator. If a Consumer Request Form is collected in the suggestion box, the form will be routed to the Patients' Rights Advocate.
7. In an attempt to increase confidentiality, Psychiatric Health Facility will have two boxes, one for Suggestions and one for Consumer Request Form.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 02/01/2015 | | 2/2015Procedure Removed: "Management staff does not participate in this committee."<br>Changed: "The Behavioral Health Administrator or designee will attend at the end of the meeting to discuss the issues presented" to Administrator being a part of the Committee<br>Frequency: Changed from monthly to every-every-another month |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| 02/22/2011 | | |

| *Signature on file* | | *03/10/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 11.03 Peer Review Committee

I. PURPOSE

- To describe the Peer Review process whereby SLOBHD medical staff evaluate medical care to ensure that beneficiaries receive care that meets accepted standards
- To recommend appropriate measures to ensure that SLOBHD medical staff has not departed from accepted medical care standards

II. SCOPE

Applies to medication support services provided by SLOBHD medical staff and contract provider medical staff in all outpatient and inpatient mental health settings and substance use disorder treatment programs

III. POLICY

County of San Luis Obispo Behavioral Health Department (SLOBHD) will conduct regular reviews of the appropriateness of care rendered and formulary decision-making processes to ensure clinical efficacy, patient safety, and cost-effective prescribing within the Department. SLOBHD will utilize a Peer Review Committee to determine whether the physician/medical provider under review has met accepted standards of care in rendering medical services.

IV. REFERENCE

- Welfare & Institutions Code §4070
- Quality Support Team Work Plan
- California Code of Regulations, Title 22, Division 5, Chapter 9, Article 4, §77083

V. PROCEDURE

A. The Peer Review Committee consists of a chairperson, who is the Medical Director, medical staff from Quality Support Team (QST), and medical staff from other disciplines appointed by the Behavioral Health Services Administrator or Medical Director.

B. The committee meets monthly or as agreed upon by the members of the Committee. An agenda is prepared and minutes from the last meeting are reviewed by each member of the Committee. Corrections/amendments are made and minutes are approved.

C. QST staff select at least a 5% random, stratified, unduplicated sample of charts each from Inpatient and Outpatient program for review at each meeting. The sample is determined by

the number of patients in each program. The period in review is from the 3 months prior to the review month.

D. The Peer Review Form(s) (attachments 1, 2 & 3) is completed to document the results of the review of each medical service. Cumulative feedback by program and by provider is collected.

E. If necessary, the Committee develops and recommends corrective action. The action must be appropriate to the cause and must be documented on each indicator that exceeds the established threshold level. Areas to look at when deciding on corrective action include:

    1. System weaknesses and issues that need resolution to improve client care
    2. Areas for improvement in prescribing or documentation practices
    3. Training needs regarding documentation or prescribing practices
    4. Performance weaknesses in following established protocols

F. The Committee reports, both verbally and in written form, to the QST Committee. Reports include conclusions, recommendations, and actions.

G. The Committee ensures that any recommended actions are appropriate to the circumstances, and are structured to ensure that quality care can be delivered. The Committee gives the peer in review the opportunity to offer rebuttal information and to submit a rebuttal statement of reasonable length. Any rebuttal statement must be free of retaliatory statements to any Committee member.

H. In some circumstances, the Peer Review Committee or a subset of the committee will be asked to review the professional or personal conduct of a physician or other healthcare professional. In such instances, The Medical Director and Behavioral Health Administrator will take appropriate follow up action, which may include, but will not be limited to:

    1. Mandatory training, education or supervision
    2. Restricting or or terminating privileges
    3. Reporting findings to appropriate licensing board
    4. Personnel actions up to and including termination or contract or employment

I. All proceedings of Peer Review Committee are kept confidential to the degree allowed by law.

###

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| 11/01/16 | Entire document | Reformatted and updated language |
| 01/27/17 | Entire document | Reformatted and updated language |
| 09/08/17 | Entire document | Reformatted, added/expanded scope |
| Prior Approval dates: | | |
| 12/5/12; 11/1/16; 1/27/17 | | |

| *Signature on file* | | *09/11/2017* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, BH Administrator | Date |

# 11.04 Policy and Procedure Development

I. PURPOSE

To clarify San Luis Obispo County's Behavioral Health Department (SLOBHD) method for developing, reviewing, notifying staff of changes and implementing new Policies and Procedures

II. POLICY

SLOBHD establishes Policies and Procedures to improve client care and to ensure agency-wide adherence to laws, regulations and contractual requirements.

III. REFERENCE(S)

- Contract between the State Department of Health Care Services (DHCS) and SLOBHD, Exhibit A, Attachment I, 23 (B)

IV. PROCEDURE

A. Development and Revision of Policies

1. Policies and Procedures may be developed or revised at any time in response to Quality Support Committee (QSC) recommendation or staff, clinical, community, or administrative needs

2. Policies and Procedures for Mental Health Services are drafted or revised by the Quality Support Team (QST) Division Manager or designee, and are presented to Program Supervisors, Administration, and other key staff or providers, including the QSC, for input.

3. The QST Division Manager or designee makes any necessary modifications based on feedback. A final draft is reviewed by Administration and then forwarded to the Behavioral Health Administrator for approval.

B. Dissemination of Policies

1. Once a new or revised policy has been approved, a QST staff member will post the policy on the approved site (M-Drive or, soon, the Health Agency's Intranet Site: http://myslo.intra/health.htm)

2. The Behavioral Health Administrator or designee sends an email to all SLOBHD Staff and Providers announcing that a new policy has been approved and posted on the designated site.

3. The Program Supervisors discuss the new or revised policy with all their staff at the earliest opportunity.

4. Staff members acknowledge that they are familiar with the Health Agency and Departmental policies and procedures related to their jobs by signing a certification form at the Human Resource Department on an annual basis.

C. Training of Staff

1. The QST Division Manager provides training to the site Program Supervisors when new Policies and Procedures are ready for implementation.

2. At least twice per year the QST Division Manager or designee conducts training for all SLOBHD Staff and Contractors. This training will:

   a. Introduce the newest version of the Treatment Plan and Documentation Guidelines

   b. Update staff on any new or revised policies and procedures

3. Subsequent trainings are conducted by individual Program Supervisors at the sites throughout the year

4. QST provides additional electronic and face-to-face trainings throughout the year as necessary, especially when there are significant policy or documentation changes.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 04/23/2014 | Procedure I | Final approval by BH Admin instead of QST |
| 04/24/2015 | | Moved from Section 12 Compliance to Section 11 QI |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *11/24/2014* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 11.05 Quality Support Team

I. PURPOSE

To describe the quality management program implemented by San Luis Obispo County Behavioral Health Department (SLOBHD)

II. SCOPE

Applies to all SLOBHD county-operated and contract provider programs that provide Specialty Mental Health Services (SMHS) through the Mental Health Plan (MHP) and Substance Use Disorder Services (SUDS) as part of the Drug Medi-Cal/Organized Delivery System (DMC-ODS) Waiver

III. POLICY

A. SLOBHD's Quality Support Team (QST) will complete ongoing quality management, quality improvement, utilization management and utilization review activities as required by regulation and contract(s) with DHCS.

B. The primary goals of QST program and activities will be to:

1. Monitor and improve beneficiary outcomes and SLOBHD processes
2. Monitor and ensure timely access to and SLOBHD authorization of a full range of medically necessary services to beneficiaries of all demographic groups in all geographic regions of the county
3. Monitor beneficiary satisfaction and use of problem resolution processes
4. Improve the quality, consistency, efficacy and safety of service delivery
5. Improve the quality and consistency of documentation and application of medical necessity criteria

IV. REFERENCE(S)

- Code of Federal Regulations (CFR), Title 42, §§ 438.1 – 438.930
- California Code of Regulations (CCR), Title 9, § 1810.440
- CCR, Title 22, § 51341.1
- Contract between the Department of Health Care Services (DHCS) and SLOBHD (MHP) Exhibit A, Attachment I, Items 22-24
- Contract between DHCS and SLOBHD (DMC-ODS) Exhibit A, Attachment I, Items 22-25

**Behavioral Health Policies and Documents:**

- Health Agency Policies and Documents
- Fraud, Waste and Abuse Prevention Policy
- Compliance Plan
- Code of Conduct

- Contractor Support page: http://www.slocounty.ca.gov/health/Health_Agency_Support_Page_for_Contractors_and_Network_Providers.htm
- 10.21 Contracting and Monitoring Services
- 10.14 Monitoring and Authorizing Network Provider Services
- Quality Support Team Program Structure and Description
- Quality Support Team Work Plan (updated annually)
- Quality Support Team Work Plan Evaluations (updated annually)
- QST Audit Schedules (updated annually)

V. PROCEDURE

A. To accomplish the above goals, SLOBHD will:

1. Define its QST program and ensure adequate staffing to carryout QST functions. Details of program goals and staff assignments/duties will be found in the Quality Support Team Program Structure and Description, which is reviewed annually and updated as needed to ensure effective implementation of the program.

2. Establish quality improvement committees (QST Committee) and subcommittees to monitor various aspects of service delivery and system performance. The QST Committee will include active participation by the SLOBHD staff, providers, beneficiaries and family members/advocates, in the planning, design and execution of QST activities. For detail regarding QST Committee membership and activities, refer to Quality Support Team Program Structure and Description and committee minutes, agenda and presentation material, which will be maintained by QST staff.

3. Develop an annual QST Work Plan with input from the QST Committee to identify goals and objectives. Complete an annual evaluation of the Work Plan to ensure that SLOBHD's improvement activities produce measurable results that lead to improvements in outcomes for beneficiaries. For detail, refer to the current QST Work Plan and the previous year's QST Work Plan Evaluation.

4. Establish structured utilization review and management processes to ensure quality of care, quality of documentation and adherence to recognized coding and billing processes. For detail, refer to the current QST Audit Schedule.

5. Monitor and maintain records of certification, service delivery and adherence to practice standards of county-operated and contract providers, in collaboration with SLOBHD Fiscal and Health Agency Compliance Program staff.

###

VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 12/02/2016 | | Adopted |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *12/02/2016* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# Section 12

# Compliance and Program Integrity

# 12.08 Staff Eligibility Verification and Provider Credentialing

I. PURPOSE

- To describe the steps taken to screen, enroll, and monitor all employees and contracted staff to ensure that no one is on an excluded or ineligible list
- To describe steps taken to credential and re-credential all staff who provide Medi-Cal reimbursable services

II. POLICY

Prior to hiring or entering a contract with any individual or Community Based Organization (CBO), the County of San Luis Obispo Behavioral Health Department (SLOBHD) will verify or receive verification that each individual is eligible to complete the relevant duties. SLOBHD will not employ, certify, contract with, or pay any individual or organizational provider if the provider or any staff member is listed on any excluded list or otherwise becomes ineligible (i.e., is debarred, suspended, excluded, or has any relationship with SLOBHD prohibited by law). SLOBHD will routinely monitor employees, Network Providers and Contractor staff to ensure ongoing eligibility as required by law.

Additionally, SLOBHD will credential and re-credential all licensed, waivered, registered and certified providers to ensure that all providers who perform Medi-Cal reimbursable services meet current legal and professional standards.

III. REFERENCE(S)

- Welfare and Institutions Code §§14043 – 14045; §14123
- Code of Federal Regulations (CFR), Title 42, §§455.400 – 455.440; §438.214, §438.610, and §438.808
- DHCS – MHP contract, Exhibit A
- DHCS – DMC-ODS contract, Exhibit A
- MHSUD Information Notice 18-019
- SLOBHD P&P 10.10 *Network Provider Panel Membership and Credentialing*

IV. PROCEDURE

## A. INITIAL CERTIFICATION

1. All SLOBHD employees and contracted staff: Prior to employment or contract commencement, County of San Luis Obispo Human Resources Department or Health Agency Human Resources (HA HR) staff will complete the following for all SLOBHD Employees (including Independent Contractors and Contract Employees):

a. Pre-Employment Background Check
b. Review of application, which includes
    i. Work history
    ii. Hospital or clinic privileges and standing
    iii. Signed statement by applicant (Attachment A) describing:
        1. Any limitations or inabilities that would affect the provider's ability to perform any of the position's essential functions
        2. A history of loss of license or felony conviction
        3. A history of loss or limitation of privileges or disciplinary activity
        4. A lack of present illegal drug use that affect the provider's ability to perform any of the position's essential functions
        5. The application's accuracy and completeness
c. Standard background, which includes
    i. Criminal, civil, and DMV record checks
    ii. Education, employment and reference verification
d. Check of Federal and State databases
    i. Office of Inspector General's List of Excluded Individuals/Entities (LEIE)
    ii. Excluded Parties List System/System Award Management (EPLS/SAM)
    iii. Social Security Death Master File (SSDMF) (Effective 7/1/2017)
    iv. DHCS Medi-Cal List of Suspended or Ineligible Providers (MCS&I List)
    v. National Practitioner Data Bank (NPDB) (effective 10/1/2018 for licensed, waivered, or registered clinical staff only)
e. Review of Live Scan results
    i. Each potential SLOBHD employee will be scheduled for a Live Scan at a County of San Luis Obispo Sherriff's Department location
    ii. If Live Scan results indicate a history of criminal conviction, HA HR staff will discuss options with SLOBHD Management Team and a decision about whether to proceed or halt the hiring process will be made
    iii. Upon receipt of clear results, employment processing will continue
f. Verify identity
    i. Collect copies of approved ID, most commonly a valid California Driver's License and Social Security Card or Birth Certificate to confirm identity
g. Verify license/certification status (applies to licensed, waivered, registered, or certified staff)
    i. License verification will be obtained from a primary source, usually the licensing/certifying board's website
        1. Proof of completion of any relevant medical residency and/or specialty training
        2. Satisfaction of any applicable continuing education requirements
    ii. License/certification must be current and free of any restrictions or limitations.

iii. If the database search identifies any Public Record Actions (disciplinary actions, sanctions, convictions, judgements, liability claims, reprimands, etc.), HA HR staff will notify the hiring manager and Compliance Officer for investigation and successful resolution of the issue

h. Verify National Provider Identifier (NPI) and Taxonomy Code on the National Plan and Provider Enumeration System (NPPES) website

i. Verify Drug Enforcement Administration (DEA) number (prescribing staff only)

j. If any of the searches result in a finding that could affect employment, HA HR staff will discuss options with SLOBHD Management Team, who will decide whether to proceed or halt the hiring process. Only after successful completion of the above steps will the prospective employee receive a formal employment offer. Problems identified in the screening process will be resolved prior to employment

2. CBO staff:
   a. BH Contractor Compliance Certification form: Upon initiation and at each renewal of contract, each CBO will attest to the completion of a certification process that meets the requirements described in A(1) above and re-certification process as in C below, except that Live Scan is only applicable to positions where required by law
   b. CBOs will not employ or contract with any ineligible individual as described above and will provide evidence of a certification process that meets the requirements above upon request by SLOBHD
   c. Each licensed, registered, waivered and certified staff employed by or subcontracted by a CBO will sign a SLOBHD-approved attestation as described above in A(1)(b)(iii). The CBO will provide a copy of each attestation to SLOBHD

3. Individual Network Providers:
   a. SLOBHD Managed Care staff will credential Network Providers prior to contracting utilizing National Committee for Quality Assurance (NCQA) standards. Refer to Policy 10.10 Network Provider Credentialing for detail
   b. Managed Care credentialing staff will complete the initial database searches and the license verification in paragraph A(1)(a-c; e-h) above or will utilize a credentialing agency to complete these steps prior completion of a contract
   c. Current malpractice insurance

## B. ENTRY INTO ELECTRONIC HEALTH RECORD (EHR) PRIOR TO ACCESS

1. When a staff member will have access to information contained in an EHR, the Program Supervisor, hiring manager, or CBO manager will submit a Staff ID Application to Service Desk on behalf of the prospective employee or contractor after completion of step A, B, or C above.

2. Prior to the employee obtaining log in privileges, Service Desk staff will:

a. Re-verify license/certification status (if applicable) by search of relevant primary source database
b. Enter the license/certification number, type, and effective/expiration dates in the EHR Staff Maintenance table. License/certification must be current and free of any restrictions or limitations.
c. If the database search identifies any Public Record Actions (disciplinary actions, convictions, judgements, reprimands, etc.), Service Desk staff will notify the hiring manager and Compliance Officer for investigation and successful resolution of the issue
d. Verify National Provider Identifier (NPI) and Taxonomy Code on the National Plan and Provider Enumeration System (NPPES) website and will enter these values in the EHR Staff Maintenance. If any discrepancies or errors are noted, Service Desk staff will contact the Program Supervisor, hiring manager and Compliance Officer for investigation and successful resolution of the issue.
e. Verify and enter Drug Enforcement Administration number (prescribing staff only)

3. Only after successful completion of the above steps will the employee receive access to the EHR to begin employment duties. Issues identified at this point in the screening process will result in corrective action up to and including termination of employment.

## C. RECERTIFICATION

1. Ongoing checks and controls (See attachment A for a description of the methodology)
   a. HA HR staff will complete a monthly database check of the LEIE, NPPES, EPLS/SAM, and MCS&I databases for the following individuals:
      i. All active HA staff
      ii. All users of an EHR (SLOBHD employees, Network Providers and Contractor staff)
      iii. Any vendor or person in the SAP enterprise financial system to whom the County makes any payment.
   b. If the monthly checks identify an individual on an excluded list, HA HR staff will notify the hiring manager and Compliance Officer for investigation and successful resolution of the issue. If exclusion is verified, the Compliance Officer will promptly notify DHCS of the finding and the follow up actions taken by SLOBHD
      i. The identified individual will be immediately locked out of the EHR and reassigned to prevent provision of services pending resolution of the issue; if the individual is an employee of an agency who utilizes the County EHR, that agency's Compliance Officer will also be notified immediately.
      ii. When applicable, the Compliance Officer will coordinate repayment to DHCS of any paid claims made by the excluded provider

iii. If the issue cannot be resolved, SLOBHD will implement appropriate action up to and including termination of employment or contract

c. The SSDMF will be checked annually by a compliance program vendor and the corrective action process will be as described immediately above

d. The HA Compliance Officer will coordinate routine monitoring activities to verify that each CBO completes and documents monthly exclusion list checks for all CBO staff not entered into the HER

2. License/certification checks
   a. SLOBHD employees will receive a reminder notice from HA HR's Tracker system when a license or certification is due to expire
   b. The EHR will automatically prevent any individual with an expired license or certification from claiming for services for which an active license or certification is required
   c. Prior to expiration of license/certification or upon any change in status (i.e., when a registered Intern becomes licensed) SLOBHD staff will notify HA HR of the renewal or status change of their license/certification
   d. HA HR staff will verify license/certification status (if applicable) by search of relevant database and will print confirmation for HR file
      i. The License/certification must be current and free of any restrictions or limitations
      ii. If the database search identifies any Public Record Actions (disciplinary actions, convictions, judgements, reprimands, etc.), HA HR staff will notify the hiring manager and Compliance Officer for investigation and successful resolution of the issue
   e. HA HR staff will notify HA Service Desk staff of the renewal
   f. HA Service Desk staff will independently verify the license or certification by search of the relevant database and will update Staff Maintenance
   g. HA Service Desk staff will verify National Provider Identifier (NPI) and Taxonomy Code on the National Plan and Provider Enumeration System (NPPES) website and will update these values in Staff Maintenance when needed

3. Attestation (applies to all staff who provide covered SMHS or DMC-ODS services)
   a. HA HR staff will obtain an initial attestation for all current employees, contracted staff, and Network Providers that meets the standards identified in MHSUD IN 18-019. See Attachment B.
   b. Future hires will sign the attestation prior to employment or contracting
   c. HA HR staff will obtain a renewal attestation at least every three years

4. HA HR staff will search the National Practitioner Data Bank (NPDB) to confirm that no licensed, waivered, registered, or certified clinical staff are found on the exclusion list.

### D. DISPUTES AND APPEALS

1. SLOBHD Personnel Decisions
   a. SLOBHD will develop a process for evaluating credentialing information and making employment determinations based on the information obtained thereby
   b. When SLOBHD elects not to hire a prospective employee or takes action to terminate the employment of a staff member who is no longer eligible due to information discovered in the credentialing or re-credentialing process, HA HR will follow all current Civil Service Rules that govern employment terms
   c. Affected staff will have an opportunity to provide evidence of eligibility and a process for appealing employment determinations

2. CBOs
   a. Each CBO must develop a process for evaluating credentialing information and making employment determinations based on the information obtained thereby
   b. Each CBO will follow its established procedure for hiring and/or terminating staff members who are ineligible to provide contracted services.

3. Network Providers
   a. Individual Network Providers will follow the dispute resolution process established in SLOBH Policy & Procedure entitled *Network Provider Panel Membership and Credentialing*

## V. DOCUMENT HISTORY

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| 06/01/2018 | All | Reformatted, added attestation |
| 06/08/2017 | all | Renamed and revised entire policy |
| 04/29/2014 | 3 | Changed from checking annually to monthly |
| 10/29/2014 | 2 and attachment A | Added that contractors check lists monthly |
| 10/10/2018 | all | Reformatted; added to references and attachment B |
| 10/15/2018 | Added D | Added C4 and D |
| 8/10/2020 | 4 | Added steps to initial certification for SLOBHD employees and network providers (4A1gi & 4A3c) |
| Prior Approval dates: | | |
| 04/30/2009, 5/18/2012, 4/29/2014, 10/29/2014, 4/29/2014, 6/8/2017, 10/10/18 | | |

| *Signature on file* | | *12/18/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

Attachment A

Memo Description of Monitoring and Verification Methodologies

1. Check of State and Federal LEIE Lists and SAM Database
   SLOBHD has developed an electronic database check system that compares several databases. This system is used monthly to conduct mandatory checks of individuals and entities against the above system after the state and federal government has updated the databases (Generally around the 10th of each month), but no later than the final calendar day of the month. In addition to conducting monthly checks, the system has an interface for checks of individuals prior to employment. The system has monitoring tools to record the action, date and individual who did the check

   Monthly, HA HR staff manually uploads three government databases to this system. These are the Federal LEIE database, the CA. State LEIE database, and the SAM. In addition, the system automatically uploads Health Agency information from three County databases. These include the entire electronic employee database (Tracker), all providers in the BH EHR, and all Health Agency vendors in the County's accounts payable system (SAP).

   The LEIE check system invokes an algorithm that compares the employees, providers and vendors against the LEIE and SAM databases, then makes recommendations to research potential matches. The HA HR staff research potential matches of Health Agency employees, while the Service Desk Staff researches potential provider and vendor matches.

2. Check of NPPES Database
   SLOBH has developed a database check system that compares all SLOBH employees who have NPI numbers against the NPPES database. The system monthly uploads the NPPES database and compares NPI number and taxonomy against the employee name in the HA HR system and the employee name in the NPPES system. The system flags and recommends research on any NPI matches which have different names or taxonomy numbers between the two databases. HA HR performs the NPPES database check prior to hire, and monthly, on a schedule similar to the LEIE system checks.

3. Check of Social Security Master Death File (SSMDF)
   SLOBH contracts with a third-party vendor that specializes in checking the SSMDF. The Health Agency sends an employee file to the vendor annually and the vendor checks the employee file against the SSMFD. A check of the complete Health Agency employee file is done annually. In addition, HA HR uses the vendor's web portal to check all individuals prior to employment. The third-party vendor is a generally recognized vendor in exclusion and sanction checks.

Attachment B: Sample Attestation

**ATTESTATION**

Please review the items below and mark your response. Explain any items marked with an asterisks (*) on a separate page.

| | | |
|---|---|---|
| Do you have any limitations or inabilities that would affect your ability to perform any of the position's essential functions (with or without | ☐ Yes* | ☐ No |
| Has a licensing board or certifying entity in any state ever revoked, limited, restricted, suspended, placed on probation/conditional status, or taken other disciplinary action against you/your health care-related | ☐ Yes* | ☐ No |
| Have you ever voluntarily surrendered a health care-related professional | ☐ Yes* | ☐ No |
| Has a health care-related professional society, hospital, or other facility ever denied, cancelled, or revoked your membership or privileges? | ☐ Yes* | ☐ No |
| Are you currently or have you ever been listed on Office of Inspector General's List of Excluded Individuals/Entities (LEIE), Excluded Parties List System/System Award Management (EPLS/SAM), or DHCS Medi-Cal List of Suspended or Ineligible Providers (MCS&I List)? | ☐ Yes* | ☐ No |
| Have you ever been convicted of a felony? | ☐ Yes* | ☐ No |
| Do you currently use drugs or alcohol in a manner that would affect your ability to perform any of the position's essential functions? | ☐ Yes* | ☐ No |
| Are you aware of and do you agree to follow the County of San Luis Obispo Health Agency's Drug Free Work Place Policy? | ☐ Yes | ☐ No* |
| Are you aware of and do you agree to follow the County of San Luis Obispo Health Agency's Code of Conduct and Professional Ethics? | ☐ Yes | ☐ No* |

I hereby attest that the above information is true and correct to the best of my knowledge.

ATTACHMENT A

**COUNTY OF SAN LUIS OBISPO**
**HEALTH AGENCY**
**BEHAVIORAL HEALTH DEPARTMENT**
**Michael Hill,** *Health Agency Director*
**Anne Robin, LMFT** *Behavioral Health Director*

## ATTESTATION

Please review the items below and mark your response. Explain any items marked with an asterisks (*) on a separate page.

| | | |
|---|---|---|
| Do you have any limitations or inabilities that would affect your ability to perform any of the position's essential functions (with or without accommodations)? | ☐ Yes* | ☐ No |
| Has a licensing board or certifying entity in any state ever revoked, limited, restricted, suspended, placed on probation/conditional status, or taken other disciplinary action against you/your health care-related license/certification? | ☐ Yes* | ☐ No |
| Have you ever voluntarily surrendered a health care-related professional license | ☐ Yes* | ☐ No |
| Has a health care-related professional society, hospital, or other facility ever denied, cancelled, or revoked your membership or privileges? | ☐ Yes* | ☐ No |
| Are you currently or have you ever been listed on Office of Inspector General's List of Excluded Individuals/Entities (LEIE), Excluded Parties List System/System Award Management (EPLS/SAM), or DHCS Medi-Cal List of Suspended or Ineligible Providers (MCS&I List)? | ☐ Yes* | ☐ No |
| Have you ever been convicted of a felony? | ☐ Yes* | ☐ No |
| Do you currently use drugs or alcohol in a manner that would affect your ability to perform any of the position's essential functions? | ☐ Yes* | ☐ No |
| Are you aware of and do you agree to follow the County of San Luis Obispo Health Agency's Drug Free Workplace Policy? | ☐ Yes | ☐ No* |
| Are you aware of and do you agree to follow the County of San Luis Obispo Health Agency's Code of Conduct and Professional Ethics? | ☐ Yes | ☐ No* |

I hereby attest that the above information is true and correct to the best of my knowledge.

Signature:_____Date: _____

Printed Name: _____

*The Health Agency complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or any other protected class*

JENNIFER KENT
*DIRECTOR*

State of California—Health and Human Services Agency
# Department of Health Care Services

ATTACHMENT B

**EDMUND G. BROWN JR.**
*GOVERNOR*

DATE: April 24, 2018

MHSUDS INFORMATION NOTICE NO.: 18-019

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES
CALIFORNIA OPIOID MAINTENANCE PROVIDERS

SUBJECT: PROVIDER CREDENTIALING AND RE-CREDENTIALING FOR MENTAL HEALTH PLANS (MHPs) AND DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) PILOT COUNTIES

## PURPOSE

The purpose of this Mental Health and Substance Use Disorders Services Information Notice (IN) is to inform county Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) pilot counties, herein referred to as Plans unless otherwise specified, of the Department of Health Care Services' (DHCS) statewide uniform provider credentialing and re-credentialing requirements, established pursuant to Title 42 of the Code of Federal Regulations, Part 438.214.

## BACKGROUND

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Final Rule), which aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. County MHPs and DMC-ODS pilot counties are considered Prepaid Inpatient Health Plans, and must therefore comply with federal managed care requirements (with some exceptions).

This IN also includes policy changes DHCS has made for compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule).

On March 30, 2016, CMS issued the Parity Rule in the Federal Register (81.Fed.Reg. 18390) to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. The Parity Rule aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program.

The Managed Care Final Rule[1] requires the State to establish a uniform credentialing and re-credentialing policy that addresses behavioral health and substance use disorder services providers.

The credentialing process is one component of the comprehensive quality improvement system included in all Plan contracts. The credentialing process may include registration, certification, licensure, and/or professional association membership. Credentialing ensures that providers are licensed, registered, waivered, and/or certified as required by state and federal law.

**REQUIREMENTS**

Plans must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, registered, waivered, and/or certified.[2] These providers must be in good standing with the Medicaid/Medi-Cal programs. Any provider excluded from participation in Federal health care programs, including Medicare or Medicaid/Medi-Cal, may not participate in any Plan's provider network. For the purposes of this IN, network providers include county-owned and operated providers (i.e., MHP employees) and contracted organizational providers, provider groups, and individual practitioners.

The uniform credentialing and re-credentialing requirements in this IN apply to all licensed, waivered, or registered mental health providers and licensed substance use disorder services providers[3] employed by or contracting with the Plan to deliver Medi-Cal covered services. Effective immediately, Plans must implement and maintain written policies and procedures for the initial credentialing and re-credentialing of their providers in accordance with the policy outlined in this IN.

[1] 42 C.F.R. §438.214
[2] State Plan, Section 3, Supplement 3 to Attachment 3.1-A,
[3] Applicable provider types include licensed, registered, or waivered mental health providers, licensed practitioners of healing arts, and registered or certified Alcohol or Other Drug counselors.

**CREDENTIALING POLICY**

For all licensed, waivered, registered and/or certified providers[4], the Plan must verify and document the following items through a primary source,[5] as applicable. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information must be verified by the Plan unless the Plan can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board.

1. The appropriate license and/or board certification or registration, as required for the particular provider type;
2. Evidence of graduation or completion of any required education, as required for the particular provider type;
3. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
4. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

In addition, Plans must verify and document the following information from each network provider, as applicable, but need not verify this information through a primary source:

1. Work history;
2. Hospital and clinic privileges in good standing;
3. History of any suspension or curtailment of hospital and clinic privileges;
4. Current Drug Enforcement Administration identification number;
5. National Provider Identifier number;
6. Current malpractice insurance in an adequate amount, as required for the particular provider type;
7. History of liability claims against the provider;
8. Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/;
9. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network. This list is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp; and
10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

[4] For SUD, providers delivering covered services are defined in Title 22 of the California Code of Regulations, Section 51051.

[5] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.

**Attestation**
For all network providers who deliver covered services, each provider's application to contract with the Plan must include a signed and dated statement attesting to the following:

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation[6];
2. A history of loss of license or felony conviction;[7]
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and
5. The application's accuracy and completeness.

**Provider Re-credentialing**
DHCS requires each Plan to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed above. The Plan must require each provider to submit any updated information needed to complete the re-credentialing process, as well as a new signed attestation. In addition to the initial credentialing requirements, re-credentialing should include documentation that the Plan has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, beneficiary grievances, and medical record reviews.

**Provider Credentialing and Re-credentialing Procedures**
A Plan may delegate its authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the Plan remains contractually responsible for the completeness and accuracy of these activities. If the Plan delegates credential verification activities to a subcontractor, it shall establish a formal and detailed agreement with the entity performing those activities. To ensure accountability for these activities, the Plan must establish a system that:

- Evaluates the subcontractor's ability to perform these activities and includes an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;
- Ensures that the subcontractor meets the Plan's and DHCS' standards; and

[6] These attestation requirements comply with requirements of the Americans with Disabilities Act, 42 U.S.C. §§ 12101 *et seq*.
[7] A felony conviction does not automatically exclude a provider from participation in the Plan's network. However, in accordance with 42 C.F.R. §§ 438.214(d), 438.610(a) and (b), and 438.808(b), Plans may not employ or contract with individuals excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

- Continuously monitors, evaluates, and approves the delegated functions.

Plans are responsible for ensuring that their delegates comply with all applicable state and federal law and regulations and other contract requirements as well as DHCS guidance, including applicable INs.

Each Plan must maintain a system for reporting serious quality deficiencies that result in suspension or termination of a provider to DHCS, and other authorities as appropriate. Each Plan must maintain policies and procedures for disciplinary actions, including reducing, suspending, or terminating a provider's privileges. Plans must implement and maintain a process by which providers may appeal credentialing decisions, including decisions to deny a provider's credentialing application, or suspend or terminate a provider's previously approved credentialing approval.

If you have any questions regarding this IN, please contact the Mental Health Services Division at (916) 322-7445 or MHSDFinalRule@dhcs.ca.gov or the Substance Use Disorder Program, Policy and Fiscal Division at (916) 327-8608 or DMCODSWaiver@dhcs.ca.gov.

Sincerely,

Original signed by

Brenda Grealish, Acting Deputy Director
Mental Health & Substance Use Disorder Services

# 12.09 Practitioner Information Disclosure

I. PURPOSE

II. POLICY

San Luis Obispo Mental Health Services requires that certain health care practitioner disclose the following information to clients effective January 2011:

- Name of practitioner and license type
- Highest level of academic degree
- Board certification, if applicable

III. REFERENCE(S)

- Assembly Bill (AB) 583
- Business and Professions Code, Section 680.5
- Health and Safety Code, Section 1250

IV. PROCEDURE

A. The law requires that:

1. Eligible practitioners (including Network Providers and CBOs) prominently display appropriate notification for clients in at least 24-point type in their office. See the attached Sample Notification.

2. Practitioners who see clients in the field (e.g. IMD, school site, etc.) must display the same information in a name tag in at least 18-point type.

3. This law applies to all disciplines listed below regardless of whether direct service is provided to a client:

   a. Medical Doctors/Psychiatrists
   b. Osteopathic Physicians and Surgeons
   c. Licensed Occupational Therapists
   d. Licensed Psychiatric Technicians
   e. Licensed Psychologists
   f. Licensed Vocation Nurses
   g. Registered Nurses

B. This law does not apply to Licensed Marriage and Family Therapists or Licensed Clinical Social Workers.

C. This law applies to all settings listed below:

1. Outpatient Clinic
2. Satellite Clinic (Morro Bay)
3. Board and Care Facility

D. This law does not apply to Psychiatric Health Facilities, Juvenile Services, or Jail.

E. Questions regarding this requirement may be directed to the Department of Behavioral Health Office of Compliance (909) 382-3127.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 06/17/2011 | | Adopted |
| 11/16/2015 | All | Reviewed and modified to new policy format |
| 09/04/2018 | All | Reformatted |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *11/06/2015* |
|---|---|---|
| Approved by: | Anne, Robin, LMFT Behavioral Health Administrator | Date |

# 12.11 Verification of Services

I. PURPOSE

To clarify the process by which San Luis Obispo County Behavioral Health Department (SLOBHD) will verify that clients receive the services that are billed on their behalf

II. SCOPE

This policy and procedure applies to all face to face services delivered by SLOBHD staff at clinic locations and to all services delivered by Network Provider panel members.

III. POLICY

In keeping with Federal law and the SLOBHD contract with DHCS, SLOBHD Services will verify that clients received the services that are billed on their behalf.

IV. REFERENCE(S)

- Code of Federal Regulations, Title 42, § 455.20 and § 433.116
- SLO Behavioral Health Department (SLOBHD) contract with the Department of Health Care Services (DHCS), Exhibit A, Attachment I, 18 F

V. PROCEDURE

A. All face-to-face encounters at a clinic site (scheduled or unscheduled, routine or crisis)

1. Front Office staff will request that each client (or parent/significant support person) sign in prior to receiving a face-to-face mental health service at a clinic site.
2. A roster with removable labels will be utilized to protect client confidentiality.
3. Front Office staff will:
   a. Document the arrival time, appointment time (if the service was scheduled), and the staff member who will provide service on the removable label
   b. Ask the client /support person if there are any changes to the client's address, phone number or insurance since last visit (if there are, then the AA will update the Demographic or the financial screen in Anasazi)
   c. Obtain the client or support person's signature on the removable label
   d. Remove the label and affix it to a separate, dated sign in roster that is not visible to clients
4. The sign in roster with the original signed labels will be filed and retained in a locked drawer in the Medical Records room at the clinic site. Each month, the clinic site Health Information Technician (HIT) will forward the roster sheets to Central Health Information, where they will be securely stored for three years or until the next DHCS Triennial Review, whichever comes first.

B. Network Provider encounters

1. The Managed Care Senior Account Clerk or designee will mail an Explanation of Benefits (EOB) to all clients/legally responsible persons who receive services with a Network Provider (NWP).
2. The EOB or client contact letter will contain a statement encouraging clients to review the Network Provider's claims and to contact the Managed Care Senior Account Clerk or Managed Care Program Supervisor to discuss any billing concerns.
3. The Managed Care Program Supervisor will complete a Consumer Request Form to document the client's complaint and then will thoroughly investigate and document the disputed claim.
4. Erroneous claims must be voided and refunded to the payor, if already claimed to a third party.
5. Any and all other steps necessary to eliminate waste, fraud or abuse will be immediately taken as determined by the Managed Care Program Supervisor, Quality Support Division Manager and the Compliance Officer/Compliance Program Manager, depending on the nature of the erroneous billing.
   a. Remediation may include, but is not limited to:
      i. Repayment by the NWP to SLOBHD
      ii. Notification to DHCS and other agencies as required
      iii. Disciplinary actions up to and including termination of the NWP contract for cause
   b. Documentation of the investigation and remediation will be permanently placed in the NWP's credentialing file.

VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 12/08/2014 | | Adopted |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *12/08/2014* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# Section 13

# Medical Records

# 13.03 Protective Order Handling

## I. PURPOSE

To provide a comprehensive procedure to direct the process for receiving, reviewing, and storing protective orders received by San Luis Obispo County Behavioral Health Department (SLOBHD) staff to ensure only allowed disclosures of a client's protected health information occur and to implement requirements resulting from Assembly Bill 2275.

## II. POLICY

All SLOBHD Medical Records are considered Protected Health Information (PHI), including client demographic and scheduling information. All PHI is maintained in a secure manner and only released when allowable under state and federal law.

## III. REFERENCE(S)

- Family Code Section 6323.5
- Senate Bill 24

## PROCEDURE

When a parent or guardian provides Behavioral Health with an ex parte order restraining a party from accessing records or information, or a copy of an order with a provision specified to an essential care provider or discretionary organization or both, the following will occur:

1. Order will be received by Behavioral Health (BH) and given to BH Health Information Supervisor or Health Information staff.
   a. Order will be reviewed and sent to San Luis Obispo County Counsel for review and guidance.
2. The party that submits the copy of the order shall be provided with a receipt (see Attachment A) indicating date and time of submission and the name of the person to whom the copy was submitted. A copy of this receipt will be scanned into the electronic health record.
3. Once validated, order will be scanned into the electronic health record and an alert will be entered by BH Health Information Supervisor or Health Information staff. This alert documentation should be specific to what the order is indicating.
4. BH Health Information Supervisor or Health Information staff will:
   a. Email all treatment members on the case, including contractor staff, site supervisor, site clerical staff, billing & fiscal and division manager to inform them of the order and individual who may not access any of the client's health care information.
      i. Billing & fiscal email group: SB24-BH-Notification@co.slo.ca.us
      ii. All other staff to be notified must be keyed and is not part of the above email group.

b. Review current authorizations and rescind/revoke a(an) authorization allowing disclosures to the subject of the protective order.
c. All protective orders will be logged and saved by the HIT in a folder accessible to all staff:

Mental Health clients: M:\Health Information\Protective Order Log
Substance Use Disorder clients: S:\HIT info\Protective Order Log
Protective orders for clients receiving both mental health and substance use disorder services will be logged on both logs.

i. All staff will need to verify that there is no current protective order on the log before any verbal or written disclosures are made.

5. Behavioral Health or discretionary service organization shall not disclose information or records pertaining to the child to the restrained party during the term of the order.

## IV. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 01/11/2023 | All | Adopted |
| | | |
| Prior Approval dates: | | |
| | | |

| *E-Signature on file* | | |
|---|---|---|
| Approved by: | Anne Robin, LMFT Behavioral Health Administrator | 01/12/2023 |

**COUNTY OF SAN LUIS OBISPO**
**HEALTH AGENCY**
**BEHAVIORAL HEALTH DEPARTMENT**
**Nicholas Drews**, *Interim Health Agency Director*
**Anne Robin, LMFT** *Behavioral Health Director*

## Confirmation of Receipt of Protective Order

Date

Name of County Behavioral Health staff receiving the order:

_____

Date order was received: _____

All protective orders received by County Behavioral Health staff will be given to County Counsel to review and validate. Information and records pertaining to the subject of the restraining order will not be released to the identified restrained party before County Counsel has concluded their review of the order or during the term of a validated protected order.

All questions may be directed to:

County of San Luis Obispo Behavioral Health Department's Central Health Information:

(805)781-4724

**COUNTY OF SAN LUIS OBISPO**
**HEALTH AGENCY**
**BEHAVIORAL HEALTH DEPARTMENT**
**Nicholas Drews**, *Interim Health Agency Director*
**Anne Robin, LMFT** *Behavioral Health Director*

## Confirmación de Recibo de Orden de Protección

Fecha

Nombre del personal del Departamento de Salud & Bienestar que recibe la orden:

_____

Fecha en que se recibió el pedido: _____

Todas las órdenes de protección recibidas por el personal del Departamento de Salud & Bienestar del condado se entregarán al abogado del condado para que las revise y valide. La información y los registros relacionados con el tema de la orden de restricción no se divulgarán a la parte restringida identificada antes de que el abogado del condado haya concluido su revisión de la orden o durante el término de una orden protegida validada.

Todas las preguntas pueden ser dirigidas a:

Condado de San Luis Obispo Infomación Central de Salud del Departamento de Salud & Bienestar: (805) 781-4724

# 13.05 Medical Records Security

I. PURPOSE

II. POLICY

All San Luis Obispo County Behavioral Health Department (SLOBHD) Medical Records are considered Protected Health Information (PHI). All PHI is maintained in a secure manner. This security includes physical security, security from incidental or accidental access or viewing and security from inappropriate release of information. ***Note:*** For all Information Security Policies (e.g. Password Protection, Virus Policy, etc.) please refer to the Countywide Information Security Program located at
MySLO>Employee Information>Information Security Program

III. REFERENCE(S)

- California Welfare and Institutions Code Section 5328 and the State of California contract with the Mental Health Plan, Exhibit D, Section 6, and 45CFR Section 160 and 164 (Federal HIPAA Regulations)

IV. PROCEDURE

A. Storage:

1. Each site, which stores Medical Records, is required to establish a secure medical records storage room.
2. The medical records storage room is a lockable, secured area.
3. The assigned Medical Records Technician (MRT) is responsible for maintaining the security and integrity of the medical records contained within the storage room.
4. No unauthorized person are allowed to enter the medical records storage room.
5. Medical records security within the medical records room is accomplished by using lockable filing cabinets, shelves or other storage devices, which require a key separate from that of the key opening the medical records storage room.

B. Access:

1. Only authorized personnel have access to the Medical Records Storage Rooms and lockable storage cabinets.
2. The following sign is posted at the entrance to each Medical Records Storage Room: Authorized Personnel Only. Request for Records must be made through the Medical Record Department.
3. The Medical Records Supervisor, in consultation with the Compliance Officer, and the HIPAA Privacy Officer, establish standards of justification for access.

4. At each site, a list of Authorized Persons, including Medical Records Technicians, or other individuals required to have access the PHI, will be established in consultation between the Program supervisor, the Medical Records Supervisor, the Compliance Officer, and the HIPAA Privacy officer.
5. The list of Authorized Personnel with access is posted at the entrance of each Medical Records Storage Room. A copy of the Authorized List is included in each site-specific Policy and Procedure Manuel.
6. Regardless of access privilege, access to the medical records room or storage cabinets is granted on a on a need-to-know basis only.

C. Key Control:

1. Each site establishes a system of key control for both the medical records storage room and the medical records storage cabinets.
2. A site-specific system is developed establishing the personnel assigned to ensure the security of medical records on a daily basis.
3. A procedure is developed to ensure emergency or after-hours access to medical records at each clinic site.
4. Site-specific procedures regarding key control and emergency access are communicated to the Medical Records Supervisor, the Division Manager and the Compliance Officer.

D. Medical Records Control:

1. The control of and accountability of medical records (PHI) are the primary responsibility of the site Medical Records Technician.
2. Medical records security is also shared by each individual who has contact with the medical record or other PHI, whether clinician, auditor, administrator, transporter, other employees or contractors who have contact with the medical record in the line of their duties.

E. Medical Records Check-Out

1. To facilitate medical records control, each site initiates a standardized medical records
2. check out system. The check out system requires the MRT, or other authorized personnel within the medical records storage room, to retrieve charts from the medical records storage cabinets at the request of clinical, auditing or other approved personnel.
3. No chart leaves the medical records storage area without the signature of the staff requesting the chart.

F. Medical Records Return:

1. All medical record is required to be returned before the end of the business day
2. Upon return of the chart to the medical records storage room, the record is

returned to the medical records file cabinet and the out-guide card removed indicating the medical record has returned to the responsibility of the MRT or other authorized personnel.

3. At each clinic site, a system for secure return of charts, after hours, is established. The Medical Records Supervisor and the Compliance Officer approve this procedure.
4. At each clinic site, a system for secure overnight retention of groups of charts, which is required by a specific clinician in the next working day is developed and implemented as required within each Medical Records Storage Room.
5. No chart is left unsecured at the end of the business day.

G. Chart Pre-Request Procedure:

1. At each clinic site, a standard system for clinicians to request charts for the following business day, or any day in the future, is implemented with appropriate timelines to allow for MRT or other authorized personnel to collect and prepare those charts for clinical use on the following required day.
2. Chart requisition form is completed by the clinician at least 24 hours in advance of needing the chart. (See Attachment A, Medical Records Check-out form)
3. The MRT or other authorized personnel initials the requisition form.
4. The form is given to the MRT or other authorized personnel to process/pull the charts.
5. The MRT or other authorized personnel places an out card with the clinician's name and date in the hanging file. The clinician comes and retrieves the charts requested. ALL charts are returned no later than the end of business to the site's Medical Record Department.
6. No charts are kept overnight in staff's offices.
7. Returned charts are re-shelved by the MRT or authorized staff.

H. Emergency Chart Access

1. At each clinic site a procedure is established to allow clinicians access to charts for emergency or urgent conditions.
2. Only persons authorized to access the Medical Records Room and Cabinets facilitate emergency chart access.

I. After-Hour Requests:

1. The after-hour requests use the chart requisition form at least (24) hours in advance.
2. Charts are either doubled locked by the clinical staff or deposited in the drop box in the medical records office.
3. No charts are left unsecured at any time

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 04/30/2009 | | Adopted |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *04/30/2009* |
|---|---|---|
| Approved by: | Behavioral Health Administrator (KB) | Date |

ATTACHMENT A

| Clinician's Name:<br>Today's Date: | Date chart is needed? | Initials of MRT/staff receiving the request: | Chart Destination?<br>(e.g. P-Sup, MD, to be Filed) |
|---|---|---|---|
| Client Name | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| I have received the charts listed above:<br>_____<br>Staff signature | | | |

# 13.07 Transport of Protected Health Information

## I. PURPOSE

To ensure that client Protected Health Information (PHI) is secure when transported and to give inpatient and outpatient staff direction on safely transporting PHI.

## II. POLICY

When PHI is transported, staff will maintain control of the PHI to ensure security and confidentiality of those records.

In case of a loss of records (paper or electronic) or documents containing PHI, staff immediately notifies all of the following, even if the loss occurs during non-business hours, weekends or holidays:

- The Compliance Officer (781-4788)
- Health Agency Information Technology (IT) (788-2800) (electronic PHI)
- Health Agency Health Information Privacy and Security Policy

## III. REFERENCE(S)

- State of California contract with the Mental Health Plan, Exhibit D, Section 6, 45
- CFR Section 160 and 164 (Federal HIPAA Regulations)
- 42 CFR Part 2, Section 2.32
- California Welfare and Institutions Code Section 5328

## IV. PROCEDURE

### A. Transporting Records by Courier

1. Medical records are transported directly from one location to another via courier in a locked, opaque pouch.
2. The combinations for the pouches are maintained by the receptionist at each Behavioral Health location.
3. Medical records are kept safe from the elements and unauthorized persons.

### B. Transporting PHI by staff

1. Records or documents that contain PHI will be placed in a closed envelope and will be in the possession of and within the control of the staff transporting the documents at all times.

2. Records or documents that contain PHI that are transported in a vehicle will be kept in a closed envelope and placed in the trunk or a locked container during transportation.

C. Transporting Laptops Containing PHI

1. IT must prepare any laptop used to store or transport PHI by first having the hard drive encrypted prior to use.

2. The laptop user

   a. Must have a Windows login password that meets the county's minimum requirement for complexity (password requirements outlined in County Security Policies)
   b. Ensures that password is not written down on or near the computer or carrying case
   c. Must sign the signature card from IT department verifying that he/she has read and understands this policy prior to checking out a laptop.

3. When away from the laptop, users must ensure that Windows is *locked* or that the power is off.
4. Protected health information will not be moved onto portable storage media, such as a flash drive, unless the data or the drive is encrypted and password-protected.
5. When transporting a laptop in a vehicle, the laptop must be stored in the trunk of a locked vehicle. If there is no trunk, it must be stored out of sight in a locked vehicle.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 04/30/2009 | | Adopted |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| 4/30/2010, 1/30/2012 | | |

| *Signature on file* | | *01/30/2012* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 13.08 Sequestering Records

## I. PURPOSE

To give staff direction on when and how to sequester records and when to allow sequestered records to be reviewed by staff.

## II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) maintains the confidentiality of all clients and may sequester (restrict access to) certain records as an additional safeguard. This policy applies to paper and electronic records in Outpatient Clinics and the Psychiatric Health Facility (PHF).

## III. REFERENCE(S)

- Information Practices Act of 1977
- Health & Safety Code 123100

## IV. PROCEDURE

A. A record may be sequestered:
When a client requests that certain staff be prohibited from accessing the record
   1. If staff determines there is a risk of a breach of client confidentiality
   2. At the discretion of Administration
   3. When the record is likely to be subject to subpoena in a legal proceeding
   4. When there are extraordinary privacy concerns (i.e., when the client is a county employee or when other potential conflict of interest issues exists)

B. As an alternative to sequestering a record, Electronic Health Record (EHR) Support Team staff identify records and conduct an electronic audit of staff access.

C. A record must be sequestered in case of client death within 90 days of treatment.

D. The request to sequester a record must come from a Program Supervisor (or designee), Division Manager, Health Information Technician (HIT), or HA Administration.
   1. The request to sequester must detail the reason for the sequester and duration or triggers for removing sequestration (i.e. conclusion of investigation, resolution of conflict, etc.).
   2. The person requesting to sequester a record will contact the EHR Support Team through the HA IT Support Desk.
   3. The EHR Support Team will check Anasazi and Centricity for the client, immediately sequesters the record, and notifies the requestor and custodian of the record that the record has been sequestered.
   4. The EHR Support Team will maintain a confidential log of sequestered health records.

E. When sequestering electronic records:
   1. If the client's name needs to be protected, the HIT Supervisor assigns an anonymous name to be used in the electronic record using the following convention: Sequester one (1) Sequester two (2), etc.
   2. The following staff have access to sequestered records:
      a. EHR Support Team
      b. Morbidity and Mortality Committee Members
      c. Billing Supervisor
      d. BH Medical Records Supervisor
      e. DAS HIT
      f. Treating staff as needed to facilitate the completion of a discharge summary, if the client was open to BH services at the time of their death
   3. Staff access to sequestered records may be provided by the EHR Support Team only if permission has been obtained from the Program Supervisor and BH Medical Record Supervisor. County Counsel will be consulted anytime a client or an attorney (Evidence Code 1158) requests access to a sequestered record.

F. When sequestering paper records:
   1. Each site has a designated locked file cabinet specifically for sequestered records.
   2. When a record is identified to be sequestered:
      a. If the record is closed, Central Health Information (CHI) places the record in the locked cabinet, completes an out-guide card and places it on the shelf in place of the record. (Attachment A)
      b. If the record is open to an outpatient site, the site HIT places the record in the locked cabinet and makes a hanging file for the record labeled with the client's real or Sequester name and Medical Record # that will be kept in the file cabinet with other records as a place holder to indicate that the record is sequestered.
      c. If a "Sequester" name is used, the cover of the record and the out guide will be labeled with the "Sequester" name. All documents within the record will use the correct name of the client.
      d. The HIT completes the Sequestered Record Cover Sheet (Attachment B) and places it in the record on the front of Administrative Data for outpatient records (or on the left side of PHF records).
      e. If a Cost Explanation Agreement is completed, it will be sent to the Billing Supervisor in a separate envelope that is sealed and marked "CONFIDENTIAL" from other paperwork for added confidentiality.
   3. The review of paper records must take place in the Health Information office. HITs ensure that prior permission has been obtained before allowing a sequestered record to be viewed by staff.

G. Unsequestering Records
   1. The request to unsequester a record is sent to the EHR Support Team through the HA IT Support Desk.
   2. The following individuals may recommend a record be un-sequestered:
      a. Members of the EHR Support Team
      b. Program Supervisors
      c. Division Managers

   d. HIT's
   e. BH Medical Record Supervisor
3. A record may be un-sequestered:
   a. When a client has been deceased for one year or longer
   b. When case review is complete
   c. If a client is known to have moved from the area and has not received services in more than one year
   d. When court proceedings related to the client have concluded
   e. If the client requests their record be un-sequestered
4. The EHR Program Manager (or designee) will review the Sequester Log monthly to determine which records should remain sequestered and review any requests to un-sequester.
   a. Upon monthly review, if the EHR Program Manager (or designee) determines it may no longer be necessary to continue sequestering a record, they will contact the appropriate Program Supervisor(s) to determine if the sequester may be removed.
   b. The EHR Support Team will notify the Custodian of Record when a record has been un-sequestered.
   c. THE EHR Support Team will update the Sequester Log monthly.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 12/18/2009 | | Adopted |
| 09/04/2018 | All | Formatting |
| 10/13/2020 | References & Procedure | References added and revisions to the procedure were made to reflect sequester requests, determinations, and monitoring are the responsibility of the EHR Support Team |
| Prior Approval dates: | | |
| 10/21/2011 | | |

| *Signature on file* | | *10/13/2020* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 13.10 Destruction and Retention of Medical Records

I. PURPOSE

To ensure that San Luis Obispo County Behavioral Health Department (SLOBHD) adheres to the records retention and destruction guidelines set forth in State and Federal regulations

II. POLICY

SLOBHD follows the guidelines set forth in State and Federal regulations in regard to retention and destruction of medical records.

In absence of laws specifying a retention schedule, the department adopts the best business practice as recommended by its administration. Retention will be based on consideration of frequency of use, space constraints, and good business practices. A record may be kept longer than required by law to satisfy business needs.

III. REFERENCE(S)

- Information Practices Act of 1977, CA Civil Code 1798 et seq.
- CA Civil Code 56.101
- CA Business and Professions Code 2919, 2620.7
- CA Health & Safety Code 123145
- CA Welfare & Institutions Code 14124.1
- 42 CFR 438.3(u)
- 22 CCR 51476, 73543, 77141, 77143, 77127
- HIPAA, 45 CFR Part 160 and 164

IV. PROCEDURE

A. Retention of Records: All client records are completed promptly upon discharge and filed in a designated storage area on the premises or stored electronically. Records are retained for a period specified in the table below:

| Type of Record | Retention Time |
|---|---|
| Client Records- Adult | 10 years from the last date of service or the completion of any audit, whichever is later. |
| Client Records-Minors | 10 years from the date of majority, last date of service, or the completion of any audit, whichever is later. |

Refer to County of San Luis Obispo Health Agency Record Retention and Destruction Schedule

B. Destruction of Records after Retention Period

1. Closed records are reviewed annually to identify records that have passed the period of retention and are ready for destruction.

2. In addition to destroying the original client records, health information to be destroyed includes items such as sound and video recordings, microfilm, magnetic tape, electronic media and any other documents that are part of the official record and contain protected health information.

3. Records involved during an investigation, audit, or litigation should not be destroyed even after the retention period.

4. The destruction/disposal log includes:

    a. Date of destruction/disposal
    b. Method of destruction/disposal
    c. Description of the destroyed/disposed record series or medium
    d. Inclusive dates covered
    e. A statement that the resident information records were destroyed/disposed of in the normal course of business
    f. Signatures of the individuals supervising and witnessing the destruction/disposal

5. A second medical record staff reviews the face sheet or electronic demographic prior to records being destroyed.

6. Records are destroyed according to the guidelines of National Institute of Standards and Technology (NIST) so that there is no possibility of recovery or reconstruction of information. Methods of destruction include shredding, pulverizing, erasing, or otherwise modifying the personal information in those records to make it unreadable or undecipherable.

7. If destruction/disposal services are contracted, the contract must provide that the contactor (business associate) will establish the permitted and required uses and disclosures of information as set forth in the federal and state law and include the following:

    a. Appropriate safeguards to prevent use of disclosure of the information
    b. Indemnification of the facility from loss due to unauthorized disclosure
    c. Method of destruction/disposal
    d. Requirement that the Business Associate always maintain liability insurance in specified amounts that the contract is in effect
    e. Proof of the method of destruction
    f. Indication of how material will be protected/secured until it is destroyed
    g. Indication of the amount of time that will elapse between acquisition and destruction of the records
    h. Report(s) to the facility of any inappropriate use or disclosure of information

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 09/14/2011 | | Adopted |
| 09/14/2015 | I | Added purpose |
| 09/04/2018 | All | Formatting |
| 04/05/2023 | All | Added to retention guidelines |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *04/11/2023* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 13.12 Complete Health Records

I. PURPOSE

- To establish documentation standards for a complete medical record.
- To establish a consistent practice for correcting incomplete records.
- To establish a consistent practice for processing incomplete records following the termination of employment of Behavioral Health or contractor staff.

II. SCOPE

This policy applies to all San Luis Obispo Behavioral Health Department (SLO BH) and/or contractor staff who enter client information into paper or electronic health records

III. POLICY

SLO BH shall maintain a complete health record that in a manner consistent with relevant Federal and State regulations, Department of Health Care Services (DHCS) contract requirements, SLO BH documentation guidelines, and reasonable and customary industry standards. The health record shall contain sufficient clinical documentation about diagnoses, treatment and the provision of services so that the high quality, coordinated care provided to each client is supported by the record.

IV. REFERENCE(S)

- California Code or Regulations, Title 9, §1810.440(c); 1810.435; 1830.205
- California Code or Regulations, Title 22, §77143
- DHCS – MHP Contract, Exhibit A Attachment I, Section 11
- Documentation Guidelines

V. DEFINITIONS

| | **Outpatient** | **PHF / 24 hour service locations** |
|---|---|---|
| **Timely** | Completed and signed by the end of the business day that follows the date of service | Completed and signed within 24 hours of the service |
| **Late (billable)** | Completed and signed more than one business day but less than 14 calendar days after the date of service | Completed and signed more than 24 hours but less than 14 calendar days after the date of service |
| **Late (not billable)** | Completed and signed more than 14 calendar days after the date of service | |

VI. PROCEDURE

## A. ACTIVE SLO BH OR CONTRACTOR STAFF MEMBERS

1. General Considerations:

    a. Clinical documentation serves many important clinical, legal, ethical and fiscal functions. High quality, ethical client care must be accompanied by high quality clinical documentation.
    b. Documentation content must meet the Department of Health Care Services (DHCS) contract requirements. Refer to the most recent Documentation Guidelines for additional detail.
    c. Clinical staff must complete required documentation in a timely manner. Refer to the Definitions table above for timeliness requirements.
    d. Documentation is not finished until the author "Final Approves" it.

        i. Final Approval prevents unauthorized changes to the clinical content of a document, which is important for medical records security/integrity.
        ii. Final Approval normally occurs immediately after the last signature is obtained on a document. Failure to Final Approve does not render a document void or unbillable. Instead, the author is directed to Final Approve as soon as the omission is detected.

2. Staff Signatures and Co-signatures

    a. Signature and co-signature requirements vary depending on the license status of the document author and the type of document. Refer to the Documentation Guidelines for specific detail.
    b. When a signature or co-signature is required on an electronic document, the document is "routed" within Anasazi to the person who must sign. It is the responsibility of the staff member completing the document to properly route the document in a timely manner.
    c. Timely signature/co-signature is important because documents cannot be Final Approved until required signatures are obtained. Supervisory staff are expected to regularly check notifications for documents that require signature and to sign and route documents in as timely a manner as possible. Co-signatures must be obtained within 14 calendar days of the service.

3. Progress Notes:

    a. For outpatient services, a Progress Note is required for each service contact. Some programs have alternate or additional frequency requirements (For example, daily and weekly notes are required for Day Treatment Intensive; certain notes on the Psychiatric Health Facility are written each shift or more frequently). Clinical staff must know and follow the frequency standards for the programs in which they work.

b. Daily completion of Progress Notes is the standard expectation for all staff.

   i. Late (billable) Progress Notes written more than 1 business day after the service must begin with the phrase "Late Entry" in the top line of the body of the note.
   ii. Late (unbillable) Progress Notes are written, but the Billing Type is changed to "Late Entry" to prevent billing.

c. Progress Notes must describe how the intervention provided by the clinician reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning as described in the Treatment Plan.
d. Progress Notes are part of the legal health record. Progress Notes are accessible to a client, may be released to third parties and are discoverable in court proceedings. Further, it is the client's record. Therefore, staff must use strength based and objective/descriptive language and avoid blaming or pejorative language.
e. Progress Notes are not "process" or "Psychotherapy Notes" as defined in Code of Federal Regulations 45, Subpart E, §164.501.
f. Progress Note correction summary table:

| Problem: | Clinician (Progress Note author) Corrective Action: |
|---|---|
| Incomplete clinical content | • Finish the Progress Note/add content<br>• Add "Late Entry" to text (If applicable, see Definitions)<br>• Change Billing Type to "Late Entry" (If applicable, see Definitions)<br>• Sign (Clear and resign if previously signed, as signature must reflect the date content was completed)<br>• Final Approve |
| Missing Signature | • Sign and Final Approve<br>• Date stamp will reflect actual signature date and time |
| Not Final Approved | • Click Final Approve |

4. Assessments (Forms):

   a. Assessments are used to establish medical necessity for services, to document client needs and to meet legal requirements.
   b. Assessments often have due dates which may be tied to billing, policy or legal timelines. Assessment due dates often have significant treatment or business operations implications. Timely completion of assessments is a standard expectation.
   c. Assessments must be signed in a timely manner, as defined above.
   d. Each staff member must only complete assessments that are within the scope of his/her professional practice.

5. Treatment Plan (TP):

   a. A current, complete TP is required to allow documentation and billing of services. Timely completion is vital to treatment and business operations. Refer to the most recent Documentation Guidelines for additional detail.

   b. A TP is a collaborative effort between the treatment provider and the client and must reflect the client's goals and objectives. Client agreement with and participation in the development of a TP must be clearly documented.

   c. A complete TP contains:

      i. Clinical content:
         a) Client strengths which can be used in treatment
         b) A problem/focus of treatment statement which identifies the client's needs and functional impairments as a result of an included diagnosis
         c) Specific observable/measurable goals/objectives that are directly related to the functional impairments identified in (2) above
         d) Interventions that target the functional impairments identified in (2) above and are consistent with the objectives in (3) above
         e) Interventions must be listed, described and assigned a proposed frequency and duration

      ii. Required signatures:
         a) Required client and/or Legally Responsible Person signatures
         b) Required staff signatures (varies by type of services and staff licensure)

   d. Documentation that a copy of the TP was offered to the client (MH TPs)

   e. TP correction summary table:

| Problem: | Clinician Corrective Action: |
|---|---|
| **Incomplete clinical content** (see above for required elements) | • Call or meet client<br>• Complete TP<br>• Document client's agreement with TP<br>• Obtain client signature<br>• Obtain any required staff signatures<br>• Final Approve TP<br>• Using the Deletions/Additions Form (Attachment A), void all services except Assessment, Plan Development and Crisis until TP is completed |
| **Missing reason for non-signature and missing client signature** | • Call client, document client's agreement with TP<br>• Schedule a Plan Development service<br>• Obtain client signature<br>• Obtain any required staff signatures |

| | |
|---|---|
| | • Final Approve<br><br>• Using the Deletions/Additions Form (Attachment A), void all services except Assessment, Plan Development and Crisis until reason for non-signature is documented |
| **Missing client signature, <u>but</u> TP documents reason for non-signature** | • Schedule a Plan Development service<br>• Obtain client signature<br>• Obtain any required staff signatures<br>• Final Approve |
| **Missing Approved Category of Staff signature** | • Obtain Approved Category of staff signature<br>• Obtain any other missing staff signatures<br>• Final Approve<br>• Using the Deletions/Additions Form (Attachment A), void all services except Assessment, Plan Development and Crisis until signature is obtained |
| **Missing MD/NP signature for Med Support** | • Obtain MD/NP signature<br>• Obtain any other missing staff signatures<br>• Final Approve<br>• Using the Deletions/Additions Form (Attachment A), void Medication Support services and any services billed to Medicare prior to MD/NP signature |

6. Client Transfers/Discharges:

    a. The clinician will review the client record and ensure that documentation is complete and Final Approved prior to transfer/discharge.
    b. HIT staff complete Transfer/Discharge checklists and will notify clinician and Program Supervisor of any missing or incomplete documentation, which must be promptly corrected to allow timely transfer of care responsibilities.
    c. When transfer of care is in the client's best interest, the transferring and receiving Program Supervisors may agree to a transfer of the case, despite incomplete or missing documentation. Incomplete or missing documentation is then obtained by the receiving program staff.

7. Documentation Completion prior to Staff Transfer to another Program:

    a. Whenever possible, staff whose transfer between SLO BH programs is planned in advance will be directed and supported to complete documentation prior to transfer
    b. Examples of support activities may include, but are not limited to:
    c. HIT staff runs a report to determine incomplete/missing documentation.
    d. Clinician and Program Supervisor develop a plan to complete documentation prior to transfer.
    e. With Program Supervisor's approval, the clinician blocks off scheduled time to finish documentation before transferring to a new program.

**B. STAFF MEMBER NO LONGER EMPLOYED BY SLO BH OR CONTRACTOR**

1. Whenever possible, staff whose termination of employment is planned in advance will be directed and supported to complete documentation prior to termination as described above.

2. When missing or incomplete documentation is discovered after a staff member leaves employment, corrective action must be taken by the Program Supervisor or by the Medical Director, depending on scope of practice concerns.

    a. Incomplete Assessments:

        i. If a staff member who left employment launched an assessment, but did not add any clinical content, the assessment may be deleted. Delete removes the assessment from the record permanently.
        ii. If an assessment was launched and started, it is important that the information remain in the record, even if incomplete.
            a) Add a statement to the assessment to indicate who started the assessment, that the assessment is incomplete, and that the current signer did not complete the assessment in question. This will provide evidence on the assessment that the signatory did not conduct the assessment in question.
            b) Delete any optional signatures. If the original author signed, do not delete or clear.
            c) Add an "Incomplete Record Confirmation" signature line and sign.
            d) Final Approve
            e) Void the assessment. Voided assessments remain in the record.
                i. Add a new Informational Note. In the "Subject" field, select "Incomplete Record Explanation" and write a brief explanation of the corrective actions taken.
                ii. In many instances a new, complete assessment will be required.

3. Progress Notes

    a. Services are not billable when the Progress Note clinical content is incomplete or if the original provider did not sign.

        i. Edit the billing ribbon to change the Billing Type to "Voided".
        ii. If the service already billed, the service must be voided. Refer to the Documentation Guidelines for the current process.

    b. If the clinical content and billing ribbon are complete and the original provider signed, but did not Final Approve, the Program Supervisor or Medical Director who is correcting the record may Final Approve.

        i. Add a line to the note to indicate that the record was reviewed and appears

complete.
ii. Sign in the second line – leave the original author's signature
iii. Final Approve

4. Treatment Plans

   a. Follow the TP correction table above.
   b. Add a new Informational Note. In the "Subject" field, select "Incomplete Record Explanation" and write a brief explanation of the corrective actions taken.
   c. In many instances, the new Single Accountable Individual (SAI) will meet with the client to develop a new, complete TP.

## C. DOCUMENTATION MANAGEMENT TOOLS:

1. Scheduled Services panel: For services scheduled in Anasazi, the Scheduled Services panel provides both an easy way to launch Progress Notes and a visual reminder of completed and/or missing notes (The green check mark next to the scheduled service indicates that a Progress Note was written for the service).

2. Notifications panel: Clinical staff must regularly (preferably daily) review the staff Notification panel in Anasazi and:
   a. Finish/Final Approve Progress Notes for each service provided.
   b. Finish/Final Approve Assessments that are pending.
   c. Finish/Final Approve TPs prior to the expiration date of a previous TP.

3. Reports:

   a. Health Information Technician (HIT) staff run reports on a monthly basis to identify missing and non-Final Approved Progress Notes, Assessments and Treatment Plans.
      i. The reports are forwarded to the clinician and to the clinician's Program Supervisor for correction
      ii. Prompt correction of missing and/or incomplete documentation is a standard work expectation for all clinical staff

## D. QUALITY SUPPORT ACTIVITIES:

1. Quality Support Team clinical staff conduct periodic record reviews to monitor documentation quality.

2. Quality Support Team staff provide training to improve documentation quality. Documentation Guidelines training occurs twice per year or more frequently when requested by program or individual staff.

###

VII. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 10/12/2015 | | Adopted |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *10/14/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# ATTACHMENT A

Deletions / Addition Form Change initiated by (staff name):_____ MRT Initial:_____

| Client Number | Add Procedure | Delete Procedure | Service Date | RU | Staff Number | Time |
|---|---|---|---|---|---|---|
| | | | | | | |
| Reason for change: | | | | | | |
| | | | | | | |
| Reason for change: | | | | | | |
| | | | | | | |
| Reason for change: | | | | | | |
| | | | | | | |
| Reason for change: | | | | | | |
| | | | | | | |

# 13.14 Electronic Signatures

## I. PURPOSE

To describe the process for maintaining signatures in the electronic health record

## II. POLICY

San Luis Obispo County Behavioral Health will maintain electronic signatures in the electronic health record (EHR) in a manner consistent with all applicable Federal and State laws, Department of Health Care Service (DHCS) Letter, and San Luis Obispo's Countywide Information Security Program.

## III. REFERENCE(S)

- United States Code, Title 15, Chapter 96, Subchapter I, § 7006
- California Government Code, Section 16.5
- Department of Mental Health Letter 08-10
- SLO Countywide Information Security Program @ http://myslo.intra/Assets/ITD/Security

## IV. DEFINITION

Electronic Signature : Federal law defines an electronic signature as "an electronic sound, symbol, or process, attached to or logically associated with a contract or other record and executed or adopted by a person with the intent to sign the record." Under California law, a digital signature is defined as "an electronic identifier, created by computer, intended by the party using it to have the same force and effect as the use of a manual signature."

## V. PROCEDURE

### A. Anasazi Complete EHR Electronic Signature Security

1. Anasazi Complete EHR Version 1.0 is certified as a Complete EHR by the Office of the National Coordinator for Health Information Technology. Anasazi meets the certification criteria in the areas of Access Control, Audit, and Authentication as required by DMH Letter 08-10.

2. Electronic signatures in Anasazi are:

    - Unique to the signer
    - Under the signer's sole control
    - Capable of being verified
    - Linked to the data so that, once a form is electronically signed and 'Final Approved', the data cannot be changed.

B. Acceptable Use Acknowledgement

1. At the onset of employment and annually thereafter, all Behavioral Health staff are required to read and sign acknowledgment of Information Security Program Acceptable Use Policy, which states that users:
   - Are solely responsible for the security of their accounts.
   - Are not authorized to share their passwords.
   - Must change their password in accordance with established policies and individual application requirements

C. Password Strength and Frequency of Change Requirements

1. Behavioral Health staff are required to establish "strong" passwords. For more information, refer to Information Security Program Password and Authentication Policy.

2. Minimum Standard

   - At least 8 characters (preferably more)
   - Must be changed every 90 days
   - Must contain three out of four of the following:
     - ✓ Upper case letters
     - ✓ Lower case letters
     - ✓ Digits (0-9)
     - ✓ Punctuation characters (, ! # $ % ^ & * ( ) _ - + = \ : ; " „ { } [ ], ? / .)

D. Electronic Signature Agreement

1. Behavioral Health maintains an Electronic Signature Agreement for the terms of use of an electronic signature, signed by staff using the EHR and the county mental health director/designee. The signed Electronic Signature Agreements (or a copy) from county employees and contract providers are available to the DHCS auditor at the time of an audit.

E. County Mental Health Director's Electronic Signature Certification

1. The Behavioral Health Administrator certifies that electronic systems used by the county's mental health operations meet the standards. The signed Electronic Signature Certification is available to the DHCS auditor at the time of an audit.

###

VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 12/21/2012 | | Adopted |
| 11/23/2015 | | Added purpose |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *11/23/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# Section 14

# Staff Related

# 14.00 Mental Health Services for Employees and Their Families

I. PURPOSE

To ensure the most appropriate level of service for employees of San Luis Obispo County Behavioral Health Services and their family members.

II. POLICY

The County of San Luis Obispo is concerned about the welfare of employees and their families. It is the policy of Mental Health Services to find the most appropriate level of service for employees and their family members.

III. REFERENCE(S)

IV. PROCEDURE

A. Whenever possible, the ongoing treatment for employees and their families will be referred outside of the San Luis Obispo County Mental Health facilities.

1. The County Employee Assistance Program (EAP) provides preventative health services and counseling for all San Luis Obispo employees and their families.

B. If treatment is not available through EAP the following will apply:

1. Treatment will take place outside of the employee's work unit. Treatment is approved by the Program Supervisor and Division Manager of the site.

2. Cases will not be discussed at Site Approval Team meetings, or case review time, but discussed privately with the staff, treating psychiatrist and Program Supervisor.

3. Records are Sequestered in The Health Information office in the program where treatment is being given and the record is treated as a **sealed record**.

4. Electronic records are sequestered. (See Policy 13.08 Sequestering Records)

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 02/27/2009 | | Adopted |
| 06/01/2015 | All | Added purpose and information on sequestering record |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *06/01/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 14.01 Bilingual Certification

## I. PURPOSE

To provide direction for establishing and operating the Bilingual Certification Committee that will evaluate and certify staff to provide bilingual interpretation services.

## II. POLICY

Provision of bilingual treatment services or facilitation of treatment services by means of bilingual interpretation and translation services, are evaluated, and certified by The Bilingual Certification Committee.

## III. REFERENCE(S)

- Code of Federal Regulations, Title 42, §438.10
- Welfare & Institutions Code §14727(d)
- California Code of Regulations, Title 9, §3200.210
- Mental Health Plan Contract with DHCS
- Drug Medi-Cal Organized Delivery System contract with DHCS
- SLOBHD Cultural Competence Plan and Updates
- SLO Health Agency Non-discrimination and Language Access Plan

## IV. PROCEDURE

A. The Ethnic Services Manager will be responsible for the establishment and continued operation of a Bilingual Certification Committee (BCC).
B. The BCC is comprised of the Ethnic Services Manager and three bilingual staff members, at least one of whom is a native speaker of the threshold languages in the county.
C. The committee is responsible for developing a minimum of four clinical scenarios in each threshold language when evaluating candidates for certification. The committee will develop an evaluation checklist which will require a score from 0-25 for each of the areas described below for a maximum possible score of 100. The checklist will include, but not be limited to:
    1. Fluency, the ability to communicate with ease, verbally and non-verbally
    2. Depth of Vocabulary, including the ability to communicate complex psychiatric/psychological concepts which may or may not have direct corollaries in the language in question
    3. Grammar, appropriate use of tense and grammar
    4. Cultural considerations related to potential client

D. The certification process is conducted by two bilingual committee members, one of whom is the committee's identified native speaker. The native speaker assumes the role of the client as described in one of the four clinical scenarios presenting for an initial Assessment. The certification interview will follow a standard initial Assessment format.
E. The certification interview should take approximately 30 minutes. The BCC members may ask follow-up questions for clarification. The candidate is given an opportunity to make any remarks she or he may wish for clarification.
F. Following the departure of the candidate the BCC members separately score their evaluation of the candidate's performance. The evaluators' score is then averaged. A passing score will be 60 or greater. The candidate is notified by a memo issued from the committee as to the outcome of the evaluation, with copy given to Health Agency Human Resources.
G. A candidate who has failed to be certified may appeal to the Bilingual Certification Committee and request to be retested by two other committee members who will repeat the process.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 02/27/2009 | | Adopted |
| 09/04/2018 | All | Formatting |
| 8/21/2020 | All | Updated language and procedure |
| Prior Approval dates: | | |
| | | |

| | | |
|---|---|---|
| *E-Signature on file* | | *08/21/2020* |
| Approved by: | Behavioral Health Administrator(KB) | Date |

# 14.02 REGISTERED ASSOCIATES, ASSISTANTS, AND TRAINEES: SUPERVISION, CO-SIGNATURE, AND DOCUMENTATION WAIVER REQUIREMENTS

## I. PURPOSE

Applies to all SLOBHD employees, volunteers, and student interns (paid and unpaid) who provide clinical services in Behavioral Health programs and who are gaining experience for academic credit and/or toward professional licensure.

## II. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) will implement an effective program of clinical supervision and supervised experience for Trainees and Registered Associates. The main goals of the program are:

1. To provide supervised work experience for Trainees and Registered Associates that will enable program participants to gain valuable work experience and to progress toward professional licensure
2. To improve consumer access to services by expanding SLOBHD's workforce
3. To support long-term availability of Behavioral Health professionals by supporting professional skill and career development

## III. REFERENCE(S)

- California Business & Professions Code (BPC), Division 2, §§ 500-4999
- Welfare & Institutions Code (WIC) § 5751.2
- Department of Mental Health Letter 10-03
- MHSUDS Information Notice 17-040
- California Board of Behavioral Sciences: http://www.bbs.ca.gov/
- California Board of Psychology: http://www.psychology.ca.gov/
- SLOBHD Policy & Procedure: 13.12 Complete Health Records
- SLOBHD Clinical Supervisor Manual
- Quality Support Team (QST) Progress Note and Treatment Plan Audit Tools
- Professional License Waiver Request: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/Mental_Health/DHCS_1739.pdf

## IV. PROCEDURE

A. Internship Coordinator and Participant Selection
   1. SLOBHD's Clinical Supervision and Training Coordinator will act as liaison with Graduate School programs to recruit trainees and to organize the overall functioning of the traineeship program.

2. The Clinical Supervision and Training Coordinator will work closely with Health Agency Human Resources and Program Supervisors to interview, select, and onboard participants in the program.
3. Successful applicants will complete Compliance and Privacy training provided by SLOBHD and will sign a Confidentiality Statement. Other training and onboarding requirements will apply as deemed necessary
4. Unlicensed clinical staff will only provide services within their scope of practice and under the direction of a licensed Clinical Supervisor.

B. Client Notification of Unlicensed Status

1. Prior to providing services to a client, each Registered Associate, Trainee, or Psychology Assistant (PA) will verbally notify the client of the provider's unlicensed status.
2. At minimum, the notification will include:
   a. The provider's current status as a Trainee, Associate, or PA
   b. Registration number (except Trainees)
   c. Name of the employer
   d. Name and license number of the Clinical Supervisor
3. The Registered Associate, Trainee, or PA will provide the client (aged 12 and older) or legally responsible person (under age 12, conserved individuals) with a Unlicensed Trainee or Associate Notification letter (Attachment A), which will be scanned into the client's electronic health record under client attachments.

C. Supervision

1. The Clinical Supervision and Training Coordinator will assign each Registered Associate, PA, and Trainee to an appropriately licensed, trained, and experienced Clinical Supervisor, who will develop a supervision plan with the supervisee. Clinical supervision may be a combination of individual and group supervision, as long as the supervision plan and agreement meet all current regulations and requirements of the relevant licensing board. See SLOBHD's current Clinical Supervision guidelines for additional detail.
2. The Clinical Supervisor will ensure that the Associate, PA, or Trainee receives clinical guidance and an appropriate level of experience (in number of hours and clinical acuity appropriate for the supervisee's education and experience level).
3. The Clinical Supervisor will ensure that each consumer served by an Associate, PA, or Trainee receives high quality care. The Associate, PA, or Trainee will provide services under the direction of the licensed Clinical Supervisor, meaning that the Clinical Supervisor directs and is ultimately responsible for the client care provided by the Associate, PA, or Trainee.
4. The Associate, PA, or Trainee will follow graduate program and/or licensing board requirements to document experience, training, and supervision hours.

D. Clinical Supervisor Documentation Review and Co-Signature Requirements

1. Clinical Supervisors will review and recommend edits to documentation submitted by the Associate, PA, or Trainee. This review plays an important role in training and helps ensure that the documentation meets SLOBHD's standards.
2. Clinical Supervisors will co-sign all clinical documentation written by a Trainee for the duration of 6 months and all documentation by an Associate or PA for at least the first month of work experience at SLOBHD. The co-signature is evidence that documentation was reviewed during a specified timeframe to identify training needs. After the established timeframe, any documentation needs identified by the Clinical Supervisor will be reported to the Program Supervisor and QST for additional documentation training.
3. After the specified timeframe (i.e., 6 months for a Trainee, 1 month for an Associate or PA) if there are no identified documentation training needs (e.g., the Trainee, Associate, or PA's documentation consistently meets SLOBHD's standards during documentation reviews), the Clinical Supervisor may stop providing co-signature on progress notes and assessments. The Clinical Supervisor will consult with the Program Supervisor regarding their decision to stop co-signature. The Program Supervisor will continue to review and co-sign for assessments as part of the intake process.
4. Clinical Supervisors will review and co-sign documentation in a timely manner to ensure adequate direction for unlicensed staff. SLOBHD defines 'timely' as within one week from when the Trainee, Associate, or PA completes the documentation and assigns the Clinical Supervisor as a co-signer.
5. Clinical Supervisors are recommended to complete quarterly reviews of a Trainee, Associate, or PA's documentation to ensure they continue to meet SLOBHD's standards. If documentation needs are identified during a review, the Clinical Supervisor may resume co-signing documents and/or discuss documentation needs with the Program Supervisor and QST staff to develop a training plan.

E. QST Documentation Review and Training

1. When a Clinical Supervisor identifies a documentation related training need, the clinical supervisor will notify the Program Supervisor and QST staff.
2. QST staff will audit the Trainee, Associate, or PA's documentation to identify specific areas of growth. QST staff will communicate the Trainee, Associate, or PA's strengths/needs and training plan to the staff, Clinical, and Program Supervisors.
3. QST staff will provide direct training and review of documentation until they decide the Trainee, Associate, or PA is able to complete documentation to SLOBHD's standards.
4. QST staff will notify the Clinical and Program Supervisors that the Trainee, Associate, or PA is ready to complete documentation independently.

F. Co-signature Waiver Request

1. A Clinical Supervisor, in consultation with the Program Supervisor responsible for a Trainee's program, may elect to waive the Trainee co-signature requirement when the staff's documentation consistently meets SLOBHD's standards during Clinical Supervisor's and Program Supervisor's documentation reviews.
2. Co-signature waiver does not change the Clinical Supervisor's responsibility to provide appropriate supervision and direction for services.
3. To complete a Co-signature Waiver Request the Clinical Supervisor will:
   a. Complete documentation review and provide corrective feedback as needed.
   b. Discuss the plan and new expectations with the Program Supervisor and the Trainee.
   c. Complete a Co-signature Waiver Request (Attachment B)
   d. Sign and obtain Program Supervisor's signature, which establishes the effective date of the waiver
   e. Scan and email or send by County mail to the Medical Records Supervisor, who will retain an electronic copy for use during documentation audits by DHCS

V. DEFINITIONS

- Trainee: An individual enrolled in a graduate program in a Behavioral Health-related field. Marriage and Family Therapist Trainee (MFTT), Professional Clinical Counselor Trainee (PCCT), and Social Work Student Intern (MSWI), are the most common trainee credential designations.
- Registered Associate (formerly "Intern"): An individual with a Master's Degree in a Behavioral Health-related field and current registration with the Board of Behavioral Sciences (BBS). Depending on field of study and professional goal, the most common designations are Registered Associate Marriage and Family Therapist, Registered Associate Professional Clinical Counselor, and Associate Clinical Social Worker (ASW). A Registered Associate must remain registered with BBS while working in the field until licensed, even if no longer accumulating hours of experience for licensure.
- Psychology Assistant and Registered Psychologist: A Psychology Assistant (PA) (sometimes called a pre-doctoral intern) is an individual in a Doctoral program in Psychology who already earned a Master's degree. A PA does not have to register with the CA Board of Psychology when completing an APA, APPIC or CAPIC approved internship program and does not need a Professional Licensing Waiver (PLW) from the Department of Health Care Services (DHCS). A Registered Psychologist (sometimes referred to as a post-doctoral intern) holds a doctoral degree, must be registered with the CA Board of Psychology unless enrolled in an APA, APPIC or CAPIC approved internship program, and must apply for and receive a PLW from DHCS.

- Professional Licensing Waiver (PLW): A PLW is an agreement that applies in two situations: 1.) To all Registered Psychologists and 2.) To any Licensed Psychologist, LMFT, LPCC, or LCSW recruited from out of state to provide Specialty Mental Health Services for SLOBHD. For additional detail, see Department of Mental Health Letter 10-03 and WIC § 5751. A PLW expires after 5 years. California Code of Regulations, Title 9, refers to "waivered" staff, meaning staff with a valid PLW.
- Co-Signature Waiver: A SLOBHD-established process whereby the Clinical Supervisor and the Program Supervisor of a Trainee may indicate that some or all of the Trainee's documentation no longer requires co-signature by the Clinical Supervisor. SLOBHD considers Trainees who no longer need co-signature as "waivered".
- Clinical Supervisor: A licensed, trained, and qualified staff member who provides training and supervision for Trainees and Registered Associates in keeping with BBS and CA Board of Psychology guidelines for each respective discipline. Trainees and Registered Associates provide clinical care "under the direction of" the Clinical Supervisor, who assumes responsibility for the care provided. Clinical Supervisors receive a pay differential for supervision.

## VI. REVISION HISTORY

| Status: Initial/ Revised/Archived Description of Revisions | Section(s) Revised: | Author | Details of Revision: |
|---|---|---|---|
| 02/02/2018 | All | Greg Vickery, LMFT<br>QST Division Manager | Replaces Policies 14.02,14.03 and 14.04 |
| 11/4/2021 | IV.B.3. | Amanda Getten, LMFT | Edited procedure for providing informing material |
| 9/26/2022 | IV.D-F & V | Amanda Getten, LMFT | Edited co-signature and documentation training procedure and requirements |
| Prior Approval dates: | | | |
| | | | |

| *E- Signature on file* | | *10/20/2022* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

| | | | |
|---|---|---|---|
| 9/26/2022 | IV.D-F & V | Amanda Getten, LMFT | Edited co-signature and documentation training procedure and requirements |
| Prior Approval dates: | | | |
| | | | |

| | | |
|---|---|---|
| *E- Signature on file* | | *10/20/2022* |
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

**COUNTY OF SAN LUIS OBISPO**
**HEALTH AGENCY**
**BEHAVIORAL HEALTH DEPARTMENT**

## Unlicensed Trainee or Associate Notification

The County of San Luis Obispo Behavioral Health Department often uses unlicensed clinicians who are in the process of completing requirements for licensure to provide services. Trainees and Associates work under the direction and supervision of a licensed mental health professional, called a Clinical Supervisor. The names of the unlicensed Trainee or Associate who will provide services to you or your child and the licensed Clinical Supervisor are listed below.

Please talk with your provider or call the Clinical Supervisor if you have any questions. The Patients' Rights Advocate (PRA) responds to complaints about Trainees and Associates. To file a complaint, contact the PRA at (805) 781-4738, BH.PatientRightsAdvocate@co.slo.ca.us, or complete a Consumer Request Form (located in each clinic lobby). The Board of Behavioral Sciences responds to complaints regarding services provided by Registered Associates. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830. Your signature below indicates that we discussed this arrangement with you and that you agree to receive services from an unlicensed, but supervised clinician.

| Name of Trainee or Associate: | Registration Number: | Phone Number: |
|---|---|---|
| Name of Clinical Supervisor: | License Number: | Phone Number: |

Client Name:_____ Client #:_____

**COUNTY OF SAN LUIS OBISPO**
**HEALTH AGENCY**
**BEHAVIORAL HEALTH DEPARTMENT**

## Notificación de Asociado o Aprendiz sin Licencia

El Departamento de Salud Mental del Condado de San Luis Obispo utiliza a menudo médicos sin licencia que están en el proceso de completar los requisitos para obtener la licencia para proporcionar servicios. Los aprendices y asociados trabajan bajo la dirección y supervisión de un profesional de salud mental con licencia, llamado Supervisor Clínico. Los nombres del aprendiz ó asociado sin licencia que le proporcionará servicios a usted ó su hijo(a) y el supervisor clínico autorizado se detallan a continuación.

Hable con su proveedor o llame al Supervisor Clínico si tiene alguna pregunta. La Defensora de los Derechos de los Pacientes (PRA) responde a las quejas sobre Los Aprendices y Asociados. Para presentar una queja, comuníquese con la PRA al (805) 781-4738, BH.PatientRightsAdvocate@co.slo.ca.us, o complete un Formulario de Solicitud del Consumidor (ubicado en cada lobby de la clínica). La Junta Directiva de Ciencias del Comportamiento responde a las quejas relativas a los servicios prestados por Asociados Registrados. Puede comunicarse con la Junta Directiva en línea al www.bbs.ca.gov, o llamando al (916) 574-7830 Su firma a continuación indica que discutimos este acuerdo con usted y que acepta recibir los servicios de un médico sin licencia, pero supervisado.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Nombre de Asociado o Aprendiz | Numero de registración | Numero de teléfono |
| _____ | _____ | _____ |
| Supervisor Clínico: | Numero de licencia | Numero de teléfono |

Client Name:_____Client #:_____

# CO-SIGNATURE WAIVER REQUEST

**To:** Amanda Getten, LMFT
Quality Support Division Manager

**From: _____, Clinical Supervisor**

**Re:** Request to waive Co-Signature Requirements for:

**Registered Associate's name:**_____

**Internship Start date: _____**

**Effective Date**: _____

In accordance with the requirements of Policy titled *Registered Associates, Assistants, and Trainees: Supervision, Co-Signature, and Documentation Waiver Requirements*, the co-signature requirement is waived for_____ for the following document types:
*(Registered Associate's name)*

- ☐ Clinical intake assessment
- ☐ Treatment Plans
- ☐ Progress Notes
- ☐ Other (specify): _____

_____ _____ _____
Clinical Supervisor: License Date:

_____ _____
Program Supervisor: Date:

cc: Central Health Information
Attention: Kathy McGuire

# 14.03 Clinical Supervisor Requirements

I. PURPOSE

To provide direction for the process of becoming a Clinical Supervisor for the County of San Luis Obispo Behavioral Health Department (SLOBHD).

II. POLICY

SLOBHD Clinical Supervisors provide clinical oversight and training to support the growth and development of Trainees and Registered Associates.

III. REFERENCE(S)

- California Board of Behavioral Sciences: http://www.bbs.ca.gov/
- California Board of Psychology: http://www.psychology.ca.gov/

IV. PROCEDURE

**A. NEW CLINICAL SUPERVISORS**

1. A clinician speaks with their program supervisor/manager about their interest in providing clinical supervision at SLO County Behavioral Health.
   a) This conversation may be initiated by a clinician's interest in providing clinical supervision, or because the supervisor/manager has identified the clinician as a good fit to meet the department's clinical supervision needs.
2. If there is agreement that the clinician will move forward toward this goal:
   a) The clinician reaches out to the Clinical Supervision and Training Coordinator and participates in the Clinical Supervision interview process and completes any required training to be eligible to provide clinical supervision.
3. If the clinician is successful in this process, the clinician works with the Clinical Supervision and Training Coordinator to begin offering clinical supervision.
   a) New clinical supervisors will complete 15 CEs in Clinical Supervision within the first 60 days of providing clinical supervisor. Clinical supervisors will maintain their ability to provide supervision by taking 6 CEs in clinical supervision every 2 years upon completion of original coursework.
   b) New clinical supervisors will complete the Clinical Supervisor Self-Assessment and submit to the BBS at the start of supervision.
4. If the clinician is unsuccessful in this process, the Clinical Supervision and Training Coordinator provides information to clinician and supervisor/manager regarding the reason for this determination and to discuss possible plans to support the clinician's development and readiness to offer clinical supervision.

   a) Supervisor/manager may suggest the clinician work with the Clinical Supervision and Training Coordinator to identify a plan to support the clinician's development and preparedness.
5. If the supervisor/manager determines the clinician should not move forward with the process of becoming a clinical supervisor right now:
   a) Supervisor/manager provides information to clinician regarding the reason for this determination.
      i. Reasons could include: the supervisor/manager may not have a current need to add additional clinical supervisors, the current caseload demands would not allow the clinician to devote time to providing clinical supervision, or training/staff development is needed before the clinician would be a strong candidate to provide clinical supervision.

## B. DUTIES & RESPONSIBILITIES OF THE CLINICAL SUPERVISOR

1. Provides informed consent as it relates to clinical supervision.
   a) Clinical supervisors will review the SLO County Supervision Agreement as part of the informed consent process at the start of a new supervisory relationship and will revisit as indicated throughout the supervision.
   b) Clinical supervisors will complete Addendum 1 Emergency Contact Information and Addendum 6 Supervision History Form at the start of supervision (see SLO County Supervision Agreement).
2. Assumes legal liability and responsibility for services offered by the supervisee.
3. Oversees and monitors all aspects of patient care including case conceptualization and treatment planning, assessment, and intervention including emergent circumstances, duty to warn and protect, legal, ethical, and regulatory standards, diversity factors, management of supervisee reactivity or countertransference to patient, strains to the supervisory relationship, and is available when the supervisee is providing patient services.
4. Reviews and signs off on all reports, case notes, and communications until the supervisee has met BH Documentation standards and has been waived or the responsibility is delegated to a program supervisor.
5. Develops and maintains a respectful and collaborative supervisory relationship within the power differential.
6. Practices effective supervision that includes describing supervisor’s theoretical orientations for supervision and therapy and maintaining the distinction between supervision and psychotherapy.
7. Assists the supervisee in setting and attaining goals.
8. Provides feedback anchored in supervisee training goals, objectives, and competencies.
9. Provides ongoing formative and end of supervisory relationship summative evaluation.
10. Informs supervisee when the supervisee is not meeting competence criteria for successful completion of the training experience and implements remedial steps to assist the supervisee’s development.

11. Discloses training, licensure including number and state(s), areas of specialty and special expertise, previous supervision training and experience, and areas in which he/she has previously supervised.
12. Meets and maintains the clinical supervision licensure requirements as outlined by the Board of Behavioral Sciences (Reference `Supervisor Resources - Board of Behavioral Sciences (ca.gov)` for more information).
13. Reschedules to adhere to the standard and the requirements of this agreement if the supervisor must cancel or miss a supervision session.
14. Maintains documentation of the clinical supervision and services provided.
15. If the supervisor determines that a case is beyond the supervisee's competence, the supervisor may join the supervisee as co-therapist or may transfer a case to another therapist, as determined by the supervisor to be in the best interest of the client.
16. The supervisor will serve as a gatekeeper for the profession by enhancing the professional functioning of the supervisee while monitoring the quality of professional services offered to the clients.

## C. CLINICAL SUPERVISOR EXPECTATIONS-COVERAGE, CRISIS SUPPORT, AND EVALUATION

### 1. COVERAGE:

#### a) PLANNED ABSENCE

i. If the clinical supervisor has a planned absence, the clinical supervisor will call/email current clinical supervisors at least 2 weeks prior to their scheduled time off to discuss coverage needs. Current clinical supervisor information can be found on the Clinical Supervision Spreadsheet that is updated and emailed monthly.

ii. When a coverage clinical supervisor is identified, the clinical supervisor will let the supervisee know who will provide clinical supervision and how to schedule supervision.

iii. The supervisee will reach out to the identified clinical supervisor providing coverage to schedule supervision.

- Supervisees will be asked to reach out to the identified coverage supervisor within 1 day of being provided with their name/contact information to schedule supervision.

iv. Both clinical supervisors will let their program supervisors know of the plan for supervision coverage.

v. If clinical supervision is provided by a clinician from a different clinic, the clinical supervisor will develop a plan with the program supervisor and supervisee about who to contact about safety concerns and other clinical/programmatic needs. This plan will be communicated to the covering clinical supervisor.

vi. If the clinical supervisor is having difficulty identifying someone to provide coverage, the clinical supervisor may contact the Clinical Supervision & Training Coordinator (CSTC) for support and/or coverage.

**b) UNPLANNED ABSENCE**

i. If the clinical supervisor has an unplanned absence, the program supervisor will notify the supervisee(s) to cancel supervision.
   a. The clinical supervisor will maintain their calendar, including scheduled supervision sessions, so that the program supervisor will know which supervisee(s) to notify.
   b. The clinical supervisor is expected to reschedule their supervision session during that business week if they return to work and their schedule allows.
   c. If the clinical supervisor is unable to reschedule supervision for that business week due to their schedule, then they will reach out to the BH Clinical Supervisors and/or CSTC to request coverage.
   d. If the clinical supervisor is not anticipated to return to work during that business week, then the program supervisor will notify the supervisee(s) and the CSTC.
      - The CSTC will call and/or email current clinical supervisors to inquire about their ability to provide coverage and communicate the outcome to the program supervisor and supervisee. If a clinical supervisor is not able to be identified, the CSTC will provide coverage when able.

ii. The program supervisor will develop a plan with the supervisee about crisis contacts and other clinical/programmatic needs. The program supervisor will communicate the plan with the covering clinical supervisor.

## 2. EMERGENCY CONTACT INFORMATION

a) The clinical supervisor will identify and review emergency contact information with the supervisee at the start of supervision per BBS regulations.
   i. The supervisee will be provided in writing the names and contact information for their individual, group, and program supervisors.
   ii. The supervisee will be provided in writing local emergency and crisis numbers.

b) If the clinical supervisor is a part time employee, the clinical supervisor will discuss the crisis coverage needs with the program supervisor and supervisee and develop a coverage plan for the clinical supervisor's scheduled days off.

c) The program supervisor may provide crisis coverage when the clinical supervisor is out of the office.

## 3. EVALUATIONS FOR SUPERVISOR AND SUPERVISEE

**a) Supervisee Evaluations**

i. Clinical supervisors will complete an evaluation of the supervisee at least

annually and at time of termination per BBS regulation.

- The evaluation is separate from the employee performance evaluation and does not replace direct and timely feedback regarding the supervisee's skill development.
- Clinical supervisors may share information about staff development needs with the program supervisor if a supervisee is not progressing.

**b) Clinical Supervisor Evaluations**

i. The CSTC will send out supervisee evaluations of their clinical supervisors at least annually to gather information about the quality of clinical supervision being provided.

ii. The CSTC will report information gathered to clinical supervisors to help with skill development, as well as use the information to inform policies and practices related to clinical supervision.

## V. DEFINITIONS

A. Trainees: MFT or ASW Trainees are individuals who are enrolled in a Master's level graduate program in Psychology, Counseling or Social Work and are working on clinical hours for graduation.

B. Associates: Associates are individuals who have graduated from a Master's level program in Psychology, Counseling or Social Work. Associates are working on clinical hours for licensure and are registered as Associates with the Board of Psychology or California Board of Behavioral Sciences.

C. Clinical Supervisor: Clinical Supervisors are licensed mental health professionals who meet the minimum qualifications to provide supervision to trainees and/or associates who are pursuing licensure. Clinical supervisors must be licensed for a minimum of 2 years and have practiced psychotherapy and/or provided direct supervision during at least 2 out of the last 5 years prior to the commencement of supervision. Clinical Supervisors must sign and comply with required supervision related forms, as well as complete supervision related training per the BBS regulations.

## VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/7/2023 | All | Adopted |
| | | |
| Prior Approval dates: | | |
| | | |

| *E-Signature on file* | | 09/24/2024 |
|---|---|---|
| Approved by: | Star Graber, PhD, LMFT Behavioral Health Administrator | Date |

# 14.05 Gifts, Donations and Loans

I. PURPOSE

To ensure that gifts and donations are processed and accounted for consistent with County of San Luis Obispo organizational values and professional ethical standards.

II. POLICY

Mental Health Staff will not accept gifts from clients or agencies for their personal use.

III. REFERENCE(S)

- Please refer to San Luis Obispo County Policy on County Staff Receiving Gifts and Gratuities – Attachment A - Contract with DHCS, Exhibit A, Attachment 1

IV. PROCEDURE

A. When monetary donations are made, they are forwarded to Accounting with a memo identifying the donor's name, the amount of the donation and the service that the donation was intended for, if specified

   1. The amount of the donation is credited to the service specified, if no services were specified the amount would be distributed to all programs.

   2. The Behavioral Health Administrator's secretary prepares a letter of acknowledgment as above.

B. When a non-monetary gift is received on behalf of the Mental Health Services, the Behavioral Health Administrator is promptly notified of the gift, the donor's name, address, date and service, and what the gift was intended for, if specified.

   1. A letter of acknowledgment is then prepared for the Behavioral Health Administrator's signature. It is desirable to have the person arranging for the gift to co-sign the letter of acknowledgment.

   2. The donor may specify a dollar value for the gift if that is to be included in the letter.

   3. The item is labeled with the donor's name and the date that the gift was made.

C. The Mental Health Services Gift Fund is deposited as a Departmental Fund and needs the approval of the Behavioral Health Administrator prior to its use.

D. Individuals or programs should not maintain informal gift funds outside of the policy and procedures described.

E. Mental Health Services does not accept equipment, material/supplies or works of art on a loan basis.

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V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 04/30/2009 | | Adopted |
| 06/08/2017 | All | Revision and reformatting |
| 09/04/2018 | All | Reformatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *09/11/2017* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 14.08 Transportation of Clients To- and- From Other Facilities

## I. **POLICY**

County of San Luis Obispo Behavioral Health Department shall transport a client to and from clinic sites and other facilities regardless of their legal hold, except inmates. No client shall be transferred or discharged to another facility, unless arrangements have been made in advance for transfer to such facility and the person legally responsible for the client has been notified, unless it is an emergency.

## II. **PURPOSE**

1. To ensure a safe, appropriate and timely coordinated transfer of clients to and from another facility.
2. To maintain optimal health and well-being of the client while being transported.

## III. **REFERENCES**

- County Code 2.84.010 Rules for Use of Vehicles on County Business

## IV. **PROCEDURE**

A. General Principles

1. A transfer of a client shall be carried out if the client requires a higher level of care due to medical condition or due to third party payer requirement.
2. A transfer shall not be carried out if in the opinion of the staff psychiatrist, in consultation with the Medical Director and Clinical Director, in that such transfer would be contraindicated.
3. All staff will follow the Rules for Use of Vehicles on County Business, Policy 10.05 Operating County Vehicles, and Policy 10.04 County Drivers Cell Phones.
4. No smoking is allowed in County vehicles.
5. Staff will wear photo ID badge issued by the Health Agency at all times.
6. Clients shall never be transported in an employee's personal vehicle or other personal vehicles. In cases when the number of County vehicles cannot meet the demand for use, preference will be given to employees needing to transport clients.
7. Volunteers and interns may drive County vehicles provided they have a valid California Driver's License, have read County regulations regarding the use of County vehicles, and have been cleared by the County Risk Management.

8. If lead staff determines that, the client presents an imminent risk for elopement or violence, toward others, staff will consult with program supervisor, or psychiatrist to determine most appropriate form of transportation.
9. Seat belts are to be used at all times.
10. Clients on a legal hold shall never transported by family or community members.
11. Every staff must carry an operable cell phone during client transport and be available to respond to calls from the PHF at all times Use of cellular phones will comply with current motor vehicle regulations including hands free operation while driving.
12. The staff shall notify the Program Supervisor or delegate when emergencies occur during transportation. Upon completion of a trip, the staff shall report to the shift lead on duty any incidents that may have occurred Incident Report(s) and Report(s) of Vehicle Accident/Incident/Damage will be completed as required.
13. In the event of an emergency (i.e. elopement, medical, assault) call 911, take immediate steps for safety and contact Program Supervisor when safe to do so.
14. In the event of an accident, the staff will notify local law enforcement, the Program Supervisor, and complete a vehicle accident report, which includes the police report, number and the appropriate information related to any other drivers.
15. Meal reimbursements for clients will only be approved for meals purchased outside the county of San Luis Obispo. Exceptions will be made on emergency basis when the staff is providing 1:1 support in the community. Reimbursements will be approved for meals purchased by employee staff for clients during transport. Staff must include client number on receipt.

B. When Transporting a client to a Courthouse, the staff will:

1. Assure that the client is dressed in appropriate clothes and not in hospital clothes.
2. Obtain the address of the Courthouse, Department number, hearing time as well as directions to the Courthouse (refer to Court Transport Guidelines – Attachment A)
3. Remain with the client in the Courthouse at all times, as they are on a legal hold. The client must always be within arm's length of the staff.

C. When staff or ambulance transports a client to or from a medical facility ,staff will:

1. Ensure that the following forms are either completed or transported with the client:
    a. Mental Health to Hospital Transfer Form
    b. Consent to Transfer to another Medical Facility
    c. Certification by Physician for Transfer of client with Emergency Medical Condition

2. Ensure that a nurse-to-nurse followed by a doc-to-doc report has been completed prior to transporting the client to or from medical facility.

3. Notify the client of where he/she is being taken and the reason for the transport. If the client is a minor, notify the parent or legally responsible person, where the minor will be transported.
4. All transport personnel including Law Enforcement must receive confirmation from PHF Staff only, that the client has been accepted on the PHF.

D. When transporting a client to another psychiatric facility, placement or discharge the staff will:

1. Ensure that they have any records or documents required by the receiving facility.
2. Obtain name, address and phone number of the receiving facility, as well as directions to it, and to whom to report. For State Hospitals, the staff needs to know the client's unit number.
3. Gather all of client's belongings, including personal medications. If the client is being transported from the PHF, staff will check the PHF safe, wardrobe, sharps box, individual's suitcases, and bags for their property Check that the Personal Property List has been completed and signed, and place clients' property and Personal Property List in rear of the vehicle. The staff will ensure that the client will not have access to their property during transport.
4. Provide food and fluids, towels, pillow, blanket, basin/urinal (if needed), and tissue within reach of client in the vehicle.
5. Prompt the client to use the toilet before departure.
6. Inform the client (or legal guardian) where he/she is going.
7. Check client for sharps and/or contraband before allowing him/her into vehicle.
8. Ask the contact person at facility for paperwork and client property to be taken back to the PHF.
9. Assist client into the County vehicle and prompt the client to fasten their seat belt.
10. Staff will contact Program/Nursing Supervisor if there are any identified client needs or concerns.
11. Report any observable vehicle maintenance needs to the PHF Supervisor.
12. Remove all litter and property from the vehicle upon return, including any used urinals

E. When transporting a client to treatment related appointments and activities.

1. Assure that the client is dressed in appropriate clothes and not in hospital clothes.
2. Obtain the address of and directions to the destination.

3. Remain with the client at all times. If they are on a legal hold, the client must always be within arm's length of the staff.
4. Ensure that they have any records or documents required for the appointment/activity.
5. Prompt the client to use the toilet before departure.
6. Inform the client (or legal guardian) where he/she is going.
7. Check client for sharps and/or contraband before allowing him/her into vehicle.
8. Assist client into the County vehicle and prompt the client to fasten their seat belt.
9. Prior to returning, ask the contact person at facility for paperwork and client property to be taken back.

## I. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 11/01/2015 | | |
| | | |
| 01/02/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *09/11/2017* |
|---|---|---|
| Approved by: | Daisy Ilano, MD, Medical Director | Date |

| *Signature on file* | | *09/11/2017* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 14.09 E-Learning

I. PURPOSE

- Assist employees, contracted employees and volunteers to meet training and licensing requirements
- Ensure our workforce's ability to provide high quality of care and culturally and linguistically competent services to the community.
- Help employees develop and/or enhance their professional skills and to assist them with their career development goals.

II. POLICY

In accordance with State requirements and Department goals, San Luis Obispo County Behavioral Health Department (SLOBHD) provides education and training to its employees, contracted employees, and volunteers as part of its commitment to staff training and development. SLOBHD provides online courses from Essential Learning within Elevate, the county's electronic learning program.

III. REFERENCE(S)

IV. PROCEDURE

A. Training and Education

1. Mandatory Courses

i. SLOBHD provides mandatory training for all employees on topics such as safety, confidentiality, HIPAA, ethics, work-related topics and organizational policies. Employees are given access to their training plans via a password-secured log-in to the County's Electronic Learning program. Mandatory training and other agency requirements are listed with specific due dates on the employee's training plan. Employees are provided Certificates of Completion as part of the e-learning service.

ii. All mandatory training is expected to be completed on or before the "required by" date. Employees should use normally scheduled work hours to complete mandatory online courses with the prior approval from their supervisor.

iii. Employees cannot earn overtime or accrue comp time while completing online training.

iv. Timely completion of mandatory training will be a consideration in an employee's performance evaluation. Fulfillment of this requirement does not guarantee raises, promotion or other compensation or alter the "at will" status of employment.

2. Recommended Courses: A Program supervisor may occasionally recommend specific online courses as a performance improvement activity or as part of an employee's professional development plan. Employees may schedule time to complete recommended online courses pre-approved by their Supervisor during normally scheduled work hours.

3. Elective Courses: Essential Learning provides a library of professional courses on a variety of behavioral health and human service topics. Employees may take online courses for continuing education credit, for professional development, or personal interest at no cost. Employees choosing to take elective online courses at their own discretion must do so on their own time. They will not be compensated for their time.

B. Supervision of E-Learning

1. Supervisors' Role: SLOBHD Program Supervisors are expected to register new employees as users, assign courses, monitor progress, and report progress as part of training expectations in staff evaluation. Program Supervisors should stay abreast of new online courses offered by the provider and make recommendations for courses which contribute to the professional development of their assigned staff. Program Supervisors are expected to allow mandatory and recommended course training time within normal work hours.

2. Program Supervisors may also approve requests for elective learning, and have staff assure that County time is not used for elective online courses.

C. Maintaining Staff Assignments within the E-Learning System

1. Program Supervisors refer to the "Elevate Quick Guide for Supervisors and Managers" for instructions and consult the help features of the e-learning web site for enrolling users, assigning courses, and maintaining training records.

2. Program Supervisors use the tools and reports provided by the e-learning system to document staff training assignments and completion of assigned courses. Supervisors remind staff when training deadlines near and document staff failure to complete assigned training.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 08/19/2011 | | Adopted |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *08/19/2011* |
|---|---|---|
| Approved by: | Behavioral Health Administrator (KB) | Date |

# 14.11 Designation to Write 5150/5585 Holds

## I. PURPOSE

To establish San Luis Obispo County Behavioral Health Department's (SLOBHD) procedures for the identification and training of professionals who will be designated to perform functions under Welfare and Institutions Code (W&I Code) §§ 5150 – 5585.59

## II. SCOPE

Applies to all staff seeking designation from SLOBHD to write a 5150/5585 hold.

## III. POLICY

The SLOBHD Administrator shall implement a process for identifying, training, testing, designating and monitoring individuals who will perform functions under Welfare and Institutions Code (W&I Code) §§ 5150 – 5585.59

## IV. REFERENCE(S)

- W&I Code Division 5, Part 1, Chapter 2, § 5121
- W&I Code Division 5, Part 1, Chapter 2, §§ 5150 – 5585.59
- California Code of Regulations (CCR) Title 9 §§ 821 – 825

## V. DEFINITIONS

- 5150 or Involuntary hold: The *Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment* (DHCS 1801) is the form commonly referred to as a "5150" or "involuntary hold". The 5150 documents the specific information that results in probable cause to detain an individual for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the SLOBHD.
- Criteria for an involuntary hold: W&I Code § 5150 (§ 5585 for minors) details the criteria for an involuntary hold. The key components are that, as a result of a mental health disorder, an individual is a danger to self or others or is gravely disabled and cannot be properly served without being detained.

## VI. PROCEDURE

### A. Eligibility for Designation

1. Professional Status: License or registration with the relevant board must be current and in good standing. Eligible staff include:

- Staff who are licensed/registered/waivered or who work under the direction of a staff in one of the following disciplines: Psychiatry, Psychology, Marriage and Family Therapy, Social Work, Professional Clinical Counseling

- Nursing staff: Registered Nurses, Licensed Psychiatric Technicians (LPT) or Licensed Vocational Nurses (LVN)

- Other Qualified Providers as determined eligible by the SLOBHD Administrator on a case-by-case basis

2. Experience: Designated professional staff must have a minimum of two years of experience providing treatment to individuals with mental illness or other behavioral health needs.

3. Training: Initial Designation requires:
   - Completion of a SLOBHD approved face-to-face training or tele-conference (ZOOM) course.
   - Successful completion of training post-test (must provide 100% correct responses). Scores with less than 100% accuracy will result in additional educational support by training staff to ensure understanding.
   - Sufficient experience working in crisis situations.

4. Re-designation requires the completion of a SLOBHD approved refresher course, which may be an E Learning module (RELIAS), successful completion of training post-test (must provide a minimum of 80% correct responses), and submission of a sample of an DHCS 1801 to the SLOBHD Administrator or designee for review. The sample may be an actual DHCS 1801 completed by the staff member or a vignette written for the designation process. The sample must also be on the most current version of the DHCS 1801 form. Re-designation will occur every two (2) years, or more frequently as recommended by Mental Health Evaluation Team (MHET) Supervisor, Adult or Youth Services Program Supervisor or Division Manager, or SLOBHD Administrator.

B. Designation Process and Designee List

1. The designee will complete the initial 5150 training (4 hours) and submit post test to a member of the designation training committee designated by the SLOBDH Administrator for review.

2. The designee's Supervisor or Manager will ensure designee has sufficient experience working in crisis. Supervisors or Managers must approve this step to continue with designation process.

3. Designee will complete and submit a 5150 sample (DHCS 1801) to SLOBHD Administrator for approval. *See Attachment A*

4. The SLOBHD Administrator will review and sign the *Designation Card* once designation steps are complete*. See Attachment B*
   - Designation will be valid for a period not to exceed 2 years
   - Designation will expire if the designee leaves employment or becomes ineligible for another reason (i.e., fails to maintain license/registration in good standing, fails to follow policy or procedure, or at the discretion of the SLOBHD Administrator).
   - If the SLOBHD Administrator denies or revokes an individual's designation, the SLOBHD Administrator will provide a written notification to the person who made the request for designation of the individual, and the individual who is the subject of the request for designation, describing the reasons for denial or revocation.

5. Each approved and signed designation card will be logged and mailed to designated staff by PRA or designee.

6. The PRA or designee will maintain a spreadsheet that will log the dates staff complete training or other parts of the designation process.

C. Quality Monitoring

1. SLOBHD's QST will review each DHCS 1801 that results in admission to the Psychiatric Health Facility (PHF) during Utilization Review (UR). The QST UR clinician will promptly notify the QST Division Manager and the Medical Director of documentation concerns.

2. The PHF UR Committee will review involuntary holds that do not adequately document probable cause for the hold or that are identified during UR as needing additional review.

3. The QST Division Manager will make corrective action recommendations to the SLOBHD Administrator as needed. Recommendations adopted by the SLOBHD Administrator may include additional training, mentoring or other corrective actions and may include suspension or termination of designation.

4. MHET shall establish a separate system of supervision and monitoring for MHET staff to ensure adequate documentation by contractor staff as detailed in the contract with SLOBHD.

5. Contractors whose staff are designated must develop a quality management process to review the holds written by contractor staff.

###

VII. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 03/03/2017 | | Adopted |
| 09/04/2018 | All | Formatting |
| 5/24/2019 | IV | Added OQP and minor changes to shadowing process |
| 12/16/2022 | VI | Updated requirements for staff to meet qualifications to be designated |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | 1/4/2023 |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

**ATTACHMENT A**

State of California
Health and Human Services Agency

Department of Health Care Services

**APPLICATION FOR UP TO 72-HOUR ASSESSMENT, EVALUATION, AND CRISIS INTERVENTION OR PLACEMENT FOR EVALUATION AND TREATMENT**

***Confidential Client/Patient Information***

**Welfare and Institutions Code (W&I Code), section 5150 (g)(1),** requires that each person, at the time they are first taken into custody under this section, shall be provided, by the person who takes them into custody, the following information orally in a language or modality accessible to the person. If the person cannot understand an oral advisement, the information shall be provided in writing.

☐ **Complete Advisement** ☐ **Incomplete Advisement**

**Date of Advisement/Attempt:** _____

Good Cause for Incomplete Advisement

**DETAINMENT ADVISEMENT**

My name is _____. I am a (peace officer/mental health professional) with (name of agency). You are not under criminal arrest, but I am taking you for examination by mental health professionals at (name of facility).

You will be told your rights by the mental health staff.

**If taken into custody at their residence, the person shall also be told the following information:**

You may bring a few personal items with you, which I will have to approve. Please inform me if you need assistance turning off any appliance or water. You may make a phone call and leave a note to tell your friends or family where you have been taken.

| Advisement Completed/Attempted By: | Position | Language or Modality Used: |
|---|---|---|
| | | |

**To** (*name of 5150 designated facility*): _____

Application is hereby made for the assessment and evaluation of _____, date of birth of _____, and residing at _____, California, for up to 72-hour assessment, evaluation, and crisis intervention, or placement for evaluation and treatment at a designated facility pursuant to Section 5150, et seq. (adult) or Section 5585 et seq. (minor), of the W&I Code.

If authorization for voluntary treatment is not available for a minor/conservatee, indicate to the best of your knowledge who has legal authority to make medical decisions on behalf of the minor/conservatee: (name and contact information, if available)

(**Check one**): ☐ **Parent(s)** ☐ **Legal Guardian(s)** ☐ **Conservator** ☐ **Other:** _____

Indicate to the best of your knowledge whether the minor is under the jurisdiction of the juvenile court:

**(Check one): ☐ W&I Code 300 (dependent) ☐ W&I Code 601, 602 (ward)**

The detained person's condition was called to my attention under the following circumstances:

_____

_____

Specific facts that I have considered that lead me to believe that this person is, as a result of a mental health disorder, a danger to others, a danger to self or or gravely disabled:

_____

_____

☐ I have considered the historical course of the person's mental disorder as follows:

_____

_____

☐ No reasonable bearing on determination

☐ No information available because: _____



DHCS 1801 (Revised12/2019)

**Please Note: A copy of this application shall be treated as the original.** Page **1** of **2**

State of California
Health and Human Services Agency

Department of Health Care Services

**APPLICATION FOR UP TO 72-HOUR ASSESSMENT, EVALUATION, AND CRISIS INTERVENTION OR PLACEMENT FOR EVALUATION AND TREATMENT (CONTINUED)**

| OPTIONAL INFORMATION | | | |
|---|---|---|---|
| **History Provided by (Name)** | **Address** | **Phone Number** | **Relation** |
| | | | |
| | | | |
| | | | |

Based upon the above information, there is probable cause to believe that said person is, as a result of mental health disorder:

☐ **Danger to Self (DTS)** ☐ **Danger to others (DTO)**

☐ **Gravely disabled (as defined in W&I Code section 5008 or 5585.25)**

**NOTIFICATIONS TO BE PROVIDED PURSUANT TO SECTION 5152.1 AND/OR 8102 OF THE WELFARE AND INSTUTIONS CODE**

Notify behavioral health director/designee: _____ _____
*(Name)* *(Phone)*

and peace officer/designee: _____ _____ of
*(Name)* *(Phone)*

person's release or end of detention if either of the boxes below are checked.

**NOTIFICATION OF PERSON'S RELEASE IS REQUESTED BY THE REFERRING PEACE OFFICER BECAUSE:**

☐ The person has been referred to the facility under circumstances which, based upon an allegation of facts regarding actions witnessed by the officer or another person, would support the filing of a criminal complaint.

☐ Weapon was confiscated pursuant to Section 8102 W&I Code.

*Signature*, *title* and *badge number* of peace officer, professional person in charge of the facility designated by the county for evaluation and treatment, member of the attending staff, designated members of a mobile crisis team, or professional person designated by the county.

| **Name:** | **Title/Badge Number:** | **Date:** | **Phone:** |
|---|---|---|---|
| **Signature:** X | | **Time:** | |

| Name of Law Enforcement Agency or Evaluation Facility/Person: | Address: |
|---|---|
| | |

**REFERENCES**

**Welfare and Institutions Code**

**Sections:** 300, 601, 602, 5008, 5150, 5150.05, 5152.1, 5328, 5585.25, 5585.50, 8102

**Name of Individual Detained:** _____ **DOB:** _____

DHCS 1801
(Revised12/2019)

**Please Note: A copy of this application shall be treated as the original.** Page 2 of 2

**ATTACHMENT B**

**Name, Credentials**
**Job Title/Agency**
805-

The person named above is designated to perform functions under WIC 5150/5585 in San Luis Obispo County. **Expires on:**

_____

Anne Robin, LMFT
Behavioral Health Administrator

# 14.12 Mandatory Use of Cerner Scheduler

## I. SCOPE

Applies to all County of San Luis Obispo Behavioral Health outpatient clinical staff

## II. PURPOSE

The County San Luis Obispo Behavioral Health (SLOBHD) utilizes centralized scheduling to accomplish the following objectives:

- To improve customer service by utilizing standard check-in and reminder procedures
- To ensure clinical coverage during staff absences
- To verify service delivery and track client attendance
- To enable close monitoring of Medi-Cal eligibility
- To monitor documentation of services and to manage capacity

SLOBHD serves clients by assigning the client to a treatment team. Coordination between members of the treatment team and support/supervisory staff accomplishes a number of SLOBHD goals, including improving customer service, managing clinical coverage, and monitoring service delivery to ensure that services reach our target population. Cerner (Anasazi) Scheduler allows SLOBHD staff to more efficiently coordinate services, resulting in improved outcomes. It supports other goals such as enabling support/supervisory staff to complete service verification, Medi-Cal verification, monitoring, and tracking activities as required by regulation and contract with the California Department of Health Care Services (DHCS).

## III. POLICY

All clinical staff must utilize the Cerner Scheduler to document all scheduled appointments, face-to-face services, and other non-billable activities, including time off.

## IV. REFERENCE

- M:\BHEHR\BHEHR Procedures\Scheduler Single Day View

## V. DEFINITIONS

- Reserved Time: Blocks of time set aside for specific services, often scheduled by Managed Care. Reserved Time in Scheduler looks lavender until filled.
  Examples include:
  - Intake
  - Urgent Services

- Services: Meetings with individual or groups of clients to provide medically necessary treatment. Scheduled services are blue in Scheduler and appear on the clinician's Scheduled Services pane in Clinician's Homepage. Typically, clinicians document services from the Scheduled Services pane. Specialty Mental Health Services (SMHS), Medi-Cal Administrative Activities (MAA), and Substance Use Disorder Services (SUDS) are examples of Individual or Group Services in Scheduler.

- Appointments: Any work time not related to a specific client, group of clients, or MAA. This may include, but not be limited to meetings, training, and time off.
  - Appointments are "Busy" in Scheduler when staff block off their schedule to prevent double booking with other services. Busy Appointments are blue.
  - Appointment may be single events or may recur (weekly, monthly, etc.)
  - Examples include:
    a) Meetings, training, and other regular work time activities that are not Services
    b) Time off: Vacation, Medical Appointments, Jury Duty
  - Appointments are "Free" when the purpose is to let others know to schedule services during the time indicated. Free Appointments are green.
  - Free Appointments may be in a large block or in smaller blocks (i.e., hour-long appointments for therapy, clinic crisis coverage, etc.)

- "White space": Gaps of regular work time not blocked off for services or appointments

- Single Day/Multiple Day views: Scheduler allows staff to see scheduled services and appoints in two different ways, each with advantages and limits. Multiple Day view allows staff to see multiple days' worth of one staff member's calendar. This view allows a bigger picture look at one staff. Single Day view allows staff to view many different staff schedules one day at a time. This view allows Front Office staff to build a custom template for a select group of staff – for example, all staff at a clinic site. The major advantages of Single Day view are that it helps coordinate of a team and that the layout mimics a color-coded calendar. Note: The choice of view merely changes the look and feel, not the content of scheduled services and appointments. In other words, an event scheduled in one view will appear in the other.

## VI. PROCEDURE

### A. Busy Appointments

1. Clinical staff will discuss time off and protected time with Program Supervisor to obtain approval and will then add a Busy Appointment to block time off and protected time in Scheduler
2. Clinical staff will cancel (or arrange for another team member to cancel or cover) previously scheduled Services when blocking time off
3. Staff who schedule clients will refrain from double booking a Service during a Busy Appointment without the clinician's permission. Staff will attend to the warning

dialogue box that appears when this occurs and will find another suitable time to schedule unless the clinician gives permission to schedule.

B. Free Appointments (optional) and white space (default)

1. Clinical staff may elect to schedule Free Appointments or use the default white space to designate available times for client services.
2. Front Office staff will assist with creating Free Appointments when needed.
3. Staff who schedule clients will prioritize scheduling in Free Appointments. Staff will use white space to schedule Services when clinical staff elect not to use Free Appointments.

C. Services

1. Staff will enter all face-to-face services in Scheduler
   a. Clinical staff may schedule or request that Front Office staff schedule services
   b. Front Office staff will schedule all walk in and crisis services with the clinician who responds to the client.
2. Clinical staff will resolve scheduled services by writing a Progress Note, except when Front Office staff cancel the service following a phone call from a client
3. Clinical staff will document phone calls and services provided without the client present by writing a Progress Note. These services do not require use of Scheduler.

D. Single Day View templates: Front Office Staff will develop and maintain a Single Day view Scheduler template for the program they support.

E. Use of Scheduler to Enhance Customer Service

1. Front Office staff will utilize Scheduler to make reminder calls as determined by the program
2. Front Office staff will utilize Scheduler to check clients in and to alert clinicians that a client is waiting
3. Front Office staff will use Scheduler to cancel clients when clinicians are sick

F. Medi-Cal Verification

1. Front Office staff will utilize Scheduler to identify clients scheduled for the next business day and will verify Medi-Cal eligibility
2. When a client loses Medi-Cal eligibility, Front Office staff will:
   a. Alert the clinician
   b. Begin the Cost Agreement/Fee Agreement process

###

VII. REVISION HISTORY

| Status: Initial/ Revised/Archived Description of Revisions | Section(s) Revised: | Author | Details of Revision: |
|---|---|---|---|
| 02/02/2018 | All | Greg Vickery, LMFT<br>QST Division Manager | Initial Release |
| Prior Approval dates: | | | |
| | | | |

| *Signature on file* | | *02/04/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# Section 15

# Incidents - Safety- Mandated Reporting

# 15.00 Employee Incident Reports and First Aid

## I. PURPOSE

To provide direction for staff to assist injured person(s) to obtain proper emergency medical care.

## II. POLICY

When Behavioral Health employees have an injury or illness that relates to their employment, an Employee Injury/ Illness Report will be completed within 24 hours of the incident. Every effort will be made to assist an injured person in obtaining proper emergency medical care.

## III. REFERENCE(S)

## IV. PROCEDURE

A. In the event of staff injury, the immediate supervisor of the staff must complete the following:

1. Fill out the Supervisor's Investigation Report.
2. Fill out the DWC-2 Form. Note: ONLY lines 1, 11, 12 and 16.
3. Ask the employee to complete the Employee Report of Occupational Injury or Illness Report (if the employee is able to do so).
4. Fax all 3 forms to Risk Management (fax 781-4880) immediately.
5. Send a copy to Health Agency Human Resources (HAHR) (fax 781-4281).
6. If the accident involved a county vehicle, fill out a Vehicle Accident Report. Located http://myslo.intra/RM/RM_Safety/Forms.htm
7. Make a copy of all of the forms and keep for your records.
8. Give the employee the original DWC-1 form with lines 1, 11, 12, and 16 completed.
9. Print out and give the employee the entire employee packet containing all forms and FAQ's located on the Workers Compensation Intranet page listed below.
10. All forms are available from the HAHR Department, or from the County Website (http://myslo.intra/RM/RM_WorkersCompensation.htm)

B. In case of a medical emergency:

1. Properly trained staff (i.e., Medical Doctor, Registered Nurse, Licensed Vocational Nurse, and Psychiatric Technician) may offer first aid assistance to help an injured person to be safely transported to a medical facility.

2. An Incident Report is completed by the Program Supervisor or designee for visitor or client injuries and is available from HAHR or on the Risk Management Intranet page http://myslo.intra/Assets/RM/Safety/Forms/Incident.Accident+Form

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 04/30/2009 | | Adopted |
| 06/01/2015 | All | Updated forms and inserted links |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| | | |
|---|---|---|
| *Signature on file* | | *04/30/2009* |
| Approved by: | Behavioral Health Administrator (KB) | Date |

# 15.01 Fire and Disaster Plan

I. PURPOSE

To provide direction for staff to safely and appropriately respond to fire and disasters to ensure safety of staff and clients

II. POLICY

In the event of a fire or disaster, staff will follow the directions on the County Emergency Action Plan that is maintained at each Outpatient program site. Program Supervisors at each site will ensure that all staff are familiar with and informed of the location of the County Emergency Action Plan document.

III. REFERENCE(S)

IV. PROCEDURE

A. If an emergency situation arises in or around the work site staff will immediately report to the site supervisor and refer to the County Emergency Action Plan posted at each site.

B. Follow the instructions on the Emergency Action Plan for the type of emergency or disturbance that threatens the area.

C. Ensure the safety of clients and visitors that are in the building at the time of the emergency

D. In the case of fire, in addition to following the instructions on the Emergency Action Plan staff will do the following:

1. The person who first becomes aware of the fire loudly announces to others in the area: CODE RED

2. Staff in the area of the fire immediately:
   a. Assist clients and visitors to vacate to the pre-planned evacuation area (e.g. parking lot).
   b. Inform all other staff to vacate to the pre-planned evacuation area
   c. To the extent possible, after clients have been evacuated, staff will do the following:
      i. Close all doors in the area;
      ii. Unplug all electrical appliances in the immediate area threatened by fire; and

iii. Use a fire extinguisher or hose to extinguish or control the fire until the Fire Department arrives.

E. If the program site needs to be closed temporarily, the Program Supervisor or designee follows the procedure outlined in policy titled 15.05 Temporary Closing of Clinic.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 06/01/2015 | All | Combined with policy 15.10 Disaster Plan |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *12/30/2015* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 15.02 Morbidity and Mortality Committee

I. PURPOSE

To describe the process for review of care in the event of a client death or serious injury

II. SCOPE

Applies to all SLOBHD County-operated and contract Specialty Mental Health Service and Substance Use Disorder Service programs

III. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) will conduct a quality of care review in the event of a client death or serious injury. The Morbidity & Mortality (M&M) Committee, a subcommittee of the Quality Support Team (QST) Committee, will conduct such review. All proceedings of the M&M Committee are confidential and are not subject to discovery in a legal proceeding.

IV. REFERENCE(S)

- Welfare & Institutions Code §14725
- Welfare & Institutions Code §5328(n)
- California Code of Regulations, Title 9, Chapter 11, §1810.440
- Code of Federal Regulations, Title 42, §§438.230, 438.310-438.340
- California Evidence Code §1157.6
- Contracts with Department of Health Care Services (DHCS) with MHP and DMC-ODS

V. PROCEDURE

A. The M&M Committee will consist of the SLOBHD Medical Director (chairperson), additional medical staff designated by the Medical Director, and staff from QST, including the QST Division Manager. The Behavioral Health Administrator may appoint additional members.

B. The committee will meet monthly or as scheduled by the Medical Director, but no later than 2 months after the client's death or serious injury, even if the Coroner's report or Death Certificate is not available yet.

C. M&M Committee records will include an agenda, approved minutes, investigative reports, and related documentation for other sources, including Coroner's report, when available. QST staff will maintain committee records confidentially for a minimum of 10 years following the expiration of the DHCS contract period during

which the incident occurred.

D. In the event of death or serious injury of a client who was open for services with SLOBHD or a contracted provider (or who was open within the 90 days preceding the incident):

1. Staff who learn of the incident will complete an Incident Report (see policy 15.04 Outpatient Incident Report)
2. Staff will forward the Incidents Report to QST for review
3. QST staff will sequester the record and schedule the M&M review

E. The M&M Committee will assign a member to review the record and the Incident Report at the next meeting. The SLOBHD Medical Director will then guide a discussion of the pertinent facts related to client care. If follow up or additional information is needed, an M&M Committee Follow-up Request will be sent to obtain the information needed. A staff member familiar with the client's treatment may present the information in writing or in person in the next scheduled M&M Committee meeting.

F. At the conclusion of the review, the M&M Committee chairperson will forward written findings to the QST Committee. Findings may include:

1. Recommendation(s) to improve care provided or prevent occurrence of serious injury or death, if needed
2. A recommendation to unsequester or keep the record sequestered
3. When necessary, that follow-up actions will be taken by SLOBHD to report incidents to State Department of Health Care Services or other oversight body

G. The Medical Director and/or QST Division Manager will lead a discussion of the findings at the next QST Committee meeting to encourage active participation by the SLOBHD's providers, beneficiaries, and family members in the quality improvement process.

###

I. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 06/5/2015 | All | Changed "PQI" to "QST"; "Locked Record" to "Sequestered Record"; Added references; Changed Mental Health to Behavioral Health |
| 09/08/2017 | All | Minor revisions, reformatted, added scope |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| 3/30/2009, 4/30/2010,1/21/2011, 6/5/2015 | | |

| *Signature on file* | | *09/11/2017* |
|---|---|---|
| Approved by: | Daisy Ilano, MD, Medical Director | Date |

| *Signature on file* | | *09/11/2017* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 15.03 Occupational Exposure to Blood Borne Pathogens

## I. PURPOSE

To ensure that Behavioral Health Department staff follow the OSHA guidelines and provide them with means of eliminating, minimizing or limiting risks and/or exposure to blood borne pathogens and other potentially infectious materials in the performance of their duties and activities.

## II. POLICY

San Luis Obispo County Behavioral Health Department (SLOBHD) will comply with the OSHA guidelines to increase employee safety by adhering to the following Exposure Control Plan in the event of an occupational exposure to blood-borne pathogens.

## III. REFERENCE

- California Code of Regulations, Title 8, Section 5193
- Standards – 29 CFR, Part 1910.1030 Occupational Safety and Health Standards, Bloodborne Pathogens

## IV. PROCEDURE

### A. Exposure Determination

1. For the purpose of this Plan, occupational exposure means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties. This determination is based on risks incurred while performing one's job or procedures without the use of personal protective equipment.
2. All licensed staff have potential occupational exposure; including but not limited to physicians, nurse practitioners, registered nurses, psychiatric technicians, and licensed vocational nurses in whatever area of the Inpatient and outpatient clinics in which they work.
3. The tasks and procedures performed by these staff where occupational exposures may occur include administering injections and handling contaminated sharps. Other less frequent occurrences, specifically for Inpatient Unit, may include attempting to restrain a combative patient, which includes the risk of being bitten or scratched.

B. Compliance

1. Universal precautions will be observed to prevent contact with blood or other potentially infectious materials. According to this concept, all human body fluids shall be considered potentially or known to be infectious for HIV, HBV, and other blood-borne pathogens.
2. Hand washing facilities will be readily accessible to all staff and are required to wash between injections.
3. Staff will use safety syringes and will dispose of them in appropriate puncture-resistant labeled containers. These containers will be disposed of as required (Refer to either PHF 7.11 and or SLOBHD 7.09 Syringe Policies)
4. Staff must wash hands or skin with soap and water, or flush mucous membranes with water as soon as feasible following contact of such body areas with blood or other potentially infectious materials.
5. Personal protective equipment (e.g., gloves) will be provided at no cost to the employee for use as needed.
6. Hepatitis B vaccine will be made available at no cost to all staff listed in Section C1 of this plan.
7. The work site will be maintained in a clean and sanitary condition.

C. Training

1. All staff who are considered to have a higher risk of occupational exposure will be given access to information and training on blood- borne pathogens within one (1) year of their employment and annually thereafter (per OSHA regulations).
2. Staff will be provided information on the Hepatitis B vaccine, including information on its efficacy, safety, and benefits. Hepatitis B vaccine will also be offered at no cost to the staff.
3. Staff will be given an explanation of the procedure to follow if an exposure incident occurs.
4. Dates, content, names, and disciplines of staff attending the training and the name and qualifications of the instructor(s) of all training sessions will be recorded and kept for three (3) years.

D. Post- Exposure Evaluation and Follow up

1. When an exposure incident occurs (e.g., contaminated needle stick), the area affected will be flushed with soap and water immediately and apply appropriate first aid, if necessary.
2. Report exposure immediately to Program Supervisor.
3. Document exposure incident, route of exposure and source individual on an Employee Report of Occupational Injury (See Policy titled Employee Incident Report/First Aid policy for further information and instruction).

4. Laboratory tests must be conducted by an accredited laboratory tests at no cost to the employee. Identifying and immediately testing the source individual with appropriate consents obtained is a must. Laboratory tests must include but not limited to communicable diseases such as HIV, HBV and Hepatitis. Results of the testing of the source individual will be made available to the exposed staff.
5. A follow up evaluation of the staff must also be done which includes a confidential medical evaluation documenting the details of the incident, follow up of tests results and post-exposure prophylaxis initiated when medically indicated.
6. A vaccine may be offered at the time of exposure to help build resistance.

E. Record Keeping

1. Incident reports will be kept confidential and kept in a secured area by the Quality Support Team.
2. Medical Records of the exposed staff, which includes tests results and medical evaluation, will be kept confidential in their medical personnel file and maintained for at least the durations of the employment or ten (10) years, whichever is longer. Immediate supervisor do not have access to this information.

###

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 06/01/2015 | | |
| 11/14/2017 | All | Uniform to BH Health Agency Policy, formatting |
| Prior Approval dates: | | |
| 04/30/2009 | | |

| *Signature on file* | | *02/01/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 15.04 Outpatient Incident Report

## I. PURPOSE

To describe the use of the Behavioral Health Incident Report to monitor and improve quality of care

To provide direction to County of San Luis Obispo Behavioral Health Department (SLOBHD) staff for reporting outpatient client incidents

## II. SCOPE

Applies to staff in outpatient Mental Health and Drug & Alcohol Services staff and contracted programs

## III. POLICY

SLOBHD Quality Support Team (QST) will monitor quality of care concerns and will take or recommend appropriate action to resolve identified issues. To accomplish this goal, SLOBHD staff and contractor staff will complete a Behavioral Health Incident Report (IR) to document quality of care issues. Staff will forward the IR form to QST for review and follow up.

An IR is a confidential, internal, risk management and quality improvement document. Neither the IR contents, documentation of the review, nor follow up are subject to discovery in a legal proceeding. IR forms will be maintained confidentially and will not be photocopied, faxed, scanned, or emailed (unless encrypted and password protected).

Reporting an incident does not replace or eliminate the need for separate corrective or disciplinary personnel actions or other mandated reporting responsibilities (e.g. Child or Elder Abuse reports, breach reports, or Tarasoff warning).

## IV. REFERENCE(S)

- California Evidence Code §1157.6
- For Psychiatric Health Facility (PHF) Incidents, see PHF Policies 13.05 Incident Reports and 13.06 Unusual Occurrences

## V. PROCEDURE

A. An Incident Report Form (Behavioral Health Incident Report, Attachment A) is completed in the following situations:

1. Client death (open SLOBHD case or closed within 90 days)
2. Serious suicide attempt (open SLOBHD case or closed within 30 days)
3. Major accident, significant injury, or assault occurs on site

4. When staff make a Tarasoff warning is made to protect others from a serious threat of harm
5. When a client requires or receives emergency medical care or experiences negative consequences as a result of an unexpected side effect of prescribed medication or a medication error
6. When Emergency Medical Services, Law Enforcement or Fire Department respond to a client health or behavioral emergency on site (excludes calls made to or by Mental Health Evaluation Team)
7. When there is a known or suspected breach of Protected Health Information (PHI)
8. When staff become aware of a significant ethical violation in the provision of client care. (Note: The incident reporting process does not replace or eliminate the need for other legal or personnel actions)
9. At the discretion of the Program Supervisor or Division Manager

B. Incident reports involving breach of client PHI:

1. Staff will immediately notify the Health Agency (HA) Privacy Officer by telephone (781-4788) or by email at privacy@co.slo.ca.us. See Health Agency's Health Information Privacy and Security Policy for detail.
2. Staff will complete and forward the IR via inter-office mail (or hand deliver it) to QST. QST staff will log the IR and will forward it to the Privacy Officer for follow up.

C. Incidents involving death of a client:

1. Staff will, upon becoming aware of a client death, complete an IR and forward it to the Program Supervisor (as soon as possible, but always within 24 hours after being informed of a client's death)
2. If the client was open for treatment, staff will follow program guidelines for a discharge summary. The discharge summary will describe what staff know regarding the client's death. Generally, a discharge summary and closing outcome measures (if required by the program) are the only documents added to the record after staff learn of a client death.
3. The Program Supervisor or designee will:
   a. Complete the Program Supervisor comments section of the IR and will notify the Division Manager of the death
   b. Finish the Discharge Summary and Final Approve (DAS) or route to the Health Information Technician for Final Approval (MH).
4. The Division Manager will review, add any additional detail, and initial the IR prior to sending it to QST within two (2) working days of the discovery of the client's death.
5. QST will staff sequester the record (see policy 13.08 Sequestering Records) and add the record to the agenda for the next Morbidity & Mortality Committee meeting.

D. All other Incident Reports:

1. Any BH staff who becomes aware of an incident will initiate the IR and will forward

the completed report to the Program Supervisor.
2. The Program Supervisor will complete and will forward the IR to QST for review within five (5) working days of the discovery of the incident.

E. Contract providers shall submit a copy of their agency's Incident Report to the QST Division for review within five (5) working days of discovery of the incident (or in the case of a death, within two (2) working days). The original report shall be kept in a secure location at the contractor's site. The BH IR may be used by any contract agency for reporting.

F. Incident Report Review and Reporting:

1. The QST Incident Report Review Committee (IRC) will review each IR and will make recommendations to improve client care when needed. IRC will request additional information when needed and follow up until resolution of the issue. IRC will report a summary of findings to the QST Committee each month.
2. The Morbidity and Mortality Committee, a subcommittee of the QST Committee, will review client death or serious negative outcomes. The Morbidity and Mortality Committee will report findings and follow up recommendations, if any, to the QST Committee each month.
3. The HA Privacy Officer or designee will review suspected privacy incidents and suspected breaches. The Privacy Officer will complete a risk assessment report as needed to Department of Health Care Services and to the Office for Civil Rights of the US Department of Health and Human Services.

G. QST staff will retain IRs for ten years after the end of the contract period in with the incident occurred. (See Policy 13.10 Destruction and Retention of Medical Records)

H. General Guidelines for Completing Incident Reports

1. Send an IR to QST in a timely fashion; additional written information may follow when it becomes available.
2. An Incident Report must be completed legibly (handwritten or typed)
3. Do not document the IR in the client record.
4. Correct errors by drawing a line through the mistake, write "Error", and initial. Do not use correction fluid.
5. If the staff's immediate supervisor is not onsite, (e.g. AA or HIT) the site Program Supervisor or Division Manager can sign the IR.
6. Only complete one IR per incident. When several staff are involved in an incident, the staff member who has the most immediate knowledge of the event will complete the IR. List additional staff on the IR.
7. If the incident results in a physical injury to staff, staff is referred to county-designated provider. (See Policy 15.00 Employee Incident Reports and First Aid.)

VI. REVISION HISTORY

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| 5/4/2015 | Purpose | Added Purpose |
| | All | Changed PQI to QST. Updated review process |
| | Procedure, #B | New Procedure for reporting Breach of PHI |
| | Procedure #A | Report deaths for clients closed within 90 days (from 1 yr) |
| | Procedure #A | Added link to the BH Incident Report Form |
| | Procedure #B | Added link to the email and the BH Privacy Policy |
| 9/8/2017 | All | Reformatted, minor revisions to text, added scope |
| Prior Approval dates: | | |
| 4/18/2008, 3/30/2009, 4/15/2010, 1/24/2011, 8/19/2011, 5/4/2015 | | |

| *Signature on file* | | *09/11/2017* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# BEHAVIORAL HEALTH OUTPATIENT INCIDENT REPORT

| FORWARD COMPLETED OUTPATIENT INCIDENT REPORTS VIA INTER-OFFICE MAIL TO: QST, HEALTH CAMPUS, SECOND FLOOR | *office use* |
|---|---|

## DO NOT FAX, PHOTOCOPY, SCAN OR EMAIL

| REPORT DATE: | NAME OF STAFF COMPLETING REPORT: |
|---|---|
| CLIENT'S NAME: | CLIENT'S MEDICAL RECORD # |

WHERE DOES THE CLIENT RECEIVE SERVICES? *(please specify site location)*

☐ DRUG AND ALCOHOL ☐ MENTAL HEALTH ☐ OTHER SITE:

| DATE OF INCIDENT: | TIME OF INCIDENT: | LOCATION OF INCIDENT: |
|---|---|---|

## TYPE OF INCIDENT:

| | | | | | |
|---|---|---|---|---|---|
| | BREACH OF PROTECTED HEALTH INFORMATION (PHI) - (REQUIRES IMMEDIATE NOTIFICATION: PRIVACY@CO.SLO.CA.US, OR 781-4788) | | | | |
| | SUICIDE ATTEMPT | | EMS/PD CALLED | | CLIENT MEDICATION ERROR |
| | DEATH | | CRISIS/MHET | | ASSAULT/SAFETY ISSUES |
| | TARASOFF | | INJURY/ACCIDENT | | OTHER : |

OTHER STAFF INVOLVED/WITNESS:

## DESCRIPTION OF INCIDENT (USE PAGE 3 IF MORE SPACE IS NEEDED)

SIGNATURE OF STAFF COMPLETING FORM: DATE

| SUPERVISOR'S COMMENTS AND RECOMMENDATIONS: | |
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| | |
| SUPERVISOR PRINTED NAME: | |
| SUPERVISOR SIGNATURE: | DATE: |
| DIVISION MANAGER'S INITIALS (CASES INVOLVING DEATH) | DATE: |

**QST INCIDENT REPORT REVIEW COMMITTEE COMMENTS AND RECOMMENDATIONS:**

| REFER TO: | | PRIVACY OFFICER | | MEDICAL DIRECTOR | | PATIENTS' RIGHTS ADVOCATE |
|---|---|---|---|---|---|---|
| | | M&M | | OTHER: | | |

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☐ QST INCIDENT REVIEW COMMITTEE HAS REVIEWED THIS REPORT AND FINDS THAT APPROPRIATE STEPS WERE TAKEN. NO FURTHER ACTION IS RECOMMENDED AT THIS TIME.

COMMITTEE CHAIR SIGNATURE DATE

**COMPLIANCE OFFICER COMMENTS AND RECOMMENDATIONS (FOR BREACH):**

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☐ COMPLIANCE OFFICER COMPLETED BREACH ASSESSMENT

COMPLIANCE OFFICER SIGNATURE DATE

**MEDICAL RECORD #**

# 15.06 Thefts or Break-Ins

I. PURPOSE

To give staff direction in the even that Behavioral Health BH) property is stolen of a facility has been broken into or vandalized.

II. POLICY

In the event that BH property is stolen or a facility has been broken into or vandalized, the staff person on the scene reports the incident according to the procedure outlined below.

III. REFERENCE(S)

IV. PROCEDURE

A. Report the incident to the proper law enforcement agency immediately.
B. Notify the Program Supervisor or designee as soon as possible. If the item stolen consists of IT equipment, IT department must be notified as soon as possible (788-2800).
C. The Program Supervisor or designee notifies the Division Manager. If the site's Division Manager is not available, any Division Manager may be notified.
D. The Division Manager informs the Behavioral Health Administrator or the Deputy Director who ensure that General Services are informed of the incident.
E. In the event of a theft, the staff member should be prepared to give an accurate and complete description of the item(s) missing.
F. If a staff member believes that a theft or break-in is in progress, he/she must not enter the building, but rather should contact either the local police or sheriff's department.
G. An incident report is sent to Quality Support Team according to policy 15.04 *Outpatient Incident Report*.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 06/01/2015 | I | Purpose added |
| 09/04/2018 | All | Formatting |
| Prior Approval dates: | | |
| 04/23/2009, 04/20/2012 | | |
| *Signature on file* | | *06/01/2015* |
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 15.07 Suspected Child,Elder-Dependendent Adult Abuse Reporting (SCAR)

## I. PURPOSE

- To describe the process whereby County of San Luis Obispo County Behavioral Health Department (SLOBHD) employees shall be notified of and shall acknowledge reporting obligations
- To provide resources to SLOBHD employees for fulfilling reporting obligations
- To provide directions for SLOBHD staff for documenting mandatory reports in a manner that meets regulatory requirements, protects SLOBHD consumers, and reduces risk for staff and SLOBHD

## II. SCOPE

Applies to all SLOBHD staff and contractors

## III. APPLICABLE STANDARDS/REGULATIONS

- California Penal Code (PC) Part 4, Title 1, Chapter 2, Article 2.5, §§ 11164-11174.3
- Welfare & Institutions Code (WIC), Division 9, Part 3, Chapter 11, §§15600-15750
- WIC, Division 5, Part 1, Chapter 2, §§ 5328(12), 5328.5
- Code of Federal Regulations (CFR) Tittle 42, Part 2, Subpart B, § 2.12(c)(6)

## IV. POLICY

SLOBHD shall provide all employees with required notification and regulatory background information regarding abuse reporting requirements. Employees shall attest that they are aware of the mandatory reporting requirements.

SLOBHD staff and contractors shall comply with relevant laws regarding the reporting of suspected child abuse and elder/dependent adult abuse, including requirements for timely telephone and written reports.

## V. PROCEDURE

### A. Notification of Employees

1. County of San Luis Obispo Health Agency Human Resources shall give each employee a copy of the Pre-employment Notice of Abuse Reporting Requirements and the Child/Elder/Dependent Adult Handout upon hire. Prior to reporting to work, all SLOBHD employees shall electronically sign an attestation in the NeoGov onboarding system (or similar system) attesting to the fact that they received a copy of the child abuse and elder abuse reporting law and that they read the notice of

Child Abuse Mandated Reporter and Adult/Elder Abuse Mandated Reporter.

2. SLOBHD shall ensure that each contract contains information for contractors regarding abuse reporting obligations and shall give each contract provider a link to the Support Page for Contractors and Network Providers: http://www.slocounty.ca.gov/Departments/Health-Agency/Compliance-and-Privacy-Program/Compliance-and-Privacy-Program-Services/Health-Agency-Contractor-and-Network-Provider-Supp.aspx

B. Mandated Reporters

1. Child abuse reporting: PC 11165.7. contains an complete list of mandated reports, which includes all health care providers including all substance use disorder counselors.
2. Elder abuse reporting: All health practitioners are mandated reporters of suspected elder abuse. AB 575, effective 1/1/2018, amended WIC 15610.37 to include all substance use disorder counselors as mandated reporters of suspected elder or dependent adult abuse.

C. Report Timelines

1. All SLOBHD staff shall make verbal, telephonic reports as soon as practically possible after the discovery of reportable suspected child, elder or dependent adult abuse.
2. SLOBHD staff who are legally mandated reporters shall make written reports using the most current fillable forms provided by the Department of Social Services within 36 hours of discovery of reportable suspected abuse. The report forms will include sufficient detail to help those responsible for investigating the report to effectively protect the alleged victim(s). The use of quotes and specific detail is helpful; SLOBHD staff are not tasked with investigating the allegation, though.
3. SLOBHD staff who are not legally mandated reporters, but who may witness what they believe may be child, elder or dependent abuse, shall document in writing and report the incident to their supervisor as soon as possible.

D. Immunity from Civil Liability : SLOBHD staff who are mandated reporters of abuse are immune from civil liability for reports made in good faith.

E. Privacy Considerations

1. Suspected child abuse creates an exception to privacy rules for both Mental Health and Substance Use Disorder treatment (CFR 42 §2.12 (c)(6)) and is reportable without client consent.
2. CFR 42 does not create an exception to privacy to allow DAS staff to report suspected elder or dependent adult abuse, even though treatment staff (all LPHA and all registered/certified counselors) are mandated reporters under State law (WIC §§15600-15750). DAS staff shall provide an anonymous report without

identifying the client or staff as involved in a DAS program. The report shall make no mention of the client's substance use disorder, involvement in the Drug & Alcohol program, and shall not contain information that can lead a reasonable person to infer that the person is involved with the Drug & Alcohol Program. Staff may use the generic term, "Health Agency" or "Behavioral Health" to reference their work location.

3. Disclosure must be limited to the original report of suspected abuse. Further disclosure of PHI for investigation, follow-up, or criminal/civil proceedings requires the written consent of the client.

F. Documentation in the Electronic Health Record

1. SLOBHD staff shall document in the appropriate electronic health record that verbal and written reporting responsibilities were discharged. Such documentation serves both a risk management and client care function.
   Examples:
   - "Consulted with (identify staff/agency, i.e. Sally S. Worker with Child Welfare Services) and fulfilled any mandated reporter requirements."
2. Whenever possible, staff shall enter "SENSITIVE INFORMATION" or other disclaimer at the beginning of the Progress Note to alert a reviewer that the note contains information that must be carefully evaluated prior to third part disclosure.
3. SLOBHD staff shall use discretion with regard to the detail in which allegations of abuse are documented in the record. Generally, staff will summarize in the record, but will provide detail in the SCAR or APS report. Detail that helps staff provide treatment will be included; extraneous or salacious detail that does not help in the provision of care will not be included in the record. An additional consideration when deciding how much detail to document shall be client and third-party access and the effect such access will have on the client if the document is disclosed to a third party.
4. SLOBHD staff shall document allegations of abuse using quotes and conditional language except for those behaviors personally witnessed. When staff, in the course of work duties, personally witness reportable abuse, documentation in the record shall be made using descriptive and behaviorally specific language.
   Examples:
   - "Client reports that…."
   - "Client's mother alleges that…"

G. Incident Report Documentation
   1. SLOBHD staff shall complete an incident report following the current processes detailed in Policy and Procedure 15.04 "Outpatient Incident Report" in these circumstances:
      - The identified accused perpetrator is/was a SLOBHD staff or contract provider.

H. Maintenance of the SCAR/APS report and response letters

1. SLOBHD staff shall file copy of the abuse report form and the response letter from CWS in a secure location. Behavioral Health staff will forward reports and response letters to the Medical Records Supervisor, who will maintain the records as required by law.
2. Neither the Suspected Child Abuse Report nor the Suspected Dependent Adult/Elder Abuse Report forms are part of the designated record set. These documents shall not be scanned into the electronic health record nor disclosed to any third party other than as required for investigation and protection of the alleged victim(s).

RESOURCES

- Notice to Employees: http://myslo.intra/Assets/HA/HA+Policies+and+Procedures/Child+$!26+Elder+Abuse+Mandated+Reporter+Notice.pdf
- Employee Legal References Handout: http://myslo.intra/Assets/HA/HA+Policies+and+Procedures/Child+$!26+Elder+Abuse+Mandated+Reporter+LEGAL+HANDOUT.pdf
- SLOBHD Code of Conduct and Professional Ethics http://myslo.intra/Assets/HA+Privacy+and+Compliance/Code+of+Conduct+and+Professional+Ethics.pdf
- Suspected Child Abuse report # (805) 781-KIDS (5437) or 1-800-834-KIDS
- Adult Protective Services (APS) # (805) 781-1790 or 1-844-729-8011 (after hours)
- Suspected Child Abuse Report form (SCAR) – Fillable form http://ag.ca.gov/childabuse/pdf/ss_8572.pdf
- Suspected Dependent Adult/Elder Abuse Report form – Fillable form https://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC341.pdf

###

VI. REVISION HISTORY

| **Effective/Revision Date:** | **Sections Revised** | **Author** | **Status: Initial/ Revised/Archived Description of Revisions** |
|---|---|---|---|
| 02/01/2019 | Entire Policy | Greg Vickery, LMFT QST Manager | Initial Release |
| 09/17/2020 | Procedure | | F1. Revised<br>G – added protocol |
| Prior Approval dates: | | | |
| | | | |

| | | |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 15.09 Duty to Protect (Tarasoff)

## I. PURPOSE

To provide San Luis Obispo Behavioral Health Department (SLOBHD) staff with guidance about how to protect reasonably identifiable potential victims from serious threats of imminent harm.

## II. SCOPE

Applies to all SLOBHD staff and Contractor staff

## III. POLICY

A. SLOBHD and Contractor staff (staff) will take reasonable protective action when a client, family member, or other credible third party communicates a serious threat of imminent harm to a reasonably identifiable victim(s).
B. Protective actions will include notifying the intended victim(s) (verbally and in writing) and law enforcement (verbally and in writing). Additional actions may occur, but do not replace or modify the duty to protect and notify identifiable victims of threat of imminent harm.

## IV. DEFINITIONS

- **"Reasonable"** is defined in the law to mean that a staff "…need not render a perfect performance but merely exercise 'that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances.'"
- **"Imminent"** mean reasonably likely to occur in the near future such that disclosure is a reasonable and necessary step to protect the identifiable victim(s). If the threat is not imminent, other protective actions that leave confidentiality intact may be indicated.
- **"Serious threat"** means reasonably credible based on assessment of risk
- **"Harm"** is defined as any action that could reasonably be expected to cause death or serious bodily injury

## V. REFERENCE(S)

- California Civil Code §43.92
- Welfare & Institutions Code §5328(18); §8100
- Evidence Code §§ 1010, 1012, 1024
- Penal Code 203
- Penal Code 243(f)(4)
- Code of Federal Regulations, Title 45, §164.512 (j)

- Code of Federal Regulations, Title 42, Part 2
- Relevant Case law (see Attachment F for detail)
- Tarasoff v. Regents of the University of California
- Ewing v. Goldstein
- Ewing v. Northridge Hospital Medical Center
- Hedlund v. Superior Court of Orange County
- Thompson v. Alameda County
- Menendez v. Superior Court of Los Angeles
- Jablonski v. U.S.
- People v. Wharton
- Mavroudis v. Superior Court of San Mateo

VI. PROCEDURE

**A. ASSESS RISK AND DOCUMENT RESULTS**

1. Non-clinical staff must immediately report any threats of harm to a Program Supervisor, site leader/shift lead or other clinical staff, who will assess risk
2. Clinical staff will do the following:
   a. Gather as much information as possible about the specific threat to complete a risk assessment
      i. Interview the client
      ii. Interview collateral sources whenever possible
      iii. Review treatment record
      iv. Consult with the treatment team
   b. The purpose of the risk assessment is to help determine whether the threat is serious and imminent enough to trigger the need for protective actions

**B. ELEMENTS OF A RISK ASSESSMENT INCLUDE, BUT ARE NOT LIMITED TO: See Attachment A Risk Assessment Background**

1. Current presentation or recent changes to client's behavior (i.e. rumination, exacerbation of psychotic symptoms, agitation, other change in mental status) that might increase likelihood of acting upon a threat
2. Motives and goals
   a. What is driving the threatening behavior? What is it meant to achieve or communicate?
   b. What options exist to reduce risk, coach replacement behaviors or increase protective factors?
3. Concerning, unusual, or threatening communications
   a. Direct threats to an identifiable victim may or may not be present
   b. Indirect threats voiced to others (friends, family members, or to the treatment team) or on social media are more commonly observed
   c. Collateral informants are often concerned about client's statements or behaviors and may be aware of other threats or behaviors that are vital to consider.

4. Excessive interest in weapons, school shooters, mass attacks, or other violence
5. Recent stressful events (trauma, setbacks, challenges, or losses)
6. Mental Health: The mere presence of mental illness does NOT predict violence. There is ample research to show that individuals with mental illness are more likely to be victims than perpetrators of violence. However, a risk assessment considers:
    a. Hopelessness, desperation, or despair are more important than any specific diagnosis as a predictive factor of violence
    b. Significant behavioral or mental status changes from baseline
    c. Psychosis – there is mixed evidence about psychosis as a contributing factor for violence. Some studies suggest that a pattern of acting upon command hallucinations and paranoid ideation, (rather than ignoring or challenging) may be significant. An exacerbation of symptoms that results in poorer functioning and a reduced ability to utilize coping mechanisms or supports (i.e., when more isolated due to internal preoccupation or when not medication adherent) is noteworthy.
    d. Capacity for planning – the ability to plan and follow through with actions increases the risk of some types of violence. As with many other factors in this category, the ability to plan and carry out a threat is more important than a specific diagnosis.
    e. Impulsivity/angry outbursts/behavioral dyscontrol – some types of violence are impulsive rather than planned. Consider the client's ability to manage impulses and general ability to utilize coping skills.
    f. Role of Trauma – most trauma survivors do not perpetrate abuse or violence, but many perpetrators were themselves victims. It is important to assess the role of historical trauma in a risk assessment without blaming the victim or creating blind spots in the assessment that might underestimate risk. An empathetic exploration here may create opportunities for treatment of trauma and prevention of violent behavior.
7. Substance Use/Substance Use Disorder
    a. Change from baseline is more important than mere presence of SUD as a predictive factor of violence.
    b. Some evidence suggests that when substance use is associated with an increase risk in violent behavior it is because substance use may reduce behavioral control, result in poorer overall coping or an increase in risk factors (i.e., loss of job, family, or status), and/or reduce availability of positive supports (i.e., when sober supports are absent to due to individual's use).
8. Access to weapons (not just guns), means, and to the intended victim(s)
9. Evidence of a plan/likelihood of carrying out the plan
10. Prior history of violence/attack-related behavior (including any menacing, harassing, and/or stalking-type behavior)
11. Protective factors that reduce risk include:
    a. Supportive relationships
    b. Hopefulness
    c. An ability to utilize alternatives

d. History of utilizing alternative coping strategies
e. If the threat was made by a client who is present at a treatment site, staff will remain with client until assessment, consultation, and notification of intended victims and law enforcement (if needed) are completed
f. If the threat is made by a client who leaves a treatment site prior to the completion of a risk assessment and/or completion of notifications, notify law enforcement **IMMEDIATELY**
g. Gather as much information as possible about the intended victim(s) for effective notification:
    i. Name, location, and contact information are extremely important, if available
    ii. If the intended victim(s) is identified by the client by relationship, rather than name (i.e. "my boss" or "my upstairs neighbor") or can be indirectly inferred by a reasonable person, then the identifiable victim standard is met.
    iii. If the intended victim is an entity in the community (i.e. "my math class", "the post office", or the "church on Broad and Main Street" and a reasonable person can infer the intended victims, then identifiable victim standard is met and a broader notification to the entity may be reasonably necessary to ensure the safety of intended victims and bystanders.
h. Consult with a Program Supervisor, shift lead, on-call/attending psychiatrist, Mental Health Evaluation Team (MHET) or other clinical staff to determine if the client's threat presents a serious risk of imminent harm to a reasonably identifiable/foreseeable victim(s)
i. Determine if an evaluation for inpatient psychiatric services are needed. If the danger to others is due to a mental health disorder, a staff member designated to write a 5150/5585 hold will assess whether the person who made the threat requires admission to (or continued stay at) the Psychiatric Health Facility (PHF) or another inpatient facility.
**j. Document the risk assessment thoroughly in the medical record by the end of the current business day. Explicitly write into the record the factors you considered and how you reached your decision to act. Your documentation is essential for good client care and is your primary protection from liability!**

## C. SUBSTANTIATED THREAT: TAKE PROTECTIVE ACTION

1. If clinical staff determine that the threat does represent a serious risk of violence to a reasonably identifiable/foreseeable victim or victims, each SLOBHD staff member has a duty to protect any potential victim(s), even if:
    a. The person making the threat is admitted to the PHF or any other inpatient facility, jail or juvenile detention facility
    b. The credible threat was made while the client was detained at the PHF, jail or juvenile detention facility
2. As with abuse reporting, an individual staff member may be designated to complete notifications on behalf of the treatment team, but only if all notifications can be completed in a timely manner.

3. It is never acceptable to defer or delegate notification to a staff member who is not present to accept responsibility for making the notifications.

**4. VERBALLY NOTIFY THE INTENDED VICTIM**

a. Immediately warn the intended victim(s) by telephone or in person of the nature of the threat and who made the threat.
b. If the risk assessment determines that a broader notification is necessary given the nature of the identifiable victim(s) and/or potential location of where the threat will be executed, then staff member must make a reasonable effort to contact the person or entities at risk (i.e. school district, place of employment, post office).
c. Disclose enough information to allow the intended victim to make reasonable decisions about what steps to take to be safe. Both HIPAA and Welfare & Institutions Code 5238(18) allow disclosure of protected health information to protect intended victims. Details about the threat will be disclosed (Menendez v Superior Court of Los Angeles). Details about the client's illness or treatment will not be disclosed.
d. CFR 42 Part 2 prohibits any disclosure that would affirmatively identify that an individual has been or is being diagnosed or treated for alcohol or drug abuse in a substance use disorder treatment program.
e. Sample statement:
*"My name is ___ and I am calling to inform you that on (date), (client's name) made a serious threat of violence toward you. (Client's name) said (use plain language about the threat). I also notified (name of law enforcement agency) about this threat."*

f. Inform the intended victim(s) that you will follow up with a mandatory written notification and ask if the intended victim prefers to receive the notification by email or certified letter. Email is preferable because it allows more rapid completion of this step. Obtain the appropriate address (es).
g. If the intended victim is a minor or a conservatee, also notify the parent/guardian/conservator or legally responsible person of the nature of the threat
h. If unable to speak directly with the intended victim for any reason:
    i. Contact law enforcement having jurisdiction over the area where the intended victim is currently located (if known) or resides and inform law enforcement that the intended victim has not yet been notified. Ask for help in notifying the intended victim.
    ii. Leave a generic voice mail message
        1. A voice mail message does not replace directly talking with the intended victim(s) because there is no way to know when or if the intended victim(s) will receive the message.
        2. It is acceptable to leave a generic message.
        3. Do not leave details regarding the threat or the name of the person making the threat on voice mail.

4. Sample voice mail message:

*"My name is ---------- It is important that I speak with you regarding an urgent safety issue. Please call me at ###-###-#### as soon as possible. If I am not able to answer your return call, please call."*

iii. Continue to make reasonable attempts to contact the intended victim
iv. Document the date, time and results of all efforts to inform the intended victim in the client record by the end of the current business day.

**5. NOTIFY THE INTENDED VICTIM IN WRITING**

**a.** Modify the sample warning letter and send it by email (preferred) or by certified letter within 24 hours of evaluating the threat **(see Attachment B Notification Letter template and Attachment C Sample letter).**

b. Certified mailing procedures:
   i. The site AA (or clinical staff if AA support is unavailable) will complete the envelope and the certified receipt, if needed. Add the medical record number to the return receipt for future filing purposes.
   ii. Certified letters which are hand delivered to the SLO Adult Outpatient clinic by 10:00 AM or to the General Services Mail Room by 3:00 PM on a normal business day will be metered and mailed by General Service's staff, and the postage cost will be billed to SLOBHD.
   iii. Alternatively, any staff may mail the certified letter at a USPS location. SLOBHD employees may submit claims for petty cash reimbursement if a cost is incurred (Submit a copy of the USPS receipt with the claim).
c. Print a copy of the email, warning letter, USPS receipt and return receipt.
d. Submit a copy of the letter for scanning into the correspondence section of the EHR

**6. NOTIFY LAW ENFORCEMENT TO PROTECT THE INTENDED VICTIM**

a. Immediately telephone the law enforcement agency having jurisdiction over the area where the intended victim is currently located (if known) or resides.
b. Promptly telephone the law enforcement agency having jurisdiction over the area in which the person making the threat is currently located (if known) or resides, if not completed above (sometimes referred to as a "duty to report")
c. Law enforcement must be informed of the exact nature of the threat to the intended victim, the identity of the intended victim, the location of the intended victim (if known), the identity of the person making the threat, and whether the victim was successfully notified. Disclose enough information to allow law enforcement to effectively protect the intended victim – details about the threat are more important than details about treatment.
d. Document the name/phone number of the law enforcement agency, the name/badge number of the officer taking the report, the report number, and any additional information available at the time the report is made.

e. If you are only able to reach dispatch and not an officer to take a report, continue with step f below. If you are subsequently able to provide a report to an officer, update the Law Enforcement Notification worksheet as necessary.
f. Fax a copy of the intended victim warning letter **(Attachment B)** and the Law Enforcement Notification worksheet **(Attachment E)** to all the law enforcement agencies notified. Print the fax report, which will show date and time of transmission, as proof of delivery. Submit a copy of the fax report and Law Enforcement Notification for scanning into the correspondence section of the client record.

**7. DOCUMENT THE STEPS YOU TOOK TO PROTECT INTENDED VICTIM(S)**

a. Thoroughly document your Risk Assessment in a Crisis Progress Note **(see Attachment D)** for several samples.
b. Provide copies of all letters and written correspondence for scanning
c. If the individual who made a threat is taken into custody on an involuntary hold, provide copies of the written correspondence to the PHF for inclusion

## D. UNSUBSTANTIATED THREAT: TAKE PROTECTIVE ACTION

1. If clinical staff determine that the threat does not represent a serious threat of imminent harm to an identifiable victim or victims, clinical staff must:
   a. Document client/family member/third party statements and any additional information obtained during the risk assessment.
   b. Document all consultations with a Program Supervisor, site leader/shift lead, on-call psychiatrist or other clinical staff.
   **c. Clearly document the clinical rationale for the decision to not make a Tarasoff warning by the end of the current business day. It is just as important to document why you did not provide notification to others as it is to document why you did.**
2. Evaluate/modify the current treatment plan, with the client's participation, as needed to meet clinical needs.
3. Continue to monitor the client for risk factors

## E. UNCERTAIN LEVEL OF THREAT

1. Should there be uncertainty as to whether the threat triggers a duty to protect a third party, clinical staff must:
   a. Document client/family member/third party statements and any additional information obtained during the risk assessment.
   b. Consult with and document discussions with Program Supervisor, Division Manager, site leader/shift lead, on-call psychiatrist or other clinical staff.
   c. Should a question still remain, the Division Manager will notify the Behavioral Health Administrator, who may consult with County Counsel for a legal opinion.

2. A final determination of substantiated or unsubstantiated will be made based on all available clinical and consultation information and will be documented in the record by the end of the current business day.

**F. INCIDENT REPORT DOCUMENTATION:**

1. Serious threats of imminent harm which result in a Tarasoff warning always result in the creation of an Incident Report and risk review by Quality Support Team staff. Refer to Policy 15.04, Outpatient Incident Report and PHF Policy 13.05, Incident Report & Unusual Occurrence, for detail.
2. The QST Division Manager will coordinate administrative risk review whenever indicated.

VII. ATTACHMENTS

A. Risk Assessment Background
B. Notification Letter Template
C. Sample Notification Letter
D. Sample Crisis Notes
E. Law Enforcement Notification worksheet
F. Legal References (Code and Case Law) highlights

VIII. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 10/01/2015 | All | Reformatted and re-organized for clarity |
| 02/23/2016 | B | Law Enforcement may be notified in writing by fax, client by email |
| 03/01/2018 | • Procedure A2a2 and A2d(1)<br>• All | Formatting & Procedure<br>PHF 2.14 Hyperlinked to 15.09 OP (original) |
| 4/15/2019 | • Procedure and Attachments | Minor clarifications, additional resources |
| Prior Approval dates: | | |
| 12/18/2013, 04/29/2014, 10/01/2015, 2/23/2016, 3/1/2018 | | |

| *Signature on file* | | *06/04/19* |
|---|---|---|
| Approved by: | Daisy Ilano, MD, Medical Director | Date |

| *Signature on file* | | *06/04/19* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

**TARSOFF AND RISK ASSESSMENT BACKGROUND AND RESOURCES**

**Attachment A Risk Assessment Background**

Assessing risk of violence to others is complicated by the there are many types of violence with different characteristics. For example, some domestic terror incidents reveal, after the fact, meticulous planning, calculation, preparation, and attention to detail, and may have a "cold" emotional quality. On the other end of the spectrum are those intimate partner violence episodes that may be impulsive and have a "hot" emotional quality, with many different variations and combinations in between. There is no consistently observed profile of an individual that always predicts potential violence. Instead, it is important to consider many different factors and weigh risk factors against protective factors.

The following are general principles gleaned from research by the US Secret Service, the Department of Homeland Security, the National Threat Assessment Center, and the Centers for Disease Control. These are by no means exhaustive resources, but can help guide clinical assessment.

**General Principles**:

1. An individual's right to life and safety outweighs a client's right to privacy. As a result, when necessary to ensure safety, the law requires clinical staff to disclose confidential information to ensure the safety of others.
2. Always complete AND DOCUMENT a thorough risk assessment. If you do not document that you assessed risk, the assumption will be that you did not, and you lose immunity from liability. Failure to assess risk in a manner consistent with sound professional practice exposes you to liability and is a substandard level of care.
3. Consult with team members to be sure you aren't missing important information
4. The risk assessment must clearly document the factors you considered and what contributed to your decision to act or not act. The factors below are meant to help guide your risk assessment and

**Risk Assessment Factors:**

1. Assess motives and goals:
    - What is driving the threatening behavior? What is it meant to achieve or communicate?
    - Understanding motivation may provide opportunities to intervene to reduce risk or increase protective factors and may help clarify seriousness and imminence of the threat
    - Common motivations cited by the National Threat Assessment Center include:
        - To get help
        - To cause problems for someone else (i.e., a coworker, classmate, family)
        - To avenge a perceived wrong or injustice
        - To bring attention to a problem
        - As a means to end a perceived problem
        - As a means to consider (or commit) suicide (i.e., "suicide-by-cop")

2. Assess values that may increase risk – certain values may be associated with an increased risk of intimate partner violence, including:
    - Limiting beliefs about relationship roles and power
    - Attitudes justifying or accepting violence as a problem-solving strategy
    - Emotional dependence and insecurity
    - Other related factors that may be associated with violence include antisocial thinking or any believe that devalues, dehumanizes, or diminishes the worth of another

3. Assess concerning, unusual, or threatening communications:
   - Direct threats to an identifiable victim may occur in only a minority of instances
   - Indirect threats voiced to others (friends, family members, or to the treatment team) or on social media are more commonly observed
   - Ask collateral informants if they are concerned about client's statements or behaviors

4. Assess interest in weapons, school shooters, mass attacks, or other violence:
   - Important to contextualize this based on age, culture
   - Some post event data suggests an association with violence-themed social media posts, internet searches, and video games, but correlation is not causation
   - This may be more common in certain types of violence than in others

5. Assess recent stressful events (trauma, setbacks, challenges, or losses):
   - Material losses (possessions, finances, etc.)
   - Relationship losses (death, role changes, separations) in family and/or peer group
   - Status losses (changes in occupational or other role changes
   - Changes in self-perception/self-esteem
   - Relationship conflicts including bullying
   - Assess coping skills and status

6. Assess congruence in statements across settings:
   - Look for consistency in statements in a variety of contexts by asking collateral informants. When an individual says in one setting that he is doing well, but, for example, posts contradictory information, the risk for acting out may increase.
   - Concealment/hiding of risk behaviors or plans may be associated with increased risk

7. Assess Emotional/Developmental/Mental Illness factors: Clearly, presence of mental illness does NOT predict violence. There is ample research to show that individuals with mental illness are more likely to be victims than perpetrators of violence. Here are key factors to assess:
   - Hopelessness, desperation, or despair – more important than any specific diagnosis as a predictive factor of violence, these factors appear consistently in research about violence!
   - Change from baseline – more important than mere presence of SMI as a predictive factor of violence
   - Psychosis – mixed evidence in the literature about psychosis as a contributing factor. Some evidence suggests that command hallucinations and paranoid ideation are mildly predictive, especially when the client has a history of acting on delusional thinking or complying with a command hallucination (versus resisting or ignoring). When psychotic symptoms are suggestive of increased risk, it is most likely to occur when an exacerbation of symptoms results in poorer overall coping with stressors and a reduced ability to utilize coping mechanisms or protective factors (i.e., when more isolated due to internal preoccupation or when not medication adherent).
   - Impulsivity – mixed evidence, likely because of the huge variety of violent behavior. Some violence is meticulously planned while some is highly impulsive. This factor is important to assess, but also to contextualize. High levels of impulsivity may increase the risk of some violent behaviors.
   - Angry Outbursts – similar to impulsivity in terms of predictive power and implication for risk assessment. Some violence is cold and calculated.

- Capacity for planning – for some types of violent behavior, the ability to plan and follow through with actions increases the risk and must be clearly assessed/documented. As with many other factors in this category, the ability to plan and carry out a threat is more important than a specific diagnosis.
- Role of Trauma – most trauma survivors do not perpetrate abuse, but many perpetrators were themselves victims. It is important to assess the role of trauma in a risk assessment without blaming the victim or creating blind spots in the assessment that might underestimate risk. An empathetic exploration here may create opportunities for treatment of trauma and prevention of violent behavior.

8. Assess Substance Use/Substance Use Disorder: Like mental health concerns described above, the mere presence of substance use or a substance use disorder does not predict violence.
   - Change from baseline is more important than mere presence of SUD as a predictive factor of violence.
   - Some evidence suggests that when substance use is associated with an increase risk in violent behavior it is because substance use may disinhibit behavioral controls, result in poorer overall coping or an increase in risk factors (i.e., loss of job, family, or status), and/or in reduce availability of positive supports (i.e., when sober supports are absent to due to individual's use).

9. Assess access to weapons (not just guns) and resources (means)
   - Access and means increase risk and are key factors in determining whether a threat is "serious" and "imminent"

10. Assess evidence of planning:
   - Evaluate the presence of a plan. Developmental and situational factors may influence whether increased detail predicts greater risk of imminent violence.
   - Evaluate the likelihood of carrying out the plan. Ask about barriers or what would prevent implementing the plan.

11. Assess prior history of violence
   - Past violence to solve problems may be the strongest predictor of future violence, but it is not foolproof
   - Ask about history of using prosocial alternatives
   - Ask about history of attack-related behavior, including any menacing, harassing, and/or stalking-type behavior – is the current threat part of an escalating pattern of behavior

Resources:
ENHANCING SCHOOL SAFETY USING A THREAT ASSESSMENT MODEL
An Operational Guide for Preventing Targeted School Violence
US Dept. of Homeland Security, US Secret Service, National Threat Assessment Center: July 2018
https://www.dhs.gov/sites/default/files/publications/18_0711_USSS_NTAC-Enhancing-School-Safety-Guide.pdfhttps://www.dhs.gov/sites/default/files/publications/18_0711_USSS_NTAC-Enhancing-School-Safety-Guide.pdf

Risk Factors for Intimate Partner Violence Perpetration
https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html

**Attachment B: Warning Letter Template**

COUNTY OF SAN LUIS OBISPO
BEHAVIORAL HEALTH
Health Information Unit
(805) 781-4724 Tel (805) 781-4271 Fax

## TARASOFF WARNING LETTER

Date: _____

To:

NAME: _____

ADDRESS: _____

_____

We are authorized by law to inform you that _____
(person making threat)
has made a serious threat to harm you. During an evaluation on _____
(date of evaluation)
the person listed above made the following threat (describe threat made):

_____

_____

_____ was notified of this threat on _____.
(name of law enforcement agency) (date notified)
Officer/Deputy _____ Badge/Id # _____ took the call.
(officer's/deputy's name) (officer's/deputy's badge #)
The phone number for the above listed officer is _____ and the case
(law enforcement agency phone #)
number or log number assigned is _____
(case number or log number)

If the person named above is being detained by San Luis Obispo County Jail, Juvenile Services Center, or the Psychiatric Health Facility and you wish to be informed when they are released, please contact the facility directly at the phone numbers listed below.

- SLO County Jail: (805) 781-4600
- Juvenile Services Center: (805) 781-5352
- Psychiatric Health Facility: (805) 781-4712

If you have any questions, please contact me at: _____
(phone number)
Name/Title: _____
(name and title of person mailing or emailing letter)
CC: _____
(copy of letter sent to)

**Attachment C: Sample Warning Letter**

COUNTY OF SAN LUIS OBISPO
BEHAVIORAL HEALTH
Health Information Unit
(805) 781-4724 Tel (805) 781-4271 Fax

## TARASOFF WARNING LETTER

Date: 04/09/19

To: Stefani Mannicotti
4712 Pacific Coast Highway
Malibu, Ca 90263

We are authorized by law to inform you that Jackson Cooper has made a serious threat to harm you. During an evaluation on 04/08/19, Mr. Cooper stated that he planned to "break into (your) home, sexually assault (you), and then choke (you) to death with my bare hands."

The San Luis Obispo Police Department and the Los Angeles County Sheriff's Department were notified of this threat on 04/08/19. Officer Krupke (SLOPD) and Deputy Vance Badge/Id 24601 & 10451 took the call.

The phone number for the above listed officer is 805- 543-3131 & 213-229-1700 and the case number or log number assigned is 112284 & 71818

If the person named above is being detained by San Luis Obispo County Jail, Juvenile Services Center, or the Psychiatric Health Facility and you wish to be informed when they are released, please contact the facility directly at the phone numbers listed below.

- SLO County Jail: (805) 781-4600
- Juvenile Services Center: (805) 781-5352
- Psychiatric Health Facility: (805) 781-4712

If you have any questions, please contact me at: 805-501-2316

Name/Title: Jaclyn A. Miller, Behavioral Health Clinician III, County of San Luis Obispo
CC: San Luis Obispo Police Department (Case # 112284 & LA County Sheriff (Case # 71818)

**Attachment D: Sample BH Crisis Intervention assessment (HI) with Tarasoff notification (complex)**

**County of San Luis Obispo**

**Behavioral Health Department**

**CRISIS INTERVENTION**

**Client Contact Information** (If any client contact information needs to be updated, please launch a Demographics to record updates)

Telephone: 555-5554

Address: 14 Fiction Way Apt:

City/State/Zip: SAN LUIS OBISPO CA 93401

**Presenting Problems:** (Describe the crisis)

*Ct presents at the North County MH clinic today requesting to speak with "someone who can help me." Ct states that he is depressed and distraught over the recent break-up of from his girlfriend of 1 1/2 years.*

**Collateral Contacts:** (What do significant others or credible 3rd parties say? Are they concerned about recent behavior?)

*Ct is not accompanied by any friends or family members. Ct states that his parents live out of state and that he has no other family members or close friends living nearby.*

**Behavioral Observations/Presentation:**

Client's gender, age, marital/relationship status, race, other cultural factors

*Ct is a 23-year-old white male who recently ended a relationship with his gf of 1.5 years. Ct's appearance is slightly disheveled, though he presents in clean clothing. This writer notes that ct has not shaven recently, which is a departure from his typical clean-cut appearance. Ct presents as anxious, though at times this is expressed as anger. His behavior is slightly disorganized, and he exhibits difficulty staying on topic. Ct is oriented to date, time, and place, but displays a tangential thought process accompanied by loose associations at times. Ct denies AH/VH; however, this writer observes that throughout this assessment ct appears to be responding to internal stimuli, especially when he is asked direct questions regarding his thoughts of harming others. Ct denies SI, but endorses thoughts of,"wanting to hurt them."*

Appearance:(Manner of dress and hygiene; note any recent or notably significant changes in client's appearance)

☐ Well Groomed ☐ Appropriate ☒ Disheveled ☐ Unkempt ☐ Bizarre ☐ WNL

Attitude/ Behavior: (i.e. ability to make and maintain eye contact, psychomotor functioning and a clinical determination about client's ability to provide reliable information)

☐ Cooperative ☒ Guarded ☒ Suspicious ☒ Belligerent ☐ Uncooperative ☐ WNL

Speech: (i.e. rate, volume, spontaneity, and coherence)

☒ Rapid ☒ Loud ☒ Pressured ☐ Excessive ☐ Slurred ☐ WNL

Mood: (i.e. underlying emotional state)

☐ Euthymic ☐ Elevated ☐ Euphoric ☒ Depressed ☒ Anxious ☒ Irrit ☐ WNL

Affect: (include visible reactions that client is displaying about information being discussed)

*Ct's affect throughout crisis assessment notably blunted and incongruent with emotions client reports experiencing.*

Thought Process: (i.e. rate and flow of thoughts)

☐ Linear ☐ Circumstantial ☒ Tangential ☒ Loose ☐ Flight of ideas ☐ WNL

Thought Content: (i.e. presence of irrational thought, thought fixations)

☐ Appropriate ☒ Obsessions ☐ Phobia ☐ Illusions ☐ Odd Thoughts ☐ WNL

Hallucinations:

☒ Auditory ☐ Visual ☐ Command ☐ Tactile ☐ Olfactory ☐ None Reported

Delusions:

☐ Grandiose ☐ Persecutory ☐ Somatic ☒ Jealous ☐ Mixed Type ☐ None Reported

Attention/Concentration:

○ Intact ○ Adequate ⊙ Impaired

Orientation: Person: ⊙ Yes ○ No Place: ⊙ Yes ○ No
Time: ⊙ Yes ○ No Purpose: ⊙ Yes ○ No

Insight: (i.e. ability to identify the existence of a problem and to have an understanding of its nature)

○ Intact ○ Adequate ⊙ Impaired

Judgement: (i.e. ability to make logical decisions)

○ Intact ○ Adequate ⊙ Impaired

Impulse Control: (i.e. ability to delay or think through a choice)

○ Intact ○ Adequate ⊙ Impaired

Describe any significant mental status or behavioral observations:

*While Ct denies he presence of any AH or VH, this writer observes ct quietly whispered "Shh.." under his breath. Ct became visibly agitated when asked about his anxiety and yelled, "I'm fine!" Ct jumped to his feet and began pacing the rest of session. Ct denied having SI stating, "I don't want to hurt myself. It's not my fault." When asked about HI, client stated, "I just want to hurt them."*

**Risk Assessment:**

Current Suicidal Ideation: ○ Yes ⊙ No

If Yes, describe the ideation.

Current Homicidal Ideation: ⊙ Yes ○ No

If Yes, describe homicidal ideation.

*When directly asked about thoughts of HI, ct states, "I just want to hurt them." When this writer asked follow-up questions ct stated that he feels that he is being, "laughed at by all the engineering students," and that he has "fantasized about shutting them up with my gun."*

Evidence of planning: (Does client have a plan? How likely is it to occur as planned? What are barriers that would keep it from happening? Are there support persons who can reliably intervene?)

*Ct acknowledged owning a firearm and keeping it in his off-campus apartment. Ct stated that he even purchased ammunition for it yesterday. Ct also admitted to, "scoping out the entrance and exit points," in the engineering building in order to ensure, "a quick escape." Ct admits that he continues to be distraught by the recent break-up from his gf but is unwilling to say if she is the target of his fantasy. Ct states that he finds himself drinking to go to sleep, but states that he cannot stay asleep. Ct cannot remember the last time he took his psychiatric medication, though he states that he remembers picking the refill up from the pharmacy.*

Access/Means: (Does the client have access to weapons or other means? Taken steps to acquire means? How lethal? Describe steps taken to remove access. Are there support persons who can reliably remove access?)

*Ct states that he owns a firearm that is kept in his apt off campus; however, he is unwilling to answer how many firearms he owns or has access to. Ct states that he recently purchased ammunition at a local sporting goods store, but again refused to answer how much ammunition was purchased or for what purpose.*

History of prior violence or self-injury: (Describe past attempts or significant ideation. If evaluating DTO, is there a history of attack-related behavior (i.e., menacing, stalking, threatening, etc.)?)

*Ct does acknowledge obsessive thoughts re: whereabouts and activities of ex-girlfriend (i.e. who she is spending time with. what she doing, is she dating other men or women). Ct states that he has, "waiting for her outside some of her classes like I used to do," but states that when his ex has seen him she has refused to speak with him and, "run away from me." Ct also states that he has gone to the sorority house where his ex resides to see what she is doing/who she is with, but has not, "gone up to the door."*

Motives and goals: (What drives the behavior? What does the client want?)

*Ct states that, "I just want to be able to talk with her [ex-girlfriend] to find out how I can fix this [their relationship]."*

Environmental and cultural factors; values that increase risk to self or others. (What are the client's beliefs about self and others that mayincrease or mitigate risk to self or others? Is the client a member of a

subgroup at higher risk ofself-injury (i.e., LGBTQ) or violent behavior?

*Ct is a 23-year-old Caucasian male who states that he was raised in a strict sext of the Southern Baptist religion. "We do not believe in sex before marriage, because it is a sin punishable by internal damnation." Ct states that prior to being in this relationship with his ex-girlfriend that he was a virgin and feels as though if he is unable to reconcile with her then he will go to hell.*
*Having reviewed ct's current and previous tx records, it is worth noting that a substantial amount of work has been done with ct around reality testing to do with his preoccupation about potential consequences he feels he will face from God as a result of his religious beliefs and the faith he was brought up in. It is difficult to ascertain if these beliefs are delusional in nature; however they cause ct significant distress when he feels he has, "committed a transgression."*

Communications: (What does the client say or write about DTS/DTO? Do statements match across settings (i.e., in session, with peers or family, social media)?

*As noted above, ct states, "I just want to hurt them." Ct states that he feels that he is being, "laughed at by all the engineering students," who are reportedly friends of his ex-friend and acknowledges that he has "fantasized about shutting them up with my gun."*

Interest in weapons, violence, or media related to DTS/DTO:

*Ct appears to a vast amount of knowledge about firearms, ammunition and their various uses (i.e. self defense, target practice, hunting). According to previous tx records, ct was raised in a family who went hunting recreationally and engaged in target practice for sport. While his knowledge and use of firearms may not be incongruent with how he was raised, it is worth noting that ct's recent statements regarding wanting to hurt others with his guns, acquiring ammunition as recently as yesterday, and his obsessive and ruminating thoughts about his recent break-up coupled with his religious ideology are worrisome and indicate a significant departure from how ct reportedly has handled stressful situations in the past.*

Recent stressful events: (Losses, setbacks, relationship changes, conflicts, victim of crime, victim of bullying?)

*Ct reports that his girlfriend of 1 1/2 years ended their relationships 2 weeks ago.*

Historical trauma: (How has the client coped? What are potential risks or relationship to current crisis?)

*Ct denies any history of abuse. This is however incongruent with current treatment records where client discloses being inappropriately touched, "down there," by members of the church he attended as a child. Treatment records state that client was a prepubescent teen and that the abuse was perpetrated by a "respected female member of the church."*

Hopelessness, Desperation, Despair: (Assess current state)

*Ct presents as desperate to understand what the catalyst was that led to ending of his romantic relationship. He is preoccupied with obsessive and ruminating thoughts regarding the activities and whereabouts of his ex and states that if he is unable to repair the relationship that, "my transgression [sex out of wedlock] will be punishable with eternal damnation."*

Presence of psychotic symptoms: (Note any recent exacerbation, how does client cope with intrusive symptoms (i.e., with command hallucinations or paranoid ideation)?)

*Ct denies he presence of any AH or VH, however this writer observes ct quietly whispered "Shh.." under his breath. Throughout assessment, this writer notes that coupled with ct's obsessive and ruminating thoughts re: his ex and her whereabouts and activities, he seems convinced that she was, "trying to make a fool out of me," and is, "having sex with one of her sorority sisters."*

Impulsivity/Angry Outbursts:

*Ct became visibly agitated when asked about his anxiety and yelled, "I'm fine!" Ct paced throughout crisis assessment and had difficulty understanding that he may never get an answer from his ex-girlfriend regarding her reasons for ending the relationship. Ct exhibited no insight into his behaviors and how others, including his ex might perceive them as inappropriate or dangerous.*

Substance Use: (Recent increase in use or changes in functioning related to use?)

*Ct states that he finds himself drinking to go to sleep, but states that he cannot stay asleep. He denies using any other substances or medications (either prescribed or OTC)*

Recent change in behavior (include changes in sleep, eating, socializing, or other behaviors)?

*Ct reports that he continues to have difficulty falling and staying asleep. Ct states that his appetite is non-existent. He states that he has withdrawn from the few friends he has, preferring to be in his dark bedroom alone.*

**Review of current and previous treatment records:** (Describe steps taken to review treatment records and significant findings)

*As noted in various portions of this assessment I was able to review ct's current treatment records from when he began seeking services in 2017. Ct states that prior to moving to Ca he was being seen in his home state of Texas by a private psychologist, Dr. Kathleen Eldridge. Ct refused to sign a ROI; however I contacted the provider and requested previous tx records or a tx summary. That request is pending.*

Current Treatment Team: (List current treatment team or program; look at Assignments Tab in Anasazi. Describe results of consultation with current providers or your supervisor(s) here.):

*Terri Eliot, MH Therapist*
*Josh Simpson, Med Manager*
*Dr. Rogers, current psychiatrist*
*I reached out ct's current treatment providers, although none of them were immediately available for a consult.*

Medication and medication adherence:

*Per ct's treatment record*

Interventions and Outcome of Risk Assessment (i.e., consultation with other professionals, safety plan, contact w/ MHET):

*Given all risk factors present at the time of assessment (i.e. reasonably identifiable victim- i.e. students in engineering dept at school, access to firearms at his home, recent purchase of ammunition for said firearms, increase use of ETOH, inconsistent compliance with psychiatric medication, recent stressor from the break up his romantic relationship, lack of familial and peer support due to isolating behaviors and being away at college, changes to his appearance, reported insomnia, presence of mood sxs (feeling hopeless and depressed), as well as history of psychotic sxs and observation of disorganized thought process, behavior, and response to internal stimuli) this writer contacted the Mental Health Evaluation Team so that ct could be placed on a hold for danger to others.*

*While ct was being evaluated by MHET crisis worker, this writer consulted with , Rachel McSpadden-Tarver, LMFT and Program Supervisor, Dr. Kathleen Cohen regarding the need to begin a Tarasoff notification.*

*After consultation, this writer contacted San Luis Obispo Police Department (the law enforcement agency having jurisdiction where ct resides) as well as Cal Poly SLO campus police (law enforcement agency having jurisdiction where the intended victims reside) to notify them that client had made statements of wanting to harm students in the engineering department. This writer detailed ct's statements (i.e. "wanting to hurt them" "fantasized about shutting them up with my gun.") as well as behavior he admits taking in order to carry out his plan (i.e. purchasing ammunition for his legally owned firearm, "scoping out the various entrance and exits to the engineering building to make a clean escape" as well as the recent changes to his behavior, presence of alcohol use, inconsistent compliance with psychiatric medication, and recent life stressor (i.e. break up with a girl who is an engineering major). This writer made it clear to law enforcement agencies in both jurisdictions that she is unable to notify intended victims or client's ex-girlfriend due to lack of information but will contact the engineering department at Cal Poly SLO so that they are able to take any precautions necessary to protect their students.*

*This writer then phoned Cal Poly University SLO and spoke with Dr. Amy Fleischer, Dean for the College of Engineering. This writer notified the Dean of the threats made by client against students in the engineering department (i.e. "wanting to hurt them" "fantasized about shutting them up with my gun.") and discussed with the Dean client's stated plan and steps he has taken toward carrying out this threat. This writer also noted that client indicated that his ex-girlfriend, Alyssa is a student in the engineering department, but writer is unable to locate or notify her because her last name at this time is unknown to this writer.*

*After both law enforcement agencies and Cal Poly SLO, Department of Engineering were notified via phone, this writer completed the necessary Tarasoff letter and faxed it to San Luis Obispo Police Department and Cal Poly Campus Police Department and emailed a separate letter to Dr. Amy Fleischer, Dean for the College of Engineering at the email address she provided during the earlier phone conversation.*

*This writer consulted with the MHET crisis worker and was notified that client was placed on a 5150 involuntary hold for danger to others and is currently being evaluated at the San Luis Obispo Psychiatric Health Facility.*

**Safety Plan and Protective Factors:**

**Disposition and Follow-up:**

*At this time client is currently on an involuntary hold for danger to others and placed at the local Psychiatric Health Facility. This writer will coordinate inform client's treatment team and assist in discharge planning with PHF staff.*

If client is a DTO:

☒ Phone call to intended victim(s)
☒ Tarasoff Notification letters sent
☒ Phone call to Law Enforcement
☒ Tarasoff Worksheet faxed to Law Enforcement

BHCI version 1.04; 05/28/2019

**Attachment E Law Enforcement Fax**

COUNTY OF SAN LUIS OBISPO
HEALTH AGENCY/BEHAVIORAL HEALTH DEPARTMENT
Health Information Unit
(805) 781-4724 Tel (805) 781-4271 Fax

# TARASOFF NOTIFICATION

**TO:**

| | Law Enforcement Office | Fax # | Phone # |
|---|---|---|---|
| | Arroyo Grande | 473-2198 | 473-5100 |
| | Atascadero | 461-3702 | 461-5051 |
| | Cal Poly Campus PD | 756-5051 | 756-7410 |
| | Grover Beach | 473-4517 | 473-4511 |
| | Morro Bay | 772-2224 | 772-6225 |
| | Paso Robles | 227-1013 | 237-6464 |
| | Pismo Beach | 773-3505 | 773-2208 |
| ✓ | San Luis Obispo PD | 543-8108 | 781-7312 |
| | San Luis Obispo Sheriff | 781-1234 | 781-4550 |
| | | | |

**FROM:** San Luis Obispo Behavioral Health Dept
**NAME:** Jaclyn A. Miller, LMFT
**PAGES:** 1
**DATE:** 04/08/19 **TIME:** 2:24 pm
**RE:** Tarasoff Warning & Notification
**PATIENT:** Jackson Cooper

**This is a written follow up to the verbal Tarasoff Warning given to:**

**( Officer / Deputy)** Krupke **Badge #** 24601 **Report #** 112284

*(circle one)* *(name)*
**On** 04/08/19 **at** 1:32 pm **AM / PM** **BY** Jaclyn A, Miller, LMFT
*(date)* *(time)* *(circle)* *staff member giving report (please print)*

**Person making threat:** Jackson Maine **Patient ID #** 624051

**Residing at:** 9340 Flora Lane San Luis Obispo, Ca **Phone #** 805-951-4538

**Threats made:** Patient threatened to break into the home of Stefani Germanotta (4712 Pacific Coast Highway Malibu, Ca 90263),sexually assault her, and choke her to death with his bare hands.

**Intented Victim:** Stefani Germanotta **Email:** sjagerman@att.net

**Residing at:** 4712 Pacific Coast Highway Malibu, Ca 90263 **Phone #** 310- 875-0328

**Intended victim notified by (phone / in person)?** **YES / NO** **If yes: Date/Time** 04/08/19 1:06 pm

*(circle one)*
**Email letter sent to the intended victim?** **YES / NO** **If yes: Date/Time** 04/08/19 1:13 pm

**Certified letter mailed to intended victim?** **YES / NO** **Copy of the letter attached?** **YES / NO**

**If intended victim has not been notified please explain why:**

N/A

**Additional notes:**

**CONFIDENTIAL PATIENT INFORMATION – NOT TO BE FORWARDED**

This information has been disclosed to you from records that are **confidential** and protected by **state confidentiality law** that protects mental health records (See California Welfare and Institutions Code Section 5328). Information subject to release in accordance with Federal Privacy Act of 1974 (Public Law 93-597). This information has been disclosed to you from records protected by **Federal confidentiality rules** (42 CFR, Part 2, Section 2.32). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Total pages included:

**Attachment F: Codes and Case Law Background Information**

DUTY TO PROTECT:
The court ruling in Tarasoff v. Regents of the University of California confirmed that treatment professionals, when made aware of a serious threat of imminent harm, incur a duty toward the reasonably identifiable potential victim or victims of these threats.

“When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.”

Notification of the intended victim and law enforcement is the minimum action necessary to meet the “reasonable” care standard. Other additional actions might include involuntary hospitalization, for example, but hospitalization or incarceration of the person making the threat does not replace notification of the intended victim and law enforcement.

Originally, the duty to protect was only triggered when a client communicated a threat to the therapist. In Ewing v. Goldstein, the court ruled that treatment professionals are required to take action to protect reasonably identifiable victims when a client’s family members or credible third parties report that the client made a serious threat of imminent harm.

Thompson v. County of Alameda added two conditions under which a Tarasoff warning applies: 1) The intended victim(s) must be reasonably identifiable and 2) The peril must be foreseeable.

Menendez v. Superior Court of Los Angeles allows psychotherapist making Tarasoff warnings to include statements made by the client in order to convey the seriousness of the threat to the intended victim(s).

Jablonski v. US made psychotherapists responsible for reviewing all current and previous treatment records in determining the seriousness of a threat. The ruling also includes the responsibility of the psychotherapist to thoroughly document the risk assessment performed in the client’s record and communicate with other treatment providers responsible for and assuming care to ensure continuity of care.

People v. Wharton determined that the content of the Tarasoff warning and the communication that led the psychotherapist to determine that the client was dangerous are admissible in court.

Mavroudis v. Superior Court of San Mateo ruled that imminence is necessary for a Tarasoff duty to exist: “The therapist's duty is further limited by his patient's interest in privacy. The (therapist's) duty to preserve the privacy of his patient requires that he not disclose a confidence of his patient unless such disclosure is necessary to avert danger to others. An assessment of the necessity of the disclosure which gives rise to the therapist's duty must take into account the imminence of the danger posed by the patient. If the patient does not pose an imminent threat of serious danger to a readily identifiable victim, a disclosure of the patient's confidence would not be necessary to avert the threatened danger and the therapist would be under no duty to make such a disclosure.”

And this: “The therapist need not render a perfect performance but merely exercise "'that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances.”

LIABILITY:
California Civil Code 43.92 focuses on when a provider is potentially liable for failure to protect and immune from liability for taking protective action. California Civil Code §43.92 states:

(a) “There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to protect from a patient's threatened violent behavior or failing to predict and protect from a patient's violent behavior except if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

(b) There shall be no monetary liability on the part of, and no cause of action shall arise against, a psychotherapist who, under the limited circumstances specified in subdivision (a), discharges his or her duty to protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.”

Hedlund v. Superior Court of Orange County expanded therapist’s liability to include harm to foreseeable bystanders if the therapist does not fulfill Tarasoff responsibility.

EXCEPTION TO CONFIDENTIALITY:
HIPAA (CFR, Title 45, §164.512 (j)) and California law allow information to be disclosed as necessary to a reasonably foreseeable intended victim and to law enforcement without client authorization. Welfare & Institutions Code §5328(18) states:
“When the patient, in the opinion of his or her psychotherapist, presents a serious danger of violence to a reasonably foreseeable victim or victims, then any of the information or records specified in this section may be released to that person or persons and to law enforcement agencies and county child welfare agencies as the psychotherapist determines is needed for the protection of that person or persons.”

Evidence Code 1024: “There is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.”

# 15.10 Electroconvulsive Therapy (ECT)

I. PURPOSE

- To provide a comprehensive policy for the provision of Electroconvulsive Therapy (ECT) that supports rapid medical response while protecting the rights of clients for whom ECT is recommended
- To summarize the legal requirements for the use of ECT for both adult and minor consumers, including both voluntary and involuntary clients, who may or may not be capable of giving informed consent
- To identify mandatory documentation and reporting requirements concerning provision of ECT

II. SCOPE

Applies to any provider with San Luis Obispo County who provides ECT and any provider outside San Luis Obispo County who provides ECT for a San Luis Obispo County Medi-Cal beneficiary.

III. POLICY

The County of San Luis Obispo Behavioral Health Department (SLOBHD) will approve a list of physicians who are qualified to review ECT requests and will monitor requests for Electroconvulsive Therapy (ECT) as required law.

Status as a voluntary or involuntary client will not automatically determine competence to give informed consent for Electroconvulsive Therapy (ECT). SLOBHD will consider a person incapable of giving written informed consent if he/she cannot understand, or knowingly and intelligently act upon, the information provided as specified in Section 5326.2. A person involuntarily confined shall not be deemed incapable of refusal solely by virtue of being diagnosed as a person with a mentally illness.

IV. REFERENCE

- California W&I Code Sections 5325.1 through 5326.95
- California Code of Regulations, Title 9, §§ 835 – 849
- Health & Safety Code § 123115(a)
- California Code of Regulations, Title 17, §§ 50801 et seq.

V. PROCEDURE

A. Basic Requirements of Informed Consent (WIC 5326.2, 5326.5, 5326.7, and 5326.85)

1. The client must give written informed consent for ECT, and must do so knowingly and without coercion. No ECT shall be performed if the client, whether admitted to the facility under voluntary or involuntary status, is deemed capable to give informed consent and refuses to do so. To constitute voluntary informed consent, the treating physician must furnish the client, and with the client's consent, a responsible relative of the client's choosing, and conservator or guardian if there is one, with the following information in a clear and explicit manner:

    a. The reason for the treatment, specifically the nature and severity of the illness;
    b. The procedures to be used in the treatment, including probable frequency and duration;
    c. The probable degree and duration (temporary or permanent) of improvement or remission expected with or without the treatment;
    d. The nature, degree, duration and probability of side effects and significant risks commonly associated with ECT; especially noting the degree and duration of memory loss, including its potential irreversibility; and how and to what extent they may be controlled;
    e. That there exists a divergence of opinion as to the efficacy of the proposed treatment;
    f. The reasonable alternative treatments, and why the physician is recommending this particular treatment, and
    g. That the client has a right to accept or refuse the proposed treatment, and that if consent is given, has the right to revoke such consent at any time for any reason without prejudice to the client.

2. Withdrawal of consent may be either verbal or written, and shall take effect immediately. If the client subsequently changes his/her decision, a new consent must be secured.

3. The client must sign a written informed consent form before ECT can be administered. At least 24 hours must elapse between the oral advisement by the treating physician and the signing of the consent form by the client.

4. Consent shall be for a specified maximum number of treatments over a specified maximum period of time, not to exceed 30 days. A new consent needs to be secured for treatment extension.

5. The above should be explained so that there is no doubt the client understands the procedure. This may require the presence of an interpreter for the hearing impaired or for clients whose primary language is not English, or special techniques to assist low literacy clients to understand their options.

6. A responsible relative of the client's choosing, or the guardian/conservator, if there is one, shall be given the oral explanation by the attending physician as required by

Section 5326.2. Should the person choose not to inform a relative or should such chosen relative be unavailable, this requirement is dispensed with.

7. The fact of the execution of such written consent form and of the oral explanation shall be entered into the patient's treatment record, as shall a copy of the consent form itself.

8. If the client is deemed capable to give informed consent and refuses to do so, the physician shall indicate in the treatment record the treatment was refused despite the physician's advice and explanation to the client of his/her responsibility for any untoward consequences of the refusal.

9. A consent form similar to the most current version of the form DHCS 1800 is highly recommended.

B. Documentation Requirements for All ECT Clients

1. The following information shall be placed in the treatment record by the treating physician:

   a. Reasons for the procedure;
   b. All reasonable alternative treatment modalities considered, and
   c. A statement that ECT is definitely indicated and is the best available alternative available at this time.

C. Review Procedure for Involuntary Clients

1. In addition to the review of the treating psychiatrist, a review of the client's treatment record is to be conducted by a committee of two physicians, at least one of whom shall have personally examined the client.

   a. One physician shall be appointed by the facility and one shall be appointed by the SLOBHD mental health administrator or his/her designee.
   b. Both shall be either board-certified or board-eligible psychiatrists or neurologists.
   c. This review committee must unanimously agree with the treating physician's recommendations, and both physicians shall document such agreement in the client's treatment record.
   d. Persons who serve on review committees must not be personally involved in the treatment of the client whose case they are reviewing.

D. Review Procedure for Voluntary Clients

1. A psychiatrist or neurologist, other than the treating physician, must examine the client and verify that the client has the capacity to give and has given informed

consent. This verification must be documented in the chart and signed by the treating physician.

2. If there is no verification as required, or the client does not have the capacity to give informed consent, then the procedure for involuntary clients is to be followed.

E. Procedure to Determine Capacity to Give Written Informed Consent

1. The client's attorney or public defender must agree as to the client's capacity or incapacity to give written informed consent, and that the client who has the capacity to give written informed consent has done so. If either the attending physician or attorney believes that the client does not have the capacity to give informed consent, the following procedures are to be initiated:

   a. A petition shall be filed in San Luis Obispo County Superior Court to determine the client's capacity to give such consent. The court will hold an evidentiary hearing within three judicial days after the petition is filed.
   b. The client is to be present and represented by legal counsel. If the court determines that the client lacks the capacity to give written informed con- sent, then treatment may be performed upon gaining the written informed consent of a responsible relative or the person's guardian or conservator, as defined in Sections 5326.2 and 5326.5.
   c. A client declared incompetent has the right to regain competency at any time during the course of treatment. If this occurs, the client's competency must be reevaluated.

F. ECT and Minors

1. Under no circumstances shall ECT be performed on a minor under 12 years of age.

2. Minors who are 16 and 17 years of age shall have all the rights guaranteed voluntary and involuntary clients outlined above.

3. Minors over 12 and under 16 may be administered ECT only if all the provisions for voluntary and involuntary clients are met, and in addition:

   a. It is an emergency situation and electroconvulsive treatment is deemed a lifesaving treatment
   b. This fact and the need for and appropriateness of the treatment are unanimously certified to by a review board of three board-eligible or board-certified child psychiatrists appointed by the SLOBHD mental health administrator, or his/her designee, and
   c. The procedure is performed in full compliance with regulations promulgated by the Director of State Hospitals (under section 5326.95 of the State Welfare and Institutions Code) and is thoroughly documented and reported immediately to the State of California Director of Health Care Services.

G. Reporting Requirements for All ECT Treatments

1. On a quarterly basis, each physician or facility administering ECT shall report such treatments to SLOBHD Patients' Rights Advocate using the most current DHCS-approved reporting form DHCS 1011.

2. The SLOBHD Patients' Rights Advocate shall forward the reports to the SLOBHD mental health administrator, who shall forward a copy to the Director of Health Care Services by the last day of the month following the end of the quarter. The individual physicians and facilities shall include in their reports the number of persons who received ECT wherever administered in each of the following categories:
   a. Patient Distribution
      i. Involuntary clients who gave informed consent
      ii. Involuntary clients who were deemed incapable of giving consent and received ECT against their will
      iii. Voluntary clients who gave informed consent
      iv. Voluntary clients deemed incapable of giving informed consent
   b. Total Number of ECT treatments
   c. Complications Attributable to ECT
   d. Excessive Treatments

3. These physician and facility reports shall be reviewed quarterly by the SLOBHD Quality Support Committee.

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VI. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 06/01/2018 | Entire Policy | Adopted |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *08/22/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 15.11 Protection of Trafficking Victims

## I. PURPOSE

This purpose of this policy is to ensure that the County of San Luis Obispo Behavioral Health Department (SLOBHD) and its contractors comply with the Trafficking Victims Protection Act (TVPA) of 2000.

## II. SCOPE

This policy applies to all SLOBHD service providers, entities, individuals and programs providing any Specialty Mental Health Service (SMHS), Substance Use Disorder Service (SUDS), Prevention & Early Intervention (P&EI) activity or any other related or support services under a contract or subcontract with SLOBHD.

## III. POLICY

SLOBHD shall ensure full compliance with section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000 as amended (22 U.S.C. §7104(g)) as amended by section 7102) and shall immediately terminate the contract, subcontract, or employment relationship with any individual or entity who violates the terms of the TVPA, which includes prohibitions on any of the following:

1. Engaging in severe forms of trafficking in persons during the contract or employment period
2. Procuring a commercial sex act during the contract or employment period
3. Using forced labor in the performance of duties under the contract or employment

## IV. APPLICABLE STANDARDS/REGULATIONS

- United States Code (U.S.C.) Title 22, §7104(g))

## V. RESOURCES

- SLOBHD Boilerplate contract, Exhibit E, Special Conditions, 24. TVPA

## VI. DEFINITIONS

- Human Trafficking: Trafficking in persons is modern-day slavery. The common denominator in all trafficking scenarios is the use of force, fraud or coercion to exploit a person for commercial sex or to subject a victim to involuntary servitude, debt bondage, or forced labor. The use of force or coercion can be direct and violent or more subtle/ psychological.

- Forced Labor: Most instances of forced labor occur when unscrupulous recruiters and employers take advantage of gaps in law enforcement to exploit vulnerable workers. These workers are made more vulnerable to forced labor practices because of unemployment, poverty, crime, discrimination, corruption, political conflict, and cultural acceptance of forced labor. Immigrants are particularly vulnerable, but individuals are also often forced into labor in their own countries. Forced labor can include bonded labor, involuntary servitude, or child labor, in violation of labor laws

VII. PROCEDURE

A. Contract Language
   1. Each contract entered with SLOBHD by any contractor, subcontractor, entities, or individual shall include information about the TVPA and prohibited acts
   2. Each contract will specify a means for reporting suspected violations of the contract and consequences for violation of the TVPA

B. Reporting alleged violations of the TVPA
   1. Each contractor, subcontractor, individual, and/or employee of SLOBHD shall immediately report any suspected violations of the TVPA to the Behavioral Health Administrator or designee by telephone
   2. Follow up reporting in writing may be requested by the Behavioral Health Administrator or designee

C. Investigation
   1. The Behavioral Health Administrator shall promptly investigate or direct a designee to promptly investigate the allegation
   2. The investigation shall remain confidential

D. Enforcement
   1. If the results of the investigation support the validity of the allegation, the Behavioral Health Administrator shall direct the immediate termination of the contract, subcontract or employment of the individual found to be in violation of the terms of the contract and the TVPA
   2. The Behavioral Health Administrator will consult with County Counsel regarding any other necessary remedies, including, but not limited to reporting to credentialing or licensing agencies and criminal prosecution

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## VIII. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 12/01/2018 | All | Implemented |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *12/13/2018* |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# Section 16
# Drug Medi-Cal Organized Delivery System (DMC-ODS)

# 16.01 Capacity Managment Interim Services State Reporting

I. PURPOSE

This policy shall apply to all client applicants to Drug and Alcohol Services when the maximum treatment capacity has been reached. It is to ensure that client applicants understand the capacity list process in a fair and equitable manner and the interim services available.

II. POLICY

**Capacity List(s):** A Capacity List will be developed when the capacity is exceeded by the treatment demand. The Caseload Capacity report is published on a weekly basis on Mondays and reviewed by the Program Supervisor and the Division Manager. The Program Supervisor will determine the need for a capacity list when the capacity for the clinic has reached or exceeded 90%. Capacity lists are kept on a regional clinic basis as each clinic is under its own provider number. The Program Supervisor will also determine the availability of treatment slots and when removal from the capacity list is to begin. Admission priority has been established by DHCS in the following order:

1. Pregnant injecting drug users;
2. Pregnant substance users;
3. Injecting drug users; and
4. All others.

The "all others" order is determined upon the acuity level of the client's need, the length of time the client has been on the capacity list, and the client's compliance with check-in procedures (case management services). The capacity list priorities are posted in each lobby of the Drug and Alcohol Services clinics when the clinic is at capacity.

**Urgency**

As part of walk-in screening a client for SUD treatment services, the Clinician must decide about the urgency in which the client will be seen for their next service (SUD Assessment). Urgency requirements are as follows:

**CRISIS/EMERGENCY:**

Pre-Authorization for services is not required. The client must be seen for SUD Assessment within 24-48 hours of Screening. The client is considered crisis/emergency due to one or more of the following:

- Substance Use Crisis (recent overdose, at risk to continue use substances in a dangerous manner, other recent hospitalization or emergency room visit, as examples)
- Mental Health Crisis (danger to self, danger to others, recent Psychiatric Health Facility (PHF) discharge within 48 hours)
- Pregnancy (must contact within 48 hours as directed by DHCS Perinatal Guidelines)

- Requesting withdrawal management and/or Medication Assisted Treatment (MAT) services
- Requesting Narcotic Treatment Program services

**URGENT:**
Services are urgent and the client must be seen for SUD Assessment within 96 hours (4-Days) from Screening. The client is considered urgent due to one or more of the following:

- Those using drugs through IV methods
- Those that are parenting young children (ages 0-5)

**ROUTINE:**
Routine services indicate the client must be seen for SUD Assessment within 10 business days from Screening.

**Interim Services**

1. Interim services must include counseling and education about:
   a. HIV
   b. TB
   c. Risk of needle sharing
   d. Risk of HIV and TB transmission to sexual partners and infants
   e. Steps to ensure HIV and TB transmission does not occur
   f. If necessary, referral for HIV or TB treatment services
2. Interim services for pregnant women must also include:
   a. Counseling on the effects of alcohol and drug use on the fetus
   b. Referral for prenatal care. When the program is unable to admit a substance-using pregnant woman because of insufficient capacity due to non-budgetary reasons or because the program does not provide the necessary services, referral to another program must be made and documented.
3. Pregnant women must be referred to another program or provided with interim services no later than 48 hours after seeking treatment services. Pregnant women receiving interim services must be placed at the top of the capacity list for program admission.
4. When there is insufficient capacity to provide treatment services to a pregnant or parenting woman who is using drugs intravenously, and a referral has been made, the provider must:
   a. Admit the woman to the program no later than 14 days after making the request for services: or
   b. If any individual cannot be placed in comprehensive treatment within 14 days, then the provider must admit the woman no later than 120 days and provide interim services no later than 48 hours after the request
5. When a client is waiting and/or preparing to go to Residential Treatment, Interim Services and Case Management will be provided.
6. To assist programs in making appropriate referrals, Drug and Alcohol Services will make

available a current directory of its provider network.
7. The appropriate Notice of Adverse Benefit Determination must be provided to the client as applicable when timely access is not available.
8. Consumers without Medi-Cal receive services based on medical necessity and to the extent resources are available.

III. REFERENCE(S)

- DHCS Substance Use Disorder Perinatal Practice Guidelines
- 45 CFR, §§ 96.121 & 96.126

Related SLOBHD Policy and Procedure:
- Notice of Adverse Benefit Determination
- SLOBHD Policy 16.06 Perinatal Practice Guidelines

IV. PROCEDURE

1. The Program Supervisor will determine the need for a capacity list when the treatment capacity is exceeded by the demand for services, reaching 90% or greater. Capacity lists are specific to level of care in a regional location.
2. Upon screening or walk-in intake, the client will be placed onto a capacity list. The capacity list priority (1 - 4) as listed above will be gathered from information supplied by the client during the screening/intake/admission process.
3. In lieu or in addition to the Capacity List placement, client will be referred to:
   a. Alternative provider at the same ASAM level of care
   b. Other County operated clinic at the same ASAM level of care
   c. An Out-of-County subcontracted provider at the same ASAM level of care
   d. A lower ASAM level of care treatment during the interim period
4. When a client is placed in MAT but is awaiting placement into an outpatient treatment program and placed on a capacity list, the client will be considered as receiving outpatient treatment services. CalOMS will be filled out and the client will be admitted to MAT treatment services.
5. The Capacity List Procedures shall be explained to the client by the Assessment Coordinator conducting the walk-in screening.
6. While on capacity list, client will be provided with:
   a. Interim services.
   b. Case management stabilization group service and any other appropriate case management services.
   c. Referrals based on the assessment of individual needs which may include, but are not limited to self-help recovery groups, pre-recovery and treatment support groups, sources for housing, food and legal aid, case management, family and children's services, medical services, and Cal Works\Medi-Cal services.
7. When it is determined by the Program Supervisor that treatment capacity is open, the Program Supervisor, or designee, will determine the order of admission. The acuity

ASAM level of care for the client, the length of time on the capacity list, and other high-risk indicators (such as positive drug tests, MH crisis interventions) will determine the order of admission into program services for "all others".

8. The Program Supervisor, or designee, will instruct the Assessment Coordinator to notify the client by telephone (or in writing) to schedule an assessment appointment and/or the first scheduled group appointment. The Assessment Coordinator will change the status of the client from capacity list program to treatment program and assign to the primary Specialist/Clinician in the SmartCare electronic health record. The Assessment Coordinator will notify the Specialist/Clinician of the pending individual appointment or group services that have been scheduled.

V. STATE REPORTING

1. In addition to internal monitoring of capacity by Program Supervisor, reports are submitted monthly to DHCS using Drug and Alcohol Treatment Access Report (DATAR) for each clinic provider as well as subcontracted providers.
2. Health Information Technician prepares DATAR Report for each County Provider ID with number on Waiting List for each service type and duration. If clients are afforded care at same ASAM level through an alternate provider at same site, County-run clinic, or subcontracted provider, they are not included in DATAR reporting to DHCS.
3. Monthly DATAR report submission is to be uploaded via State BHIS platform to DHCS by 10th day of each calendar month by Health Information Technician.
4. In the event a treatment facility has insufficient capacity to provide perinatal treatment services, SLOBHD must refer the woman to DHCS through its capacity management program the DATAR. The DATAR system is used to collect data on SUD treatment capacity and waiting lists. When a SUD perinatal treatment provider serving intravenous substance users reaches or exceeds 90 percent of its treatment capacity, the provider must report this information to the DATAR for each month by the 10th of the following month. Notify DHCS by emailing DHCSPerinatal@dhcs.ca.gov. Subject line in the email must read "Capacity Management".
5. If the provider or its subcontracted providers experience system or service failure or other extraordinary circumstances that affect its ability to timely submit a monthly DATAR report, and/or to meet data compliance requirements, the provider shall report the problem in writing before the established data submission deadline.

###

VI. REVISION HISTORY

| Effective/Revision Date: | Sections Revised | Status: Initial/ Revised/Archived Description of Revisions |
|---|---|---|
| 04/16/2004 | | Initial release |
| 08/12/2012 | | |
| 09/15/2014 | | |
| 07/06/2016 | | |
| 02/01/2019 | | Changed language to capacity list, aligned with updated Perinatal Guidelines. |
| 7/30/2020 | | II, VI : Added urgency criteria (II) Added description of DATAR reporting to DHCS (VI) |
| 06/30/2021 | Entire Policy | BH adopted Drug Medi-Cal Organized Delivery System (DMC-ODS) |
| 9/18/2024 | IV.8 & V.4 | Updates to procedure for state reporting and capacity monitoring |

| | | |
|---|---|---|
| Signature on file | | |
| Approved by: | Star Graber, PhD, LMFT, Behavioral Health Administrator | Date |

# 16.02 CalOMS Treatment Policy and Procedure

## I. PURPOSE

To establish a procedure to ensure compliance in the monthly submission of CalOMS admission, discharge, and annual updates treatment data to the State Department of Health Care Services Substance Use Disorders programs.

## II. BACKGROUND

The State collects data upon admission, annual update, and discharge to measure individual client progress. This treatment data and summary reports support outcome data and contribute to the understanding of treatment and the improvement of substance use disorder treatment programs in the continuum of prevention, treatment, and recovery services.

## III. POLICY

It is the policy of Drug and Alcohol Services Division, County of San Luis Obispo Behavioral Health Department to submit CalOMS Treatment data and meet the timeline (late submissions shall not exceed 5% for any report month) and error rate (% rejected records shall not exceed 5% of each report month) benchmarks for all CalOMS submissions for admissions, discharges, and annual updates.

## IV. REFERENCE(S)

- Intergovernmental Agreement Exhibit A, Attachment I, III, FF, 4, i, c-f
- Intergovernmental Agreement Exhibit A, Attachment I, III, AA, 1-2 iv
- SABG Application, Enclosure 2, III, 2, C-G

## V. PROCEDURE

A. Upon walk-in or intake assessment, the clinician shall conduct a CalOMS assessment on every client at admission using the "CalOMS Guide for Clinicians" to minimize errors while inputting into Anasazi, our electronic health record.
B. Clinician shall complete CalOMS assessment at discharge from treatment and for annual review if client remains in treatment at same level of care and location for more than one year.
C. Should client transfer to new clinic location or new level of care, discharge CalOMS is required for exited location/level of care, and admission CalOMS is required for new location/level of care. Discharge and admission CalOMS will be coded at least one day apart (not on same day).

D. Each clinician shall check for errors and assign CalOMS to clinic Health Information Technician (HIT) for oversight and final approval.
E. The CalOMS Administrator will further 'scrub' the CalOMS submission through Anasazi and notify the clinician of any remaining errors prior to submission to the BHIS/State website.

VI. DEFINITIONS/GLOSSARY

CalOMS = California Outcomes Measurement System

VII. REVISION HISTORY

| **Effective/Revision Date:** | **Sections Revised** | **Status: Initial/ Revised/Archived Description of Revisions** |
|---|---|---|
| 04/21/2007 | Entire Policy | Initial Release |
| 08/10/2012 | | |
| 05/12/2021 | Entire Policy | Additional review by HIT and change to BHIS platform for submission, minor formatting changes |
| 06/30/2021 | Entire Policy | BH Adopted Drug Medi-Cal Organized Delivery System (DMC-ODS) |

| Signature on file | | 06/30/2021 |
|---|---|---|
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 16.03 Training Requirements for SUD Clinicians

## I. PURPOSE

Training Guidelines are established to ensure that all staff providing substance use disorder treatment services are adequately trained in current methods to treat Drug and Alcohol Services clients most effectively, and to meet standards set forth in state and federal requirements.

## II. POLICY

A. All registered, certified, and licensed staff must complete trainings as required by their governing boards and are responsible for notifying Human Resources of change in credentials. Failure to maintain current credentials will result in loss of Electronic Health Record permissions to enter client services and be referred to Supervisor and Division Manager.

B. Documentation Training:
   1. Week-long documentation training is provided to new DAS staff providing services to clients, including but not limited to the California State Department of Health Care Services AOD treatment program standards, Drug Medi-Cal treatment regulations (Title 22), SUD assessments, treatment plans, progress notes, discharge, and recovery support services.
   2. Quarterly refresher training is provided for DAS treatment staff, covering any updates to AOD standards, newly implemented processes, and common issues requiring training as identified by the Quality Improvement Committee.
   3. Additional one-on-one training is provided by QST clinician to focus on identified areas of concern for a specific clinician.

C. Addiction-related Continuing Education:
   1. A minimum of five (5) Continuing Education hours related to addiction medicine are required for all LPHA's and Medical Director per year.
   2. Staff is instructed to upload documentation to their NeoGov profile, and completion is tracked by QST Administrative Services Officer.

D. ASAM Level of Care training
   1. Drug and Alcohol Services provides ASAM training by e-learning through the Change Companies in two modules: "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care".
   2. ASAM training is required of all staff who assess clients for medical necessity.
   3. Staff is instructed to upload certificates of completion to personal NeoGov profile, and completion is monitored by QST Administrative Services Officer.

E. Evidence-Based Practices (EBP) – See County of San Luis Obispo DMC-ODS Plan Practice Guidelines for current menu of evidence-based practices
   1. SLOBHD hosts staff trainings on Evidence-Based Practices on an ongoing basis. Generally, trainings on a specific EBP will recur every two years so that new staff can participate.
   2. Selection of practices may vary with program-specific population needs (example: criminal justice or perinatal services.), and Supervisor will ensure staff has been trained on required EBPs.
   3. While some EBP's may be used throughout all services, as in Motivational Interviewing, others will be documented in the EHR by a particular Progress Note Type (example: SA Matrix Group).

III. DEFINITIONS/GLOSSARY

- SUD: Substance Use Disorder
- DAS: Drug and Alcohol Services
- AOD: Alcohol and Other Drug
- LPHA: Licensed Practitioner of the Healing Arts. This group includes any professionally licensed staff (Psychologist/LMFT/LCSW/LPCC) or staff registered with a licensing board (registered AMFT/ASW/APCC).
- ASAM Criteria: American Society of Addiction Medicine's national set of criteria for providing outcome-oriented and results-based care for the treatment of SUD.
- QST: Quality Support Team

IV. REVISION HISTORY

| **Effective/Revision Date:** | **Sections Revised** | **Status: Initial/ Revised/Archived Description of Revisions** |
|---|---|---|
| 05/12/2021 | Entire Policy | Initial Release |
| 06/30/2021 | Entire Policy | BH adopted Drug Medi-Cal Organized Delivery System (DMC-ODS) |
| Prior Approval dates: | | |

| | | |
|---|---|---|
| Signature on file | | 05/12/2021 |
| Approved by: | Anne Robin, LMFT, Behavioral Health Administrator | Date |

# 16.06 Perinatal Practice Guidelines

I. PURPOSE

To ensure the County of San Luis Obispo Behavioral Health Department (SLOBHD) delivers quality substance use disorder (SUD) Perinatal services and adhere to state and federal regulations.

II. POLICY

SLOBHD will provide SUD treatment services for pregnant and parenting women that are comprehensive, individualized, family-centered and utilize best practices.

III. REFERENCE

- California Health and Safety Code (HSC) Division 10.5, Part 1, Chapter 2, Alcohol and Drug Affected Mothers and Infants Act
- Code of Federal Regulations (CFR), Title 45, Public Welfare, Part 96, Subpart L; California HSC Division 10.5, Part 1, Chapter 2, Alcohol and Drug Affected Mothers and Infants Act
- 45 CFR §§ 96.124(e), 96.131(a), 96.126(e), 96.131(b), 96.125, 96.124 (e)
- 22 California Code of Regulations (CCR) §§ 51341.1, 51341.1(c) (3), 50260
- Welfare and Institutions Code (WIC) 14184.100 – 14184.800
- Title 42, United States Code (USC) Section 300x-22(b)
- Department of Health Care Services Behavioral Health Information Notice 21-014

IV. PROCEDURE

A. Priority Population and Coverage Period

1. The priority population for the SUD Perinatal Practice Guidelines (PPG) is pregnant and parenting women. Due to the harmful effects of substance use on the fetus, pregnant women require more urgent treatment services.
2. In accordance with Substance Use Block Grant (SUBG) requirements, all SUD treatment providers must treat the family as a unit and admit both women and their child(ren) into treatment services. SUD treatment providers must serve the following individuals with a SUD:
    - Pregnant women
    - Women with dependent children
    - Women attempting to regain custody of their children
    - Postpartum women and their children
    - Women with substance exposed infants
3. SUD providers offering services funded by Drug Medi-Cal Organized Delivery System (DMC-ODS) shall address specific treatment and recovery needs of pregnant and parenting women.
4. The postpartum coverage period for individuals receiving postpartum care services begins after the last day of pregnancy through the last day of the month in which the 365th day occurs. Individuals will maintain coverage through their pregnancy and the 12-month postpartum coverage period regardless of income changes, citizenship, immigration status, or how the pregnancy ends.

B. Admission Priority
   1. It is required that SUD providers serving women shall provide preference to pregnant women with access to more urgent treatment services due to the harmful effects of substance use on the fetus. Specifically, priority must be given to pregnant women who are seeking or referred to treatment in the following order:
      - Pregnant injecting drug users
      - Pregnant substance users
      - Injection drug users
      - All others
   2. Best Practices for Admission Priority – SLOBHD will work to identify prenatal drug exposure and provide timely care to pregnant women with a SUD as it provides a significant buffer against adverse pregnancy outcomes, including premature births and low birth weight.

C. Outreach and Engagement
   1. It is required to use outreach and engagement. Effective outreach engages individuals in need of treatment services, making it more likely they will attend treatment, participate in activities, complete the treatment, and participate in recovery support services. Pregnant and parenting women with a SUD are at risk for potential harmful effects to both mother and child. Outreach efforts educate pregnant and parenting women on the harmful effects of drug use and the services available. SUD treatment providers that serve pregnant and parenting women using injection drugs must use the following research-based outreach efforts:
      - Select, train and supervise outreach workers
      - Contact, communicate and follow-up with high-risk individuals with SUDs, their associates and neighborhood residents, while complying with federal and state confidentiality requirements
      - Promote awareness among women using injection drugs about the relationship between injection drug use and communicable diseases such as Human Immunodeficiency (HIV), Hepatitis B, Hepatitis C and Tuberculosis (TB)
      - Recommend steps to ensure that HIV transmission does not occur
      - Encourage entry into treatment
   2. SUD treatment providers delivering treatment services to pregnant and parenting women must publicize the availability of such services. It is important for women to be aware of the services available to them within their community.
   3. Best practice for outreach and engagement – SLOBHD will use the following methods to publicize the availability of services and engage pregnant women and parenting women:
      - Street outreach programs
      - Public services announcements
      - Advertisements
      - Posters placed in strategic areas

- Notification of treatment availability distributed to the network of community-based organizations, health care providers and social service agencies
- Clearinghouse/information resource centers
- Resource directories
- Media campaigns
- Brochures
- Speaking engagements
- Health fairs/health promotion
- Information lines
- Multidisciplinary coalitions

D. Partnerships
1. It is required for SUD providers to coordinate treatment services with other appropriate services, including health, criminal justice, social, educational, and vocational rehabilitation, as well as additional services that are medically necessary for pregnant and parenting women to prevent risk to a fetus, infant, or mother. Providers shall also provide or arrange for transportation to ensure access to treatment.
2. Best Practices for partnerships – SLOBHD will develop and maintain partnerships among other local agencies and neighboring communities to share resources to aid in the delivery of services in remote areas. In addition, provide education to bring awareness to the community-based organizations that serve pregnant and parenting women. Cultivating true partnership is important as it can lead to constructive collaboration and ensure pregnant and parenting women receive services wherever they are in the community. Training should include other social healthcare facilities and personnel within the community to enhance awareness, identify women with SUDs, and increase appropriate referrals.

E. Screening
1. It is required to conduct an alcohol and drug use screening to identify women who have or are developing SUD. Unhealthy alcohol and drug use screening must be conducted using validated screening tools. Screening is a brief process for identifying whether certain conditions may exist and involves a limited set of questions to establish whether a more thorough evaluation and referral(s) are needed.
2. Providers are required to implement infection control procedures designed to prevent the transmission of tuberculosis. In doing so, providers must screen pregnant and parenting women and identify those at high risk of becoming infected.
3. Some refer to screening and assessment interchangeably, however, it is significant to understand the difference to determine and ensure the most appropriate treatment services:
    - Screening is a process for evaluating the possible presence of a particular problem. The outcome is normally a simple yes or no.

- Assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.

4. Best practice for screening – SLOBHD will regularly screen women to effectively minimize the risk of fetal exposure to alcohol or drugs. When women are screened for SUD during pregnancy, education can be provided about the risks of substance use. In addition, it serves to identify women whose pregnancies are at risk due to their substance use, which allows for pregnant and parenting women to receive early intervention services, or to receive a referral for appropriate treatment services. Screening often is the initial contact between a woman and the treatment system, and the client forms her first impression of treatment during screening and intake. The screening method can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client. Although screening can reveal an outline of a client's involvement with alcohol, drugs, or both, it does not result in a diagnosis or provide details of how substances have affected the client's life. The most important domains to screen for when working with women include:
    - Substance use
    - Pregnancy considerations
    - Immediate risks related to serious intoxication or withdrawal
    - Immediate risks for self-harm, suicide and violence
    - Past and present mental disorders, including posttraumatic stress disorder and other anxiety disorders, mood disorders and eating disorders
    - Past and present history of violence and trauma, including sexual victimization and interpersonal violence
    - Health screenings, including HIV/AIDS, Hepatitis, TB and sexually transmitted diseases

F. Intervention
1. It is required to provide intervention services to pregnant and parenting women. Intervention services are designed to motivate and encourage individuals with a SUD to seek and/or remain in treatment.
2. Women have a unique set of needs that are often not addressed in co-ed settings. SUD treatment providers must provide or arrange for gender-specific treatment and other therapeutic interventions for pregnant and parenting women, such as issues of relationships, sexual and physical abuse and parenting. Childcare services must be provided while the women are receiving gender-specific treatment services. SUD treatment providers must also provide or arrange for therapeutic interventions for the children of the women receiving SUD treatment services to address the child's needs.
3. Best practice for intervention – SLOBHD will use brief interventions. SUD treatment providers who identify specific risk factors associated with initiation of use, such as people of introduction, may determine client's potential barriers and specific problem areas, anticipate intervention strategies, and develop compatible

individually tailored treatment plans (hereafter referred to as "care plans"). The following is a list of the potential benefits of using brief interventions:

- Reduce no-show rates for the start of treatment
- Reduce dropout rates after the first session of treatment
- Increase treatment engagement after intake assessment
- Increase group participation
- Increase compliance with outpatient mental health referrals
- Serve as interim intervention for clients on treatment program waiting lists

G. Assessment

1. It is required to conduct assessments of pregnant and parenting women. Required assessment guidelines and documentation provided is in alignment with DMC-ODS services.
2. Assessments may be initial and periodic and may include contact with family members or other collateral support persons if the purpose of the collateral's participation is to focus on the treatment needs of the client.
3. SLOBHD shall use criteria adopted by the American Society of Addiction Medicine (ASAM) to determine the appropriate level of care for SUD treatment services.
4. The intake process begins with assessing the individual's needs to assure that clients are placed in the most appropriate treatment modality and are provided with a continuum of services that will adequately support recovery.
5. Outpatient drug free (ODF), Naltrexone treatment, day care habilitative, and licensed residential SUD providers delivering perinatal services, shall meet the following requirements:
    - The provider shall develop and document procedures for the admission of beneficiaries to treatment
    - The provider shall complete a personal, medical, and substance use history for each beneficiary upon admission to treatment
    - The physician shall review each beneficiary's personal, medical and substance use history within 30 calendar days of the beneficiary's admission to treatment date
6. All SUD providers should attempt to obtain physical examinations for beneficiaries prior to or during admission. In addition, providers must obtain medical documentation that substantiates the woman's pregnancy. Physical examination requirements are as follows:
    - The physician shall review the beneficiary's most recent physical examination within 30 days of admission to treatment. The physical examination should be within a 12-month period prior to admission date
    - Alternatively, the physician, a registered nurse, or a physician's assistant may perform a physical examination for the beneficiary within 30 calendar days of admission
7. If the physician or a physician extender, has not reviewed the documentation of the beneficiary's physical examination or the provider does not perform a physical examination of the beneficiary, then the LPHA or counselor shall include in the

beneficiary's initial and updated care plans the goal of obtaining a physical examination, until this goal has been met.

8. Best practice for assessment – SLOBHD will provide initial and ongoing assessments to ensure pregnant and parenting women are continuously placed in the appropriate level of care. The assessment process offers pertinent information in determining the types of services and treatment pregnant and parenting women may need. Appropriate placement of care is dependent on the assessment, which considers the nature and severity of a woman's SUD, the presence of co-occurring mental or physical illnesses or disabilities and the identification of other needs related to her current situation.

H. Care Planning

1. It is required to complete a care plan. Care planning is a service activity that consists of development and updates to documentation needed to plan and address the beneficiary's needs, planned interventions, and to address and monitor a beneficiary's progress and restoration of a beneficiary to their best possible functional level.
2. The provider shall prepare an individualized care plan or problem list based on the information obtained during the intake and assessment process. SUD treatment providers shall make an effort to engage all beneficiaries, including pregnant and parenting women, to meaningfully participate in the preparation of the initial and updated care plans or problem lists.
3. Providers offering perinatal services shall address treatment and recovery issues specific to pregnant and parenting women. Perinatal-specific services shall include the following:
    - Mother/child habilitative and rehabilitative services, such as parenting skills and training in child development
    - Access to services, such as arrangement for transportation
    - Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant
    - Coordination of ancillary services, such as medical/dental, education, social services, and community services
4. Pregnant women who are dependent on opioids and have a documented history of addiction to opioids, may be admitted to maintenance treatment without documentation of a two-year addiction history or two prior treatment failures.
5. Physicians shall reevaluate the pregnant woman no later than 60 days postpartum to determine whether continued maintenance treatment is appropriate.

I. Referrals

1. It is required for a SUD treatment provider to submit a referral when the provider has insufficient capacity to provide treatment services to a pregnant and/or parenting woman. SLOBHD shall establish, maintain and update individual patient records for pregnant and parenting women, which shall include referrals.
2. If no treatment facility has the capacity to provide treatment services, SLOBHD will

make available or arrange for interim services within 48 hours of the request, including a referral for prenatal care.

3. Best practices for referrals - The State utilizes the data from the Drug and Alcohol Treatment Access Report (DATAR) report to effectively locate and refer applicants to available and appropriate treatment options. Data in DATAR is collected monthly, however, to meet our obligations to our communities and funding sources, it is best we update our data more frequently. Please also note that when reporting referrals, do not include referrals to non-treatment services such as medical appointments, twelve-step programs, or other recovery support services.

J. Interim Services

1. It is required for SUD treatment providers to make interim services available for pregnant and parenting women awaiting admission into treatment. The purpose of providing interim services is to reduce the adverse health effects of substance use, promote the health of the woman and reduce the risk of disease transmission.
2. If a SUD treatment provider has insufficient capacity to provide treatment services to pregnant and parenting women using drugs intravenously, and a referral to treatment has been made, the provider must:
    - Admit the woman no later than 14 days of the request; or
    - Admit the woman no later than 120 days of the request and provide interim services no later than 48 hours after the request
    - At a minimum, interim services include the following:
        - Counseling and education about the risks and prevention of transmission of HIV and TB
        - Counseling and education about the risks of needle-sharing
        - Counseling and education about the risks of transmission to sexual partners and infants
        - Referral for HIV or TB services
        - Counseling on the effects of alcohol and drug use on the fetus; and referrals for prenatal services for pregnant women
3. Referrals based on individual assessments that may include, but are not limited to self-help recovery groups, pre-recovery and treatment support groups, sources for housing, food and legal aid, case management, children's services, medical services and Temporary Assistance to Needy Families Medi-Cal services.
4. Best practices for interim services – SLOBHD uses these additional methods for providing Interim Services for pregnant and parenting women while they are awaiting admission into treatment:
    - Peer mentorship
    - Services by telephone or e-mail
    - Risk assessment activities
    - Drop-in centers

K. Capacity Management

1. It is required to maintain a capacity management system to track and manage the

flow of clients with SUDs entering treatment. These systems serve to ensure timely placement into the appropriate level of care.

2. When a SUD treatment provider cannot admit a pregnant and parenting woman because of insufficient capacity, the provider will provide or arrange for interim services within 48 hours of the request, including a referral for prenatal care.
3. In the event a treatment facility has insufficient capacity to provide treatment services, SLOBHD must refer the woman to DHCS through its capacity management program the DATAR. The DATAR system is used to collect data on SUD treatment capacity and waiting lists. When a SUD treatment provider serving intravenous substance users reaches or exceeds 90 percent of its treatment capacity, the provider must report this information to the DATAR for each month by the 10th of the following month.
4. Best practices for capacity management - It is encouraged to update DATAR data more frequently to effectively track excess treatment capacity. This allows programs to effectively refer individuals to a treatment facility that currently has capacity.

L. Waiting List

1. It is required to maintain a waiting list to ensure pregnant and parenting women receive timely treatment. Long waiting periods and delayed services serve as a barrier for substance users seeking treatment.
2. SLOBHD will submit waiting list information to DATAR upon reaching capacity. Waiting lists must include a unique patient identifier for each injection substance user seeking treatment and include those receiving interim services while awaiting admission into treatment.
3. SLOBHD will:
    - Develop a mechanism for maintaining contact with the women waiting for admission to treatment.
        - As space becomes available, SUD treatment providers will match clients in need of treatment with a SUD treatment provider that renders the appropriate treatment services within a reasonable geographic area.
    - Ensure injection drug users are placed in comprehensive treatment within 14 days.
        - If any individual cannot be placed in comprehensive treatment within 14 days, SLOBHD must admit the woman no later than 120 days and provide interim services no later than 48 hours after the request.
    - A woman may be removed from the waiting list and not provided treatment within the 120 days if she cannot be located or refuses treatment. It is important to note that:
        - Days waited will only include those days waiting for treatment due to an unavailability of a slot.
        - Circumstances unique to the individual's life are not counted as day on the waiting list.

M. Case Management
   1. It is required that SUD treatment providers provide or arrange for case management to ensure that pregnant and parenting women, and their children, have access to the following services:
      - Primary medical care, including prenatal care and child care
      - Primary pediatric care, including immunizations
      - Gender-specific treatment
      - Therapeutic interventions for children to address developmental needs, sexual and psychological abuse, and neglect
   2. Best practices for case management - It is encouraged to apply the following case management principles:
      - Case management is client-driven and driven by client needs – the aim of case management is to provide the least restrictive level of care necessary so that the client's life is disrupted as little as possible
      - Case management involves advocacy - the paramount goal when dealing with substance use clients and diverse services with frequently contradictory requirements is the need to promote the client's best interests.
      - Case management is community-based - all case management approaches can be considered community-based because they help the client negotiate with community agencies and seek to integrate formalized services with informal care resources such as family, friends, self-help groups and faith-based organizations
      - Case management is pragmatic - case management begins "where the client is," by responding to such tangible needs as food, shelter, clothing, transportation or childcare
      - Case management is anticipatory - case management requires an ability to understand the natural course of addiction and recovery, to foresee a problem, to understand the options available to manage it, and to take appropriate action
      - Case management must be flexible - the need for flexibility is largely responsible for the numerous models of case management and difficulties in evaluating interventions
      - Case management is culturally sensitive - accommodation for diversity, race, gender, ethnicity, disability, sexual orientation and life stage (for example, adolescence or old age), should be built into the case management process

N. Transportation
   1. It is required for SUD treatment providers to provide or arrange for transportation to ensure that pregnant and parenting women, and their children, have access to all the services in the case management section:
   2. SLOBHD shall provide or arrange transportation to ensure service access to and from medically necessary treatment for pregnant and parenting women.
   3. Medi-Cal offers transportation to and from appointments for services covered by Medi-Cal. This includes transportation to medical, dental, mental health, or SUD

appointments, and to pick up prescriptions and medical supplies.

4. Best practices for transportation – SLOBHD uses these methods for providing transportation services:
    - Provide vouchers and tickets for public transportation
    - Implement contracts with community-based transportation services (i.e., Uber, Lyft, shuttle services, etc.)
    - Provide company owned vehicles

O. Recovery Support
1. It is required to provide recovery support services for pregnant and parenting women who have a SUD. Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives and strive to reach their full potential. SUD Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse and the development of parenting skills.
2. Upon treatment completion and discharge from a treatment provider, pregnant and parenting women shall continue receiving recovery support services to encourage continued health and wellness.
3. Providers shall complete a discharge summary for pregnant and parenting women being discharged. The discharge summary shall be completed within thirty (30) calendar days of the date of the last face-to-face treatment contact with the beneficiary. The discharge summary shall include:
    - The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment
    - The reason for discharge
    - A narrative summary of the treatment episode
4. Best practices for recovery support – SLOBHD uses a variety of recovery support methods as the process of recovery is highly personal. Methods may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness and managing setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery. SAMHSA's Four Major Dimensions of Recovery:
    - Health – Overcoming or managing one's disease(s) or symptoms, and making informed, healthy choices that support physical and emotional well-being
    - Home – Having a stable and safe place to live
    - Purpose – Conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
    - Community – Having relationships and social networks that provide support, friendship, love, and hope

Recovery support services help people enter into and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and live full lives in communities of their choice.

P. Treatment Modalities
   1. It is required to provide Residential, ODF Treatment Services, Narcotic Treatment Programs, Intensive Outpatient Treatment Services, and Naltrexone Treatment Services to pregnant and parenting women.
   2. Pregnant women who were eligible for Medi-Cal and received Medi-Cal during the last month of pregnancy shall continue to receive the full breadth of medically necessary services through the end of the 365-day postpartum period. Postpartum begins on the last day of pregnancy.
   3. A pregnant or parenting woman can stay in residential treatment longer than the 30 or 60 days if the assessment indicates such a need.
   4. Providers must adhere to the following requirements when delivering SUD services in Licensed Residential Facilities or Outpatient Programs that deliver treatment services to pregnant and parenting women:
      - Licensed Residential SUD Treatment Services – Providers offering residential SUD services to pregnant and parenting women shall provide a range of activities and services. Supervision and treatment services shall be available day and night, seven days a week.
      - Outpatient Programs – Mother and child habilitative services shall be provided to pregnant and parenting women. During Intensive Outpatient Treatment services, group counseling shall be conducted with no less than two and no more than 12 clients at the same time

Q. Parenting Skills
   1. It is required to incorporate parenting skills into a woman's care plan to help the woman and her child(ren) while the woman is in treatment. Parenting skills are defined as a relationship between a woman and her child(ren) that includes identification of feelings, empathy, active listening, and boundary setting. The mothers can practice these skills alone or with their children.
   2. Parenting skills can be improved through education in child development, skill-building training, counseling, modeling, and problem-solving in specific instances of parent-child interactions.
   3. Best practices for parenting skills – SLOBHD will work to match parenting, coaching, and/or other support groups to the women's services that can help improve her ability to cope with new parenting skills. Parents need time to practice their new parenting skills and change patterns of behavior to improve interactions with their children. Topics for parenting skills and relationship building can include, but are not limited to, the following:
      - Developmentally age-appropriate programs for children
      - Parenting education for mothers
      - Strategies to improve nurturing for mothers and children
      - Appropriate parent-child roles, including modeling opportunities
      - Integration of culturally competent parenting practices and expectations
      - Nutrition
      - Children's mental health needs

- Integration of culturally competent parenting practices and expectations
- Education for mothers about child safety
- Children's substance use prevention curriculum
- Children's mental health needs

R. Child Care

1. SLOBHD provides on-site, license-exempt childcare through a cooperative arrangement between parents for the care of their children. Conducting childcare within close proximity of the SUD treatment provider may serve as a motivation for the mothers to stay in treatment.
2. All the following conditions must be met for the cooperative arrangement:
    - Parents shall combine their efforts, so each parent rotates as the responsible care giver with respect to all the children in the cooperative arrangement
    - Any person caring for the children shall be a parent, legal guardian, stepparent, grandparent, aunt, uncle, or adult sibling of at least one of the children in the cooperative arrangement
    - No monetary compensation, including receipt of in-kind income, may be provided in exchange for the provision of care
    - No more than 12 children can receive care in the same place at the same time
3. When possible, it is recommended that women offering childcare in the cooperative arrangement be directed under supervision of an experienced staff member with expertise in child development. This staff member can teach the women how to respond appropriately to a child's needs and help women address child-specific issues. NOTE: This staff member should have passed a background check before working in the program's childcare.
4. For women in SUD treatment, access to childcare is a critical factor that may serve as a barrier to a woman's participation in treatment. Children born to mothers with SUDs are at a greater risk of in-utero exposure to substances. As a result, many of these children struggle to achieve basic developmental milestones and they often require childcare that extends beyond basic supervision.
5. In addition, it is recommended that child care services include therapeutic and developmentally appropriate services to help identify a child's developmental delays, including emotional and behavioral health issues.
6. When appropriate, child care services should be tailored to each child and support the child's individual developmental needs. This includes considering a child's culture and language to incorporate culturally responsive practices and deliver culturally appropriate services.
7. Furthermore, if other clinical treatment services for the child are deemed medically necessary, services should be comprehensive and, at a minimum, include intake; screening and assessment of the full range of medical, developmental, emotional-related factors; care planning; residential care; case management; therapeutic child care; substance use education and prevention; medical care and services; developmental services; and mental health and trauma services.

V. REVISION HISTORY

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 8/30/2024 | All | Adopted |
| | | |
| Prior Approval dates: | | |
| | | |

| *Signature on file* | | *09/10/2024* |
|---|---|---|
| Approved by: | Star Graber, PhD, LMFT, Behavioral Health Administrator | Date |

# 16.07 Coordination and Continuity of Care

## I. PURPOSE

To ensure that all Medi-Cal beneficiaries receive the correct level of care (LOC) for their substance use disorder (SUD) throughout the treatment episode, and that all care placements and care transitions are determined and coordinated by the County. Transitions between levels of care shall be seamless and structured as followed below, without disruptions to services.

## II. POLICY

County of San Luis Obispo Drug & Alcohol Services (DAS) will provide access to SUD services for Medi-Cal beneficiaries through established assessment, re-assessment, and referral procedures and will arrange, provide, or subcontract medically necessary services in the County in compliance with 42 CFR. Services will be delivered within a continuum of care as defined in the ASAM criteria.

During initial screening, assessment for admission, and reassessment throughout the treatment episode, the beneficiary will be assessed for the correct level of care to provide the safest as well as least restrictive SUD treatment prescription. All ASAM, SUD Assessments, and DSM5 diagnoses will be completed by an LPHA.

The County will use the electronic health record (EHR) to assist with continuity of care for all County operated clinics and for those contracted community-based organizations that choose to utilize the same system.

The County will coordinate with a Medi-Cal Managed Care Plan (CenCal Health) regarding the medical care of individual clients within the standards of 42 CFR 438.208. While coordinating care, each beneficiary's privacy is protected in accordance with all federal and state laws, including but not limited to 45 CRF 160 and 164, to the extent that such provisions are applicable.

## III. REFERENCES

- California Code of Regulations, Title 9, §§ 10280—10415
- Code of Federal Regulations, Title 42, Part 2 §§ 2.1—2.67
- Code of Federal Regulations, Title 45, 160 and 164
- County Specific—ODS San Luis Obispo County
- DMC-ODS Waiver Intergovernmental Agreement
- Standard Terms and Conditions, 89-119 and 265-282

IV. PROCEDURE

A. Assessment
   1. Referrals and Beneficiary Point of Entry
   2. Walk-ins to Contractor-operated clinics
   3. Walk-ins to subcontracted DMC-ODS service providers
   4. Calls to the Central Access Line (CAL)
   5. Criminal Justice System
   6. Narcotic Treatment Programs (NTPs)
   7. Primary care clinics
   8. Emergency departments
   9. Other community-based social and human services

B. Formalized referrals will be entered into the electronic health record (EHR) using a Form 815 Universal Referral Form and Consent for Release of Information form.

C. The County of SLO will provide a 24/7 toll-free Central Access phone line for initial screening and brief ASAM questionnaire. Alternatively, the Contractor shall allow beneficiaries to appear in person at any Contractor-operated or subcontracted DMC-ODS service provider for screening and ASAM assessment.

D. Central Access Line (CAL)
   1. County of SLO shall provide a toll-free 24/7 CAL, also known as the Beneficiary Access Line, to beneficiaries seeking access to Substance Use Disorder (SUD) services.
   2. The CAL shall service beneficiaries in all applicable threshold languages.
   3. The CAL shall collect beneficiary eligibility and demographic information, triage for risk, provide a brief ASAM questionnaire, and refer to a provisional Level of Care (LOC), if deemed necessary.
      i. After a triage for risk, the CAL clinician shall refer the beneficiary to a walk-in clinic or schedule an assessment appointment with an Assessment Coordinator at the desired clinic location.
      ii. The CAL clinician shall be an LPHA during business hours.
      iii. The CAL shall provide 24/7 linkage to services for urgent conditions and medical emergencies.

E. Initial screening and ASAM assessment:
   1. For beneficiaries that present to the County, the Assessment Coordinator will triage for risk, screen for substance use disorder diagnostic criteria (medical necessity), assess for preliminary LOC using ASAM criteria, and give treatment recommendations. Initial screening is required to take place within 90 days of service request.
      i. During screening, the beneficiary will be provided the name and telephone contact information for their assigned Access Case Manager.

The name and telephone number of the Access Case Manager will be offered to the beneficiary in writing in the DAS Client Services Handbook.

2. Assessment Coordinator shall schedule the beneficiary for an individual full ASAM assessment, taking into account the beneficiaries' preferences when possible.
    i. For non-urgent cases, the beneficiary will be scheduled for an individual full ASAM and assessment within 10 business days, taking into account the beneficiaries' preferences when possible.
    ii. For beneficiaries whose CAL screening suggests that withdrawal management, OTP, medication assisted treatment, and/or residential treatment is necessary, the Assessment Coordinator shall schedule the full ASAM assessment within one business day.
3. County of SLO shall ensure that assessments are conducted by the Assessment Coordinator or by a certified/registered alcohol and drug counselor and reviewed and approved by a LPHA.
4. If the entity screening or assessing the beneficiary determines that the medical necessity criteria pursuant to DMC-ODS Special Terms and Conditions (STCs) 128 (e), has not been met and that the beneficiary is not entitled to any SUD treatment services, then a written Notice of Adverse Benefit Determination shall be issued in accordance with 42 CFR 438.404.

F. The County shall comply with the following timely access requirements:
    1. The County shall include language in its provider subcontracts outlining timely access to care requirements and performance standards, taking into account the urgency of need for services.
    2. The County shall require hours of operation during which services are provided to DMC beneficiaries to be no less than the hours of operation in which the provider offers services to non-DMC beneficiaries.
    3. The County shall provide, directly or through CAL, referral to services 24 hours a day, 7 days a week, when medically necessary.
        i. The CAL and DMC-ODS providers will follow policy and procedures in place to screen for emergency medical conditions and immediately refer beneficiaries to emergency care.
        ii. DMC-ODS providers shall admit eligible, non-urgent beneficiaries within10 business days from the initial assessment. In the unlikely event, that admission to treatment shall be greater than 10 business days, due to non-budget related capacity issues, DMC-ODS providers shall provide interim services and seek to link the beneficiary with another provider offering the appropriate ASAM LOC. In addition to providing interim services within the required timeframe, the Contractor shall also provide the beneficiary with referrals to other programs that have immediate availability.
        iii. The County shall provide beneficiaries requiring OTP services a face-to-face appointment within 3 days of Service Request.

iv. In instances where a residential treatment provider submits a prior authorization request to the Central Access Coordinator, the County shall respond with a determination within 24 hours of the request.
v. Authorization requests for residential services received after hours, during holidays, or on the weekend shall be initiated on the morning of the next business day. The County shall allow presumptive authorizations for admission for after hours, on holidays, or weekend admissions. Presumptive authorization shall not guarantee payment.
vi. In the event of non-compliance with timely access to care requirements, the County shall offer the provider or subcontractor technical assistance to adhere to the requirements. The County shall also issue a written report documenting the non-compliance and require the provider or subcontractor to submit a Corrective Action Plan.

G. Full ASAM assessment and admission:
1. County of SLO shall provide the beneficiary with a full ASAM assessment appointment with the Assessment Coordinator.
i. The beneficiary shall be admitted within one business day for Outpatient and Intensive Outpatient, when deemed medically necessary.
2. The Assessment Coordinator shall be a LPHA.
3. The County of SLO shall use the SUD Assessment and ASAM Criteria during the assessment process.
4. Medical necessity for DMC-ODS services shall be determined as part of the intake assessment process and shall be performed through a face-to-face interview or via telehealth.
5. The Medical Director, a licensed physician, or a LPHA must diagnose the beneficiary as having at least one DSM5 Substance Use Disorder.
6. The Assessment Coordinator shall facilitate a warm hand-off to the assigned DMC-ODS County's Case Manager, LPHA, certified or registered Specialist.
7. In the event that the full ASAM assessment yields an ASAM LOC that does not agree with the preliminary ASAM assessment result, the LPHA or Case Manager shall transition the beneficiary to the appropriate level of care.

H. Re-assessment:
1. The Specialist shall reassess all Outpatient and Intensive Outpatient treatment beneficiaries, at least of every 90 days, unless there are significant changes warranting more frequent reassessments. Changes that could warrant reassessment and possibly a transfer to a higher or lower LOC include, but are not limited to:
i. Achieving treatment plan goals
ii. Inability to achieve treatment plan goals despite amendments to the treatment plan
iii. Identification of intensified or new problems that cannot adequately be addressed in the current level of care
iv. Lack of beneficiary capacity to resolve his/her problems

v. At the request of the beneficiary

2. The Assessment Coordinator or Central Access shall reassess beneficiaries initially authorized for residential treatment, at a maximum of every 30 days. Reauthorizations will occur in accordance with the reassessment results, as needed.

I. Transitions to other levels of care:
   1. The Assessment Coordinator and Case Managers shall transition beneficiaries to appropriate LOC. This may include step-up or step-down in SUD treatment services. For complicated care transitions, Case Managers shall provide warm hand-offs and transportation to the new LOC, as needed.
      i. Assessment Coordinators or Case Managers shall ensure transitions to other LOCs occur no later than 10 business days from the time of assessment or reassessment with no interruption of current treatment services.
      ii. If the beneficiary is transitioning to residential treatment, an authorization request shall be submitted to the Assessment Coordinator and an authorization decision shall occur within 24 hours of the request. Case Managers from both the discharging and admitting provider agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next LOC, and documenting all information in the EHR.
      iii. When a beneficiary receives or requires inpatient (SUD) services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or another Fee for Service (FFS) facility, the County will manage the transition of care provided by a DMC-ODS provider.
   2. The appropriate releases of information will be reviewed with the beneficiary and placed in the EHR to complete coordination of care activities to serve the beneficiary in with 42 CFR Part 2.

J. Authorization of services – Residential programs:
   1. Referral to residential services from the Central Access Line (CAL):
      i. When the CAL initial assessment yields a residential service need, the County shall create service request and if deemed necessary an authorization.
      ii. The beneficiary will be offered an evaluation appointment with the Assessment Coordinator within 24 hours of the initial call with the CAL or the next business day following a weekend or holiday call.
         aa. The County will determine residential service authorization during the ASAM assessment with the Assessment Coordinator.
      iii. Initial assessment may be provided face-to-face, by telephone, or by telehealth, and may be provided anywhere in the community where confidentiality can be ensured.
   2. Residential authorization requests from Walk-In Screening:

i. The Assessment Coordinator shall conduct the assessment according to the ASAM Criteria. The Assessment Coordinator will introduce the beneficiary to the Case Manager who will work to provide the smooth transition to the appropriate residential LOC, if deemed medically necessary.
ii. If the beneficiary is not eligible for residential LOC, the Assessment Coordinator shall facilitate a warm hand-off to the provider of the appropriate LOC.

3. Residential authorization requests from providers:
   i. All providers shall obtain authorization for residential services prior to referring or admitting a beneficiary. Any prior authorization requests must be addressed within 24 hours. All authorization and reauthorization shall be tracked through the EHR on the Recovery Residential Authorization Form.
   ii. Upon receipt of request for an Authorization and an ASAM assessment summary from a residential provider, the Assessment Coordinator or Central Access Supervisor shall review the request and based on the review, provide one of the following responses to the requesting provider within 24 hours: Approved as Requested, Approved as Modified, Deferred, or Denied.
   iii. Beneficiaries participating in a face-to-face assessment with the Assessment Coordinator that meet the ASAM Criteria definitions of medical necessity for residential treatment shall be referred. The Assessment Coordinator will authorize residential treatment services and sends an authorization approval to the provider.

K. Early Intervention (ASAM Level 0.5):
   1. Early Intervention Services (ASAM Level 0.5) include Screening, Brief Intervention and Referral to Treatment (SBIRT) shall be provided by primary care providers and local emergency departments to beneficiaries at risk of developing a substance use disorder.

L. Outpatient Services (ASAM Level 1)
   1. Outpatient Services (ASAM Level 1) shall be provided to beneficiaries (up to nine hours a week for adults, and less than six hours a week for adolescents) when determined by a Medical Director or LPHA to be medically necessary and in accordance with an individualized beneficiary treatment plan.
   2. Outpatient Services shall be provided in-person, by telephone or by telehealth by a licensed professional or a certified/registered counselor in any appropriate setting in the community in accordance with 42 CFR Part 2.
   3. The components of Outpatient Services include intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning and discharge services.

4. For beneficiaries in Outpatient Services, case management services will be provided to coordinate care with ancillary service providers and facilitate transitions between levels of care.
5. Reassessment shall occur, at least, every 90 days.

M. Intensive Outpatient Services (ASAM Level 2.1):
1. Intensive Outpatient Services (ASAM Level 2.1) shall be provided to beneficiaries (a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents) when determined by a Medical Director or LPHA to be medically necessary and in accordance with an individualized beneficiary treatment plan.
2. Lengths of treatment shall be extended when determined to be medically necessary. Services can be provided in-person, by telephone or by telehealth by a licensed professional or a certified/registered counselor in any appropriate setting in the community in accordance with 42 CFR Part 2.
3. Intensive Outpatient Services consist primarily of counseling and education about addiction-related problems, with specific components including intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning and discharge services.
4. For beneficiaries in Intensive Outpatient Services, case management services will be provided to coordinate care with ancillary service providers and facilitate transitions between levels of care.
5. Reassessment shall occur, at least, every 90 days.

N. Residential Treatment Services:
1. Residential Treatment services will be provided to non-perinatal and perinatal beneficiaries in DHCS licensed residential facilities that have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.
2. The length of residential services ranges from one to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents, unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis.
3. Only two non-continuous 90-day regimens shall be authorized in a one-year period. Perinatal and criminal justice beneficiaries shall receive a longer length of stay based on medical necessity.
4. d. Perinatal beneficiaries will be provided lengths of stay up to the length of the pregnancy and postpartum period (60 days after the pregnancy ends), if assessed for need.
5. Lengths of stay for criminal justice offenders shall be extended, if assessed for need, for a maximum of six months.
6. The components of residential treatment include intake, individual and group counseling, family therapy, patient education, safeguarding

medications, collateral services, crisis intervention services, treatment planning, transportation services, case management and discharge services.

7. Case management services will be provided for beneficiaries in residential treatment to coordinate care with ancillary service providers and facilitate transitions between LOCs.
8. ASAM LOC Designations for 3.1 (Clinically Managed Low-Intensity Residential Services) will be available for adolescents, perinatal and non-perinatal beneficiaries.
9. ASAM Level 3.3 (Clinically Managed Population-Specific High-Intensity Residential Services) and 3.5 (Clinically Managed High-Intensity Residential Services) will be available by or before the end of implementation year three (June 30, 2020).
10. Reassessment shall occur, at least, every 30 days.

O. Case Management:
   1. Case management services will be provided to all eligible beneficiaries, based on needs.
   2. Assessment Coordinators and Case Managers will provide case management services.
   3. The components of case management services include comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services.
   4. Case management services may also include transitions to a higher or lower LOC, development and periodic revision of an individual treatment plan, communication, coordination, referral and related activities, monitoring service delivery to ensure beneficiary access to services, monitoring the beneficiary's progress, patient advocacy, linkages to physical and mental health care, and transportation.
   5. Case management shall be consistent with and shall not violate confidentiality of alcohol or drug clients as set forth in 42 CFR Part 2.
   6. The Assessment Coordinator, the Case Manager, a LPHA, registered/certified counselor shall provide case management services face-to-face, by telephone, or by telehealth with the beneficiary. Registered and certified counselors shall adhere to all requirements in the CCR, Title 9, Chapter 8, and registered counselors shall be under the supervision of LPHA pursuant to STC 146.
   7. A comprehensive case management model will be used based on the ASAM bio-psycho-social assessment to identify needs, develop a case plan, and the SAMHSA CSAT TIP 27 (Treatment Improvement Protocol) Comprehensive Case Management for Substance Abuse Treatment will be followed.
   8. While approved DMC-ODS providers can provide case management services to a beneficiary while in treatment at the certified program, the County of SLO is responsible for coordinating the overall case management LOC, including providing any case management services outside of a treatment episode, providing case management services to the most complex

beneficiaries, and overseeing all care coordination activity in the DMC-ODS.
9. The beneficiary will be provided with contact information for the Case Management and Assessment Coordinator.

P. Physician Consultation:
   1. Physician Consultation will include DMC-ODS physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists for complex cases which may address medication selection, dosing, side effect management, adherence, drug-to-drug interactions or LOC considerations.

Q. Recovery Services:
   1. Recovery services shall be available once a beneficiary has completed the recommended course of treatment.
   2. Contractor staff will coordinate, monitor and support peer recovery support workers and volunteers to provide substance abuse assistance and relapse prevention.
   3. Recovery services shall be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community in accordance with 42 CFR Part 2.
   4. The components of recovery services include outpatient individual or group counseling, recovery monitoring/coaching, peer-to-peer assistance, linkages to services to enhance education and job skills, and linkages to family support, support groups and ancillary services.
   5. Reassessment shall occur, at a minimum, every 180 days.

R. Withdrawal Management:
   1. The County of SLO or subcontractor shall provide Withdrawal Management ASAM (Levels 1-WM and 2-WM) to beneficiaries, when medically necessary.
   2. Withdrawal Management services shall be determined by the Medical Director or by contracted and licensed physicians, as medically necessary, and in accordance with an individualized beneficiary's treatment plan.
   3. The components of Withdrawal Management services are intake, observation, medication services, care coordination and discharge services.
   4. Access to ASAM Level 3.7 – WM (Medically Monitored Inpatient Withdrawal Management) and ASAM Level 4.0 – WM (Medically Managed Inpatient Withdrawal Management) shall be available, when medically necessary, with the local hospitals.
      i. The County of SLO shall coordinate care with these providers to smoothly transition and support beneficiaries to less intensive LOCs. Memorandums of Understanding (MOU) shall be developed with each of the hospital organizations to ensure compliance with the referral processes, the anticipated timelines, and the roles in each treatment modality.

ii. Case management services will be provided to ensure a smooth and timely transition while the client is stepping up to ASAM level 3.7 and level 4.0 Inpatient Withdrawal Management or stepping down into substance use disorder treatment, including residential treatment facilities.

5. For beneficiaries in Withdrawal Management, the County of SLO or subcontractor shall provide case management services to coordinate care with ancillary service providers and facilitate transitions between LOCs.
6. Reassessment shall occur, at least, every 30 days.

S. Opioid (Narcotic) Treatment Program Services:
1. Subcontractor shall provide Opioid (Narcotic) Treatment Program (ASAM OTP Level 1) services in Narcotic Treatment Provider licensed facilities. Medically necessary services shall be provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and authorized according to the State of California requirements.
2. The components of OTPs include intake, individual and group counseling, patient education, transportation services, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy and discharge services.
3. Subcontractor shall provide the beneficiary, at minimum 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.
4. Subcontractor shall schedule beneficiaries for their first face-to-face service and intake assessment on the same day they are admitted.
5. Subcontractor shall provide case management services to coordinate care with treatment and ancillary service providers and facilitate transitions between levels of care. Beneficiaries may be simultaneously participating in OTP services and other ASAM LOCs.

T. Additional Medication Assisted Treatment (MAT):
1. Additional MAT (ASAM OTP Level 1) shall include the assessment, treatment planning, ordering, prescribing, administering, and monitoring of all medications for SUDs. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber working within their scope of practice.
2. The County of SLO or subcontractor shall provide administration of buprenorphine, naltrexone (oral and injectable), acamprosate, disulfiram, and naloxone.
3. The County of SLO shall provide case management to coordinate care with treatment and ancillary service providers and facilitate transitions between levels of care. Beneficiaries may be simultaneously participating in MAT services and other ASAM LOCs.

U. Recovery Residences:
   1. County of SLO shall provide Recovery Residences (RR) to beneficiaries who require housing assistance in order to support their health, wellness and recovery.
   2. County of SLO will develop standards for subcontracted RR providers and shall monitor to these standards.
   3. Beneficiaries may participate simultaneously in other ASAM LOCs.
   4. Reassessment shall occur, at least, every 30 days.

V. Telehealth:
   1. Telehealth services will include, but not limited to, consultative and direct beneficiary care including medication screening, MAT, assessment, evaluation, monitoring, and management.
   2. A Drug and Alcohol Services staff (LPHA, Licensed Psychiatric Technician, certified/registered Specialist or worker with lived experience) shall be with the beneficiary, while the qualified staff is on the other end of the camera.
   3. Group counseling services will not be conducted through telehealth.

W. Coordination with Managed Care Organization (CenCal Health): See SLOBHD Policy 8.00 Coordination of Care with Other Health Care Providers.
   1. At walk-in screening, client will complete a Health Questionnaire.
      i. Assessment Coordinator will review the Health Questionnaire during screening session.
      ii. Health Questionnaire is referred to the Medical Director. Action taken by Medical Director is documented on the form.
      iii. The Health Questionnaire is added to the client's EHR (scanned).
   2. At walk-in screening, client will be asked to authorize (via signature) a Release of Information for Physical Exam Referral (SACPER).
      i. If client has reported a physical examination within the last 12 months, physical exam records are requested from the provider identified by the client by Health Information Technician.
      ii. If client has reported that they have not had a physical examination with the last 12 months, a physical exam referral is submitted by Health Information Technician to the provider client identifies on SACPER.
   3. Specialist will follow Drug Medi-Cal Title 22 Regulations in regard to client physical examination requirements (51341.1(h)(iv)(a-c).
   4. Specialist will obtain a Release of Information with the client's authorization to coordinate with physical healthcare providers as necessary. Special circumstances regarding an individual client's health will be included on the Treatment Plan.

###

VI. DOCUMENT HISTORY

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| 12/18/18 | Procedure, Section 5. | Added how beneficiary will be informed of Access Case Manager contact information. |
| Prior Approval dates: NA | | |

| | |
|---|---|
| *Signature on File* | *10/30/18* |

Approved by: Anne Robin, LMFT Date
Behavioral Health Administrator

# 16.08 Alumni Involvement

## I. PURPOSE

Drug & Alcohol Services encourages the involvement of Alumni to enhance the treatment experience for all beneficiaries. The goal of Alumni involvement is to decrease beneficiaries return to substance use through positive social connections.

## II. POLICY

Drug & Alcohol Services will encourage former clients to make return visits and to serve as volunteers in end stage social support treatment groups and in Recovery Support Services groups.

## III. REFERENCES

- Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System (DMC-ODS) FAQ's, Recovery Services, Revised August 2017 http://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS_Waiver/DMC-ODS_Recovery_Services_FAQ.pdf

- DMC-ODS Special Terms and Conditions, Sec. 152 http://www.dhcs.ca.gov/provgovpart/Pages/Special-Terms-and-Conditions.aspx

- DHCS Information Notice 17-008, Peer Support Services in the DMC-ODS Waiver

- DHCS Information Notice 17-017, Alcohol and/or Other Drug Certification Standards, Sec 9000 http://www.dhcs.ca.gov/provgovpart/Documents/MHSUDS_Information_Notice_17-017_AOD_Certification_Standards.pdf

## IV. DEFINITIONS

"Alumni" means:

An individual who has completed a substance use disorder (SUD) treatment program and is in recovery. An Alumnus does not meet medical necessity for Recovery Support Services.

"Recovery Support Services" means:
Medically necessary recovery services after completing the course of treatment. An individual in Recovery Support meets medical necessity for DMC-ODS services

V. PROCEDURE

1. Alumni members will sign a "confidentiality statement for alumni members" form prior to attending any treatment or Recovery Support Services group.

2. Alumni members also attend "Alumni" groups in which no confidentiality form will be necessary.

VI. DOCUMENT HISTORY

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| | | |
| Prior Approval dates: | | |

| | |
|---|---|
| *Signature on file* | *4/19/2018* |

Approved by: Anne Robin, LMFT Date
Behavioral Health Administrator

# 16.09 Response to Relapse During SUD Treatment Services

## I. PURPOSE

Drug & Alcohol Services will continue to provide treatment services or provide appropriate referral in the event of a beneficiary's relapse during an SUD treatment episode. The policy below is consistent with the alcohol and drug-free environment of the program.

## II. POLICY

Drug & Alcohol Services provides a drug-free environment. Thus, service delivery after a relapse episode will be consistent with this standard. Drug & Alcohol Service treatment staff will respond to a beneficiary's relapse with support that is individualized to the beneficiary's needs.

## III. REFERENCES

- AOD Certification Standards, Sec 7080 http://www.dhcs.ca.gov/provgovpart/Documents/MHSUDS_Information_Notice_17-017_AOD_Certification_Standards.pdf

## IV. DEFINITIONS

"Behavioral Intervention Agreement" means:

A. A contract that asks the beneficiary to complete specific actions to comply with their treatment plan and engage in safe behavior as to avoid further decline.

"Relapse" means:

A. Returning to substance use after a period of abstinence.

## V. PROCEDURE

A. Throughout treatment, beneficiaries will be encouraged to contact their primary Specialist/Clinician and utilize their relapse prevention plan should they be in crisis (strong desire to use) or in the event that they do have a relapse.
B. When a beneficiary reports a relapse, or a relapse is indicated with evidence of alcohol/drug test results, the primary Specialist/Clinician will schedule an individual counseling session. A relapse analysis will take place during the session.
C. Should the referring agency, such as Child Welfare Services, Probation, or Parole need to be notified of the beneficiary's relapse, the primary Specialist/Clinician will encourage the beneficiary to make a self-report. The Specialist/Clinician will also follow-up with the referring agency with notification and will discuss the plan for treatment intervention.

D. The primary Specialist/Clinician will consider interventions that are in the best interest of the beneficiary which can include:
    - increase in level of care
    - increase referrals (ex. Mental Health)
    - increase social support (ex. AA/NA, other community meetings)
    - addition of ancillary services (ex. MAT, psychotropic medications, family counseling)
    - contact with referring agency
    - implementation of a Behavioral Intervention Agreement
    - return to court
E. Any and all interventions will be documented in the chart.

VI. DOCUMENT HISTORY

| Revision Date: | Section Revised: | Details of Revision: |
|---|---|---|
| | | |
| Prior Approval dates: | | |

| | |
|---|---|
| *Signature on file* | *4/19/2018* |

Approved by: Anne Robin, LMFT Date
Behavioral Health Administrator

# 16.10 Naloxone Availability and Opioid Overdose Response Policy

## I. POLICY STATEMENT

The County of San Luis Obispo (SLO County) Drug and Alcohol Services (DAS) and any DHCS licensed SUD treatment facilities contracted with SLO County shall always maintain at least two doses of naloxone or any other FDA-approved opioid antagonist medication on-site to ensure the ability to respond promptly to an opioid overdose emergency. Staff shall be trained in the administration of naloxone, and documentation of this training shall be maintained in compliance with state regulations.

## II. PURPOSE

To ensure that DAS clinics and DHCS licensed SUD treatment facilities contracted with SLO County are equipped and prepared to effectively respond to opioid overdose emergencies by maintaining sufficient supplies of naloxone and ensuring staff are properly trained in its use.

## III. SCOPE

This policy applies to all DAS clinics, and any DHCS licensed SUD treatment facilities contracted with SLO County.

## IV. BACKGROUND

### A. Indications

- Naloxone is a medication that works almost immediately to reverse opioid overdoses. It is an opioid antagonist, which means it blocks opioids from binding to receptors in the brain and reverses the respiratory depression caused by an opioid. Naloxone is not a controlled substance. It has few known adverse effects, no potential for abuse, and can be rapidly administered through nasal spray. Narcan, brand name naloxone nasal spray, does not require a standing order.

### B. Contraindications

- Naloxone is only contraindicated in patients known to have a hypersensitivity to naloxone hydrochloride or to any of the other ingredients in naloxone.
- Pregnancy and breastfeeding are not contraindications to naloxone.
- There are no age contraindications for administering naloxone.

### C. Precautions

- Naloxone doses should be given every 2-3 minutes until the person revives; there may be a slower response in the face of certain other drugs, including

buprenorphine and more doses may be needed with substances containing Fentanyl.

- Naloxone will not harm, nor will it be effective, when respiratory depression is due to non-opioid drugs including sedative (i.e., benzodiazepines and alcohol), stimulants (i.e. methamphetamine, cocaine, crack, MDMA), hallucinogens (psilocybin, LSD, ketamine).
- Naloxone will not harm when the respiratory depression is caused by a medical issue including cardiac arrest, pulmonary embolism, or another medical condition.

D. Adverse Reactions

- Abrupt reversal of opioid effects in persons who are physically dependent on opioids **may** precipitate an acute withdrawal syndrome which may include, but is not limited to, the following signs and symptoms:
    - Body aches, fever, sweating, runny nose, sneezing, piloerection, yawning, weakness, shivering or trembling, nervousness, restlessness, irritability, diarrhea, nausea, vomiting, abdominal cramps, increased blood pressure, and/or tachycardia.

V. PROCEDURES:

A. Naloxone Supply and Storage Policy:

- **Naloxone Supply:**
    - Each licensed SUD recovery or treatment facility must maintain, at all times, at least **two** unexpired doses of naloxone or any other opioid antagonist medication that is FDA-approved for the treatment of opioid overdose.
    - Naloxone doses must be regularly checked to ensure they are not expired. Expired naloxone should be replaced immediately to maintain the required supply.
    - Facilities must have a system in place to track inventory, including expiration dates, to ensure the continuous availability of naloxone.
- **Naloxone Storage:**
    - Naloxone must be stored in an accessible and easily identifiable location, known to all staff members on the premises. This location should be free from obstructions and clearly labeled.
    - It should be kept at room temperature, between 59°F and 77°F (15°C to 25°C), and protected from direct sunlight, heat, and extreme cold. Exposure to temperatures outside this range can compromise the effectiveness of the medication.
    - Naloxone should be stored in a dry place, away from moisture or damp conditions, which could damage the packaging or the medication.

- Facilities should ensure naloxone is secured but readily accessible in case of an emergency. Staff should be aware of the exact location and method for accessing naloxone to avoid delays during overdose situations.
- If stored in portable kits (e.g., first aid kits), these kits should be clearly marked, and their location should be communicated to all staff members. Portable kits should also be routinely checked to ensure that the naloxone is within its expiration date.
- Staff should be trained on proper storage practices and the importance of maintaining the effectiveness of naloxone, including what to do if naloxone has been exposed to inappropriate temperatures.

B. Staff Training and Location Knowledge:

- **On-Site Staff Requirements:**
  - At least one staff member must be present on-site at all times who knows the specific location of naloxone and has been trained in its administration.
  - All staff must be familiar with the location and accessibility of naloxone, ensuring a swift response during an emergency.
- **Staff Training:**
  - Staff training will encompass comprehensive education on opioid overdose prevention and response, which includes:
    - **Recognition of Opioid Overdose Symptoms:**
      - Identifying key signs of an opioid overdose, such as unresponsiveness, shallow or absent breathing, blue lips or fingernails, and gurgling or choking sounds.
      - Understanding the differences between overdose symptoms and other medical emergencies.
    - **Naloxone Administration:**
      - Step-by-step instructions on how to properly administer intranasal naloxone.
      - Explanation of how naloxone works to reverse opioid overdoses and the importance of timing and proper technique.
      - Hands-on practice with naloxone kits (using training devices, if available) to ensure staff are confident in its use.
    - **Responding to an Opioid Overdose:**
      - Following the standard response steps: Check for responsiveness, call 911, administer naloxone, perform rescue breathing or CPR (if trained), and monitor until emergency responders arrive.
      - Review of Good Samaritan laws and legal protections in place to encourage bystander intervention during an overdose situation.

        - Importance of calling emergency services even after naloxone has been administered, as multiple doses may be necessary.
    - **Use of Online Resources:**
        - Staff will be directed to use online resources for additional information on opioid overdose prevention and response. Recommended training resources include:
            - National Harm Reduction Coalition's Opioid Overdose Basics: Provides detailed guidance on how to recognize, respond to, and treat opioid overdoses, as well as best practices for using naloxone effectively.
            - **Additional resources** may include training videos, interactive modules, and FAQs to further enhance knowledge and confidence in handling overdose emergencies.

- **Training Certification and Documentation:**
    - Staff shall certify that they have completed training in opioid overdose prevention and naloxone administration by signing a training acknowledgment form. This certification will be updated annually or as needed.
    - Training records shall be maintained by the facility, including details of when each staff member was trained and the topics covered, ensuring all personnel meet the training requirements and can respond effectively during an opioid-associated emergency.

C. Training Documentation:

- **Record Keeping:**
    - Proof of training completion must be documented in each staff member's individual personnel file. This ensures that the facility can verify that all staff members are adequately trained and can respond to an opioid overdose emergency effectively.
    - Documentation should include:
        - **Date of Training:** The specific date when the training was completed, including any refresher courses or updates.
        - **Training Provider Information:** The name and credentials of the organization or individual who conducted the training, ensuring that it meets established standards.
        - **Training Topics Covered:** A summary or checklist of the key topics addressed during the training session, such as overdose recognition, naloxone administration procedures, and legal protections.

        - **Certificates of Completion:** Where applicable, a copy of any certificates issued to staff upon successful completion of the training, demonstrating their competency in opioid overdose response.

- **Compliance with California Code of Regulations (CCR), Title 9, Section 10564(k):**
    - All training documentation shall comply with **California Code of Regulations (CCR), Title 9, Section 10564(k)**, which mandates maintaining a detailed record of required staff training.
    - Facilities must keep these records for a period specified by the regulation to ensure ongoing compliance during audits or inspections by regulatory bodies. The documentation should demonstrate that the facility has met all required training protocols, including:
        - **Initial and Ongoing Training:** Details on both initial training upon hiring and any ongoing or periodic training sessions staff members attend to stay current on best practices in overdose response.
        - **Refresher Courses:** Records of refresher courses that ensure staff remain proficient in administering naloxone and up-to-date with the latest overdose prevention strategies and legal guidelines.
        - **Accessibility of Records:** Training documentation must be readily accessible during inspections or audits by state licensing authorities to verify compliance with CCR Title 9 regulations. Facilities should also have a clear protocol on how to update and maintain training records, including who is responsible for ensuring their accuracy.

D. Monitoring and Compliance:

- **Regular Supply Checks:**
    - The facility manager or a designated staff member shall conduct **monthly inventory checks** to verify that the naloxone supply is unexpired, properly stored, and meets the minimum required quantity (at least two doses). These checks ensure that the facility is always prepared to respond to an opioid overdose emergency.
    - During each inventory check, the expiration dates of all naloxone doses should be reviewed, and any doses that are approaching expiration within the next 30 days should be flagged for replacement. This proactive approach helps avoid shortages and ensures that only effective, non-expired doses are available for use.
    - Facilities should implement a **tracking log** that includes:
        - Date of the inventory check
        - Number of doses on-site
        - Expiration dates of each dose
        - Name of the staff member who conducted the check

- Any expired naloxone must be safely disposed of according to state regulations and immediately replaced to maintain compliance.

- **Presence of Trained Staff:**
  - Facility management must **schedule and confirm** that at least one trained staff member is on-site at all times, as required. This responsibility includes coordinating shifts and ensuring adequate staffing coverage during all operational hours.
  - A **staff roster** should be maintained, noting who is trained in naloxone administration. The roster should be updated regularly to reflect new staff training and any staff departures, ensuring that the facility always has a clear understanding of who is qualified to respond to an overdose.

- **Annual Compliance Audits:**
  - In addition to regular checks, facilities should conduct **annual compliance audits** to ensure that all procedures around naloxone supply, storage, and staff training meet the required standards. The audit should include:
    - Verification of staff training records to confirm that all personnel have received initial and refresher training as required.
    - Review of naloxone storage practices to ensure they comply with recommended guidelines and that all doses are accounted for.
    - A summary report of the audit findings should be shared with the facility director, including any recommendations for improvement and action plans to address identified issues.

E. Emergency Response:

- **Immediate Action:**
  - In the event of a suspected opioid overdose, trained staff must act quickly to assess the situation. The priority is to determine if the individual is unresponsive, has slowed or stopped breathing, or shows other signs of an overdose (e.g., blue lips or fingernails, gurgling sounds, pinpoint pupils).
  - Once an opioid overdose is suspected, staff should **immediately administer naloxone**. It is crucial to act without delay, as prompt administration of naloxone can reverse the life-threatening effects of an overdose.

- **Step-by-Step Emergency Procedures: (Also documented in Appendix B)**
  - **Check Responsiveness:** Attempt to wake the person by calling their name and giving a firm rub on the sternum (sternal rub). If they are unresponsive, proceed to administer naloxone.
  - **Administer Naloxone:** Follow the proper administration procedure (intranasal or) as outlined in staff training. Ensure the dose is delivered correctly and note the time it was administered.

- **Call 911:** Even if naloxone has been administered, **call 911 immediately** to ensure that emergency medical services (EMS) are on their way. Provide clear details to the dispatcher, including:
  - The address and location of the facility
  - Description of the individual's condition and that naloxone has been administered
  - Any additional relevant information, such as the approximate time of the overdose

- **Monitor and Provide Support:**
  - Stay with the individual after administering naloxone. Continue to monitor their breathing and responsiveness. If they do not start breathing or do not regain consciousness within 2-3 minutes, administer a second dose of naloxone using a new device or syringe.
  - Perform **rescue breathing or CPR** if trained, particularly if the person is not breathing adequately. This can provide life-saving oxygen until EMS arrives.
- **Additional Naloxone Administration:**
  - If the individual does not respond after the first dose, or if overdose symptoms reappear, administer additional doses every 2-3 minutes as needed, following the instructions for the type of naloxone available.
- **Prepare for EMS Arrival:**
  - When EMS arrives, provide them with a brief overview of the situation, including:
    - The symptoms observed
    - The actions taken (e.g., number of naloxone doses administered, CPR performed)
    - Any known information about the individual (e.g., substances used, allergies, medical conditions)
  - Staff should assist EMS personnel as needed, ensuring a smooth handoff for further medical care.
- **Post-Emergency Protocol:**
  - After the situation is under control, staff should **document the incident** in the facility's records, including the time and details of the response, naloxone administration, and the individual's outcome.
  - The incident should be reviewed to identify any potential improvements to the emergency response plan, and any staff involved should have the opportunity to debrief and address any concerns or emotional responses to the situation.
  - **Restock Naloxone Supplies:** Ensure that the naloxone supply used during the emergency is immediately restocked, and check that all remaining doses are unexpired and stored properly.

VI. REVISION HISTORY:

| Revision Date: | Section(s) Revised: | Details of Revision: |
|---|---|---|
| 10/25/2024 | | Adopted |
| | | |
| | | |
| Prior Approval dates: | | |
| | | |

| *E-Signature on file* | | *10/25/2024* |
|---|---|---|
| Approved by: | Star Graber, PhD, LMFT, Behavioral Health Administrator | Date |

## APPENDIX

### Appendix A: California Naloxone Access Laws

**Naloxone Access Law**

Cal. Civ. Code § 1714.22; Cal. Bus. & Prof. Code § 4052.01; 16 CCR § 1746.3
Prescribers may prescribe and give out naloxone, either directly or by standing order, to a person at risk of overdose or a family member, friend, or other person in a position to help. If a person receives naloxone via standing order, they must complete training from an opioid overdose prevention and treatment training program.

Pharmacists may give naloxone to persons with a history of use of opioids or persons in contact with someone with a history of use of opioids without that person first getting a prescription for it as long as they follow a statewide protocol. The protocol requires the pharmacist to be trained. Before giving out naloxone, a pharmacist must provide a consultation outlined in the law.
A health care provider acting with reasonable care has civil and criminal immunity for issuing a prescription for naloxone and cannot be professionally sanctioned.

A person who gives out naloxone under a prescription or standing order is not subject to civil action, criminal prosecution, or professional review.

A person who administers naloxone and has received proper training who acts with reasonable care, in good faith, and without payment is not subject to civil action, criminal prosecution, or professional review.

**Good Samaritan Law**

Ark. Code. Ann. § 20-13-1701 et. seq.
A person who acts in good faith and calls for help for a drug overdose, whether for themselves or others, may not be arrested, charged, or prosecuted for possession of a controlled substance, if evidence for the offense was found as a result of calling for help.

A person who acts in good faith and calls for help for a drug overdose, whether for themselves or others, may not be penalized for a violation of restraining or protective order, pretrial release, probation, or parole, if evidence for the violation was found as a result of calling for help. These protections apply for violations based on possession of a controlled substance only.

## Appendix B: Recognizing and Responding to Opioid Overdose

### Step 1: Evaluate for Signs of Overdose

1) Look for signs of an overdose which may include:

- Discolored skin (especially in lips and/or nails)
- Small, constricted pupils
- Falling asleep or losing consciousness
- Slow, weak or no breathing
- Choking or gurgling sounds
- Cold and/or clammy skin

2) If an opioid overdose is suspected, stimulate the person by:

- Provide a "Sternal Rub": Vigorously rub knuckles up and down on victim's breastbone. This introduces a painful stimulus that will not cause damage to the person and helps assess whether the person is conscious or not.

### Step 2: Call 911

Call 911 and inform emergency personnel that someone is not breathing or is unresponsive.

### Step 3: Administer Naloxone

It's important to know that naloxone has no effects if opioids are not present. If unsure, air on the side of safety and administer naloxone.

*Intranasal Administration*

- Tilt the patient's head back
- Spray into one nostril until all the medication has been dispensed

### Step 4: Provide Rescue Breathing (if you are trained and feel comfortable doing so)

Rescue breathing can sustain someone until emergency personnel arrive:

- Clear the person's airway.
- Tilt the head to open the airway by lifting the neck or chin.
- Pinch the nose shut.
- Make a seal over the mouth with your mouth.
- Give 2 rescue breaths and continue one breath every 5 seconds.

### Step 5: Monitor the Person's Response

Most individuals respond by returning to spontaneous breathing. This generally occurs within 2-3 minutes of administering naloxone. If the person is not responding, give a second dose of naloxone and continue rescue breathing.

*After an Overdose Reversal:*

Once naloxone begins working, an individual may show signs of opioid withdrawal. These symptoms are uncomfortable, but not life threatening. After an overdose, a person should be monitored closely.

- Don't leave the person alone, as sedation may return.
- Wait for emergency personnel to arrive.
- If possible, encourage the person to refrain from using additional opioids as the naloxone can wear off and they can experience another overdose.
- Please encourage the person to seek medical attention.

Additional Resources for Responding to an Opioid Overdose

- National Harm Reduction Coalition: Responding to Opioid Overdose
- CDC The National Institute for Occupational Safety and Health (NIOSH): Responding to a Suspected Opioid Overdose