TUOLUMNE COUNTY BEHAVIORAL HEALTH DEPARTMENT

Clinical Practice Guidelines

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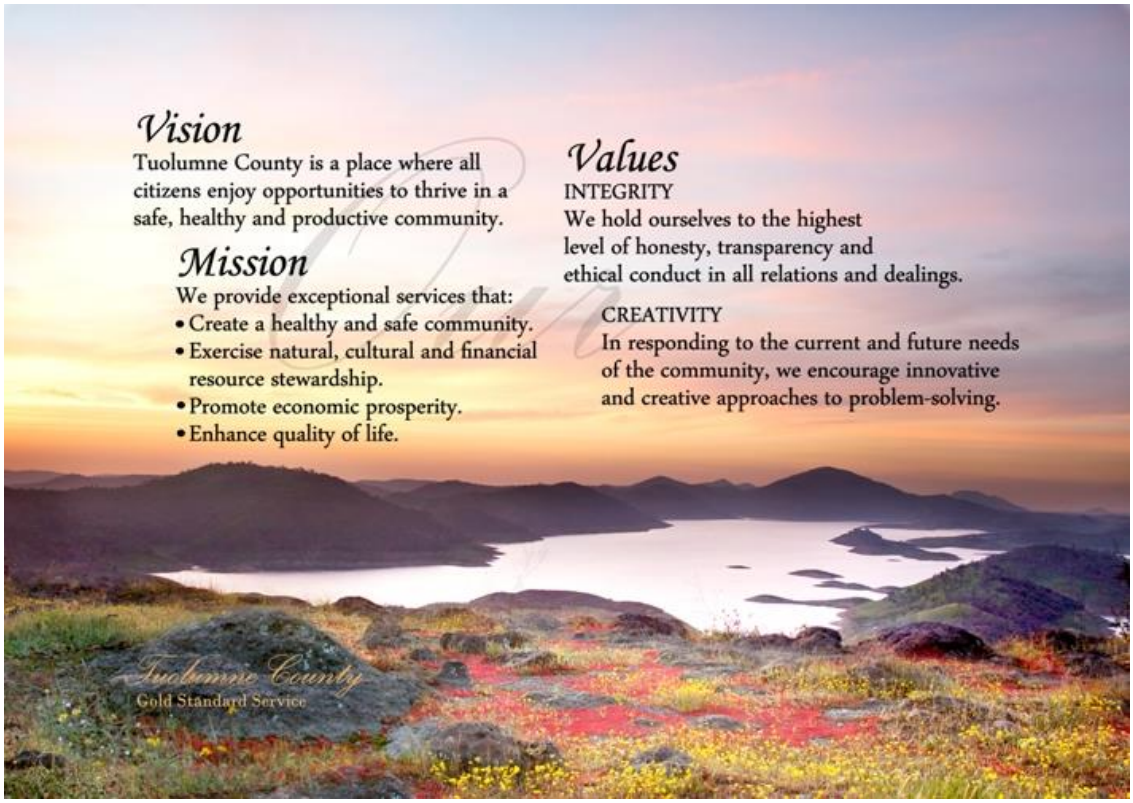
Tuolumne County Vision



Health and Human Services Agency Mission, Vision, and Values

Our mission is to support and empower our community by providing quality health and human services.

Our vision is Tuolumne County is a resilient, inclusive, and thriving community.

Our values are adaptability, integrity, commitment, kindness, excellence, and teamwork.

Tuolumne County Behavioral Health Mission

Our mission is to provide respectful, culturally sensitive and strength based behavioral health services which provide wellness, self-sufficiency and recovery from mental illness and/or addiction**.**

Integration of Behavioral Health Services

Tuolumne County Behavioral Health has an integrated administration of specialty mental health and substance use recovery services. This includes a combined electronic health record, a single screening for both Substance Use Disorder Services (SUD) and Specialty Mental Health Services (SMHS), a comprehensive adult intake and children's intake that address both mental health and substance use treatment issues, and treatment teams that include representatives from both SUDS and SMHS on every delivery team.

Culturally Sensitive Service Delivery

Tuolumne County Behavioral Health is committed to providing culturally sensitive services for our beneficiaries in all delivery of clinical services.

Tuolumne County Behavioral Health Programs

Crisis Assessment and Intervention Program (CAIP)

The Crisis Assessment and Intervention Program (CAIP) offers a compassionate response and support services 7 days a week/24-hours a day. Many crisis situations that result in hospitalization and placement out-of-county may have been prevented by talking or meeting with trained counselors or therapists prior to an emergency situation.

People are encouraged to call 209-533-7000 or come in to CAIP when they feel they are struggling emotionally. Brief solution-focused services will be provided to help avoid a crisis or resolve the current issue at any time. An assessment will also be provided for eligibility of ongoing behavioral health services. Medications will not be prescribed or offered during this service.

In partnership with Adventist Health Sonora, law enforcement, and other social service agencies, crisis assessment is provided for inpatient psychiatric services when needed. If a person is determined to be a danger to themselves, or someone else, or unable to meet their basic needs due to a mental disorder, admission to a psychiatric hospital will be arranged.

Full Service Partnership

Full Service Partnership (FSP) is an intensive service program for Behavioral Health consumers experiencing and/or at risk of institutionalization, homelessness, incarceration, or psychiatric inpatient services. FSP services may also support a consumer as they transition to a lower level of care.

Each FSP enrolled consumer participates in the development of an Individual Services and Support Plan (ISSP) that is focused on the consumer's wellness and recovery goals. The treatment team is available at times or in conjunction with the crisis team to provide crisis services to the client.

Together, the consumer and treatment team determine the type and frequency of services provided based on the client's recovery goals. Services provided are unique to each individual consumer, because of this not all persons will require all the services listed.

The following mental health and supportive services are examples of potential services that consumers might receive if participating in FSP:

- Counseling, psychotherapy, and case management
- Field-based services
- Peer and family support services
- 24/7 Crisis assessment services
- Self-help and peer support groups
- Independent living skills training
- Social / recreational skills training
- Pre-vocational services
- Accessing educational programs
- Learning transportation services

- Assistance in finding a place to live or in remaining in one's home
- Access to physical health care
- Establishing benefits for qualified individuals
- Financial management training
- Substance recovery services

Outpatient Services

TCBH provides Specialty Mental Health outpatient services to beneficiaries of all ages at the clinic in Tuolumne County. Services are also provided in the field by our providers at schools, in the community, in the home and within residential placements as needed to serve beneficiary needs. The TCBH clinic is staffed with a multi-disciplinary team that provides a wide array of evidence-based services designed to treat severe symptoms of mental illness. TCBH provides the following outpatient services:

- Individual and group therapy;
- Individual and group rehabilitation;
- Medication Support Services;
- Day Treatment Intensive;
- Day Rehabilitation;
- Crisis Intervention;
- Crisis Stabilization;
- Mobile Crisis Benefit;
- Adult Residential Treatment Services;
- Crisis Residential Treatment Services;
- Psychiatric Health Facility Services;
- Intensive Care Coordination (for beneficiaries under the age of 21);
- Intensive Home Based Services (for beneficiaries under the age of 21);
- Therapeutic Behavioral Services (for beneficiaries under the age of 21 who qualify);
- Therapeutic Foster Care (for beneficiaries under the age of 21);
- Psychiatric Inpatient Hospital Services;
- Targeted Case Management;
- Other Mental Health Services; and
- For beneficiaries under the age of 21, medically necessary Specialty Mental Health Services required under EPSDT requirements.

Documentation Standards

Documentation standards for beneficiary care meet the minimum standards to support claims for the delivery of specialty mental health services and shall be addressed within the beneficiary record. Documentation standards ensure that documentation requirements for all SMHS and DMC services are met when documenting client service encounters in accordance with Department of Health Care Services (DHCS) standards.

Specialty Mental Health Services

Medi-Cal beneficiaries with serious mental illness are eligible to receives Specialty Mental Health Services (SMHS). SMHS assist beneficiaries with serious mental illness in symptom reduction and development of coping, resiliency, and recovery skills to improve overall functioning in daily life.

These services are monitored to ensure ongoing adequate services for the anticipated number of beneficiaries that are and will be served by the MHP (9 CCR § 1810.310 (a)(5)(A)). TCBH maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries that will be served

by the TCBH. TCBH delivers age-appropriate services to beneficiaries. It is ensured that TCBH will have these by ongoing monitoring.

Each quarter a full monitoring of age, services delivered, and anticipated penetration rates are reviewed. Quality Improvement completes ongoing data collection for quarterly reports which are presented to the Quality Management Committee. This committee is comprised of both Clinical Supervisors, Administration, management and line staff and our Ethnic Services Coordinator. If there is a needed change to shift because of ongoing monitoring the Quality Management Committee will identify the needed changes to ensure that the anticipated number of beneficiaries that are and will be served by the MHP, TCBH maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries, and age-appropriate services are being delivered. In addition, a secondary monitoring is done daily through the Case Administration Team. This team reviews all assessments and annual assessments to ensure provider capacity and adequate authorization of services.

TCBH provides an array of services as follows:

- Outpatient Services
- Psychiatric Inpatient Hospital Services
- State Hospital
- Crisis Assessments
- Mobile Triage Response
- Full Service Partnership
- Early Periodic Screening Diagnosis Treatment
- Therapeutic Behavioral Services

Substance Use Disorder Services

Substance Use Disorder (SUD) is a disease that affects a person's brain and behavior which can lead to an inability to control the use of a legal or illegal drug or medication. Substances such as alcohol, prescription medications, marijuana and nicotine are also considered drugs. When you are addicted, you may continue the drug despite the harm it causes.

With SUD treatment, a person can recover from the active use of substances. Recovery is a process of change through which people can improve their health and wellness, live a self-directed life and reach their full potential. Even people with severe and chronic substance use disorders can, with help, overcome their illness and regain health and social function. Being "in recovery" is when those positive changes and values become part of a new healthy and worthwhile lifestyle.

SUD services offered by TCBH:

- Substance Use Disorder Treatment:

  Individual, group and family treatment for persons with a substance abuse or addiction problem.

- Dual Diagnosis Treatment:

  Counseling for clients who have alcohol and/or drug problems in addition to a mental health disorder.

- Perinatal Treatment Program:

  Specialized alcohol and drug treatment for pregnant and/or parenting women. Priority

will be given to pregnant women who are intravenous substance users.

- Adolescent Youth Treatment (AYT):

  Early intervention for youth and teens using alcohol and/or drugs through individual and family counseling for ages 12 to 25.

- Residential Preauthorized Services:

  Youth and Adults Services are available. Short-term residential services are determined by medical necessity and include group counseling, patient education, individual counseling, crisis assistance and case management.

Beneficiary Education

Beneficiary Handbook

The handbook explains client benefits and how they can get care, including:

- How to access specialty mental health services
- What benefits clients have access to
- What to do if there is a question or problem
- Clients' rights and responsibilities as a Medi-Cal beneficiary

Clinical Services

Access and Screening Services

A beneficiary referred for services will participate in a screening assessment to determine Medi-Cal eligibility. Individuals who do not meet the Medi-Cal requirements for treatment, will be provided with referrals. Beneficiaries who meet Medi-Cal requirements for SMHS will be given an appointment for an assessment. Once assessed, the beneficiary will be referred to the appropriate level of care (LOC). Staff performing screening and assessment may refer beneficiaries directly to any network provider. The screening will be completed by licensed staff, which may include Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselors (LPCC), Licensed Marriage and Family Therapist (LMFT) and licensed-eligible staff working under the supervision of licensed clinicians. Once the beneficiary has completed the initial assessment process, the beneficiary will be offered an intake appointment.

Assessment: Comprehensive Behavioral Health Assessment

- Comprehensive Behavioral Health Assessment for Adults
- Comprehensive Behavioral Health Assessment for Children
- Performed to identify Medical Necessity:
- Included Problem Statement and DSM-V Diagnosis
- Functional Impairment in Major Life Areas
- Interventions that are consistent with the diagnosis
- Initial assessments build the foundation required to develop the Plan of Care, due 60 days from intake date.

Crisis Services

Crisis Services are provided for a condition that requires a timelier response than a regular visit and are targeted to the acuity of the symptoms or the risk of harm to self or others. Crisis

services are provided 24/7.

Mobile Crisis Services

Community-based mobile crisis intervention services provide rapid response, individual assessment and community-based stabilization for Medi-Cal beneficiaries who are experiencing a mental health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques that reduce the immediate risk and subsequent harm and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

Mobile crisis services include warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care. Mobile crisis services are directed toward the beneficiary in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the beneficiary in addressing their behavioral health crisis and restore the beneficiary to the highest possible functional level. For children and youth, in particular, mobile crisis teams shall work extensively with parents, caretakers and guardians, as appropriate, and in a manner that is consistent with all federal and state laws related to minor consent, privacy and confidentiality.

Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the beneficiary a behavioral health crisis. Locations may include, but are not limited to the beneficiary's home, school or workplace, on the street, or where a beneficiary socializes. Mobile crisis services cannot be provided in hospitals or other facility settings. Mobile crisis services shall be available to beneficiaries experiencing behavioral health crises 24 hours per day, seven days per week, 365 days per year.

Collateral Services

A service activity to a significant support person or persons in a beneficiary's life for the purpose of providing support to the beneficiary in achieving client plan goals. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the beneficiary in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the beneficiary; and family counseling with the significant support person(s) to improve the functioning of the beneficiary. The beneficiary may or may not be present for this service activity. Effective with the transition to CalAIM claiming on 7/1/2023, collateral services cannot be claimed as a stand-alone service. Claiming for collateral contacts will be dependent on the provision of a covered service. A collateral claim must be submitted together with the claim for the covered service, or it will be denied. Counties can claim for collateral-type services and are advised to identify codes that best describe the activity performed by the non-clinical staff when billing for those services. HCPCS codes that that

may be used for collateral- type contacts are available in every category except Therapy.

Plan of Care

Plans of Care (POC) are client-centered and collaborative. They are in place within sixty days of a mental health treatment admission which reflects Medical Necessity. The POC will be updated throughout treatment as appropriate. To ensure client services delivered have specific, observable or quantifiable treatment goals which support the proposed type(s) of intervention(s), are consistent with the client goal(s), and are consistent with the diagnosis. The Plan of Care is to ensure the client's involvement in planning their own care with their personal goals documented.

Individual Therapy

Interventions must be consistent with the diagnosis, and there must be the expectation that the intervention will either significantly diminish the impairment or prevent significant deterioration.

- Tie service to the identified symptoms on the POC
- Include specific interventions used
- Document focus on symptom reduction
- Document consumer's response to your intervention
- Document Plan for continued service or discharge

Group Therapy

2 or more identified clients must be present to be considered a group.
Interventions must be consistent with the Problem List and diagnosis, and there must be the expectation that the intervention will either significantly diminish the impairment or prevent significant deterioration identified in Problem List or POC.

- Tie service to the identified symptoms on the Problem List or POC
- Include specific interventions used
- Document focus on symptom reduction
- Document consumer's response to your intervention
- Document Plan for continued service or discharge

Individual Rehabilitation Services

Assistance to improve, maintain or restore:

- Functional Skills
- Daily Living Skills
- Support Resources
- Meal Preparation Skills
- Social and Leisure Skills

Supports:

- Advised
- Suggested
- Offered
- Discussed
- Talked about
- Problem-solved
- Encouraged Modeled
- Role played
- Provided training
- Assisted
- Empowered
- Educated
- Provided Skills

Tie service to the identified behaviors or symptoms on the POC

- Describe how you intervened and assisted consumer deal with his/her MH symptoms or behaviors
- Document consumer's response to your intervention
- Document the plan for continued services.

Group Rehabilitation Services

2 or more identified clients must be present to be considered a group.

Assistance to improve, maintain or restore:

- Functional Skills
- Daily Living Skills
- Support Resources
- Meal Preparation Skills
- Social and Leisure Skills
- Medication Education

Supportive Counseling:

- Advised
- Suggested
- Offered
- Discussed
- Talked about
- Problem-solved
- Encouraged Modeled
- Role played
- Provided training
- Assisted
- Provided support
- Helped
- Empowered
- Educated/Taught
- Provided Skills
- Training

The service needs to be tied to the identified behaviors or symptoms on the Problem-List or POC. Describe how you intervened and assisted consumer deal with his/her MH symptoms or behaviors. Document consumer's response to your intervention and the plan for continued services.

Peer Support Services

Peer support services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, 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. 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 condition and the process of recovery.

Peer support services may be provided face-to-face, by telephone or by telehealth with the beneficiary or significant support person(s) and may be provided anywhere in the community. Peer support services are based on an approved plan of care. This service includes one or more of the following service components:

- Therapeutic Activity: A structured non-clinical activity provided by a certified Peer Support Specialist 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 beneficiary and others providing care or support to the beneficiary, family members, or significant support persons.

- Engagement: Peer Support Specialist led activities and coaching 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.

- Educational 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 should promote skill building for the beneficiary in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

- Collateral: A service activity to a significant support person or persons in a beneficiary's life for the purpose of providing support to the beneficiary. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the beneficiary in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the beneficiary; and family counseling with the significant support person(s) to improve the functioning of the beneficiary. The beneficiary must be present for this service activity.

Peer support services may be provided by a Peer Support Specialist.

Targeted Case Management

Activities to access needed medical, educational, social prevocational, vocational, rehabilitative or other community services

- Tie service to the identified symptoms on the Problem List or POC
- Use a verb that describes the Case Management activity: Linked, Monitored, Consulted, Advocated, Connected, Referred, Brokered and Coordinated
- Comment on consumer functioning in one of the following spheres: living arrangement, social support, health, daily activities
- Planning discharge for when moving to a higher/lower level of care can be used if coordination of resources is included when discharging to client home.

Prior to the last 24 hours of the hospitalization brokerage activities reported with this code must be accompanied by location "Z".
Within the last 24 hours of hospitalization discharge brokerage activities reported with this code must be accompanied by location code "Office".

Therapeutic Behavioral Services

Therapeutic Behavioral Services (TBS) are supplemental Specialty Mental Health Services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit as defined in California Code of Regulations section 1810.215. TBS are intensive, one-to-one services designed to help beneficiaries and their parents/caregivers manage specific

behaviors using short-term measurable goals based on the beneficiary's needs. TBS are available to beneficiaries in accordance with the Department of Mental Health Information Notice 08-38, the TBS Coordination of Care Best Practices Manual, version 2 (October 2010), and the TBS Documentation Manual, version 2 (October 2009). A youth may be eligible for a TBS assessment if they:

- Have severe emotional problems.
- Live in a mental health placement or are at risk of placement; or
- Have been hospitalized recently for mental health problems or are at risk for psychiatric hospitalization.

If a client gets other mental health services and still feel very sad, nervous, or angry, they may be able to have a trained mental health coach help them. This person could help them when they have problems that might cause them to get mad, upset, or sad. This person would come to their home, group home or go with them on trips and activities in the community.

Medication Services

Psychotropic medications are used at the sole discretion of the treating psychiatrist who is providing psychiatric direction to the treatment of those patients in whom medical necessity has been established. The psychotropic medications will be used in accordance with the established standard of care set forth by the American Psychiatric Association (APA) guidelines and through the medication monitoring guidelines in the Quality Assurance Plan for this agency. Assignment to Medication Services will be through the formal assigning of cases, Case Administration Team. SAI and the medication staff will work with the treating psychiatrist to attend to refills, case manage as indicated by clinical changes, be part of the clinical interview of patients as they are seen through the clinic, and when appropriate, attend to other duties as agreed upon with the psychiatrist.

Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)

Intensive Care Coordination (ICC) is similar to Targeted Case Management (TCM) and includes components such as facilitating assessment, care planning and coordination of services, including urgent services for youth. ICC is delivered using a Child and Family Team and is intended for children or youth whose treatment requires cross-agency collaboration.

Intensive Home Based Services (IHBS) are individualized, strength-based interventions designed to better mental health conditions that interfere with a youth’s functioning. These interventions are aimed at helping the youth build skills for successful functioning in the home and community and improving the family’s ability to help the youth successfully function in the home and in the community.

Therapeutic Foster Care

Therapeutic Foster Care (TFC) is provided to all children and youth who meet the following criteria: (1) under the age of 21, (2) eligible for full scope Medi-Cal, and (3) meets medical necessity criteria for specialty mental health services. (California Code of Regulations, Title 9, Chapter 11, Section 1830.205 or Section 1830.210). Note that membership in the Katie A. subclass / Pathways to Wellbeing is not a prerequisite to receiving TFC. It is not necessary for a child or youth to have an open child welfare case, or be involved in juvenile probation, to be considered for TFC.

Additional Services

Day Rehabilitation

Day Rehabilitation is a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of beneficiaries and is available at least three hours and less than twenty–four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

- Process Groups: Staff facilitate these groups to help clients develop the skills necessary to deal with their individual problems/issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems. Process groups are based on the premise that much of human behavior and feeling involves the individual's adaptation and response to other people and that the group can assist individuals in making necessary changes by means of support, feedback and guidance. It is a process carried out by informally organized groups that seek change. Day rehabilitation may include psychotherapy instead of process groups or in addition to process groups.
- Skill Building Groups: Staff help clients to identify barriers/obstacles related to their psychiatric/psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.
- Adjunctive Therapies: Staff and clients participate in non-traditional therapy that utilizes self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able to utilize the modality to develop or enhance skills directed towards client plan goals.

Adult Residential Services

Adult Residential Treatment Services are rehabilitative services, provided in a non–institutional, residential setting, which provide a therapeutic community including a range of activities and services for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service is available 24 hours a day, seven days a week. Service activities may include assessment, plan development, therapy, rehabilitation and collateral.

Day Treatment Intensive Services

Day treatment intensive programs must include the skill building groups and adjunctive therapies required of day rehabilitation and must also include psychotherapy as described below. Day treatment intensive may include process groups in addition to psychotherapy.

- Psychotherapy: Psychotherapy means the use of psychosocial methods within a professional relationship to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation,

to modify internal and external conditions that affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy is provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

Crisis Residential Services

Crisis Residential Treatment Services are therapeutic or rehabilitative services provided in a non– institutional residential setting which provides a structured program for beneficiaries as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care. The service supports beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.

Non-Reimbursable Services

Guidelines about what are considered non-reimbursable services is as follows:

- Mental health services provided while a beneficiary (age 21-64) is in an Institute for Mental Disease (IMD) or Mental Health Rehabilitation Center (MHRC)
- Any service other than case management (placement services) when a beneficiary is in an acute inpatient psychiatric hospital or psychiatric health facility (PHF) setting to a lower or higher level-of-care (but not to home), or case management upon the day of discharge.
- Outpatient mental health services can be billed, only on the day of admission or day of discharge to the inpatient facility
- Any services during Day Treatment Intensive or Day Rehabilitation service hours; these services must be provided by staff outside of the Day Treatment staff to be reimbursable
- Preparing documents for court testimony
- Any documentation after client is deceased
- Academic or educational services (tutoring or helping with homework)
- Vocational services (helping someone find a job or teaching them how to work); pre-vocational services is permitted under rehabilitation
- Recreational or socialization activities (going to the zoo, taking a consumer to the movies)
- Transporting a client (unless part of another reimbursable activity)
- Language interpreting/translating only
- No service provided: missed visit; waiting for a “no-show;” documenting that a client missed an appointment; traveling to a sight and it is a “no-show”
- One-way communications (E-mails, appointment setting, leaving messages, etc.)
- Paperwork that is not directly related to a service provided (writing letters, CPS/APS reports, completing outcome measures)
- Supervision of staff

- Utilization management, peer review, or other quality improvement activities is coded as utilization review and not billable as direct services
- Services provided while a consumer is incarcerated in jail, prison or juvenile hall, unless the minor in juvenile hall has been adjudicated and is awaiting placement
- More than one staff member providing services to a consumer at the same time (check these exceptions: ICC, IHBS, CFT)
- Exception: group therapy with more than one provider; providers determine how time will be split, documented and billed

Clinical Supervision

Clinical supervision is a collaborative relationship between two clinical professionals; one having a greater degree of clinical knowledge and skill helping the other to enhance their professional competence and evidence informed practice to benefit clinical care to the beneficiaries being served. Supervision is a distinct professional competency that requires education and training. This practice guideline is intended to provide a framework to inform the development of supervisors, to encourage competent supervision, and to communicate to staff the agency's value in skilled service delivery.

Definition of Terms:

Clinical supervision is the process in which a supervisor supports a supervisee in the development of self-sustaining skills and competencies.

Supervisor is a departmentally designated staff member meeting educational and professional requirements, as set forth by their licensure board, who monitors, evaluates, mentors, and develops specific clinical competencies of the supervisee.

Supervisee is a clinical associate or pre-licensed volunteer/staff member who requires supervision to perform clinical activities per their professional licensure board, agency, and/or school regulations.

Rationale

It is essential for less experienced mental health clinicians and substance recovery counselors to be trained properly to ensure that their practice is effective. Supervision protects the individuals and families being served, supports practitioners, and ensures that professional standards and quality services are delivered by competent clinicians.

Supervision paves the way for greater accountability to the practice and professionalism, while keeping the needs of the individuals and families we serve central during the supervision period. Supervision is a gateway for new clinicians to provide quality care for clients while having regular access to a more experienced clinician's expertise and experiences. The availability of supportive supervision is a valuable resource to supervisees and should be considered a necessity for maintaining high standards of service.

In addition, supervision is particularly important when working in high acuity settings with crisis services, serving people with severe mental illnesses, and with traumatized individuals.

Supervision has been consistently recommended as a means of support and self-care for the therapist, with the aim of preventing secondary trauma. Clinical supervision can aid in mitigating vicarious trauma responses in the supervisee when the supervisor brings awareness to the effects of working with trauma. Trauma-informed supervision combines knowledge about trauma and supervision and focuses on the characteristics of the interrelationship between the trauma, the practitioner, the helping relationship, and the context in which the work is offered.

Supervision can be a mutually beneficial process for all parties: the supervisor, the supervisee, and the individuals and families served. This will be achieved when there is application of ethical principles by both supervisor and supervisee. It is important that a positive learning environment is maintained during the supervision process that will maximize benefits for all concerned.

Federal and state laws supersede these Clinical Practice Guidelines. The supervisor and supervisee should familiarize themselves with and adhere to all Board of Behavioral Sciences (BBS), California Board of Psychology (BOP), and Substance Recovery Counselor (AOD) certification boards' regulations for clinical supervision. This practice guideline is to be used in conjunction with existing laws, regulations, policies, and procedures.

Common Elements for Clinician Supervision

Supervisor Competence

Supervisors are expected to stay current in clinical, legal and ethical knowledge and skills in order to provide supervisees with the knowledge and skills necessary to gain self-competence. Supervisors are expected to familiarize themselves with and adhere to all Board of Behavioral Sciences (BBS), California Board of Psychology (BOP), or AOD Counselor certification boards' regulations for clinical supervisors, whichever applies to the supervisory relationship. This includes ensuring that all requirements are met for the provision of clinical supervision. Supervisors are to provide proof of completion of supervision requirements (i.e., training certificates, current license) to the Director and Deputy Director of Clinical Services.

Supervisors are expected to have knowledge of various theoretical orientations, evidence-based practices, cultural considerations, clinical specialty areas specific to the population the supervisee is serving, and relevant events that may impact the individuals and families being served. If a supervisee is working with a specific population, the supervisor should do his/her best to ensure they have specialized experience in the communities and/or specialty areas the supervisee is serving. Competency in these areas should be obtained and maintained through education, training, and work experience. Supervisors are to be actively involved in ongoing professional development to ensure adherence to recommended best practices pertaining to the provision of clinical supervision.

Supervisors must be prepared to handle and have experience with a wide range of clinical problems and populations. Supervisors are also encouraged to participate in regular consultation with other clinical supervisors to discuss and problem-solve issues that arise during clinical supervision and to continue to develop their skill set in facilitating clinical

supervision.

Supervisory Relationship

A quality supervisory relationship is built on trust, confidentiality, support, and empathic experiences. Building a collaborative relationship is one of the key elements. This type of relationship can be built through collaborative discussions of expectations, goals, and tasks of supervision. As supervisors initiate and engage the supervisee in these discussions, supervisors should acknowledge differences such as, values, culture, and biases. Discussion of the power differential inherent in the supervisory relationship also helps to build a collaborative relationship. This type of discussion may be initiated by the supervisor verbally acknowledging the inherent power differential.

In order to maintain an effective supervisory relationship, supervisors should consistently demonstrate respect toward a supervisee and model clear and consistent boundaries. Additionally, supervisors are encouraged to find opportunities to guide the supervisee to develop and implement self-care. In kind, supervisors should have an established practice for self-care.

Supervision Contract

Supervisors should establish a written agreement, or Supervision Contract, with the supervisee at the onset of the supervisory relationship. The Supervision Contract may include:

- Responsibilities and expectations of both parties and of that of the Director or the Deputy Director of Clinical Services or Head of Service
- Program goals
- Supervision structure, including frequency and duration
- Limits of supervision responsibility
- Learning objectives
- Measurable goals that are mutually agreed upon
- Specific guidelines to evaluate the supervisee's performance

As the supervisee clinically and professionally progresses, the agreement may need to be updated to reflect new goals, responsibilities, and learning objectives.

Professionalism

Supervisors are expected to model professionalism and exemplary behavior. They are considered to be role models and should be mindful of their role and status as a supervisor. As supervisees grow professionally, they look to their supervisors for standards of how to act with peers, superiors, and individuals and families they serve. Supervisors should strive to model characteristics and interpersonal skills that are essential to the profession such as collaboration, objectivity, honesty, respectful interactions, straightforward communication, and openness to feedback.

Supervisors should be objective when handling any situations that may arise. This includes avoiding any possible dual/multiple relationships with the supervisee in which a possible conflict of interest may arise. All conflicts should be addressed in an open, honest, and explicit manner as soon as possible. Approaching conflict in this way promotes prompt conflict resolution and can aid in minimizing the impact on the supervisory relationship. The Clinical Supervisor should work with any task supervisors or Program Managers who the

supervisee is assigned in order to coordinate quality care to clients.

Frequency and Duration of Supervision

For most supervisees, they should attend weekly clinical supervision with the Supervisor for an hour length, and for all associates, they should attend group supervision for two hours weekly. In addition to regularly scheduled clinical supervision, supervisors should be accessible and provide a timely response to clinical supervision requests from the supervisee (e.g., crisis situations, consultations on child or elder/dependent adult abuse reporting). The supervisor should make coverage plans with the supervisee when the supervisor is absent or otherwise unavailable.

To enhance learning and increase the effectiveness of supervision, a systematic procedure for ongoing supervisory feedback is necessary. Assessment, evaluation, and feedback are key to the supervisory process. Supervisors are expected to give feedback regularly to supervisees in a way that encourages professional growth. A supervisor's reflection on how their supervisees progress compared to their peers is essential to determining what skills still need to be developed.

Evaluation and consistent notes/record keeping and systematic, routine feedback in the form of written communication should be provided. The supervisor may review the effectiveness of supervision regularly by keeping records and documentation. Feedback can be provided in person or remotely through electronic means of communication. An example of how feedback can be provided is through a logbook which records meeting dates, points discussed, and agreed upon action items. Significant and/or ongoing issues or concerns observed by the clinical supervisor should be brought to the attention of the administrative supervisor who the clinical supervisor directly reports to.

For pre-graduate interns, the university usually provides a weekly sign-off sheet and an online portal to record the number of hours, as well as initial goal-setting and final evaluations. For associates with the BBS, they typically have an initial agreement that must be signed by the supervisor prior to starting clinical services. Supervisees should maintain a record of supervision and remain current about their licensing or certifying board's requirements for clinical supervision.

Ethical Considerations/Confidentiality

Ethical considerations are always included in supervision guidelines. Ethical standards should be considered shared responsibilities. The supervisor and supervisee need to be aware of their responsibility to promote the collective well-being of the people they serve.

The supervisor has a primary, professional duty to monitor and to manage risk of emotional and/or physical harm to the individuals and families served, the supervisee, or to others that may arise within the sphere of supervisory responsibility. This includes identifying incompetent or unethical practice and taking appropriate steps to properly address the errors of the supervisee.

Supervisees are expected to disclose their supervisory relationship to the individuals and families they serve and explain that ongoing consultation with the supervisor will occur.

The supervisor should handle supervisory material in a confidential manner. This may include privacy of the supervisee, for instance, when personal disclosures are made by the supervisee. Boundaries/parameters also need to be considered in order not to compromise the supervisory relationship. At all times, the supervisor should be aware of their status and not abuse their position.

Board of Behavioral Sciences (BBS) Requirements

The supervisor must meet the following BBS requirements to provide clinical supervision:

- All clinical supervisors must be licensed as an LPCC, LCSW, LMFT, Licensed Clinical Psychologist, or Licensed Physician or Surgeon certified in Psychiatry by the American Board of Psychiatry and Neurology.
- The Supervisor's license cannot be under suspension or probation.
- Have been licensed in CA or any other state for at least two (2) years out of the last five (5) years prior to the commencement of supervision.
- Have practiced psychotherapy during at least two (2) years out of the last five (5) years prior to the commencement of supervision OR provided direct supervision to ASWs, APCCs, AMFTs who perform psychotherapy during at least two (2) years out of the last five (5) years prior to the commencement of supervision.
- Completed a minimum of 15 hours of supervision training that meets the course provider and course content requirements specified in regulation within 60 days of the commencement of supervision, Licensed Clinical Psychologists and Psychiatrists are exempt from this requirement. Six (6) hours of continuing professional development in supervision is required each renewal cycle thereafter.
- Sign and comply with all required supervision-related forms:
    - Self-Assessment Report in order to inform the Board they are supervising, and to self-certify they meet all qualifications to supervise.
    - BBS Supervision Agreement prior to commencement of supervision.
    - Weekly Log is required to be completed by a supervisor with a supervisee pursuing an LCSW beginning January 1, 2022.
    - New Supervision Agreement within 60 days of a change in supervisor.
- TCBH requires the following of staff seeking to be Clinical Supervisors:
- Meet performance standards, and
- Obtain approval from Deputy Director of Clinical Services.
- The following actions are required of Clinical Supervisors:
- Ensure a supervision agreement has been completed and the supervisee understands all terms and conditions thereof;
- Ensure a supervisee is receiving the correct ratio of supervision to direct contact hours: one unit of supervision for up to 10 client contact hours provided by Associates, with an additional unit of supervision in each week with more than 10 client contact hours. One unit of supervision equals one hour of individual/triadic or two hours of group.

- Self-monitor for and address supervision dynamics such as, but not limited to, countertransference, intrapsychic, interpersonal, or trauma related issues that may affect supervision;
- Notify the supervisee of any disciplinary action, including revocation or suspension, even if stayed, probation terms, inactive license status, or any lapse in licensure that affects the supervisor's ability or right to practice or supervise;
- Ensure the possession of sufficient experience, training, and education in the area of clinical supervision to competently supervise associates;
- Persons licensed by BBS who provide supervision shall complete the minimum supervision training or coursework specified in section (as described above);
- When it becomes necessary for a supervisee to obtain supervision temporarily from a substitute supervisor, a supervision agreement will be signed, and the substitute supervisor shall meet all supervisor qualifications required by BBS. Substitute supervision that will exceed 30 days consecutive calendar days will require a new supervision plan;
- An ASW is required a minimum of 104 weeks of supervision, 13 weeks of which (individual and/or triadic), must be supervised by a LCSW. In addition, a minimum of 1700 of the total licensure hours must be supervised by an LCSW.

Guide to Regulatory Board and Association Websites

- American Association for Marriage and Family Therapy (AAMFT): https://www.aamft.org/iMIS15/AAMFT
- American Psychological Association (APA): http://www.apa.org/
- Association of Social Work Boards (ASWB): https://www.aswb.org/
- Board of Behavioral Health Sciences (BBS): http://www.bbs.ca.gov/
- California Association for Licensed Professional Clinical Counselors (CALPCC): http://www.calpcc.org
- California Association of DUI Treatment Programs (CADTP): http://www.cadtp.org/
- California Association of Marriage and Family Therapists (CAMFT): https://www.camft.org/
- California Board of Psychology (BOP): http://www.psychology.ca.gov/
- California Consortium of Addiction Programs and Professionals (CCAPP): https://www.ccapp.us/
- National Association of Social Workers (NASW): https://www.socialworkers.org/

Internship / Practicum Program

The Internship Program at TCBH provides clinical training and experience working with severely mentally ill adults or children. The internship is a volunteer, unpaid position. All internships require a placement agreement between the student's college or university and TCBH. Clinical supervision is provided by a licensed supervisor in weekly individual sessions. A task supervisor is assigned in the unit where the intern works. TCBH provides the same orientation and training to interns as employed staff, including extensive training in the Electronic Health Record and documentation practices. The clinical tasks are assigned in conjunction with the program the intern is working in. The given tasks depend upon the level

of education and training the student has completed in their graduate program. Some internship tasks include:

- Individual therapy
- Group therapy (co-lead)
- Initial or annual assessments
- Individual rehabilitation
- Collateral sessions with parents of child clients
- Outreach and engagement
- Case management
- Crisis Intervention

Documentation Practices

Assessment

Once the screening tool has been administered, a person seeking care may receive a referral for an assessment by a clinician (LPHA). The Comprehensive Assessment for Adults and the Comprehensive Assessment for Children use a standard assessment format as outlined by DHCS that includes seven domains that are discussed below. Additional assessments may also be done based on the age of the individual seeking care and/or current treatment needs. During an assessment, a clinician develops a clinical understanding regarding the person's care needs, determines an accurate diagnosis, confirms the appropriate treating system, and what services are medically necessary to support the person in their goals so they can thrive in their community. Because human beings are complex, an assessment may take more than one session to fully determine the overall care needs. For some individuals completing an assessment may include
collecting information from collateral sources including, but not limited to, family members and other natural support persons, prior service providers and/or external system partners. While the assessment is in process, the person in care may simultaneously receive additional clinically appropriate treatment services such as therapy, rehabilitation, case management, medication support, etc.).

Many different tools or tests are available to assess different aspects of a person's functioning, such as tools to assess trauma, depression, suicide risk, and mental status. While the use of tools is often left to the discretion of the assessing practitioner, it is the practitioner's responsibility to use the tool for its intended purpose and to have the appropriate training for administration and scoring of the tool. Note that some tools must be completed by clinicians, while others may be completed by other types of staff, including Mental Health Rehabilitative Specialists (MHRS) or other qualified staff. Information or results from the tools utilized should be included as part of the assessment. While all persons shall receive a mental health assessment to best determine their individual treatment needs, there are different assessments to meet this requirement, based on age and type of service being sought.

Central to the completion of a comprehensive assessment is collaboration with the person in care. Centering the voice of the person in care and remaining curious and humble about the person's experiences, culture and needs during the assessment process is crucial to building

this collaboration. When assessments are conducted in this manner, they function as an important intervention and relationship building opportunity. Focusing on strengths, culture, and resiliency, in addition to challenges, creates a setting where the person in care feels seen as a whole person. Assessments must be approached with the knowledge that one's own perspective is full of assumptions, so that one can maintain an open mind and respectful stance towards the person in care. Curiosity and reflection indicate humility and a deep desire to truly understand the person in care and to help them meet their needs. A key outcome of the assessment process is the generation of shared agreement on the strengths and needs of the person in care, as well as how to best address those needs. The assessment process generates a hypothesis, developed in collaboration with the person in care, that helps to organize and clarify service planning (Clinical Documentation Guide, 2023, CalMHSA).

Required Assessment Elements

The assessment contains universally required domains that should not vary from MHP to MHP or CBO to CBO. Below is information on the standardized domains comprising the assessment for understanding the person's care needs. While each of the domains are required and must be addressed, information may overlap across domains. When conducting an assessment, it is important to keep in mind the flow of information and avoid duplication to ensure a clear and ideally chronological account of the person's current and historical need is accurately documented. Include the perspective of the person in care and, whenever possible, use their quotes within the document.

Below are the domain categories, key elements, and guidance on information to consider under each domain. The information in the outline below is not meant to be an exhaustive list. The practitioner should always consider the person within the context of their developmental growth and their larger community, including cultural norms or expectations when completing and documenting an assessment. Information within the assessment should come from the person seeking care, in their own words whenever possible. Particularly for children/youth and those with disabling impairments, this may also include information from collateral sources.

Domain 1: Presenting Problem/Chief Complaint

Domain 1 focuses on the main reason the person is seeking care, in their own words if appropriate. The goal is to document an account of what led up to seeking care. This domain addresses both their current and historical states related to the chief complaint.

- Presenting Problem (Current and History of) – The person's and collateral sources' descriptions of problem(s), history of the presenting problem(s), impact of problem on person in care. Descriptions should include, when possible, the duration, severity, context and cultural understanding of the chief complaint and its impact.
- Current Mental Status Exam – The person's mental state at the time of the assessment.
- Impairments in Functioning – The person and collateral sources identify the impact/ impairment — level of distress, disability, or dysfunction in one or more important areas of life functioning as well as protective factors related to functioning. Functioning

should be considered in a variety of settings, including at home, in the community, at school, at work and with friends or family.

Domain 2: Trauma

Domain 2 involves information on traumatic incidents, the reactions of the person in care to trauma exposures and the impact of trauma on the presenting problem. It is important that traumatic experiences are acknowledged and integrated into the narrative. Take your cues from the person in care — it is not necessary in every setting to document the details of traumatic incidents in depth.

- Trauma Exposures – A description of psychological, emotional responses and symptoms to one or more life events that are deeply distressing or disturbing. This can include stressors due to significant life events (being unhoused or insufficiently housed, justice involvement, involvement with child welfare system, loss, etc.)
- Trauma Reactions – The person's reaction to stressful situations (i.e., avoidance of feelings, irritability, interpersonal problems, etc.) and/or information on the impact of trauma exposure/history to well-being, developmental progression and/or risk behaviors.
- Trauma Screening – The results of the trauma screening tool to be approved by DHCS (e.g., Adverse Childhood Experiences {ACEs}), indicating elevated risk for development of a mental health condition.
- Systems Involvement – The person's experience with homelessness, juvenile justice involvement, or involvement in the child welfare system.

Domain 3: Behavioral Health History

Domain 3 focuses on the person in care's history of behavioral health needs and the interventions that have been received to address those needs. Domain 3 also includes a review of substance use/abuse to identify co-occurring conditions and/or the impact of substance use/abuse on the presenting problem.

- Mental Health History – Review of acute or chronic conditions not earlier described. Mental health conditions previously diagnosed or suspected should be included.
- Substance Use/Abuse – Review of past/present use of substances, including type, method, and frequency of use. Substance use conditions previously diagnosed or suspected should be included.
- Previous Services – Review of previous treatment received for mental health and/or substance abuse concerns, including providers, therapeutic modality (e.g., medications, therapy, rehabilitation, hospitalizations, crisis services, substance abuse groups, detox programs, Medication for Addiction Treatment [MAT]), length of treatment, and efficacy/response to interventions.)

Domain 4: Medical History and Medications

Domain 4 integrates medical and medication items into the psychosocial assessment. The intersection of behavioral health needs, physical health conditions, developmental history, and medication usage provides an important context for understanding the needs of the people we serve.

- Physical Health Conditions – Relevant current or past medical conditions, including the treatment history of those conditions. Information on help seeking for physical health treatment should be included. Information on allergies, including those to medications, should be clearly and prominently noted.

- Medications – Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. When available, the start and end dates or approximate time frames for medication should be included.

- Developmental History – Prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for individuals 21 years old or younger).

Domain 5: Psychosocial Factors

Domain 5 supports clinicians in understanding the environment in which the person in care is functioning. This environment can be on the micro-level (e.g., family) and on the macro-level (e.g., systemic racism and broad cultural factors).

- Family – Family history, current family involvement, significant life events within family (e.g., loss, divorce, births)
- Social and Life Circumstances – Current living situation, daily activities, social supports/ networks, legal/ justice involvement, military history, community engagement, description of how the person interacts with others and in relationship with the larger social community.
- Cultural Considerations – Cultural factors, linguistic factors, Lesbian, Gay, Bisexual, Transgender, Queer/ Questioning and other (LGBTQ+) and/or Black, Indigenous and People of Color (BIPOC) identities, gender identifications, spirituality and/or religious beliefs, values, and practices

Domain 6: Strengths, Risk and Protective Factors

Domain 6 explores areas of risk for the individuals we serve, but also the protective factors and strengths that are an equally important part of the clinical picture. Clinicians should explore specific strengths and protective factors and understand how these strengths mitigate risks that the individual is experiencing.

- Strengths and Protective Factors – Personal motivations, desires and drives, hobbies and interests, positive savoring and coping skills, availability of resources, opportunities and supports, interpersonal relationships.
- Risk Factors and Behaviors – Behaviors that put the person in care at risk for danger to themselves or others, including suicidal ideation/planning/intent, homicidal ideation/ planning/intent, aggression, inability to care for self, recklessness, etc. Include triggers or situations that may result in risk behaviors. Include history of previous attempts, family history of or involvement in risks, context for risk behaviors (e.g., loneliness, gang affiliations, psychosis, drug use/abuse), willingness to seek/obtain help. May include specific risk

screening/assessment tools (e.g., Columbia Suicide Severity Rating Scale) and the results of such tools used.

- Safety Planning – Specific safety plans to be used should risk behaviors arise, including actions to take and trusted individuals to call during crisis.

Domain 7: Clinical Summary and Treatment Recommendations

Domain 7 provides clinicians an opportunity to clearly articulate a working theory about how the person in care's presenting challenges are informed by the other areas explored in the assessment and how treatment should proceed based on this hypothesis.

- Clinical Impression – Summary of clinical symptoms supporting diagnosis, functional impairments (clearly connected to symptoms/presenting problem), history, mental status exam, cultural factors, strengths/ protective factors, risks, and any hypothesis regarding predisposing, precipitating and/or perpetuating factors to inform the problem list (to be explained further below)
- Diagnostic Impression – Clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified diagnoses)
- Treatment Recommendations – Recommendations for detailed and specific interventions and service types based on clinical impression and overall goals for care

Progress Notes

Progress notes have multiple functions. First and foremost, progress notes are used to document the treatment that has occurred (the intervention), and the intended next steps (the plan). Progress notes can also serve as communication tools to alert other practitioners (or the person in care themselves) of the status of treatment. For these reasons, each progress note should be understandable when read independently of other progress notes, providing an accurate picture of the person's condition, treatment provided, and response to care at the time the service was provided. To facilitate clear and accurate communication, abbreviations should be avoided, unless universally recognized, so that they will be accessible to a range of practitioners with whom you may wish to coordinate care. Keep in mind that progress notes can be used in legal proceedings and may also be accessed by the person in care themselves. People in care should be able to recognize the treatment described; therefore, it is recommended that clinical or programmatic jargon be avoided.

SLIRP Format

Providers shall utilize "SLIRP" template in the body of the progress note for the following intervention types: Therapy, Rehabilitation, Collateral Therapy, and Family Therapy. This includes group or individual therapy and group or individual rehabilitation.

- S = Symptoms should reflect qualifying diagnosis, observed by provider or by client report.
- L = Level of functioning and current functional impairment in each note
- I = Interventions for each note should relate to the MH functional impairment and the clients' qualifying diagnosis. Interventions must be identified within the POC prior to delivery. What the clinician did and how did the client respond.

- R = Response – Client's response to the intervention
- P = Plan – should be present in every note:
    - Short term or long-term plans
    - Any changes in approach
    - Who will do what?
    - Should be consistent with authorized services and the working diagnosis
    - If this is a group contact, document the number of clients present, the number of providers and the necessity of having more than one provider present.
    - Document any homework given to the client or plans made with the client during the Session.
    - Document the next scheduled appointment or step needed for discharge.

Group Note Format

Group therapy follows a group therapy note template.

Additional Templates

Additional templates are provided for Plan Development, Community Services, and Targeted Case Management.

Services Codes

See the Tuolumne County Service Code Definitions for Mental Health and Substance Use Disorder.

Scope of Practice

The areas in which a provider is allowed to operate in under California State law. See the Scope of Practice Matrix for Tuolumne County Behavioral Health.

Documentation Timeliness

Documentation timeliness is set at 24 hours for scheduled appointments, and same day for crisis or urgent encounters. The standards are described in further detail in the Documentation Deadline Plan Policy.

Documentation Standards for Client Records

Documentation standards for beneficiary care meet the minimum standards to support claims for the delivery of Specialty Mental Health Services and Drug Medi-Cal services and shall be addressed within the beneficiary record.

Documentation of Substance Use Disorder Treatment Sessions

Substance Use Disorder Services will ensure that all charting of progress notes will be done in a standardized format that will include appropriate treatment information relevant to the client's program and progress in treatment. SUDS documentation shall follow the guidelines outlined in the Documentation of SUD Tx Sessions Policy.

Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)

The assessing clinician shall document medical necessity for ICC and IBHS in the Children's Comprehensive Assessment. The clinician shall complete the CSOC Eligibility and

Authorization tool to determine what level of care and services are needed by the client. The clinician or BHW will document the decision by the CFT for the need for ICC/IHBS in a progress note. The clinician or BHW shall complete or update a POC prior to delivery of ICC/IBHS services to include ICC/IHBS services. A Plan of Care is required for all youth under Cal-Aim including the following elements: measurable objective, identified strengths, therapy modality, frequency, and interventions. The clinician will update the Problem List to reflect the current presentation of the client and shall include any psychosocial stressors (Z codes) identified in the CFT that need to be addressed through ICC and IHBS services. Ongoing progress notes for ICC and IHBS will reflect the appropriate codes for these services and be in the appropriate format (e.g., SLIRP format).

Therapeutic Behavioral Services (TBS)

Specialty mental health services covered as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. TBS are intensive, one-to-one, short-term outpatient services for beneficiaries up to age 21 designed to help beneficiaries and their parents/caregivers manage specific behaviors using short-term measurable goals based on the beneficiary's needs. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services to accomplish specified outcomes.

Medical Necessity Criteria for Outpatient Services

The medical necessity criteria for access to SMHS, for both adults and beneficiaries under age 21 (except for psychiatric inpatient hospital and psychiatric health facility services) (WIC Section 14184.402) is defined as follows. Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

Exceptions Where DSM-V Diagnosis is Not Required for SMHS

A mental health diagnosis is not a prerequisite for access to covered SMHS. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10 diagnosis code. In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to trauma as noted above, options are available in the CMS approved ICD-10 diagnosis code list. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services" (i.e., Z codes). DHCS may provide additional clarification and technical assistance regarding the use of Z codes (WIC Sect. 14184.402(f)(1)(A)).

Comorbid Medical Diagnoses

SMHS are reimbursable for beneficiaries with medical diagnoses if they also have mental health conditions and meet criteria for SMHS as described above. Services for symptoms or conditions solely due to a medical condition (e.g., traumatic brain injury) remain the responsibility of the MCP or the FFS delivery system.

No Wrong Door Approach

Under the "No Wrong Door" approach, services are allowed for the delivery of brief case management services to ensure beneficiaries receive timely mental health services without

delay regardless of the delivery system where they seek care (BHIN 22-011 "No Wrong Door for Mental Health Services policy).

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

Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the beneficiary meets access criteria for SMHS. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS. TCBH will 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.

Additional Coverage Requirements and Clarifications

This criteria for a beneficiary to access the SMHS delivery system (except for psychiatric inpatient hospital and psychiatric health facility services) set forth above shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

1. Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process
2. The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.
    a. Some SMHS may still require an individual plan of care, such as Targeted Case Management.
    b. The beneficiary has a co-occurring substance use disorder

SMHS need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services.

Medical Necessity Under Cal-Aim

Under Cal-Aim reforms, there have been additional emphasis on priority populations who meet medical necessity. Below is an overview of criteria for priority populations who may meet medical necessity:

- The person is experiencing homelessness,
- A youth is interacting with the child welfare or criminal justice system, or
- The person has scored high on the trauma screening tool, placing them at high risk for a mental health disorder.

AND meets the criteria as described above:

- The person has a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing as developmentally appropriate, or there is no presence of impairment.
- AND the significant impairments listed above are due to a mental health disorder diagnosed from the current version of the Diagnostic Statistical Manual or a suspected disorder that has not yet been diagnosed.

Early and Periodic Screening, Diagnostic, and Treatment (Under 21)

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan.

SMHS need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services.

Criteria for Beneficiaries under Age 21 to Access the Specialty Mental Health Services Delivery System

For enrolled beneficiaries under 21 years of age, a county mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet **either of the following** criteria, (A) or (B) below:

A. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

B. The beneficiary meets **both** criteria below:

   1. The beneficiary has **at least one** of the following:

      a. A significant impairment.

      b. A reasonable probability of significant deterioration in an important area of life functioning.

      c. A reasonable probability of not progressing developmentally as appropriate.

      d. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

1. The beneficiary's condition as described above is due to **one** of the following:

    a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

    b. A suspected mental health disorder that has not yet been diagnosed.

    c. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional (WIC § 14184.402(d)).

Adults

For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (WIC Section 14059.5 and WIC Section 14184.402(a)).

Criteria for Adult Beneficiaries to Access the Specialty Mental Health Services Delivery System

A. The beneficiary has **one or both** of the following:

1. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

2. A reasonable probability of significant deterioration in an important area of life functioning.

AND

B. The beneficiary's condition as described in paragraph (A) is due to **either of the following**:

1. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

2. A suspected mental disorder that has not yet been diagnosed.

Note: For adults and children, a neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a beneficiary meets criteria for access to the SMHS delivery system. However, MHPs must cover SMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorder not yet diagnosed) and meet criteria for SMHS as described above.

Plans of Care

Plans of Care (POC) are client-centered and collaborative. They are in place within sixty days of a mental health treatment admission which reflects Medical Necessity. The POC will be updated throughout treatment as appropriate. To ensure client services delivered have specific, observable or quantifiable treatment goals which support the proposed type(s) of intervention(s), are consistent with the client goal(s), and are consistent with the diagnosis. The Plan of Care is to ensure the client's involvement in planning their own care with their personal goals documented.

Substance Use Disorder Treatment Plans

TCBH is committed to ensuring that clients achieve positive and lasting outcomes. The collaborative development of a treatment plan provides the client and staff with a goal-oriented outline of responsibilities, expectations, and course of treatment towards recovery.

The best practice is to utilize a strategic and specific cause-effect relationship between problem identification (based on the treatment assessment), goals that directly relate to the identified problem(s), and specific objectives/ action steps taken by the client and clinician/counselor to accomplish the identified goals.

The client's participation in the development of a treatment plan is crucial to the success of the Plan. Client participation is documented by the client's signature on all treatment plans.

Treatment Timelines

- The initial treatment plan shall be completed within 30 calendar days of the admission date.
- Subsequent treatment plans are authorized for no longer than 90 days.
- Treatment plan updates will be completed every ninety days or whenever a change in problem identification or focus of treatment occurs.

Treatment Plan Process and Monitoring

- The initial treatment plan shall be developed at the time of the first scheduled appointment with a recovery counselor and client. Should the client be unable to complete the treatment plan at first scheduled appointment the counselor will work with the client in completing the treatment plan within the 30-day requirement.
- The treatment plan will be reviewed, and client progress documented approximately every thirty days hereafter.
- Documentation will consist of a progress note indicating the review of the treatment plan and any progress, not exceeding 45 days between treatment plan reviews.
- Treatment plan updates will be completed every ninety days or whenever a change in problem identification or focus of treatment occurs.
- Initial and updated *t*reatment plans completed by certified or registered counselors will be reviewed, and final approved by the Medical Director.

Substance Use Disorder Treatment Plans must include:

- Statement of problem(s) experienced by the client to be addressed
- Statement of goal(s) to be reached that address each problem

    - A goal of receiving a physical health exam is required when if at time of assessment a physical health exam could not be verified to have been received by the client in the past year
- Statement of objective(s) to address each problem: Includes action steps (interventions) that will be taken by the client and counselor to address the objective(s)
- Target date(s) for accomplishment of the objective(s) and action steps (interventions)
- Type and frequency of services
- Acknowledgement of client's participation in developing the plan
- Acknowledgement of client being offered a copy of the plan
- Client's signature
- Provider's signature
- Medical Director signature

Therapeutic Behavioral Services (TBS)

The TBS client plan shall be integrated in the E.H.R. plan of care. The Plan of Care shall provide clinical direction for one or more short term interventions. The TBS Plan of Care Worksheet is available to help the clinician create the Plan of Care and will be scanned into the chart for reference.

Therapeutic Foster Care (TFC)

Review the treatment plan or "Plan of Care" (POC) to determine:

- If the POC satisfies the provision of services,
- The POC must be signed by the clinician (LPHA) involved in providing TFC.
- SMHS collaboration must be shown by either signing the POC or documentation of agreement with the POC.
- ICC must be incorporated into the POC, or the referral must be denied for TFC.
- The TFC parent who will be providing TFC will have signed the POC.
- Evidence that the child or youth's participation is in agreement with the POC. If the child or youth refused to sign, then a written explanation must be obtained why it could not be obtained.
- Evidence that the child/youth and/or parent/caregiver were provided a copy of the POC upon request.

Targeted Case Management

Services that assist a person in care to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure access to service and the service delivery system; monitoring of individual progress.

Problem Lists

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. It includes diagnoses from the Diagnostic and Statistical Manual of Mental Disorders (DSM), most recent edition, 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 use of the Problem List has replaced the use of treatment plans except where federal requirements mandate a treatment plan be maintained.

Diagnosis – Internal Classification of Diseases 10 (ICD-10)

Information used to determine a diagnosis is obtained through a clinical assessment and may include a series of structured tools. Information may come directly from the person in care or through other means, such as collateral information or health records. A diagnosis captures clinical information about the person's mental health needs and other conditions based on the DSM-5. Diagnoses are determined by an LPHA commensurate with their scope of practice. Diagnoses are used to communicate with other team members about the person's mental health symptoms and other conditions and may document the level of distress/impairment. Diagnoses also help guide practitioners in their advisement about treatment options to the person in care.

Diagnoses should not remain static. For example, the person's clinical presentation may change over time and/or the practitioner may receive additional information about the person's symptoms and how the person experiences their symptoms(s) and conditions. As a practitioner, it is your responsibility to document all diagnoses, including preliminary diagnostic impressions and differential diagnoses as well as to update the health record of the person in care whenever a diagnostic change occurs.

While there is no longer a limited set of diagnosis codes that are allowable in relation to the provision of SMHS, the covered benefits and services responsibilities of the MHPs and MCPs remain unchanged. For example, MHPs are not required to provide Applied Behavior Analysis (ABA), a key intervention in the treatment of autism spectrum disorder (ASD), as the responsibility for providing that service remains with the MCP. However, a person in care who has ASD is able to additionally receive treatment from the MHP if their service needs require it and services are not duplicative with the other care they are receiving.

Providers may use the following options during the assessment phase of a person's treatment when a diagnosis has yet to be established:

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

Level of Care Tools

American Society of Addiction Medicine (ASAM) Treatment Criteria

ASAM's treatment criteria, formerly known as the ASAM patient placement criteria, is defined as one national set of criteria for providing outcome-oriented and evidence based treatment for addiction. The ASAM criteria utilizes comprehensive multidimensional assessment and a seamless continuum of services necessary for the treatment of individuals with substance use disorders. Properly credentialed or licensed personnel with addiction treatment experience are required when using the ASAM criteria, which is designed to deliver a person-centered, individualized, and outcome-driven success.

Level of Care Utilization System

The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) evaluates clients along six dimensions and defines six levels of resource intensity. It also provides a methodology to facilitate rapid and consistent level of care recommendations.

Short-Doyle / Medi-Cal Provider Certification

Provider Selection

TCBH does not contract with providers beyond the number necessary to meet the needs of its county-specific beneficiaries. During the process of selecting and retaining providers, TCBH will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. TCBH 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. TCBH will only use licensed, registered associates, and waivered providers acting within their scope of practice for services that require a license, waiver, or registration and who are located in the United States. Once a provider is selected, TCBH will credential and recredential network providers. TCBH shall not employ or subcontract with providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. TCBH shall give practitioners or groups of practitioners who apply to be contract providers and with whom TCBH decides not to contract written notice of the reason for a decision not to contract.

Provider Credentialing

For all licensed, waivered, registered and/or certified providers, TCBH must verify and document the following items through a primary source, as applicable. The listed requirements are not applicable to all provider types. The county is responsible to re-credential providers, to verify and document at a minimum of every three years that each network providers that deliver covered services continue to possess valid credentials, including verification of the credentialing requirements.

1. The appropriate license and/or board certification or registration, as required for 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

Provider Monitoring

TCBH shall monitor the performance of its subcontractors on an ongoing basis for compliance with the terms of the state contract and MHP contract and shall subject the subcontractors' performance to periodic formal review, at a minimum in accordance with the recertification requirements of every 1-3 years. If deficiencies or areas for improvement are identified, TCBH and the subcontractor shall take corrective action. Corrective action(s) may include corrective action plans (CAPs) up to termination of contract depending on the severity and duration of the deficiency(s).

Confidentiality and Privacy Standards

Confidentiality and HIPAA Act FY16-17

Mental Health and Substance Use Disorder Treatment Confidentiality and Health Insurance Portability and Accountability Act (HIPAA)

All client information created, received, or maintained by Tuolumne County Behavioral Health, (TCBH), is referred to as PHI, protected health information. All mental health (MH) and substance use disorder (SUD) PHI is confidential and is protected under Welfare and Institution (W&I) code 5328. Additionally, all information created for the purpose of SUD treatment is protected under the Code of Federal Regulations (CFR) 42CFR.

- Unauthorized individuals – an individual and/or TCBH staff member who does not have treatment and/or administrative responsibility for such client or client record, nor does such individual(s) have a need to know. As example, an unauthorized individual may be defined as, but is not limited to a family member, a friend, a parent of adult client, parent of a minor consent 12+Yr old, a person of a client's support system, and at times, even a fellow TCBH co-worker.
- Access – getting, receiving, getting near, retaining, observing, reviewing or makes use of information.
- Disclosure – the act of or instance of exposing information, the sharing or divulging of either PI or PHI.
- Client record – any information, demographic (personally identifiable (PI) info such as name, birth date, address, SSN, employer, marital status), or protected health information (PHI., Either mental health or alcohol and drug in nature, in electronic or paper format maintained on behalf of a Tuolumne County Behavioral Health client.
- Authorized access to a client record – occurs when a staff has an established purpose for accessing a client record based on their bona fide responsibility to treat or perform duties per their role.
- Unauthorized access to a client record – access to a client record by unauthorized individuals, e.g., TCBH workforce member or other persons access a client chart but lack treatment and/or administrative responsibilities for such client or record. i.e.,

TCBH staff member not involved with providing treatment or performing a required administrative action would be breaching a client's privacy by accessing their information.

- Third party – a person or group besides the two primarily involved in a situation; schools, Social Services, law enforcement, the County Coroner or the Secretary of Department of Health Human Services (DHHS). This is not an exhaustive list but examples of third parties.
- Breach – the acquisition, access, use, or disclosure of Protected Health Information (PHI) in a manner not permitted under HIPAA. This in which compromises the security or privacy of an individuals protected health information.

Disclosure of MH and SUD information to **non-providers** outside the BH workforce should only be accomplished with the expressed written permission of the client. This is accomplished by the accurate completion of a release of information (ROI) form. This is processed through Medical Records, per the Client Confidentiality Standards MH/SUD: Release of Information Policy

Disclosure of MH information to **outside health care providers** who are treating a mutual client may receive information for the purpose of continuity of care. This should be accomplished by gaining the expressed written permission of the client by the accurate completion of a release of information (ROI) form.

Disclosure of SUD information to **outside health care providers,** who are treating a mutual client may not receive information for the purpose of continuity of care. That is unless there is expressed written permission by the client to do so. This is accomplished by the accurate completion of a release of information (ROI) form.

Disclosure of MH or SUD information **amongst Tuolumne County Behavioral Health workforce** is only allowed when both providers (workforce members) have treatment responsibility for a mutual client, and only for the purpose of continuity of care. The sharing of information across program staff, i.e. MH & SUD, can only be accomplished by gaining the expressed written permission of the client. This is accomplished by the accurate completion of an exchange of information (ROI) form.

For urgent care needs, under the HIPAA rule**, only mental health information may be shared without the expressed written permission of the client, with only the minimum necessary being shared.** The sharing of MH information for the purpose of urgent care needs lacking an ROI, may only be done verbally. All verbal disclosures must be noted within the associated service progress note explicitly describing the reason for the disclosure and what information was disclosed. * **At no time including emergency situations, shall alcohol and drug treatment information be shared without the expressed written permission of the client.**

Examples of accessing and/or disclosing client information:

When must we share?

- We must share client information with the Secretary of DHHS, if asked (e.g., HIPAA breach investigation).
- With a client, if seeking access to their own record (unless it will cause death or serious physical harm). A formal request for review/access or amendment of records is required and managed by Medical Records staff.
- With Law Enforcement to report a crime on premise for search warrants; or when officer is in hot pursuit of an individual they have witnessed entering the Behavioral Health building.

When MAY we access, use and disclose PHI?

- For Treatment purposes staff shall only access a client record IF they have direct treatment responsibility for such individual.
- For Health Care payments, processing of claims for provided services.
- Operations purposes, i.e., billing, data processing, administrative activities.
- Law Enforcement to get help, 911 calls.
- Reporting of child/older adult abuse.
- Coordination of care for dependent minors with Social Worker, Probation Officers or adult with legal custody.
- Tarasoff "duty to warn".

When is it NOT okay to access, use or disclose PHI?

"PHI is confidential…staff may only **access the minimum amount of PHI that you need to know based on your job/treatment role…"** Therefore, it is not okay to check to see if a client is active to the agency except for the **express purpose of providing immediate services. Some examples of unauthorized access:**

1) You see a familiar name on crime graphics and look to see if the person is still open to the agency;
2) You see an obituary of a known client and open the chart to see when the last time they were seen (and you are not a Manager responsible for performing a Psych Autopsy);
3) You used to see a particular client and thought you would check up to see how they were doing;
4) A new person has moved next door to you and you believe they may have a mental illness or substance abuse history;
5) Your teenager has just started dating someone that you have seen at the Department seeing the doctor or a clinician;
6) You see someone on the street who you know has a history of being active to the department who appears to be having challenges. You open their chart to see if their doctor or therapist has been seeing them;
7) You are treating the family member of another client who is making statements about the other person. So, you check to see if the other person has been referencing your client or the issues being addressed; or
8) A non-provider staff asks you to look up client information.

At no time shall a client record be accessed by a BH workforce member who does not have direct treatment or administrative responsibility for such client record.

How do you substantiate your authorization to access a client record?

The cause for accessing a client record is substantiated by individual staff(s) role/responsibilities. The agency's various processes assist with establishing authorization.

- As an example, fulfilling documentation standards by completing the Access to Care Log and/or progress note is not just evidence of service delivery. By fulfilling paperwork obligations, you are ultimately validating your purpose, "permission", for accessing a client record.
- Another example is with the URC process (Utilization Review Committee to determine that clients are receiving quality clinical care) where the URC minutes serve as evidence of cause for accessing a client record.

Additionally, an overdue POC report run by electronic health records staff is evidence of their role and responsibility which again validates the purpose for accessing a client record.

Minimum Necessary Standards (MNS)

What is the "Minimum Necessary" Standard?

The minimum information needed to do one's job:

- Staff access to client information must be based on their job duties / treatment roles, e.g., "need to know". Provider staff must have direct treatment responsibility in order to lawfully access client records.
- All staff must exercise reasonable efforts not to access, use, or disclose more than the minimum amount of information needed to accomplish their jobs, an intended purpose and/or for service delivery.
- Be Aware: Individuals may receive fines / penalties including employee sanctions for inappropriate access, unauthorized disclosures and/or scrutiny for breaches. Additionally, unauthorized access and/or breach of client privacy will be enforced by the Office of Civil Rights (OCR).
- Authorization to access a client record is established upon the individual provider staff's responsibility to treat such individual.
- At no time shall BH staff access a client record for any other purpose outside their role/duties.

Confidentiality Standards Policy Except on Accessing PHI

1. Employees may only access protected health information (e.g., electronic, hard copy) for purposes necessary to perform their own job duties.
2. Employees may not access through the electronic health record information systems the medical/mental health or alcohol and drug information of; family members, friends, or any other individuals for personal or other non-work/non-treatment related purposes.
    - In those very rare circumstances where an employee's job requires him/her to access and/or copy the medical information of family members, a co-worker, or other personally known individuals; then he/she may do so only to the extent necessary to perform his/her job. However, employees should report the situation to their

supervisor who will determine whether to assign a different employee to complete the task involving the specific client. The employee should continue his/ her responsibility to the extent client privacy and/or treatment is not compromised.

3. Employees must not use their employee status to obtain medical/mental health or alcohol and drug information for anyone else.
4. Employees who violate these guidelines will be subject to disciplinary action. These can be up to and including termination, in accordance with the applicable local, state and federal regulations.

Managing Release of Client PHI

Electronic Health Record staff is the designated workforce members responsible for disseminating PHI in paper form. At no time shall clinical staff disseminate PHI in paper form. Release of paper documents or reproduction of such requires verification of accurate and complete release of information forms. As well as a full accounting of PHI disclosures by this agency, all of which is managed by the Electronic Health Record staff. This assigned role is to ensure compliance with all State and Federal regulation(s).

Reporting or Potential Breach of Privacy

Any concern of a potential breach shall be reported immediately upon the discovery or concern to the appropriate workforce member(s). Any person, including the person who committed a breach, a client, a workforce member, or agent of the agency is eligible to report.

Workforce members who believe that client information has been used or disclosed in any way that compromises the security or privacy of that information shall immediately notify: the designated privacy staff, custodian of records, Behavioral Health Director or the Privacy Officer for Tuolumne County. Although privacy concerns can be reported verbally, workforce members are encouraged to report by submitting a Privacy or Security Event Staff Reporting form.

Following the receipt of a potential breach report, the privacy staff investigate the details *surrounding the report and conduct a risk assessment. Based on the results of the risk* assessment, they begin the process of notifying each individual whose PHI has been or is reasonably believed by the agency to have been accessed, acquired, used, or disclosed as a result of the breach. Additionally, the agency shall also begin the process of determining what notifications are required or should be made, if any to; the Secretary of the Department of Health and Human Services (HHS), Office of Civil Rights, media outlets, or law enforcement officials.

Please contact TCBH privacy staff at (209)533-6271
TCBH custodian of records at (209)533-6271 or
County of Tuolumne Privacy Officer at (209)533-6636
if you have any questions.

Confidentiality Standard of Mental Health and AOD Client Information

In accordance with Code of Federal Regulations Title 42, Welfare and Institutions Code 5328 and California Health and Safety Code 123100-123149.5 Tuolumne County Behavioral Health Department is required to have policies in place to protect the client's confidentiality regarding the Mental Health and Drug and Alcohol client records.

The below bullet points will serve as a guideline, exploring situations when limited disclosure is indicated and including situations which require client permission for disclosure. Tuolumne County Behavioral Health prefers using an "Authorization for Request/Release of Medical Records Information" or an "Authorization for Exchange of Information" when possible but always when the client's permission is required. Specifically, for all AOD related service information.

- Welfare & Institutions Code 5328 provides that information and records of patients receiving voluntary or involuntary services shall only be disclosed under the specific conditions cited in Welfare and Institutions Code 5328.
- Unless authorized by the client, alcohol and drug records are protected specifically under Federal Regulations 42 CPR Part 2 and shall not be released without specific client authorization.
- Section 123100 of the Health and Safety Code specifies that every person having ultimate responsibility for decisions respecting his or her health care also possess a concomitant right of access to complete information respecting his/her condition and the care provided. Section 123110 provides that clients/patients are entitled to inspect their own records.
- HIV and/or Aids information is protected from unauthorized disclosure by Health and Safety Code Sections 199.21 and 120980.
- County's Patient Rights Advocates have the right to access client records as necessary to investigate or resolve specific complaints (W&I 5530 (a) and 5522). They also have the right to interview all persons providing the client with diagnostic or treatment services (W&I 5530 (b).
- Records that are otherwise confidential may be disclosed to other agencies (CCR Title 9 Chapter 11, Section 1810.415 (b) or to law enforcement under certain conditions (W & I 5633 and 5633.5) or to a county coroner in the course of an investigation by the coroner's office (Civil Code 56.1Oc.6)
- Mental Health employees shall not access charts which are not their direct clinical responsibility. Charts of family, friends, co-workers or acquaintances shall not be accessed or reviewed for any reason.
- Telephone conversations are to be kept confidential. Conversations shall not take place while an unauthorized person is in the area. The unauthorized overhearing of even one side of a conversation with or regarding a client of mental health or drug and alcohol services is defined as a breach of confidentiality.
- When summoning a client for their appointment, the clinical staff shall use first name only.

- Client medical records and information shall be kept under triple lock. Clinical records shall not be taken outside of the Behavioral Health facilities without being carried in fireproof locking box.
- Information stored on a computer or computer network server shall be protected using security safeguards. Information that identifies clients is not to be displayed on any computer screen that may be in unauthorized person's view.
- No client listings and/or information shall be posted or visible in any area of the agency.
- Paperwork containing client information that is to be destroyed shall be placed in designated receptacles for shredding.
- Use of cellular and/or cordless telephones to share confidential information shall be avoided with the exception of crisis situations. Other individuals who may be on the same telephone frequency may overhear conversations from their telephones.
- When using email, voice mail or alphanumeric pager use client's first name and last initial only.
- When using the facsimile machine to send client information, use the Agency's designated FAX cover sheet containing the required non- disclosure Confidentiality Statement disclaimer for recipient.
- When sending information to clients via the U.S. Mail or hand delivered, employees shall use the Department's mailing envelope with only the return address which does not contain the name of the Department.
- When employees visit a client's home and she/he is unable to locate the client, staff shall not leave a Behavioral Health business card nor in any manner identify themselves as a Behavioral Health employee to neighbors or friends of the client.
- During activities involving behavioral health clients in any context, staff shall not in any manner disclose the confidential relationship of the client with Behavioral Health Services. Staff shall take extra precautions not to disclose the confidential relationship with the client in any public venue.

Utilization Management Program

Authorization of Specialty Mental Health Services

The Case Administration Team (CAT) reviews the clinical assessment and determines if medical necessity exists. CAT determines which services are appropriate to meet the client's needs and assigns specific service providers (clinician, case manager, and/or psychiatrist, etc.). CAT will review medical necessity documentation by the SAI to determine whether the beneficiary's diagnosis is an included diagnosis as a Medi-Cal SMHS. If the beneficiary's diagnosis is not an included diagnosis, CAT will recommend that the clinician refer the client to a primary care provider and/or managed care plan provider, or to an appropriate treatment provider and/or community resource. CAT will review if the proposed treatment would be responsive to physical healthcare-based treatment. If so, CAT will recommend that the SAI refer the beneficiary, in accordance with state regulations, to a primary care provider and/or managed care plan provider. (CCR, Title 9, § 1810.415(d).) CAT will review whether the beneficiary meets the criteria for severe mental illness or whether the beneficiary falls into the mild to moderate range of functional impairment. If the client is mild to moderate in their functional impairment, then the client will be referred to the managed care plan for treatment services, their primary care provider, and appropriate

community resources. If the individual is denied services due to not meeting medical necessity for Medi-Cal SMHS or other allowable reasons for denials, CAT will notify the assessment clinician who will follow procedures on issuing a Notice of Adverse Benefit Determination (NOABD) to the individual and refer them to appropriate community providers and resources.

If services are denied or modified due to not meeting medical necessity or other allowable reasons, TCBH is responsible for arranging for the individual to obtain a second opinion about their mental health condition, if requested, and at no cost. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a Licensed Practitioner of the Healing Arts (LPHA) who has appropriate clinical expertise in addressing the client's behavioral health needs. Staff will notify the client in writing, via the NOABD process, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

Case Administration Team (CAT)

The review of assessments are conducted as a function of the ongoing Case Administration Team (CAT) which is comprised of a Utilization Management team that may include the Director, Medical Records Supervisor, Clinical Manager, Planned Services Program Supervisor, other clinical management staff, and/or clinical staff. During Case Administration Team meetings, a review will be conducted of the clinical documentation to ensure that clients receive medically necessary services in the amount, duration, and scope that is appropriate to meet their needs.

CAT members conduct the following activities related to TCBH clients:

1. Review clinical assessments and other relevant information to determine medical necessity.
2. Provide case assignments of the Single Accountable Individual (SAI). Assign clinical/treatment and/or case management/ support staff, as appropriate and necessary.
3. Reviews medical necessity for referred clients for Mental Health Services, Medication services, Targeted Case Management, or other specialty mental health services.
4. Reviews medical necessity for referred clients for substance use disorder services.

CAT is responsible for review of private network providers and TBS provider requests to deliver services. This process includes monitoring of services for new clients, as well as on-going services.

Utilization Review Committee

A sampling of client charts will be reviewed in a regularly scheduled Utilization Review Committee (URC) with oversight by a Licensed Supervisor evaluating the cases. This is to ensure clients at all levels of care receive appropriate treatment, identifying ways to improve the treatment plan developed for the client, and assure appropriate documentation and authorization of services both prospectively and retrospectively.

The following categories of beneficiary records will be included in URC on an ongoing basis to assure a representative sample:

- High-utilization clients, including but not limited to FSP, rehospitalizations, and individuals in the top 5% of utilized services in a given timeframe.
- Child (ages 3 to 15) or Transition-Age Youth (16 to 25) clients
- Medication Services
- Contractor Documentation (at least annually)
- Randomly selected Outpatient clients

Medical Records staff shall pre-screen client records for administrative review of documentation needs (i.e., POC, Assessment, Medication Consent, Notice of Privacy, Advance Directive, Financial Forms, etc.)

URC participants will utilize the URC audit tool and feedback forms to evaluate the client record for Mental Health Plan requirements regarding medical necessity, appropriateness and efficiency of services, documentation standards, and other practice guidelines.

Feedback for URC shall be sent to staff and Program Supervisor to review documentation with staff as needed. If documentation errors are found or standards are not met per documentation policies, a disallowance form will be completed and turned into the Medical Records Supervisor.

All URC audit tools will be submitted to QI once they are complete for ongoing monitoring of trends to be reviewed in QM.

Treatment Authorization Request (TAR)

Timeframes for submission of the TAR and documentation is 14 calendar days after discharge or 99 calendar days of continuous service if the beneficiary's stay exceeds the time frame. Late submissions require the hospital to send, in writing, documentation that meets CCR Title 9, Chapter 11, Section 1820.215, (3)(c)(1) or (2), MHP Payment Authorization General Provisions to prevent a denial based on the late submission.

For Medi-Cal reimbursement of psychiatric inpatient hospital services, the client must meet medical necessity criteria set forth in Title 9 of the CCR, section 1820.205. The client must meet the following medical necessity criteria for admission to a hospital for psychiatric inpatient hospital services:

- Have an included diagnosis;
- Cannot be safely treated at a lower level of care, except that a client who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and,
- Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to one of the following:
    - Has symptoms or behaviors due to a mental disorder that (one of the following):
    - Represent a current danger to self or others, or significant property destruction.

- Prevent the client from providing for, or utilizing, food, clothing, or shelter.
- Present a severe risk to the client's physical health.
- Represent a recent, significant deterioration in ability to function.

- Require admission for one of the following:
  - Further psychiatric evaluation
  - Medication treatment
  - Other treatment that can be reasonably provided only if the client is hospitalized

Continued stay services in a hospital shall be reimbursed when a client experience one of the following:

- Continued presence of indications that meet the medical necessity criteria;
- Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization;
- Presence of new indications that meet medical necessity criteria; and,
- Need for continued medical evaluation or treatment that can only be provided if the client remains in the hospital.

TCBH shall review documentation for sufficiency and to determine that medical necessity criteria are met for acute days and administrative day criteria are met for administrative days claimed for reimbursement of Federal Financial Participation.

Inpatient Concurrent Review

TCBH shall conduct concurrent review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services:

- TCBH shall conduct concurrent review of treatment authorizations following the first day of admissions.
- TCBH may elect to initially authorize multiple days, but each day of treatment must meet medical necessity and/or continued stay criteria.
- Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating providers, including both the hospital and treating physician, in writing, within 24 hours of the decision.
- If TCBH denies or modifies the request for authorization, TCBH must notify the beneficiary, in writing, of the adverse benefit determination.
- In the case of concurrent review, care shall not be discontinued until the beneficiary's treating provider(s) has been notified of the TCBH's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary.

A hospital may claim for administrative day services when a client no longer meets medical necessity criteria for acute psychiatric hospital services.

Outcome Measures

Adverse Childhood Experiences (ACEs)

The adverse childhood experiences (ACEs) screening instrument is a validated, accessible screening tool that can be used for early detection of common childhood traumas. The Pediatric ACEs and Related Life-events Screener (PEARLS) is used to screen children and adolescents ages 0-19 for ACEs. These trauma-informed tools are used at screening or at assessment for clients.

Child and Adolescent Needs and Strengths (CANS-50)

The Child and Adolescent Needs and Strengths (CANS) is a structured assessment for identifying youth and family actionable needs and useful strengths. It provides a framework for developing and communicating about a shared vision and uses youth and family information to inform planning, support decisions, and monitor outcomes.

Providers will complete the CANS form through a collaborative process which includes children ages 6 and youth up to age 20, and their caregivers (at a minimum). The CANS version being used is the CANS Core Item set. The CANS will need to be completed at the beginning of treatment, updated every six months following the first administration, and at the end of treatment.

Pediatric Symptom Checklist (PSC-35)

The Pediatric Symptom Checklist (PSC) is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible.

Parents/caregivers will complete the PSC-35 for their children ages 3 and youth up to age 18. The PSC-35 will need to be completed at the beginning of treatment, every six months following the first administration, and at the end of treatment.

Psychometric Instrument

Psychometric Instrument or Scale	Purpose	Brief Description
Beck Depression Inventory (BDI)	Rates depression symptoms	21-item self-report rating inventory
Brief Psychiatric Rating Scale (BPRS)	Differentiate psychotic symptoms	18 scored items clinician assessment tool
Hamilton Anxiety Rating Scale (HAM-A)	Rates anxiety symptoms	14 question clinician rating scale
Hare Psychopathy Test	To determine psychopathic characteristics	22 item clinician assessment tool
Psychometric Instrument or Scale	**Purpose**	**Brief Description**

Mini Mental Status (MMSE)	Tests 5 areas of cognitive function (orientation, concentration, attention, verbal memory, naming, and visuospatial skills)	11 question measure with 30 points score
Positive and Negative Syndrome Scale (PANNS)	A clinical instrument principally developed for use in schizophrenia to identify the presence and severity of psychopathology symptoms.	An approximately 45-minute clinical interview is conducted. The patient is rated from 1 to 7 on 30 different symptoms based on the interview as well as reports of family members or primary care hospital workers.

References

Behavioral Health Information Notices (BHIN):

- MHSUDS Information Notice 22-019: Documentation Requirements for all Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS)
- MHSUDS Information Notice 19-026: Authorization of Specialty Mental Health Services

State Documentation Guidelines

- Clinical Documentation Manual, 2022, California Mental Health Services Authority (CalMHSA)

Other References

- Health Information Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, Privacy Rule
- Title 42 of the Code of Federal Regulations CFR, Section 2.1 et seq

Appendices

Authorization of Specialty Mental Health Services Policy

Purpose	This policy describes the processes and timelines for consistently reviewing and authorizing requests for outpatient mental health services in accordance with Medi-Cal and State regulations and Tuolumne County Behavioral Health (TCBH) standards.
Definitions	CAIP: Crisis Assessment Intervention Program Client: A person who is receiving or requesting specialty mental health services who is eligible under the criteria for medical necessity DHCS: Department of Health Care Services

LPHA: Licensed Practitioner of the Healing Arts

Medical Necessity: The Medi-Cal program defines medical necessity as the provision of health care services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as described in CCR, Title 9, Chapter 11, Section 1830.205

NOABD: Notice of Adverse Benefit Determination

Procedure

I. <u>Requirements Applicable to Authorization of Specialty Mental Health Services</u>

A. Tuolumne County Behavioral Health will manage authorizations directly, but may delegate authorization functions to an administrative entity, consistent with federal law and state contract.

B. Authorization procedures and utilization management criteria must adhere to the following principles (MHSUDS Information Notice No. 19-026):
   1. Be based on SMHS medical necessity criteria and consistent with current clinical practice guidelines, principles, and processes;
   2. Be developed with involvement from network providers, including, but not limited to, hospitals, organizational providers, and licensed mental health professionals acting within their scope of practice;
   3. Be evaluated and updated, if necessary, at least annually; and,
   4. Be disclosed to TCBH's clients and network providers.
   5. Compensation to individuals or entities that conduct utilization management activities will not be structures so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

B. TCBH shall ensure that all medically necessary covered SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
   1. TCBH shall not arbitrarily deny or reduce the amount, duration, or scope of medically necessary covered SMHS solely because of diagnosis, type of illness, or condition of the client.
   2. Be required that out-of-network providers coordinate authorization and payment with TCBH.

C. TCBH shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in addressing the client's behavioral health needs.

D. No individual, other than a licensed physician or a licensed mental health professional who is competent to evaluate the specific

clinical issues involved in the SMHS requested by a client or a provider, may deny, or modify a request for authorization of SMHS for a client for reasons related to medical necessity.

E. TCBH shall notify the requesting provider in writing with a NOABD and give the client written NOABD of any decision by TCBH to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
F. TCBH shall have mechanisms in effect to ensure consistent application of review criteria for decisions for authorization and shall consult with the requesting provider when appropriate.

II. **Authorization Requirements for Concurrent Review and Prior Authorization communication**

A. Notify DHCS and contracting providers in writing of all services that require prior or concurrent authorization and ensure that all contracting providers are aware of the procedures and timeframes necessary to obtain authorization for these services for payment;
B. Maintain telephone access 24-hours a day, 7-days a week for providers to make admission notifications and request authorization for inpatient acute psychiatric hospital services and/or to request expedited authorization of an outpatient service requiring prior authorization (see Access to Behavioral Health Services Policy);
C. A physician shall be available for consultation and for resolving disputed requests for authorizations;
D. Disclose to DHCS, TCBH's providers, clients, and members of the public, upon request, the UM or utilization review policies and procedures that TCBH, or any entity that TCBH contracts with, uses to authorize, modify, or deny SMHS. TCBH may make the criteria or guidelines available through electronic communication means by posting them online;
E. Ensure the Beneficiary Handbook includes the procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for SMHS.
F. Provide written notification regarding authorization decisions in accordance with the established timeframes for the type of authorization.

III. **Inpatient and Concurrent Review**

A. For Medi-Cal reimbursement of psychiatric inpatient hospital services, the client must meet medical necessity criteria set forth in Title 9 of the CCR, section 1820.205. The client must meet the following medical necessity criteria for admission to a hospital for psychiatric inpatient hospital services:
    1. Have an included diagnosis;
    2. Cannot be safely treated at a lower level of care, except that a client who can be safely treated with crisis residential

treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and,

3. Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to one of the following:
    a. Has symptoms or behaviors due to a mental disorder that (one of the following):
    b. Represent a current danger to self or others, or significant property destruction.
    c. Prevent the client from providing for, or utilizing, food, clothing, or shelter.
    d. Present a severe risk to the client's physical health.
    e. Represent a recent, significant deterioration in ability to function.
4. Require admission for one of the following:
    a. Further psychiatric evaluation.
    b. Medication treatment.
    c. Other treatment that can be reasonably provided only if the client is hospitalized.

B. Continued stay services in a hospital shall be reimbursed when a client experiences one of the following:
    1. Continued presence of indications that meet the 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; and,
    4. Need for continued medical evaluation or treatment that can only be provided if the client remains in the hospital.

C. TCBH shall review documentation sufficient to determine that medical necessity criteria are met for acute days and administrative day criteria are met for administrative days claimed for reimbursement of Federal Financial Participation.

D. TCBH shall conduct concurrent review and authorization for all psychiatric inpatient hospital services and psychiatric health facility services:
    1. TCBH shall conduct concurrent review of treatment authorizations following the first day of admissions.
    2. TCBH may elect to initially authorize multiple days, but each day of treatment must meet medical necessity and/or continued stay criteria.
    3. Decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to beneficiaries shall be communicated to the beneficiary's treating providers, including both the hospital and treating physician, in writing, within 24 hours of the decision:

4. If TCBH denies or modifies the request for authorization, TCBH must notify the beneficiary, in writing, of the adverse benefit determination.
5. In the case of concurrent review, care shall not be discontinued until the beneficiary's treating provider(s) has been notified of the TCBH's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary.

E. A hospital may claim for administrative day services when a client no longer meets medical necessity criteria for acute psychiatric hospital services.
F. TCBH may waive the requirements of five contacts per week if there are fewer than five appropriate, non-acute residential treatment facilities available as placement options for the client. The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented.
G. In order to conduct concurrent review and authorization for administrative day service claims, TCBH shall review that the hospital has documented having made at least one contact to non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status:
   1. Once five (5) contacts have been made and documented, any remaining days within the seven (7)-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized
   2. A hospital may make more than one contact on any given day within the seven (7)-consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five (5) required contacts are completed and documented.
   3. When the five (5) contact requirement is met, any remaining days within the seven (7) day period can be authorized without a contact having been made and documented.
H. All TCBH's authorization procedures shall comply with the Managed Care and Parity Final Rule in accordance with requirements set forth in Title 42 of the CFR. (See Concurrent Review Policy.)

IV. **Service Linkage after Inpatient Facility Discharge**

A. The Clinical Manager or designee ensures that all clients admitted to acute inpatient facilities have an assigned case manager or discharge planner to monitor the inpatient stay and facilitate appropriate discharge planning.
B. If a client is discharged from an inpatient facility and does not have current authorization to receive ongoing or follow-up

services, the case manager works with the Clinical Manager or designee to ensure that the client is linked to services. TCBH may expedite the authorization process to ensure that the client receives timely access to services.

V. **Routine Intake Process (Non-Emergency)**

A. Routine (non-emergency) requests for services are described in the Access to Behavioral Health Services Policy.

VI. **Emergency Crisis Response and Inpatient Authorization**

A. Emergency crises during regular business hours are immediately referred to the on-duty Crisis Worker.
B. The TCBH Crisis Assessment and Intervention Program (CAIP) manages all crisis services (e.g., 5150 evaluations, Tuolumne County Jail safety evaluations, etc.).
C. TCBH contracts with a crisis service provider for crisis phone services outside of CAIP scheduled hours.
D. The first 24 hours of an emergency psychiatric hospitalization does not require authorization. When Tuolumne County CAIP in conjunction with Adventist Health Sonora Emergency Department completes the 5150 hold, then they seek placement in an appropriate psychiatric hospital which accepts the client's Medi-Cal or other insurance.
E. Concurrent review and authorization of inpatient services are described in the Concurrent Review Policy.
F. TCBH may not require prior authorization for an emergency admission for psychiatric inpatient hospital services or to a psychiatric health facility, whether the admission is voluntary or involuntary, and the client, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter, or clothing.
G. Upon notification by a hospital, TCBH shall authorize payment for out-of-network services when a client, with an emergency psychiatric condition, is admitted to a hospital, or PHF, to receive psychiatric inpatient hospital services or PHF services.
H. After the date of admission, hospitals must request authorization for continued stay services for the client subject to concurrent review by TCBH in accordance with this policy.

VII. **Crisis Residential Treatment Services (CRTS) and Adult Residential Treatment Services (ARTS)**

A. TCBH must utilize referral and/or concurrent review and authorization for all CRTS and ARTS. TCBH may not require prior authorization:
   1. If TCBH refers a beneficiary to a facility for CRTS or ARTS, the referral may serve as the initial authorization if TCBH

specifies the parameters (e.g., number of days authorized) of the authorization
2. TCBH must then re-authorize medically necessary CRTS and ARTS services, as appropriate, concurrently with the beneficiary's stay and based on beneficiary's continued need for service

B. In the absence of a TCBH referral, TCBH shall conduct concurrent review of treatment authorizations following the first day of admission to a facility through discharge.
C. As with authorization of psychiatric inpatient and PHF services, decisions to approve, modify, or deny provider requests for authorization concurrent with the provision of SMHS to clients shall be communicated to the client's treating provider within 24 hours of the decision and care shall not be discontinued until the client's treating provider has been notified of TCBH's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the client.
1. If the TCBH denies or modifies the request for authorization, TCBH must notify the client, in writing, of the adverse benefit determination.
2. In cases where TCBH determines that care should be terminated (no longer authorized) or reduced, TCBH must notify the client, in writing, of the adverse benefit determination prior to discontinuing services.

VIII. **Outpatient Services**

A. Priority Referrals
1. TCBH will manage resources in a manner that allow all individuals requesting planned services that indicate a high-risk concern (by category, on the referral form), receive an intake assessment appointment as soon as possible, but no later than five (5) business days after the request for services.

B. Authorization Timeline
1. TCBH authorization will occur within five (5) business days of the intake assessment appointment.
   a. This timeframe may be extended up to 14 additional calendar days if the client or the provider requests the extension, or if TCBH documents the need for additional information and that the extension is in the client's interest.
   b. If the standard timeframe could seriously jeopardize the client's life or health, or their ability to attain, maintain, or regain maximum function, TCBH will make an expedited authorization decision no later than 72 hours after the receipt of the request for service.

C. Client Plan of Care

1. Once the assessment is complete and in order to provide treatment that is appropriate and effective, Client Plans of Care must be completed within 60 calendar days of the intake assessment appointment.

D. In cases where TCBH determines that care should be terminated (no longer authorized) or reduced, TCBH must notify the client, in writing, of the adverse benefit determination prior to discontinuing services.

IX. Timeliness Delays

A. If TCBH does not meet assessment, authorization, or service delivery timelines, TCBH must provide a written Notice of Adverse Benefit Determination (NOABD) for the delay in services. See the related policy Notice of Adverse Benefit Determination Policy for information on the different types of notices and the specific timeframes and required documentation.

X. Other Authorization Processes

A. This policy is applicable to all mental health services provided or arranged by TCBH. Child Welfare Services referrals for evaluations for Pathways to Well-Being (formerly known as Katie A) mental health services are managed per this policy with additional information provided in the Katie A. Program Services Policy.

B. Decision to modify an authorization request shall be provided to the treating provider(s), initially by telephone or facsimile, and then in writing, and shall include a clear and concise explanation of the reasons for the decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. The decision shall also include the name and direct telephone number of the professional who made the authorization decision and offer the treating provider the opportunity to consult with the professional who made the authorization decision.

XI. Prior Authorization or Referral for Outpatient Specialty Mental Health Services

A. TCBH may review and approve Client Plans prior to service delivery. TCBH will ensure that services requiring a Client Plan prior to service delivery are not provided until the plan is complete.

B. TCBH may not require prior authorization for urgent needs for the following services/service activities:
   1. Crisis Intervention
   2. Crisis Stabilization
   3. Mental Health Services

4. Targeted Case Management
5. Intensive Care Coordination, and
6. Medication Support Services

C. Prior authorization or TCBH referral is required for the following services:
1. Intensive Home-Based Services
2. Day Treatment Intensive
3. Day Rehabilitation
4. Therapeutic Behavioral Services
5. Therapeutic Foster Care.

XII. Retrospective Authorization Requirements

A. TCBH may conduct retrospective authorization of SMHS, inpatient and outpatient, under the following limited circumstances:
1. Retroactive Medi-Cal eligibility determinations;
2. Inaccuracies in the Medi-Cal Eligibility Data System;
3. Authorization of services for clients with other health care coverage pending evidence of billing, including dual-eligible clients; and/or,
4. The client's failure to identify a payer.

B. In cases where the review is retrospective, TCBH's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination and shall be communicated to the provider in a manner that is consistent with state requirements.

XIII. Utilization Review

A. Functions related to utilization review and auditing of documentation standards are distinct from utilization management and authorization functions. TCBH retains the right to monitor compliance with any contractual agreements between TCBH and TCBH's network providers and may disallow claims and/or recoup funds, as appropriate, in accordance with TCBH's obligations to DHCS.
1. The Clinical Manager or designee or licensed designee is responsible for review of private network providers, planned hospital admissions, and TBS provider requests to deliver services. This process includes monitoring of services for new clients, as well as on-going services.
a. The Clinical Manager or licensed designee reviews authorization requests for planned hospital services admissions for approval and makes the final determination on all inpatient Treatment Authorization Requests (TARs), excluding the first 24 hours of an emergency inpatient admission.

- Unless otherwise noted in contract, hospitals have 10 days to notify TCBH of an inpatient admission (see Tar Overview).
- The review of inpatient stays is described in the Concurrent Review Policy.

2. The Clinical Manager or a licensed designee reviews the initial clinical assessment and determines if medical necessity exists.
   a. If the client meets medical necessity, services are authorized.
   b. If the individual is denied services due to medical necessity or other allowable reasons for denials, notification is sent to the individual in writing, using the NOABD process outlined in the Notice of Adverse Benefit Determination Policy.

B. TCBH ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a Licensed Practitioner of the Healing Arts (LPHA) who has appropriate clinical expertise in addressing the client's behavioral health needs. TCBH will notify client in writing, via the NOABD process, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (see NOABD Policy).
   1. Initial authorization of services is given for the following standard increments of time:
      a. Mental Health Services: One (1) year
      b. Targeted Case Management Services: One (1) year
      c. Medication Support Services: One (1) year

NOTE: Staff are encouraged to exercise their clinical judgment and to conjointly assess with individuals when maximum benefit from services has been achieved. Discharge prior to the end of service authorization periods may be appropriate when individuals have achieved Plan of Care goals or the maximum benefit from services.

2. Assigned staff providers are required to meet with the individual and/or family and complete Client Plan of Care.
   a. The Plan of Care must be completed and signed within 60 calendar days of the assessment appointment.
   b. All Plan of Cares must have individual and clinician signatures, or documentation explaining the reason(s) that the individual did not sign.
   c. An electronic signature of TCBH staff is acceptable, provided the staff member has a current, signed Electronic Signature Agreement on file with TCBH.
   d. Clients shall be offered copies of the Plan of Care.

3. Once services have been authorized, the assigned service provider may immediately begin delivering the following services even if the Plan of Care is not yet written:
    a. Assessment, if further information is needed or becomes available, there is a significant change in circumstance, or if there is medical necessity to assess further
    b. Plan Development
    c. Crisis Intervention
    d. Medication Support Services for urgent needs (for assessment, evaluation, or plan development; or if there is an urgent need, which must be documented)
    e. Targeted Case Management and Intensive Care Coordination for urgent needs (for assessment plan development, and referral/linkage to help a client obtain needed services including medical, alcohol and drug treatment, social, and educational services if there is an urgent need, which must be documented.)
4. These services may be delivered and billed within the first 60 days of services, before the individual's Plan of Care is in place, as long as the services are necessary and appropriate. The Plan of Care must be completed and signed within 60 business days of the assessment appointment.

XIV. Reauthorization for Continuing Services / Extended Services

A. Clients may require more than one (1) year of outpatient services such as clients who require medication support services, case management, Full-Service Partnership services, and services for high-risk clients.
B. Staff are encouraged to exercise their clinical judgment and to assess with clients when maximum benefit from services has been achieved and a reduction in services or discharge is appropriate.
C. If continuing services are warranted, clinical staff must complete the required documentation:

    1. The primary service provider completes the revised Client Plan of Care, Annual Assessment, Mental Health Severity Guide, and other required documentation.
    2. The Clinical Manager or licensed designee conduct a monitoring review of the documentation to ensure that the client demonstrates medical necessity and is receiving the appropriate level of care.

XV. Children/Youth in Out-of-County Foster Care or Other Residential Placements

A. TCBH is responsible for arranging medically necessary specialty mental health services to a TCBH child/youth who is in out-of-

county foster care or other residential placement (MHSUDS Information Notice 17-032).

1. Unless there is a waiver of Presumptive Transfer to the County of Residence, TCBH will retain responsibility to arrange for specialty mental health services.
2. If Presumptive Transfer is waived, TCBH will be responsible for setting up a contract with out of county providers within 30 calendar days (see Presumptive Transfer Procedure and Coding Structure procedure).

B. Providers that are requesting authorization for the delivery of outpatient services to TCBH children/youth who reside in foster care or other residential placement outside of Tuolumne County must contact TCBH during regular business hours.
   1. If the client or their legal guardian/representative waive their right to Presumptive Transfer, TCBH will continue to authorize services utilizing the DHCS Standard Document (Service Authorization Request [SAR] form). (See Service Authorization Request – SB785 Policy).
C. A service authorization is made within three (3) business days following the date of receipt of the request for services. TCBH authorizes the sessions needed to complete the assessment and develop the client Plan of Care.
   1. TCBH notifies the host county and the requesting provider of the authorization decision within three (3) business days following the date of receipt of the request for services.
   2. If additional information is required to determine the individual's need for services, an extension may be granted for up to three (3) business days from the date that the additional information is received, or fourteen (14) business days from the receipt of the original request for services, whichever is less.
D. TCBH must make payment arrangements with the host county MHP or with the requesting provider within 30 business days of the date that TCBH authorized services.
E. Upon receipt of the completed assessment, TCBH determines the need for ongoing specialty mental health services. TCBH notifies the host county and the requesting provider of the authorization decision for ongoing services.
   1. If the request for services is approved, a TCBH staff member sends the state Standard Documents for Foster Care (Plan of Care and Progress Notes), or equivalent forms, to the out-of-county provider via fax, email, or regular mail.
   2. If the individual is denied services due to medical necessity or other allowable reasons for denials, the Clinical Manager or designee notify the individual in writing, using the NOABD process.

3. If services are denied or modified due to medical necessity or other allowable reasons, and if a second opinion is requested, TCBH is responsible for arranging for the individual to obtain a second opinion about his/her mental health condition at no cost to the client.

F. Authorization requests, timeframes, and resolutions are logged in the Presumptive Transfer SAR Tracking Log which is maintained by the Program Supervisor or designee.

XVI. Children/Youth in Aid to Adoptive Parents OR KinGAP Aid Code

A. TCBH is responsible for providing medically necessary specialty mental health services to a child/youth in an Aid to Adoptive Parents (AAP) or KinGAP aid code whose adoptive parent or guardian reside in Tuolumne County.
B. TCBH submits a request for service authorization to the child's county of origin, utilizing a DHCS SAR form or equivalent.
C. The county of origin notifies TCBH of its authorization decision within three (3) business days following the date of receipt of the request for services. The county of origin will likely authorize TCBH two (2) sessions for completing the assessment materials.
    1. If additional information is required to determine the individual's need for services, an extension may be granted for up to three (3) business days from the date that the additional information is received, or fourteen (14) business days from the receipt of the original request for services, whichever is less.
D. Upon receipt of the completed assessment, the county of origin determines the need for ongoing specialty mental health services. TCBH is notified of the authorization decision for ongoing services.
    1. When authorization to deliver services is denied, the NOABD process is completed by the county of origin.
    2. If services are denied or modified due to medical necessity or other allowable reasons, the county of origin is responsible for arranging for the individual to obtain a second opinion about his/her mental health condition, if requested, and at no cost to the client.
E. The MHP in the child's county of origin must make payment arrangements with TCBH within 30 business days of the date that the MHP authorized services.
F. Authorization requests, timeframes, and resolutions are logged in the Presumptive Transfer SAR Tracking Log.

XVII. Adults in Out-of-County Residential Placements

A. Out-of-county residential placements for adults are authorized through a case meeting between the Clinical Manager, Program

	Supervisor, and LPS case manager, and/or at the monthly LPS and Placement meeting.
References	MHSUDS Information Notice No. 19-026: Authorization of Specialty Mental Health Services MHSUDS Information notice 17-032: Implementation of Presumptive Transfer for Foster Children Placed Out of County MHSUDS Information notice 17-040: Chart Documentation Requirement Clarifications MHSUDS Information Notice 22-016: Authorization of Specialty Mental Health Service MHSUDS Information Notice 22-017: Concurrent Review Standard for Psychiatric Inpatient Hospital and Psychiatric Health Facility Services CCR, Title 9, Sections 1810, 1830, 1840, & 1850 DMH Information Notice 08-24: Authorization Out of Plan Services DMH Information Notice 09-06: Delivery of Medi-Cal Specialty Mental Health Services for Children in a Foster Care, KinGAP, or Aid to Adoptive Parents Aid Code Placed Outside Their County of Origin DHCS-MHP Contract Title 42 of the CFR, part 438.910: Parity Rule 42 CFR, §§ 438.210(c), and 438.404
Related Policies or Documents	Access to Behavioral Health Services Policy Plan of Care Policy Documentation Standards for Client Records Policy Concurrent Review Policy Katie A. Program Services Policy Notice of Adverse Benefit Determination Policy Presumptive Transfer Procedure and Coding Structure Service Authorization Request – SB785 Policy TAR Overview Continuity of Care Policy Network Adequacy Policy

Documentation Deadline Standards Policy

Policy	It is the policy of Tuolumne County Behavioral Health (TCBH) that documentation representing client service encounters is generated in a timely

	manner. Meeting the deadline is the responsibility of each individual provider staff.
Purpose	The purpose of this policy is to ensure quality and continuity of care by generating accurate documentation of service encounters in a timely manner.
Definitions	Documentation: A set of documents provided on paper, electronically, or digitally, required by either policy or procedures, to support the business and operations of TCBH. Documentation includes, but is not limited to, scheduled events, assessment forms, screening tools, progress notes, and/or other mandated forms e.g., Grievance, medication consents, SCAR reports. Service Encounter: A service delivered to a client or provided on behalf of a client which are defined within the TCBH Service Code List
Procedure	I. All planned client encounters shall be recorded within the scheduler of the Electronic Health Record prior to the date of activity for scheduled/preplanned appointments. II. All crisis or unplanned service encounters must be recorded within the scheduler of the Electronic Health record on the **same date** of service encounter and/or prior to provider leaving shift. III. All scheduled, non-crisis. or planned service encounters must be documented within **24 hours** from the event and time of service and completed prior to staff time off. Outcome instruments must also be completed at time of assessment with the same standard of timeliness of 24 hours, and then as required during the course of treatment (e.g., LOCUS, CANS, PSC-35, and ASAM). IV. Progress notes should be completed after each session within the scheduled time allotted. Strategies may be employed to achieve this such as the use of a 45-minute session with 15 minutes for documentation, 1 ½ hour group with 30 minutes for documentation, completing crisis documentation immediately after the crisis intervention, etc. V. Staff must report all activities, including non-client related activities, for each day for which they are being paid. For paid holidays and other non-client related activities, the appropriate administrative code must be reported. VI. The number of provider hours reported within the Electronic Health Record for any one scheduled workday should be the same as the staff's paid hours or equivalent to time spent at the agency for volunteers or students. VII. All documentation must be turned in prior to leaving for a planned day(s) off.

VIII. Weekly reports will be reviewed between the provider staff and their supervisor(s).

IX. Provider staff will be responsible to report their documentation status to their Program Supervisor if they feel they will not meet the documentation deadline The Program Supervisor and staff should identify a plan to ensure future success.

A. At the discretion of the Program Supervisor, training or emergency staff situations may allow for extended time for completion of documentation.

B. The Program Supervisor will be responsible to monitor the Clinician's Homepage, Power BI, or other monitoring tools to ensure the plan is executed resulting completion of documentation.

C. Compliance monitoring of timeliness will occur monthly by use of the Electronic Health Record reports generated and presented to appropriate supervisors along with an individualized memo identifying performance.

D. Late documentation, over the 24-hour standards from the date of service, shall result in Supervisors communicating to staff a corrective action plan necessary for staff to be in compliance.

E. Late documentation over the standards 14 days from the date of service shall be disallowed through the end of month processing and would result in appropriate disciplinary action.

X. Noncompliance Verbal Discussion, Written follow-up, Plans of Correction, Information Write-ups, and Formal Personnel Write-ups will be used timely to keep the staff informed and for the purpose of Supervisors developing annual Job Performance Evaluations.

A. Consequences for non-compliance shall be instituted by the Program Supervisor. The consequences will be progressive disciplinary actions allowed by the staff's specific union MOU's.

a. Compliance monitoring of Plan of Corrections non-compliance will be monitored by the use of Electronic Health Record reports and Employee Plan of Correction binder. Identification of noncompliance will be presented to the BHD Director for handling.

References

Access to Care Log Policy

Access to Behavioral Health Services Policy

Access to SUD Treatment Services Policy

Documentation Standards of Clinical Records Policy

Plan of Care Policy

Diagnosis Update Policy

Coordination with Outside Providers

Case Administration Team (CAT) Policy

CANS and PCS35 Policy

Documentation Standards for Client Records Policy

Policy

It is the policy of Tuolumne County Behavioral Health (TCBH) that documentation standards for beneficiary care meet the minimum standards to support claims for the delivery of specialty mental health services and shall be addressed within the beneficiary record.

Purpose

The purpose of this policy is to ensure that documentation requirements for all Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) services are met when documenting client service encounters in accordance with Department of Health Care Services (DHCS) standards.

Definitions

American Society of Addiction Medicine Criteria assessment (ASAM): A comprehensive set of standards for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions

DMC: Drug Medi-Cal

DSM: Diagnostic and Statistical Manual of Mental Disorders

POC: Plan of Care

TBS: Therapeutic Behavioral Services

ICC: Intensive Care Coordination

IHBS: Intensive Home-Based Services

SMHS: Specialty Mental Health Services

Tuolumne County Behavioral Health (TCBH)

TCM: Targeted Case Management

Procedure

I. Introduction: Behavioral Health Integrated Care

Tuolumne County Behavioral Health (TCBH) provides an integrated care model for Behavioral Health Services for Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS) within the Drug Medi-Cal delivery system. TCBH uses a standardized comprehensive assessment for both SMHS and DMC.

II. Standardized Comprehensive Assessment Requirements

A. Standardized Assessment Requirements (SMHS and DMC)

1. MHPs shall require providers to use uniform assessment domains as identified below (Domains of Assessment). 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.

2. The time period for providers to complete an initial assessment is 24 hours (see Documentation Deadline Policy).
3. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature.
4. 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.
5. 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.
6. 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.

B. Domains of Assessment

Providers shall document the 7 domains in the Comprehensive Assessment and keep the assessment in the beneficiary's medical record.

For children over the age of 12 or certain other beneficiaries unable to provide a history, this information may be obtained from the parent/caregiver, guardian, etc. Assessment will contain the following documented within the associated domains:

Comprehensive Assessments shall contain 7 uniform assessment domains as follows:

B. Domain 1: Presenting Problem/Chief Complaint
Domain 1 focuses on the main reason the person is seeking care, in their own words if appropriate. The goal is to document an account of what led up to seeking care. This domain addresses both their current and historical states related to the chief complaint.

a. Presenting Problem (Current and History of) – The person's and collateral sources' description of problem(s), history of the presenting problem(s), impact of problem on person in

care. Descriptions should include, when possible, the duration, severity, context and cultural understanding of the chief complaint and its impact.

b. Current **Mental Status Exam (MSE)** – The person's mental state at the time of the assessment.
c. Impairments in Functioning – The person and collateral sources identify the impact/impairment – level of distress, disability, or dysfunction in one or more important areas of life functioning as well as protective factors related to functioning.

2. Domain 2: Trauma
Domain 2 involves information on traumatic incidents, the person in care's reactions to trauma exposures and the impact of trauma on the presenting problem. It is important that traumatic experiences are acknowledged and integrated into the narrative. Take your cues from the person in care – it is not necessary in every setting to document the details of traumatic incidents in depth.

a. Trauma Exposures - A description of psychological, emotional responses and symptoms to one or more life events that are deeply distressing or disturbing. This can include stressors due to significant life events (being unhoused or insufficiently housed, justice involvement, involvement with child welfare system, loss, etc.)
b. Trauma Reactions – The person's reaction to stressful situations (i.e., avoidance of feelings, irritability, interpersonal problems, etc.) and/or information on the impact of trauma exposure/history to well-being, developmental progression and/or risk behaviors.
c. Trauma Screening – The results of the trauma screening tool to be approved by DHCS (e.g., Adverse Childhood Experiences {ACES}), indicating elevated risk for development of a mental health condition.
d. Systems Involvement – The person's experience with homelessness, juvenile justice involvement, or involvement in the child welfare system.

3. Domain 3: Behavioral Health History
Domain 3 focuses on history of behavioral health needs and the interventions that have been received to address those needs. Domain 3 also includes a review of substance use/abuse to identify co-occurring conditions and/or the impact of substance use/abuse on the presenting problem.

a. Mental Health History – Review of acute or chronic conditions not earlier described. Mental health conditions previously diagnosed or suspected should be included.

b. Substance Use/Abuse – Review of past/present use of substances, including type, method, and frequency of use. Substance use conditions previously diagnosed or suspected should be included.
c. Previous Services – Review of previous treatment received for mental health and/or substance abuse concerns, including providers, therapeutic modality (e.g., medications, therapy, rehabilitation, hospitalizations, crisis services, substance abuse groups, detox programs, Medication for Addiction Treatment {MAT}), length of treatment, and efficacy/response to interventions.

4. Domain 4: Medical History and Medications
Domain 4 integrates medical and medication items into the psychosocial assessment. The intersection of behavioral health needs, physical health conditions, developmental history, and medication usage provides important context for understanding the needs of the people we serve.

a. Physical Health Conditions – Relevant current or past medical conditions, including the treatment history of those conditions. Information on help seeking for physical health treatment should be included. Information on allergies, including those to medications, should be clearly and prominently noted.
b. Medications – Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. When available, the start and end dates or approximate time frames for medication should be included.
c. Developmental History – Prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for individuals 21 years old or younger).

5. Domain 5: Psychosocial Factors
Domain 5 supports clinicians in understanding the environment in which the person in care is functioning. This environment can be on the micro-level (e.g., family) and on the macro-level (e.g., systemic racism and broad cultural factors).

a. Family – Family history, current family involvement, significant life events within family (e.g., loss, divorce, births)
b. Social and Life Circumstances – Current living situation, daily activities, social supports/networks, legal/justice involvement, military history, community engagement, description of how the person interacts with others and in relationship with the larger social community

c. Cultural Considerations – Cultural factors, linguistic factors, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and other (LGBTQ+) and/or Black, Indigenous and People of Color (BIPOC) identities, gender identifications, spirituality and/or religious beliefs, values, and practices

6. Domain 6: Strengths, Risk and Protective Factors
Domain 6 explores areas of risk for the individuals we serve, but also the protective factors and strengths that are an equally important part of the clinical picture. Clinicians should explore specific strengths and protective factors and understand how these strengths mitigate risks that the individual is experiencing.

   a. Strengths and Protective Factors – Personal motivations, desires and drives, hobbies and interests, positive savoring and coping skills, availability of resources, opportunities and supports, interpersonal relationships
   b. Risk Factors and Behaviors – Behaviors that put the person in care at risk for danger to themselves or others, including suicidal ideation/planning/intent, homicidal ideation/planning/intent, aggression, inability to are for self, recklessness, etc. Include triggers or situations that may result in risk behaviors. Include history of previous attempts, family history of or involvement in risks, context for risk behaviors (e.g., loneliness, gang affiliations, psychosis, drug use/abuse), willingness to seek/obtain help. May include specific risk careening/assessment tools (e.g., Columbia Suicide Severity Rating Scale) and the results of such tools used.
   c. Safety Planning – Specific safety plans to be used should risk behaviors arise, including actions to take and trusted individuals to call during crisis.

7. Domain 7: Clinical Summary, Treatment Recommendations, Level of Care Determination
Domain 7 provides clinicians an opportunity to clearly articulate a working theory about how the person in care's presenting challenges are informed by the other areas explored in the assessment and how treatment should proceed based on this hypothesis.

   a. Clinical Impression – summary of clinical symptoms supporting diagnosis, functional impairments, (clearly connected to symptoms/presenting problem), history, mental status exam, cultural factors, strengths/protective factors, risks, and any hypothesis regarding predisposing, precipitating and/or perpetuating factors to inform the problem list (to be further explained below)

b. Diagnostic Impression – clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified)
c. Treatment Recommendations – recommendations for detailed and specific interventions and service types based on clinical impression and, overall goals for care.

C. American Society of Addiction Medicine Criteria assessment (ASAM)

The ASAM is a comprehensive set of standards for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions. The comprehensive assessment includes the use of the ASAM when substance use services are requested by the client to determine treatment needs. The adolescent ASAM is used with youth ages 12-17.

III. Treatment & Care Planning Requirements

A. Targeted Case Management Treatment (TCM) Plan

1. The TCM treatment plan is initially documented in the narrative of the progress note.
2. A new case management treatment plan is not required at every single service but is covered by the initial treatment plan in the progress note.
3. The TCM Treatment Plan is reviewed annually, or more often, as clinically indicated.
4. The TCM treatment 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;
5. 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;
6. Identifies a course of action to respond to the assessed needs of the beneficiary; and
7. Includes development of a transition plan when a beneficiary has achieved the goals of the care plan.

B. Peer Support Services

1. Similar to TCM, Peer Support Services require a treatment plan documented within the progress note.
2. The Peer Support Specialist treatment plan is documented in a progress note initially in the narrative of the note and must be based on an approved plan of care documented within the progress note(s) in the client's record and approved by any

treating qualified provider who can render reimbursable Medi-Cal service.

3. A new Peer Support Specialist treatment plan is not required at every single service but is covered by the initial treatment plan in the progress note.
4. The Peer Support Specialist treatment plan is reviewed annually or more often as clinically indicated.

IV. Plan of Care (POC)

a. Plans of Care will continue to be applicable as mandated by the state, particularly in the areas of ICC, and IHBS and TBS. Plan of Care will:

1. Identify client specific strengths that will assist the client in reaching their treatment goals
2. Have specific, observable, and quantifiable goals
3. Identify specific objectives for clients identified goals
4. Identify proposed interventions that are consistent with the client plan goal, focus and address the identified functional impairment(s) as a result of the mental health disorder. Planned intervention(s) may include the following:
   a. Therapeutic Behavioral Services
   b. ICC/IHBS
5. Have a proposed duration and frequency for intervention(s).
6. Be consistent with the qualified diagnosis and the Problem List.
7. Be signed (or electronic equivalent) by:
   a. The person providing the service(s), or
   b. A person representing a team or program providing service(s), or
   c. A person representing the MHP providing service(s)
8. When the Plan of Care is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category of staff, then the service plan must be signed by:
   a. A physician or nurse practitioner
   b. Licensed/waivered psychologist
   c. A licensed/registered/waivered clinical social worker
   d. A licensed/registered/waivered Marriage Family Therapist, or
   e. A licensed/registered professional clinical counselor (LPCC)
   f. Registered nurse.
9. There will be documentation of the beneficiaries' participation in, and agreement with, the POC. Examples of participation and agreement include, but are not limited to:
   a. Reference to the client's participation and agreement in the body of the associated progress note.

b. Client signature on the plan, or
c. Description of the client's participation and agreement in progress notes.
d. Client and/or legally responsible adult, signature on the POC may solely be used as the means by which the MHP documents the participation of the client.
e. There will be documentation within the beneficiary record that a copy of the plan was offered to the beneficiary.

b. Timeliness/Frequency: Plan of Care (POC)

i. Provider will develop a POC in collaboration with the client and/or representative prior to the delivery of intervention that are subject to POC.
ii. The POC shall be updated prior to or upon the previous POC's expiration date and must be developed based on medical necessity established through either a comprehensive assessment or assessment update performed in the last 364 days or by the identification of client symptoms, conditions and/ or risk factors within the Clients Problem List.
iii. POC may be updated when there are significant changes in the beneficiary's condition and/or more often as appropriate and clinically indicated.

V. Problem List

a. Responsibility: The provider(s) responsible for the beneficiary's care shall create and maintain a problem list.
b. Description:
1. 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.
2. It includes diagnoses identified by a provider acting within their scope of practice, if any.
3. Problems or illnesses identified by the beneficiary and/or significant support person, if any.
4. The use of the Problem List has replaced the use of treatment plans except where federal requirements mandate a treatment plan be maintained (as described in this policy).

c. Time of Completion and Updating the Problem List:
1. The Problem List will be completed at time of screening, assessment, annual assessment, and when any diagnostic changes occur.
2. The Problem List is updated on an ongoing basis to reflect the current presentation of the person in care.

3. Providers shall add to or remove problems from the Problem List when there is a relevant change to a beneficiary's condition.
4. Providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.
5. A problem identified during a service encounter (e.g., crisis intervention) may be addressed by the service provider (within their scope of practice) during that service encounter, and subsequently added to the problem list.
6. The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

d. Problem Lists and Diagnoses:
   1. The Problem List includes diagnosis-specific specifiers , from the current DSM including Z codes, as well as social determinants of health codes.
   2. Accuracy of the diagnoses and the Problem List are necessary for appropriate treatment services and to support claiming.
   3. Depending upon a provider's scope of practice, the Problem List will be completed:
      a. Behavioral Health Workers may add a specific set of Z codes to the Problem List listed in the DSM: Z55-Z65.
      b. LPHA's will complete the Problem List with diagnostic codes from the DSM and/or psychosocial stressors within their scope of practice.

VI. Progress Notes

A. Requirements for Progress Notes

1. Providers shall create progress notes for the provision of all SMHS and DMC 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. 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).
3. The date that the service was provided to the beneficiary.
4. Duration of the service, including travel and documentation time. All signature dates will be the date for which the document was actually signed.
5. Location of the beneficiary at the time of receiving the service.
6. A typed or legibly printed name, signature of the service provider and date of signature. All entries in the client record will include the signature of the person providing the service (or

electronic equivalent), the person's professional degree, or licensure or job title.

7. ICD 10 code included in the electronic health record.
8. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
9. 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
10. Although BHIN 22-019 requires 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, TCBH sets the additional goal of completing progress notes within 24 hours and same day for crisis services (See Documentation Deadline Policy).
11. 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).
12. 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.

B. Format for Progress Notes for Individual and Group service encounters:
   1. Providers shall utilize "SLIRP" template in the body of the progress note for the following intervention types: Therapy, Rehabilitation, Collateral Therapy, and Family Therapy.
      a. S=Symptoms should reflect qualifying diagnosis, observed by provider or by client report.
      b. L = Level of functioning and current functional impairment in each note
      c. I=Interventions for each note should relate to the MH functional impairment and the clients' qualifying diagnosis.
         i. Interventions must be identified within the POC prior to delivery.
         ii. What the clinician did and how did the client respond.
      d. R=Response — Client's response to the intervention

e. P=Plan - should be present in every note:
   i. Short term or long-term plans
   ii. Any changes in approach
   iii. Who will do what?
   iv. Should be consistent with authorized services and the working diagnosis
   v. If this is a group contact, document the number of clients present, the number of providers and the necessity of having more than one provider present.
   vi. Document any homework given to the client or plans made with the client during the Session.
   vii. Document the next scheduled appointment or step needed for discharge.

C. Plan Development (13) or Plan of Care (15) activities shall be recorded with use of the (PID) template.
   1. P=Purpose of Consultation or Review
   2. I=Issues and Discussion
   3. D=Decision/Actions

D. Case Management activities shall be recorded using the PID template described above.

E. Frequency of Progress Notes: Progress notes will be documented at the frequency rate, by the type of service, indicated below:
   1. Every Client Service Encounter
      a. Mental Health Services
      b. Substance Use Disorder Services
      c. Therapy
      d. Collateral (Therapeutic)
      e. Family Counseling
      f. Rehabilitation
      g. Intensive Care Coordination (ICC)
      h. In Home Based Services (IHBS)
      i. Therapeutic Behavioral Service (TBS)
      j. Therapeutic Foster Care
      k. Medication Support Services
      l. Crisis Intervention
      m. Peer Support Services
   2. Daily
      a. Crisis Residential
      b. Crisis Stabilization (1x/23hr)
   3. Other
      a. Linkage/Brokerage and Targeted Case management – All targeted case management progress notes shall include a care plan using the TMC Care Plan template.
      b. As determined by MHP for other services

VII. Service Encounter Reporting Standards

The below elements are required to be identified for each service delivered to beneficiaries:

a. Date of the service encounter

b. The exact number of minutes of the service delivery.
   1. Service Duration
      a. Time spent delivering the service
   2. Documentation Time
      a. Time taken to document the service encounter.
   3. Travel
      a. Time spent traveling to offsite service location
         i. Travel includes return to provider's worksite.
         ii. Travel time shall be prorated when the time includes traveling to multiple locations for more than one client.

C. The unique Unit and Subunit to which the beneficiary is admitted and has received service.

D. Location of the Client at the time of service, i.e., Jail, Office, Field, or Home

E. Service Code: Individual, group, crisis, or medication refill.

F. Client Service Indicators (CSI) Service Strategies, e.g., Delivered in partnership with Law Enforcement.

G. Other Client Service Indicators (CSI) — See TCBH Key Guide

References

Assembly Bill (AB) 133: Describes various components of the CalAIM initiative.

Behavioral Health Information Notice No: 22-019: Documentation requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services

Cal. Code of Regs., Title 9, 1830.205(b).

Cal. Code of Regs., Title 9,§ 1810.440(c)(2)(A)(B)

Cal. Code of Regs. Title 9, 1830.2050

MHP DHCS Contract

Welfare & Institutions Code (W&I), § 14184.402, subd. (h)(3)

Related Policies or Documents

Access to Behavioral Health Services Policy

Access to SUD Treatment Services Policy

Clinical Documentation Guide, 2023, California Mental Health Services Authority (CalMHSA)

Documentation Deadline Plan Policy
Documentation of Substance Use Disorder Treatment Sessions
ICC and IHBS Policy
Medical Necessity Policy
Plan of Care Policy
Therapeutic Behavioral Services (TBS) Policy

Documentation of Substance Use Disorder Treatment Sessions Policy

Policy

It is the policy of Tuolumne County Behavioral Health that all charting of profess notes will be done in a standardized formant that will include appropriate information relevant to the client's program and progress in treatment.

Purpose

To have clearly defined expectations for substance use disorder documentation.

Definitions

Face to Face: An appointment occurring in person at a certified facility. Telephone contacts, home visits, and hospital visits shall not be considered face-to-face.

SUD: Substance Use Disorder

TCBH: Tuolumne County Behavioral Health

Procedure

I. Individual Counseling
   A. Individual counseling shall be limited to intake, crisis intervention, collateral services, treatment, and discharge planning appointments.
   B. Progress notes will contain the clinician/counselor's observations of behavior and will be based upon the process that occurs within individual sessions.
   C. Relevant information concerning the client's recovery outside the session may be included when reported or discussed with the clinician/counselor.
   D. Progress notes will follow the SLIRP format

II. Group Counseling

Group counseling is a face-to-face contact in which one or more therapists or counselors treat two or more clients at the same time, focusing on the needs of the individual s served. Group counseling sessions shall focus on short -term personal, family, job/school, and other problems and their relationship to substance use or a return to substance use

   A. A sign-in sheet shall be maintained for every group counseling session which will include the

clinician/counselor signature and legibly printed names and signatures of group participants.

B. Number of Participants: Group counseling shall have no less than two, and no more than twelve, participants in each session.
C. Group counseling shall be conducted in a confidential setting so that individuals not participating in the group cannot hear the comments of the group participants, clinician, or counselor.
D. A participant who is 17 years of age or younger shall not participate in group counseling with any participants who are 18 years of age or older.

III. Progress Notes

Individual or group counseling session notes shall include, but not be limited to 1hefollowing information:

A. Date, time, and duration of session
B. Type of session (individual or group)
C. Name and title of co-facilitator
D. Clean and sober date
E. Number of 12-Step meetings attended during the last week
F. Session topic or focus
G. Client's presentation, interactions, and responses
H. Interventions by peers or facilitators
I. Progress toward achievement of goals identified in the treatment plan
J. New issues or problems
K. Psychosocial support systems
L. Plan

IV. Collateral

A face to face sessions with clinician/counselor and significant persons in the client's life, focusing on treatment needs of the client in terms of supporting the achievement of the client's treatment goals. Significant persons are individuals that have a personal, not official, or professional, relationship with the client.

V. Case Management

A service that allows for efficient use of resources, skills, and services across systems. Case management services are provided by a single point of contact who arranges, coordinates, and monitors the services to meet the needs of pregnant and parenting women and their families. Case management offers cultural sensitivity and advocacy for each client.

VI. Crisis

	A face-to-face contact between a clinician/counselor and a client in crisis. Services shall focus on alleviating the crisis problem. Crisis means an actual relapse or an unforeseen event or circumstance which presents to the client an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the emergency situation. VII. Timeliness of Documentation A. All planned client encounters shall be recorder within the scheduler of the Electronic Health Record prior to the date of activity for the scheduled/planned appointments. B. All crisis or unplanned service encounters must be recorded within the scheduler of the Electronic Health Record on the same day of service encounters and/to prior to provider leaving shift. C. All scheduled, non-crisis or planned service encounters must be documented within 24 hours from the event and time of service and completed prior to staff time off.
References	Title 22 Section 13005(a)(2) of Title 9, CCR. Title 22 Section 13005(a)(8) of Title 9, CCR. Title 22 Section 51341.1 Title 22 Section 51490.1 https://www.ncbi.nlm.nih.gov/books/ NBK64857/
Related Policies or Documents	Documentation Deadline Policy Documentation Standards for Client Records

Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) Policy

Purpose	To describe Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) at Tuolumne County Behavioral Health (TCBH).
Definitions	**Behavioral Health Worker (BHW):** The staff member providing Intensive Home Based Services (IHBS) and Intensive Care Coordination (ICC). **Case Administration Team (CAT):** The authorization team that reviews case assignments, levels of care, and treatment services at TCBH. **Child and Adolescent Needs and Strengths (CANS):** The outcome measurement tool used to evaluate progress in children's services. **Child Family Team (CFT):** A strength based meeting that brings together youth and their family, professionals / public agency representatives, natural community supports, and formal resources led by a trained facilitator to develop a child, youth, and family-centered case plan.

CSOC Eligibility and Authorization Tool: The instrument used by TCBH to determine if a client is eligible for Pathways to Well-Being and Enhanced Services and what level of care they may need.

Intensive Care Coordination (ICC): A service that facilitates care planning and coordination services for youth who are enrolled in Specialty Mental Health Services, with serious emotional disturbance (SED), and under the age of 21.

Intensive Care Coordinator: A member of the mental health treatment team who coordinates ICC services.

Intensive Home-Based Services (IHBS): Mental health rehabilitative services for beneficiaries under 21 who are eligible for the full scope of Medi-Cal services and meet medical necessity criteria and are receiving Intensive Care Coordination.

Early Prevention Screening and Diagnoses Treatment Services (EPSDT): The service benefits providing comprehensive and preventative health care for individuals under the age of 21 who are enrolled in Medi-Cal**.**

Level of Care (LOC): A particular amount of care and services required to meet a person's treatment needs.

SMHS: Specialty Mental Health Services

Pathways to Well-Being: The expansion of services as a result of the Katie A vs. Bonta class action lawsuit which include an array of services delivered using the Core Practice Model, including ICC, IHBS, and Therapeutic Foster Care (TFC) services.

Short Term Residential Treatment Program (STRTP): A residential facility operated by a public agency or private organization that provides an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term 24-hour care and supervision to children and non-minor dependents.

Therapeutic Foster Care (TFC): A short-term foster rate that supports an intensive, highly coordinated, trauma informed, and individualized rehabilitative service covered under Medi-Cal that is provided to a child/youth (up to age 21) with complex emotional and behavioral needs.

TCBH: Tuolumne County Behavioral Health

Wraparound Services: Wraparound is a family-centered, strengths-based, and needs driven planning process for children, youth, and families that take place in a team setting.

Procedure

I. Eligibility Criteria

ICC and IHBS are provided through the EPSDT benefit to all children and youth who meet the following criteria:

A. Are under the age of 21; and

B. Are eligible for the full scope of Medi-Cal services; and
C. Meet medical necessity criteria for SMHS and are involved in and/or receiving one additional service such as TBS or WRAP.
D. The following criteria should be considered as indicators of need for ICC and IHBS:
    1. Are receiving, or being considered for, Wraparound services;
    2. Are receiving, or being considered for, a specialized care rate due to behavioral health needs;
    3. Are being considered for other intensive SMHS, including, but not limited to, TBS, or are receiving crisis stabilization/intervention services;
    4. Are currently in, or being considered for, high-level-care institutional settings, such as group homes or STRTPs;
    5. Have been discharged within 90 days from, or currently reside in, or are being considered for placement in, a psychiatric hospital or 24-hour mental health treatment facility [e.g., psychiatric inpatient hospital, psychiatric health facility (PHF), community treatment facility, etc.];
    6. Have experienced two or more mental health hospitalizations in the last 12 months;
    7. Have experienced two or more placement changes, within 24 months, due to behavioral health needs;
    8. Have been treated with two or more antipsychotic medications, at the same time, over a three-month period;
    9. If the child is zero through five years old and has more than one psychotropic medication, the child is 6 through 11 years old and has more than two psychotropic medications, or the child is 12 through 17 years old and has more than three psychotropic medications;
    10. If the child is zero through five years old and has more than one mental health diagnosis, the child is 6 through 11 years old and has more than two mental health diagnoses, or the child is 12 through 17 years old and has more than three mental health diagnoses;
    11. Have two or more emergency room visits in the last 6 months due to primary mental health condition or need, including, but not limited to, involuntary treatment;
    12. Have been detained, pursuant to W&I sections 601 and 602, primarily due to mental health needs; or
    13. Have received SMHS within the last year and have been reported homeless within the prior six months.
    14. The youth is involved with two or more child-serving systems

II. Determination of Eligibility

The clinician will complete the CSOC Eligibility and Authorization Tool which will be reviewed in the CAT meeting. CAT will assign

the appropriate level of care for the client. CAT will notify the designated staff to coordinate a CFT.

III. Child, Family, and Team (CFT) Team Meeting

The CFT meeting will be attended by the youth's clinician, supervisor, or designated individual. Designated staff will facilitate the CFT meeting to initiate level of care services including ICC, IHBS, and TFC services.

If the CFT has already occurred prior to assessment and the level of care was indicated, then a new CFT will not be needed.

IV. Intensive Care Coordination (ICC) Services

Intensive Care Coordination (ICC) is similar to Targeted Case Management (TCM) and includes components such as facilitating assessment, care planning and coordination of services, including urgent services for youth. ICC is delivered using a Child and Family Team and is intended for children or youth whose treatment requires cross-agency collaboration.

A. ICC services include the following:
   1. Planning and assessment of strengths and needs; and
   2. Reassessment; and
   3. Referral, monitoring, and follow-up services; and
   4. Transition services

B. ICC can be performed by the clinician or behavioral health worker.

V. Intensive Home Based Services (IHBS):

Intensive Home Based Services (IHBS) are individualized, strength-based interventions designed to better mental health conditions that interfere with a youth's functioning. These interventions are aimed at helping the youth build skills for successful functioning in the home and community and improving the family's ability to help the youth successfully function in the home and in the community.

A. IHBS services include the following:
   1. Intervention
   2. Coping skills
   3. Activities that teach youth functional skills
   4. Assisting youth in activity that will create a new functional skill or build on strength
   5. Modeling and coaching functional skills in the community
   6. Supporting youth to address behaviors that interfere with being successful at school or maintaining a job
   7. Promote the development, maintenance and use of social networks including the use of natural and community resources

8. This is a field-based service in the community

VI. Transition to Lower Levels of Care (LOC):

When a youth has a re-assessment and the CSOC Eligibility and Authorization tool is completed, it may be determined they can reduce their services. A CFT will be scheduled to determine the recommended service needs. The youth's BHW or Clinician will forward the case to CAT for review and determination of the level of care based upon medical necessity, CFT recommendations, and CANS scores.

VII. Documentation Requirements

A. **Assessment:** The assessing clinician shall document medical necessity for ICC and IBHS in the Children's Comprehensive Assessment.
B. **CSOC Eligibility and Authorization Tool:** The clinician shall complete the CSOC Eligibility and Authorization tool to determine what level of care and services are needed by the client.
C. **CFT Decision-Making Process:** The clinician or BHW will document the decision by the CFT for the need for ICC/IHBS in a progress note.
D. **Plan of Care:** The clinician or BHW shall complete or update a POC prior to delivery of ICC/IBHS services to include ICC/IHBS services.
    1. A Plan of Care is required for all youth under Cal-Aim including the following elements:
        a. Measurable objective
        b. Identified strengths
        c. Therapy modality
        d. Frequency
        e. Interventions: ICC/IHBS services
E. **Problem List:** The clinician will update the Problem List to reflect the current presentation of the client and shall include any psychosocial stressors (Z codes) identified in the CFT that need to be addressed through ICC and IHBS services.
F. **Progress Notes**
    1. Ongoing progress notes for ICC and IHBS will reflect the appropriate codes for these services.
    2. Progress notes will be placed in the appropriate format (e.g., SLIRP format).
G. **Documentation Standards**
    1. Staff will follow TCBH's documentation and timeliness standards.

References

Behavioral Health Information Notice (BHIN) No. 22-019: Documentation Requirements for all Specialty Mental Health Services (SMHS), Drug Medi-

	Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services Behavioral Health Information Notice No. 21-058: Claiming for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services MHSUDS Information Notice No: 16-004: Provision of ICC and IHBS as Medically Necessary Through EPSDT Pathways to Wellness, January 2019, Third Edition All County Letter #16-84
Related Policies or Documents	Authorization of Specialty Mental Health Services Policy Case Administration Team (CAT) Policy Child Family Team Policy CSOC Eligibility and Authorization Tool: The instrument used by TCBH to determine if a client is eligible for Pathways to Well-Being and Enhanced Services and what level of care they may need. Documentation Standards for Client Records Policy Documentation Deadline Policy Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, Third Edition Therapeutic Foster Care Policy

Therapeutic Behavioral Services (TBS) Policy

Purpose	The purpose of this policy is to describe how Therapeutic Behavioral Services (TBS) are provided at Tuolumne County Behavioral Health in accordance with State regulations (CCR, Title 9, Ch.11, Section 1810.405(c); CCR, Title 9, Ch.11, Section 1810.229; DMH Info. Notice 08-38).
Definitions	CAT—Case Administration Team: The review team that authorizes SMHS services including TBS services. EPSDT: Early Periodic Screening Diagnosis and Treatment. SMHS: Specialty Mental Health Services. STRTP: Short Term Residential Treatment Program: A residential treatment program for children or youth that is designed to be short-term of 6 months or less. TBS—Therapeutic Behavioral Services: An intensive short-term outpatient treatment intervention provided for children and youth who are experiencing a stressful transition in life and need additional short-term specific support services.

TCBH: Tuolumne County Behavioral Health

Procedure

I. Entry Criteria

A. Must be eligible for full-scope Medi-Cal and be under the age of 21 years and must meet the requirement for class eligibility/certification as listed below.

B. Meets medical necessity for Specialty Mental Health Services (SMHS).

C. Child/Youth must be receiving other mental health specialty services. TBS is an adjunct service to SMHS.

II. Class Eligibility

A. Those youth placed in a Short Term Residential Treatment Program (STRTP) or a locked mental health treatment facility.

B. Youth who have undergone or are at risk of an emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months.

C. Youth being considered for placement or at risk for placement to the above facilities and it is the clinical judgment that it is highly likely that without additional short term support of TBS:

1. The child/youth will need to be placed out-of-home or into a higher level of residential care because the child/youth's behavior or symptoms are jeopardizing continued placement in the current facility, or

2. The child/youth needs additional support to transition to a home or foster home or lower level of residential placement. Although the child/youth may be stable in the current placement, a change in behavior or symptoms is expected and TBS is needed to stabilize the child/youth in the new environment. TCBH and TBS providers must document the basis for the expectation that the behavior or symptoms will change.

3. The child/youth will need to be placed out-of-home, or into a higher level of residential care, because the child/youth's behavior or symptoms are jeopardizing continued placement in the current facility.

III. 30 Day Contact without Class Eligibility

A. Under certain circumstances, TCBH may authorize the provision of TBS for a maximum of 30 calendar days when class membership cannot be established or until class membership can be established whichever comes first. This may be done under the following conditions:

1. When the child/youth presents with urgent or emergency conditions and TBS is needed to address problematic behaviors because said behaviors jeopardize current living arrangements. In such situations, documentation must include evidence that TBS was medically necessary and was also the most appropriate level of service available to address the child/youth's mental health condition. Steps taken to establish class membership should also be documented.
2. TBS billing codes are described in the TCBH Client Service Code Definitions and the Tuolumne County Keying Guide.

IV. Procedures

A. TBS Referral Procedures:

1. When a full scope Medi-Cal beneficiary under the age of 21 is evaluated for psychiatric hospitalization, regardless of whether the child is hospitalized or not, parents or guardians of said child shall be given information about how to access TBS services by the crisis worker. When a child is hospitalized without TCBH involvement, a case manager shall ensure that the parents are given information about TBS services before or at discharge (EPSDT and TBS Notification Policy).
2. EPSDT and TBS notices shall also be given to any Medi-Cal beneficiary (under 21 years of age) and/or their parents or representatives when the beneficiary has been admitted with an emergency psychiatric condition to a contracted hospital, an IMD in an STRTP when TCBH is involved in the placement. Although children/youth currently at psychiatric facilities and Institutes for Mental Disease (IMD) are not eligible to receive TBS during their time in treatment there, they can establish eligibility to receive TBS immediately upon leaving these facilities.
    a. In such cases, prior to discharge, TCBH shall determine eligibility as follows:
        i. Whether the child/youth will be eligible for Medi-Cal upon discharge
        ii. Whether the child/youth will be eligible for Mental Health Services upon discharge and whether TBS are appropriate.
    b. When the child/youth is eligible in both areas, TCBH must ensure that TBS services are available upon discharge. Youth need not be a client of the TCBH to take advantage of TBS in this situation.
3. A child/youth may also be referred through the Interagency Review Committee (IRC) process.

4. Parents or guardians who desire TBS services for a specific child may also call TCBH directly and speak to the Children's or Youth Services Program Manager or designee. If the child/youth meets eligibility requirements, the Program Manager or designee shall schedule an appointment with the parents and the child/youth to assess the child's mental status and the need for and appropriateness of TBS services. If it is determined that TBS would be of benefit, a referral shall be made for a TBS Assessment.

B. Assessment and Treatment Planning

1. A referral for a TBS Assessment shall be completed by the Children or Youth Services Program Manager or designee.
2. The assessment shall include the following components:
    a. Evaluation of behavior in the context of age/development, gender and sexual identity, race, ethnicity, and culture.
    b. A review of past evaluations and assessments and other such records
    c. Interviews with parents, caregivers, teachers, and other service providers who have direct involvement with the child or youth.
    d. Observations of the youth in key settings, including residence, school, and community.
    e. Provision of specific information needed to develop an effective TBS Plan. This information shall include a functional behavioral analysis with:
        i. Targeted behaviors that are clearly described. Descriptions shall include what, when, where, who and when behaviors occur or do not occur
        ii. Specific behaviors that are barriers to the lowest appropriate level of care
        iii. Identification of possible interventions that are needed to teach the child/youth skills to effectively manage behaviors.
        iv. Identification of adaptive behaviors that the child/youth is currently using.
        v. The meaning of the behavior including the relationship between the antecedent events and the consequences.
        vi. Mediating factors which may impact behaviors such as health conditions, neurological disorders, perceptual

difficulties, thought disorders and/or cognitive distortions or beliefs.

3. Assessments shall be completed within 14 days of the referral date. When it is determined that the standard assessment time could seriously jeopardize the beneficiary's life or health or ability to attain, maintain or regain maximum function, TCBH shall complete an expedited assessment and provide notice as quickly as the beneficiary's condition requires, but no later than three working days after the receipt of the request (see Urgent Care Appointments policy).
4. If it is determined in the TBS assessment that services are warranted, an initial TBS client plan shall be developed by the assessment clinician using the following criteria:
    a. Clearly specified behaviors and/or symptoms that jeopardize the residential placement or transition to a lower level of residential placement and that will be the focus of TBS as identified in the behavioral functional analysis in the assessment.
    b. A specific plan of interventions for each targeted behavior or symptoms identified in the assessment and the client plan.
    c. A specific description of the changes in the behaviors and/or symptoms that the interventions are intended to produce, including a time frame for these changes.
    d. A specific way to measure the effectiveness of the intervention at regular intervals and documentation of changes in the planned intervention when the original plans are not achieving desired outcomes.
    e. A crisis intervention plan.
5. The TBS client plan shall be integrated in the E.H.R. plan of care. The Plan of Care shall provide clinical direction for one or more short term interventions. The TBS Plan of Care Worksheet is available to help the clinician create the Plan of Care and will be scanned into the chart for reference.
6. Notification to parents/caregiver.
    a. If TBS services are warranted, parents and/or caregiver shall be notified. They shall also be informed about the intense nature of the service.
    b. If the assessment determines that TBS services are not warranted, a Notice of Adverse Beneficiary Determination (NOABD) shall be issued to the parents/caregiver by the staff

person responsible for the assessment. A copy shall also be forwarded to the QI Department for logging.

c. At any time during the provision of TBS services, parents and/or caregivers have the right to discontinue services and shall be notified of that at the onset of services.

C. Authorization Process

1. If TBS services are recommended, the Case Administration Team (CAT) will review and authorize TBS services upon receipt of the CSOC Eligibility Form and the TBS Assessment forms. CAT shall also have the discretion as to how long authorization periods shall last.

2. Once authorized, a referral shall be made to the TBS service provider. Pertinent assessment information as well as the TBS Plan of Care shall be forwarded to the service provider.

3. When it is determined that the standard authorization time frame could seriously jeopardize the Beneficiary's life or health or ability to attain, maintain or regain maximum function, TCBH shall make an expedited authorization decision and provide notice as quickly as the beneficiary's condition requires, but no later than three working days after the receipt of the request. TCBH may extend the three working days' time period by up to 14 calendar days if the beneficiary requests such an extension or TCBH identifies a need for additional information and documents the need (see Urgent Care Appointments policy).

4. Both the initial authorization and subsequent re-authorization decisions shall be made by a licensed or approved category of staff as required by Title 9, Section 1830.215 and shall be completed in advance of services.

5. Should TCBH be the provider of TBS services, staff involved in providing TBS shall not be a part of the authorization process.

D. Re-Authorization Process

1. All providers shall submit re-authorization requests to CAT prior to the end of the specified hours or days in current authorization period.

2. CAT shall base decisions for the granting of re-authorization requests on:

a. Clear documentation on the beneficiary's progress towards the specific goals and the time frames of the Plan of Care:

b. If TBS has been effective for the beneficiary in making progress towards goals or the beneficiary has reached a plateau in benefit effectiveness, then a strategy to terminate services

shall consider the intensity and duration of TBS necessary to stabilize the behavior and reduce the risk of regression.

c. When applicable, the beneficiary's lack of progress towards specific goals and timeframes of the TBS client plan and changes needed to address the issue shall be clearly documented. If the TBS being provided has not been effective and progress has not been as expected, the provider shall make recommendations for alternatives and justify why approval of the requested additional hours/days for TBS will be effective.

d. A review and update of the TBS plan of care as necessary to address any significant changes in the beneficiary's environment (e.g. change in residence).

e. The provision of skills and strategies to parents/caregivers to provide continuity of care when TBS is discontinued.

E. CAT shall not approve any re-authorization requests until the TBS provider has submitted a new client plan which includes items required in the initial client plan as well as the following:

1. A transition plan that describes in measurable terms how and when TBS will be decreased and ultimately discontinued. This occurs when identified benchmarks have been reached or when reasonable progress towards goals is not occurring and in the clinical judgment of the individual or the treatment team developing the plan, are not reasonably expected to be achieved.

2. This plan shall also include ways the provider intends to assist caregivers/parents with skills and strategies to provide for continuity of care when TBS is discontinued.

F. CAT may request a summary of the TBS services provided, a justification for the additional authorization and a termination plan with clearly established timelines and benchmarks as well as a planned date for termination shall be submitted to the Children's Services Program Supervisor.

G. Provider Criteria and Service Delivery Requirements

1. All providers of TBS must meet the statewide provider selection criteria specified in CCR, Title 9, Chapter 11 Section 1810.435, which states:

a. TBS shall be provided by a licensed practitioner or trained staff who are under the direction of a licensed practitioner. All providers shall have TBS training.

b. All clinicians completing TBS assessments shall have training and certification in the principles and practices of Functional

Behavioral Analysis. TCBH shall provide said training and certification.

c. All individuals providing TBS services must be available on site to intervene with the child/youth beneficiary as needed within their work shift.

H. Notice of Adverse Beneficiary Determinations (NOABD)

1. A NOABD shall also be sent whenever there is a modification, reduction, or termination of a previously authorized TBS. The NOABD shall advise the beneficiary and/or parents and guardians of the right to request continuation of previously authorized services pending the outcome of an appeal and a Medi-Cal Fair Hearing if the request for an appeal or hearing is timely. The appeals process must be exhausted before a Medi-Cal State Fair Hearing can be requested.

References

CCR, Title 9, Ch.11, Section 1810.405(c)

CCR, Title 9, Ch.11, Section 1810.229

Dept. of Mental Health (DMH) Information Notice #08-38-Therapeutic Behavioral Services

Related Policies or Documents

CSOC Eligibility Form

EPSDT and TBS Notification Policy

Therapeutic Behavioral Services (TBS) Assessment

TCBH Client Service Code Definitions

Tuolumne County Keying Guide

Urgent Care Appointments Policy

Medical Necessity Criteria for Outpatient Services Policy

Purpose

This policy describes medical necessity criteria for access to Specialty Mental Health Services (SMHS).

Definitions

Child Welfare Involvement: The beneficiary has an open child welfare services case, or CWS determines is at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the beneficiary is a child whose adoption or guardianship occurred through the child welfare system.

A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement, and in the home or is placed out of the home.

DHCS: Dept. of Health Care Services, the agency that regulates SMHS.

EPSDT: Early and Periodic Screening, Diagnostic, and Treatment: The Medi-Cal benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

Homelessness: Individuals who lack a fixed, regular, and adequate nighttime residence such as shelters, campgrounds, substandard housing, etc. (See McKinney-Vento Homeless Assistance Act).

Juvenile Justice Involvement: The beneficiary has ever been detained or committed to a juvenile justice facility or is currently under supervision by the juvenile delinquency court or probation agency (e.g., juvenile detention facilities, etc. or youth who have been released home or detained/placed in foster care pending or post-adjudication, etc.).

MCP: Managed Care Plan.

Medical Necessity: A service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (WIC Section 14059.5, WIC 14184.402(a)).

MHP: Mental Health Plan.

SMHS: Specialty Mental Health Services.

TCBH: Tuolumne County Behavioral Health.

WIC: Welfare and Institutions Code.

Procedure

The medical necessity criteria for access to SMHS, for both adults and beneficiaries under age 21 (except for psychiatric inpatient hospital and psychiatric health facility services) (WIC Section 14184.402) is defined as follows.

I. Definition of Medical Necessity for Adults

For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (WIC Section 14059.5 and WIC Section 14184.402(a)).

II. Definition of Medical Necessity for Individuals Under 21 Years of Age

A. For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan.

B. SMHS need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services.

III. Medical Necessity and Clinically Appropriate Services

Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

IV. Criteria for Adult Beneficiaries to Access the Specialty Mental Health Services Delivery System

For beneficiaries 21 years of age or older, a county mental health plan shall provide covered specialty mental health services for beneficiaries who meet **both of the following** criteria, (A) and (B) below:

C. The beneficiary has **one or both** of the following:

3. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.
4. A reasonable probability of significant deterioration in an important area of life functioning.

AND

D. The beneficiary's condition as described in paragraph (A) is due to **either of the following**:

3. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
4. A suspected mental disorder that has not yet been diagnosed.

Note: For adults and children, a neurocognitive disorder (e.g., dementia) or a substance-related and addictive disorder (e.g., stimulant use disorder) are not "mental health disorders" for the purpose of determining whether a beneficiary meets criteria for access to the SMHS delivery system. However, MHPs must cover SMHS for beneficiaries with any of these disorders if they also have a mental health disorder (or suspected mental health disorder not yet diagnosed) and meet criteria for SMHS as described above.

V. Criteria for Beneficiaries under Age 21 to Access the Specialty Mental Health Services Delivery System

For enrolled beneficiaries under 21 years of age, a county mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet **either of the following** criteria, (A) or (B) below:

C. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

D. The beneficiary meets **both** criteria below:

1. The beneficiary has **at least one** of the following:

d. A significant impairment.
e. A reasonable probability of significant deterioration in an important area of life functioning.
f. A reasonable probability of not progressing developmentally as appropriate.
g. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

2. The beneficiary's condition as described above is due to **one** of the following:

a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
b. A suspected mental health disorder that has not yet been diagnosed.
c. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional (WIC § 14184.402(d)).

VI. Exceptions Where DSM-V Diagnosis is Not Required for SMHS

A mental health diagnosis is not a prerequisite for access to covered SMHS. This does not eliminate the requirement that all Medi-Cal claims, including SMHS claims, include a CMS approved ICD-10

diagnosis code. In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to trauma as noted above, options are available in the CMS approved ICD-10 diagnosis code list. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services" (i.e., Z codes). DHCS may provide additional clarification and technical assistance regarding the use of Z codes (WIC Sect. 14184.402(f)(1)(A)).

VII. Comorbid Medical Diagnoses

SMHS are reimbursable for beneficiaries with medical diagnoses if they also have mental health conditions and meet criteria for SMHS as described above.

Services for symptoms or conditions solely due to a medical condition (e.g., traumatic brain injury) remain the responsibility of the MCP or the FFS delivery system.

VIII. No Wrong Door Approach

Under the "No Wrong Door" approach, services are allowed for the delivery of brief case management services to ensure beneficiaries receive timely mental health services without delay regardless of the delivery system where they seek care (BHIN 22-011 "No Wrong Door for Mental Health Services policy).

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

Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the beneficiary meets access criteria for SMHS. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS. TCBH will 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.

X. Additional Coverage Requirements and Clarifications

A. This criteria for a beneficiary to access the SMHS delivery system (except for psychiatric inpatient hospital and psychiatric health facility services) set forth above shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening,

assessment, treatment, or recovery service under any of the following circumstances:

1. Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.
2. The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.
   a. Some SMHS may still require an individual plan of care, such as Targeted Case Management.
   b. The beneficiary has a co-occurring substance use disorder.

B. SMHS need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services.

References

Assembly Bill (AB) 133: Cal-AIM
Behavioral Health Information Notice (BHIN) No.: 21-073
BHIN 22-011: "No Wrong Door for Mental Health Services
McKinney-Vento Homeless Assistance Act.15 15 (Federal), Section 11434a
Title 42 of United States Code, Section 1396d(4)
Welfare and Institutions Code Section 14059.5
Welfare and Institutions Code Section 14184.402
Welfare and Institutions Code Section 14184.402(f)(1)(A)

Plan of Care Policies

Policy

It is the policy of Tuolumne County Behavioral Health (TCBH) that a client-centered, collaborative Plan of Care (POC) is in place within sixty days of a mental health treatment admission which reflects Medical Necessity. The POC will be updated throughout treatment as appropriate.

Purpose

To ensure client services delivered have specific, observable or quantifiable treatment goals which support the proposed type(s) of intervention(s), are consistent with the client goal(s), and are consistent with the diagnosis. The Plan of Care is to ensure the client's involvement in planning their own care with their personal goals documented.

Definitions

POC: Plan of Care

TCBH: Tuolumne County Behavioral Health

SAI: Single Accountable Individual

LPHA: Licensed Professional in the Healing Arts, which includes the following:

A. Physician
B. Licensed/Registered/Waivered Psychologist
C. Licensed/Registered/Waivered Social Worker
D. Licensed/Registered/Waivered Marriage and Family Therapist
E. Licensed/Registered/Waivered Professional Clinical Counselor*
F. Registered Nurse, including but not limited to Nurse Practitioners and Clinical Nurse Specialists

URC: Utilization Review Committee

MOU: Memorandum of Understanding

Procedure

<u>POC Timelines/Initial and Renewals:</u>

1. The Initial Plan of Care is due within sixty days from the admission/intake.
2. A delay in establishing the initial POC would not be in violation to this policy if there are documented failed attempts to meet with/contact the client. This documentation is required as it indicates the client is not engaging in the POC process. No services, aside from urgent care contacts, will be provided after 60 days without an active POC.
3. Plans of Care are renewed annually by the Single Accountable Individual (SAI) or designee.
4. A delay in establishing a renewed POC would not be in violation to this policy if there are documented failed attempts to meet with/contact the client. This documentation is required as it indicates the client is not engaging in the POC process. No further services, aside from urgent care contacts, will be provided until the renewed POC is completed.
5. The POC will be updated upon the previous POC's expiration date and must be developed based on the medical necessity established through a comprehensive assessment performed in the last 354 days.
6. A POC can be updated during the active window period for which the Plan has been established.

<u>Signatures:</u>

Both service provider and client shall sign the POC

The SAI or designee providing the service must sign the plan. When the clinical staff person signing is not licensed, registered, or waivered, the plan must be co-signed by an LPHA.

The client and/or parent/guardian are expected to sign the plan. If a client, parent, or guardian refuses, or is unavailable to sign, a progress note must document the situation. The client should be encouraged to sign at a later date. Lack of client signature does not negate the plan's validity.

Elements Required:

1. Client Strengths.
2. Recovery Barrier/Problem: The primary diagnosis signs/symptoms and other barriers/life domain challenges.
3. Client Identified Goal/Desired Results: The client's desired outcome of successful treatment.
4. Objectives: Related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.

   a.) Narrative: Describing how the objective will be met with proposed frequency, duration, modality of interventions, and quantifiable goals.
5. Objective(s): What the client will do.
6. Intervention(s): The services the staff will provide, which are consistent with the plan goals, objectives, and qualifying diagnosis.

POC Duration:

The duration of the POC will not exceed 12 months; however, the duration may be shorter if appropriate.

Contact Type:

It is expected that the initial POC is created in the presence of the client.

In some cases it is necessary to create a plan in the physical absence of the client. In order to update a plan without a client signature, the clinician must identify client involvement in plan development (ex., telephone discussion) and must seek to obtain, and document efforts to obtain, the signature at the next visit. Services provided beyond this point, without documentation of attempts to obtain the signature, may be subject to disallowance.

Reporting/Monitoring:

1. POC Coming Due and Overdue notifications are provided to SAI providers based on their caseload.
2. A complete report is given to the Clinical Manager, Clinical Supervisors, as well as the Behavioral Health Director.
3. The Utilization Review Committee (URC) reviews Plans of Care for relevant goals, timeliness and completion.

Pre-Billing:

Prior to billing, POC expiration dates will be compared with service dates staged to bill to Medi-Cal or Medicare.

1. Services rendered which require authorization which are found to be outside the POC authorized date range will be withheld from claiming.
2. Services rendered that are not planned/authorized by the POC which require authorization will be withheld from claiming.
3. Only services found to be provided during an active POC period will be claimed.

Actions for Non-Compliance:

1. Non-crisis services found to be outside the POC period, with no documented justification, will be reported directly to the Billing Supervisor, associated Clinical Supervisor, Compliance Officer, and the Behavioral Health Director.
2. Repeated offenses of non-compliance will be subject to progressive disciplinary actions per the provider's MOU.

Related Policies or Documents

TCBH Medical Necessity Policy
Long Term Client
**Licensed Professional Clinical Counselor qualifications are specified in CA Business and Professions Code Section 4999.20*