County of San Diego
Health & Human Services Agency
Behavioral Health Services

INPATIENT OPERATIONS HANDBOOK

Revised April 2026

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Table of Contents

Overview

This *Inpatient Operations Handbook* is designed to provide County of San Diego Behavioral Health Services (BHS) contracted Medi-Cal inpatient providers with information related to the provision of managed care services for Medi-Cal beneficiaries who are residents of San Diego County. The San Diego County Mental Health Medi-Cal Managed Care Inpatient Consolidation consists of County and contractor-operated services. Included is information on emergency services, acute inpatient services for Medi-Cal clients, and acute and long-term residential services for Medi-Cal and Realignment funded clients. Please note that providers of services for the Behavioral Health Plan of San Diego are governed by the requirements of Title 9, Chapter 11 of the California Code of Regulations, referred to in this document as Title 9. Website address to obtain Title 9, Chapter 11 of the California Code of Regulations, referred to in this document as Title 9 and W&I Code section 14059.5, subdivision (a) or (b).

Since 1997, the County of San Diego's Health and Human Services Agency, Behavioral Health Services, the County of San Diego Behavioral Health Plan (BHP), has contracted with Optum (previously known as United Behavioral Health) to be the Administrative Services Organization (ASO) for the BHP. In their role as the ASO, Optum provides payment authorization and utilization management for San Diego Medi-Cal beneficiaries for inpatient psychiatric services.

Optum Public Sector San Diego Utilization Management (UM) staff consists of board-certified psychiatrists and licensed mental health clinicians such as psychologists, Registered Nurses (RNs), Social Workers, Marriage and Family Therapists, and/or Professional Clinical Counselors. Optum UM staff review all requests for authorization of payment for acute inpatient psychiatric admissions for children and adolescents (excluding clients admitted to Rady Child Adolescent Psychiatric Services (CAPS) hospital) and adults/ older adults. Authorization for services is based on meeting the medical necessity criteria, MHSUDS Information Notice 19-026, Behavioral Health Information Notice (BHINs) 22-017 and 26-001. Decisions to modify or deny a treatment request shall be made by a physician who has appropriate expertise in addressing the beneficiary's behavioral health needs.

The contact information for Optum is:

Telephone Number:	**1-800-798-2254**
Mailing Address:	**Optum** **PO Box 601370** **San Diego, CA 92160-1370**
Confidential Fax:	**Utilization Management, Inpatient: 1-866-220-4495** **Utilization Management, Long Term Care: 1-888-687-2515** **Provider Services Department: 1-877-309-4862**
Website:	**optumsandiego.com**

Utilization Management staff is available on the Optum Provider Line at 1-800-798-2254 during the business hours of Monday thru Friday 8:00 am to 5:00 p.m. to support provider inquiries, and/or address any complaints. Hospitals are expected to call Optum Provider Line at (800) 798-2254

with admission authorization request 24/7, followed by faxing clinical to (866) 220-4495.

The contact information for **County of San Diego Behavioral Health Administration** is:

Telephone Number:	**619-563-2700**
Mailing Address:	**PO Box 85524, San Diego, CA 92186 or 3255 Camino Del Rio South San Diego, CA 92108-5524**
Confidential Fax:	**619-236-1953**

1. General Guidelines

Contracted psychiatric inpatient hospital service and Psychiatric Health Facility (PHF) service providers are required to follow all Federal, State, and County regulations and policies for all San Diego County Medi-Cal beneficiaries.

Admissions should be based solely on the clinical review of the client's needs. Hospitals cannot require, as a condition of admission or acceptance of a transfer, that a patient voluntarily seeking mental health or substance use disorder care first be placed on a 5150 hold. If the client meets Medi-Cal medical necessity criteria, inpatient services should not be delayed because of an authorization of payment decision. A copy of medical necessity criteria is referenced in *Section 3*.

Pre-authorization is not required for emergency services, however, inpatient providers are required to notify Optum of all admissions. County of San Diego Behavioral Health Services (BHS) contracted Medi-Cal inpatient and PHF providers shall maintain Lanterman Petris Short (LPS) designation.

2. Notification Procedures

Providers shall notify Optum of all inpatient psychiatric hospitalization and PHF admissions by calling Optum as soon as possible when the client has San Diego Medi- Cal as primary coverage. For clients who have San Diego Medi-Cal as a secondary coverage it is not necessary to notify Optum at admission, unless the client has exhausted their primary insurance coverage and the primary insurance coverage is no longer available to pay for client's care.

To notify Optum of an admission contact them twenty- four/ seven (24/7) at: **Optum Provider Line at 1-800-798-2254**, followed by faxing clinical to **(866) 220-4495**.

Optum staff will review clinical documentation prospectively and/or concurrently for all acute and administrative days requested for reimbursement.

- For cases in which the provider indicates, or the MHP determines, that following the standard procedure could jeopardize the life or health of the client, client's ability to attain, maintain, or regain maximum function, Optum will make an expedited authorization decision pursuant to the client's health condition need. Standard admission authorization decisions are made within twenty four hours of receipt of a complete request, and most authorizations will be determined within one (1) to four (4) hours. In the case of an expedited authorization request, in accordance with regulations, no expedited authorization request for inpatient hospitalization will take more than seventy- two (72) hours to be processed.

- If upon admission, a beneficiary is experiencing a psychiatric emergency medical condition, the time period for hospital to request authorization shall begin when the beneficiary's condition is stabilized. For emergency care, no prior authorization is required.

3. Psychiatric Inpatient Hospital and PHF Admission and Continued Stay Criteria

Authorization request for acute admission or acute continued stay will be based on whether the documentation submitted by the hospital meets Inpatient Medical Necessity Criteria and will result in an Optum determination to grant, modify, or deny the request.

- BHIN 26-002- *Access Criteria for SMHS delivery system*
- BHIN 26-001- *Inpatient Criteria*
- W&I Code section 14059.5, subdivision (a) or (b)
- W&I Code section 14184.402, subdivisions (a) and (i)

Medical Necessity Criteria for Psychiatric Inpatient Hospital Services and Psychiatric Health Facility (PHF) Services:

Services are medically necessary if they meet the standard set forth in W&I Code section 14059.5, subdivision (a) or (b) and BHIN 26-001.

I. The member cannot be safely treated at a lower level of care, except that a member who can be safely treated with crisis residential treatment services for an acute psychiatric episode shall be considered to have met this criterion; **AND**;

II. The member requires inpatient SMHS as the result of a mental disorder, or suspected mental disorder that has not yet been diagnosed (*ICD-10-CM Z codes do not represent mental or substance use disorders and, therefore, are not sufficient on their own to substantiate the medical necessity of inpatient psychiatric hospitalization. When a patient exhibits mental, cognitive, or behavioral symptoms indicative of a potential mental or substance use disorder, but a definitive diagnosis has not yet been established, an appropriate practice is to assign ICD-10-CM code F99 (mental disorder, unspecified) and/or F19.9 (substance use disorder, unspecified), as clinically indicated, to document the clinical presentation pending diagnostic clarification. Final coding determinations, however, rest with each BHP's coding specialists. A neurocognitive disorder (e.g., dementia) is not a "mental health disorder" for the purpose of determining whether a member meets criteria for access to the SMHS delivery system However, BHPs must cover SMHS for members with a neurocognitive disorder if they also have a co-morbid mental health disorder (or suspected mental health disorder not yet diagnosed) and meet criteria for SMHS as described within BHIN 26-002*.), due to:

EITHER

i. Having symptoms or behaviors due to a mental disorder, or suspected mental disorder that has not yet been diagnosed, that (**one of the following**):

1. Represent a current danger to self or others, or significant property destruction.

2. Prevent the member from providing for, or utilizing, food, clothing, shelter, personal safety, or necessary medical care.
3. Present a severe risk to the member's physical health

4. Represent a recent, significant deterioration in ability to function.

OR

ii. Requiring admission for one of the following:

1. Further psychiatric evaluation.

2. Medication treatment.

3. Other treatment that can reasonably be provided only if the patient is hospitalized.

Continued Stay Criteria

Continued stay services for inpatient SMHS shall only be covered when a member experiences **one of the following**:

A. Continued presence of indications that meet medical necessity, as outlined in BHIN 26-001

B. Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization or treatment in a psychiatric health facility.

C. Presence of new indications establishing medical necessity as defined by W&I Code Section 14059.5, subdivision (a) or (b) and additional criteria specified in BHIN 26-001.

D. Need for continued medical evaluation or treatment that can only be provided if the member remains in a hospital or psychiatric health facility.

4. Admission Authorization for Reimbursement of Inpatient or PHF Services

Authorization Process: The most up to date details on the process and available Optum forms will be at optumsandiego.com > "BHS Provider Resources" > "*Fee For Service Providers*" and "*Inpatient Authorization Requests*". The process for requesting reimbursement and authorization for admission to acute inpatient services is as follows:

- Optum will maintain telephone access to receive admission notification and authorization request from hospitals twenty- four (24) hours a day, seven (7) days a week at **800-798-2254**, Option 3, then Option 1. Authorizations for services are offered prospectively, within twenty- four (24) hours of receipt of a complete admission authorization request and are based on the written documentation from the hospital.

- Within twenty- four (24) hours of admission of a San Diego Medi-Cal beneficiary to a psychiatric inpatient hospital, the provider shall notify Optum and also send a Fax to Optum at **866-220-4495**, to provide a completed "*Optum Inpatient Auth Request Fax Cover Sheet*" and/or all of the following minimally necessary information:

    - A complete face sheet
    - Admission orders
    - Initial plan for care
    - A request to authorize the beneficiary's treatment (stating start date of authorization request, and specifying number/type of days requested)
    - Admission authorization may be requested for up to three (3) acute days and up to one (1) administrative day
    - For more information on administrative day requests, please review the subsequent section entitled *"AUTHORIZATION FOR REIMBURSEMENT OF ADMINISTRATIVE DAYS*" and "*CRITERIA FOR ADMINISTRATIVE DAYS*"

- Provider will specify if they are a freestanding/Short Doyle hospital and/or if they are able to bill Medi-Cal for the admission.

- Hospital initial treatment authorization request determinations to grant, modify, or deny the request will be communicated in writing to the requesting hospital within twenty- four (24) hours of receipt of all required items.

- If a request for authorization is considered to be incomplete, Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional

information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval, services may not be billable.

Emergency Admission Requirements

BHP's may not require prior authorization for an emergency admission for psychiatric inpatient hospitalization services or to a Psychiatric Health Facility (PHF), whether the admission is voluntary or involuntary, and the beneficiary, due to a mental disorder, co-occurring mental health and substance use disorders, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter, clothing, personal safety, or necessary medical care. Upon notification by a hospital, BHPs shall authorize payment for out-of-network services when a beneficiary of the BHP, with an emergency psychiatric condition, is admitted to a hospital, or PHF, to receive psychiatric inpatient hospital services or PHF services. After the date of admission, hospitals must request authorization for continued stay services for the beneficiary subject to concurrent review by the BHP.

5. Authorization for Reimbursement of Continued Stay for Inpatient Services

Continued Stay Authorization Request Process to Optum

- Continued Stay Authorization Requests from San Diego County contracted hospitals will be reviewed by Optum licensed clinician; please fax request to **866-220-4495**. When medically necessary for the beneficiary, before the end of the initial authorization period or a subsequent authorization period, the hospital shall submit to Optum a continued stay authorization request. The treating provider(s) at the hospital may request information from Optum needed to determine the appropriate length of stay for the beneficiary; Optum will identify and authenticate the caller before exchanging such information.

- There will be a set maximum number of days per authorization request submission: up to four (4) acute days/ seven (7) administrative days per request (call logs required if applicable).

- Optum will issue a decision in writing to grant, modify, or deny the San Diego County contracted hospital's continued authorization request within twenty- four (24) hours of receipt of the request and all information reasonably necessary to make a determination, including:

    - Continued plan for care which includes the beneficiary's relevant clinical information.

    - Information outlined in the "*Optum Inpatient Auth Request Fax Cover Sheet*", which specifies type of day (acute or administrative), number of days, and start date of authorization request.

        - For prospective acute day requests: please refer to the *Continued Stay Criteria*.

        - For administrative day requests: please review the subsequent section entitled "*AUTHORIZATION FOR REIMBURSEMENT OF ADMINISTRATIVE DAYS*" and "*CRITERIA FOR ADMINISTRATIVE DAYS*".

6. Authorization for Reimbursement of Administrative Days

Administrative days are defined in Title 9 as *psychiatric inpatient hospital care provided when the client's stay at the hospital must be continued beyond needed acute treatment days due to a temporary lack of placement options at appropriate, non-acute residential treatment facilities in a reasonable geographic area*.

For administrative day requests, please review the following a) to f):

a. Beneficiary must have at least one clinically approved acute psychiatric hospital service AND the beneficiary no longer meets medical necessity criteria for acute psychiatric hospital services but has not yet been accepted for or is awaiting placement at a non-acute residential treatment facility (as determined by the County of San Diego) in a reasonable geographic area. See "CRITERIA FOR ADMINISTRATIVE DAYS" section below.

b. Starting with the day the beneficiary is placed on administrative day status, hospital will provide proof of five (5) or more contacts to the non-acute residential treatment facilities per week, by making at least one (1) contact per day (except weekends and holidays) to the non-acute residential treatment facility. Document each contact, including:

    i. The Status and outcome of the potential discharge placement

    ii. Date of the contact

    iii. Name & signature of the person making the contact

    iv. Examples of appropriate placement status options include, but may not be limited to the following:

        1. The Beneficiary's information packet is under review.

        2. An interview with the beneficiary has been scheduled for (date);

        3. No bed available at the non-acute treatment facility;

        4. The Beneficiary has been put on a waitlist.

5. The Beneficiary has been accepted and will be discharged to a facility on (date of discharge);

6. The patient has been rejected from a facility due to (reason); and/or,

7. A conservator deems the facility to be inappropriate for placement.

v. This information shall be documented and referenced in the medical record. To be eligible for administrative days during retroactive authorization request, hospitals still need to make required calls to non-acute residential treatment facilities, even if Medi-Cal funding is not active at time of admission.

c. A non-acute residential facility includes:

For Adults and Older Adult:

- Crisis Residential Treatment Services (CRTS) (requires daily contacts including weekends and holidays)/Adult Residential Treatment Services (ARTS), or

- Skilled Nursing Facility (SNF), or

- Mental Health Rehabilitation Center (MHRC)/Special Treatment Program (STP)

- Administrative Days may not be used for clients awaiting placement in a non-mental health treatment program such as a Board and Care facility, Independent Living Facility, or Substance Use Disorder (SUD) treatment program.

- For more information regarding San Diego County-funded LTC facilities, please call Optum Provider Line at **(800)798-2254**, option 3 for Authorization, then option 5 for Long Term Care.

For Children and Adolescents:

- Placements through Probation, Child and Family Well-Being Department, or San Diego and Imperial County Regional Center as outlined by the County of San Diego.
    - *Note: For Regional Center consumers, psychiatric hospitals will be paid for administrative days by the Regional Center in accordance with written agreements with each hospital. Contact the Regional Center for a copy of the Working Agreement between the County of San Diego Mental Health Programs and Regional Center, for additional information regarding visitation, placement search and other Regional Center responsibilities.*

d. 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.

e. 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.**

f. Optum may waive the requirement of five contacts per week if there are fewer than five (5) appropriate, non-acute residential treatment facilities available as placement options for the beneficiary. However, hospitals still need to make at least one (1) call and document each contact.

7. Criteria for Administrative Days

San Diego County policy regarding reimbursement for inpatient Administrative Days requires that the client is awaiting one of the following mental health residential placements:

Adults and Older Adults:

a. Crisis Residential Treatment Services (CRTS) facility, (Optum is centralized contact, call **1-800-798-2254**, option 1), or

b. Skilled Nursing Facility (SNF), or

c. Adult Residential Treatment Services (ARTS) facility; or

d. MHRC/STP

e. Client has been accepted by the Optum Long-Term Care Committee for placement in a facility that is paid for by the Mental Health Plan.

Children:

a. Probation, or

b. Project Oz or Cool Beds, or

c. Crisis Action & Connection Intensive Respite Program (CAC-IRP), or

d. Youth Residential Treatment Services, or

e. Child and Family Well-Being Department, or

f. San Diego and Imperial County Regional Center for the Developmentally Disabled.

Documentation of administrative day call logs shall be sent by fax to **866-220-4495**, to the Utilization Management Department, Optum Public Sector, San Diego.

NOTE: This policy may be subject to change. In addition to the above requirements, and in accordance with Title 9, in order to meet the State standards to receive reimbursement for administrative days, the provider is required to make and document at least one contact per day (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status, with a minimum of five (5) contacts per week, with appropriate non-acute treatment facilities. The provider must contact a minimum of five (5) different facilities per week. Once five contacts have been made and documented, any remaining days within the seven consecutive day period from the day the beneficiary is placed on administrative day status can be authorized. A hospital may make more than one contact on any given day within the seven 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 required contacts are completed and documented. The County may waive the requirement

of five (5) different contacts per week if there are fewer than five appropriate non-acute residential treatment facilities available as placement options for the beneficiary. The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of the contact, and the signature of the of the person making the contact. In no case shall there be less than one contact per week. Ongoing weekly documentation shall clearly support assessment of client for continued need of long-term placement.

Other Issues Regarding Administrative Days:

- Authorization for Administrative Days for clients awaiting long term care placement will be made when the client is accepted for placement.

- Administrative Days may not be used for clients awaiting placement in a non-treatment program such as a Board and Care facility or Independent LivingFacility.

- Authorization for payment for Administrative Days starts on the day following the last acute day authorized. Administrative Days end when the client is discharged from the inpatient setting, when the client enters the chosen facility, or when the client no longer meets criteria for admission to the facility based on level of care guidelines and medical necessity criteria. Administrative Days will alsoend if the discharge plan changes to a type of facility that is not one previously mentioned.

- In accordance with State regulations administrative days are impacted if a client must be discharged to a medical/surgical unit for physical health care. Clients who have been authorized foradministrative days and who are then discharged to a medical/surgical unit for physical health care, will not be approved for administrative days if they return to the acute psychiatric unit. However, if the client remains on the medical/surgical unit, the client may meet criteria under their physical health plan.

If a client's condition improves while they are waiting for placement at a facility, administrative days will be authorized up to the day the client no longer meets medical necessity criteria for admission to an approved type of facility as noted above.

8. Other Authorization Issues

- If the BHP denies or modifies the request for authorization, the BHP must notify the beneficiary's treating providers, including both the hospital and treating physician, in writing, within twenty- four (24) hours of the decision. If the BHP denies or modifies the request for authorization, the BHP 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 BHP's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the beneficiary. In cases where the BHP determines it will terminate, modify, or reduce services, the BHP must notify the beneficiary, in writing, of the adverse benefit determination prior to discontinuing services.

- For information on authorization and criteria for retroactive requests, please see the "*Claims and Billing*", "*Retrospective (Retro) TARs*" section of the handbook.

Clinical Consultation

While reviewing an authorization request, Optum may communicate with the treating provider(s) and the treating provider(s) may adjust the authorization request in writing prior to Optum rendering a formal decision. Treating provider(s) may also request a clinical consultation with an Optum Medical Director or Associate Medical Director(s) when appropriate to determine whether they would like to submit an authorization request.

A. Electroconvulsive Therapy (ECT)

ECT providers are to maintain their own ECT Consulting Psychiatrists lists and provide their own consultants for ECT utilizing their Credentialing and Privileging guidelines. The ECT consultation is Medi-Cal reimbursable and Optum authorizes payment to a network provider. See Appendix A for details about the Procedure for Voluntary Electroconvulsive Treatment. The psychiatrist will need to attest to the client's competence for treatment (see Appendix B)Both inpatient and outpatient ECT requires authorization.

The psychiatrist requesting ECT shall complete the ECT Authorization Request and submit it to Optum Utilization Management (UM). If indications for ECT are present, up to fourteen (14) treatments over a six (6) month period may be authorized. The total of fourteen (14) treatments shall include all inpatient and outpatient treatments within a ninety-day period. ECT sessions beyond fourteen (14) shall be reviewed by the Optum Medical Director.

A course of convulsive treatment consists of several ECT treatments for which client's single written informed consent may apply. W & I Code Section 5326.7 (d) limits both the number of treatments and duration of the period (not exceeding thirty (30) days) over which the treatments are administered to the individual designated in the informed consent. Additional treatments in number or time, not to exceed thirty (30) days, shall require renewed written informed consent.

Written informed consent shall be a requirement. Only the client may give that consent, unless a Superior Court determines that the client lacks capacity, in which case the Court shall appoint a responsible relative, guardian, or conservator to consider the consent. When a request for such a determination is to be made of the Superior Court, it is to be made by a petition for such a hearing, presenting evidence of incompetency and of the need for ECT, and accompanied by the completed form "Determination RE: Capacity to Give Written Informed Consent to Convulsive Treatment and Order."

Written informed consent requires that a person knowingly and intelligently, without duress or coercion, clearly and expressly communicates consent to the treating psychiatrist and in writing on the standard consent form. Twenty-four (24) hours must pass after the explanation by the psychiatrist of potential risks and benefits of ECT before the consent form may be signed by the client. Written informed consent may be withdrawn by the client (or consenting party) verbally or in writing at any time prior to or in-between treatments.

Consent must be given in writing, and only on the standard consent form [DHCS 1800 (05/19)] prescribed by the State Department of Health Care Services (DHCS) supplemented by additional written information applicable to the client and course of convulsive treatment. A witness should also sign this form indicating that they witnessed the client's consent to ECT. Consent form DHCS 1800 is available in English (*Appendix C*) and Spanish (*Appendix D*). If an LPS Conservator is currently appointed, they shall be fully informed regarding the proposed ECT for the Conservatee. For clients on LPS conservatorship, the client's attorney or public defender must agree to the client's capacity to give written informed consent and this shall be documented in the client's treatment record. If Counsel disagrees with the client's ability to give written informed consent, then the procedure for involuntary ECT may be considered by the treating psychiatrist as described in *Appendix E* (Procedure for Involuntary Electroconvulsive Treatment).

At any time during the course of ECT treatment for a person who has been deemed incompetent, that person shall have the right to claim regained competency. Should he/she do so, the person's competency must be reevaluated, involving the client's attorney, the attending psychiatrist, and the Superior Court as delineated in W & I Code 5326.7.

For involuntary ECT clients, state regulations require that a review committee documents the review of the clients' record by at least two (2) physicians, one of whom shall have personally examined the client (see *Appendix F*) Involuntary ECT requires both physicians on the review committee to agree with the treating psychiatrist.

The review committee will include one physician appointed by the treatment facility and one shall be appointed by the Behavioral Health Services (BHS) Director (WIC 5326.7). It is the responsibility of each ECT facility to maintain a list of board-certified or board-eligible psychiatrists or neurologists approved by the BHS Director to provide second opinions regarding suitability of ECT for involuntary clients. Candidate names shall be submitted to the BHS ECT Lead via email (BHSContactUs.HHSA@sdcounty.ca.gov) for approval by the BHS Director along with a completed Involuntary Electroconvulsive Treatment (ECT) Review Committee Physician Appointment Request form (Appendix G) and the physician's CV. Once the physician is approved on behalf of the BHS Director, the physician shall remain active on the list as long as there is no change to the

physician's licensure status, professional privileges, or any restriction that may affect the qualifications of this physician appointment. The BHS ECT Lead is to be notified by the program's Medical Director via email if there are any changes that may affect the qualifications of the physician appointment. Additional physicians may be added as needed by submitting requests to the BHS ECT Lead via email (BHSContactUs.HHSA@sdcounty.ca.gov). An email receipt of approval will be considered sufficient evidence that approval has been obtained on behalf of the BHS Director.

B. Referrals by the County's Emergency Psychiatric Unit (EPU)

All clients are screened for medical necessity criteria. The receiving facility must notify Optum upon the client's admission.

C. Non-Acute Planned Admissions

Providers are required to contact Optum for authorization prior to planned admissions.

9. Admission Criteria to Edgemoor Hospital

Edgemoor Hospital is a County-operated Distinct Part Skilled Nursing Facility for persons eighteen (18) years of age and older who are eligible for Skilled Nursing Care based on Title 22 and Omnibus Budget Reconciliation Act (OBRA), 1987 regulations.

Potential residents must meet the following criteria:

- Consideration for admission will be made only after the referring acute care hospital has completed a "good faith effort" at an alternative, appropriate placement in the community. Referral packets will be accepted, and admission assessment made only after this effort has been completed.
- Referrals shall be evaluated on effectiveness of alternative placement effort, appropriateness for care in other community facilities and need for the intensity of care provided at Edgemoor Hospital.
- Bed space appropriate to the potential resident's needs must be available.
- Resident care and treatment shall be determined only by medical and nursing needs, not by source of payment.
- The potential resident or his/her legal representative must consent for Edgemoor Hospital medical staff to provide medical management and coordination of care.

Edgemoor Hospital generally deems "Not Appropriate" for admission because of the following:

- Persons able to receive necessary care at other facilities.
- Persons requiring acute care medical services, intensive nursing care, transfusions, and acute psychiatric care.
- Persons with a primary diagnosis of developmental disabilities or mental illness without significant skilled medical needs.
- Pregnant women
- Persons who do not meet Medicare/Medi-Cal criteria for Skilled Nursing level of care, although they are deemed "not easily placed" by the referring facility.
- Persons with a primary diagnosis of substance abuse or persons actively receiving treatment for substance abuse.
- Persons requiring care for violence, severe agitation, suicidal or homicidal behavior.
- Persons requiring services Edgemoor Hospital is unable to provide.

Note: Possible admissions which are rejected by the Admissions Committee can be re- submitted at any time for re- consideration

10. Medication Issues

The standard of care in the community is to discharge all clients with either a prescription or medications in hand. The exception would be a client who is discharging to a Short Term Acute Residential Treatment (START) program, which will facilitate getting psychiatric medications for Medi-Cal recipients. Indigent clients going to START programs can have medications filled through the County Pharmacy per agreement with SDCPH. Hospital physicians have the right to hold certain medications if client has recently attempted to overdose (OD) on prescribed medication or abuse medication.

Note: Issues related to medications for clients who are being discharged are being discussed at the Hospital Partner's meeting and at the Utilization Management Coordination meeting and will be included in the Inpatient Operations Handbook once decisions regarding requirements and recommendations have been made.

11. Claims and Billing

A *Treatment Authorization Request (TAR) Manual* is distributed by the State Department of Health Care Services (DHCS) formally Department of Mental Health (DMH). This manual is most helpful in delineating instructions regarding completing TARs. Please contact Optum, San Diego County Mental Health or State DHCS for a copy of this handbook if you do not have the most recent version.

Submitting Treatment Authorization Requests (TARs)

The provider shall submit an original Treatment Authorization Request (TAR) form to Optum. Optum reviews the TAR and will approve or deny the TAR, providing the necessary notes and wet signature* and forwards the completed TAR to the California Medicaid Management Information Systems (CA-MMIS) Fiscal Intermediary for processing. The Fiscal Intermediary will deny TARs sent directly to them by a hospital. All TARs for San Diego County Medi-Cal beneficiaries must be approved by Optum prior to submission for payment. Incomplete TARs or TARs completed with erroneous or conflicting information will not be processed and will be returned to the hospital of origin to complete/resubmit. Optum is required to process all TAR forms received within fourteen (14) calendar days and submit to the fiscal intermediary.

*Please note that TARS require an original physician signature. TARs that are signed by a nurse for the physician or have a stamped signature will be denied by the fiscal intermediary, which is consistent with the current requirements of the TARs manual distributed by the State Department of Health Care Services.

All TARs must include the facility's National Provider Identification (NPI) Number. The fiscal intermediary will not accept TARs without the facility's NPI Number.

The TAR processed by Optum is only the authorization for the services, Optum is not responsible for processing inpatient facility claims or issuing payment.

In addition to submitting the TAR to Optum, The hospital must submit their claim form(s) for psychiatric inpatient services directly to the CA-MMIS Fiscal Intermediary, which is matched to the TAR/days authorized by Optum in order to generate payment to the hospital from CA-MMIS.

Hospitals should submit claims directly to the Fiscal Intermediary TAR Processing Center at the address below:

TAR Processing Center
California MMIS Fiscal Intermediary
P.O. Box 13029
Sacramento, CA
95813-4029
Phone Support: (800) 541-5555 (outside of California, please call (916) 636-1960)

Retrospective (Retro) TARs

The hospital shall be required to send copies of the entire client chart and documentation as to why a TAR is being sent retroactively. Retro TARS are only accepted for one (1) or more of the following reasons (MHSUDS IN 19-026):

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or,
- Beneficiary's failure to identify payer (e.g., for inpatient psychiatric hospital services).

All Retroactive authorization requests must be submitted within four (4) months from the date of discharge or from the date the hospital was notified of the client's retroactive eligibility. Requests which are not submitted timely may be administratively denied without clinical review for medical necessity

In cases where the review is retrospective, the clinical documentation will be reviewed by a licensed clinician and the MHP's authorization decision shall be communicated to the individual who received services, or to the individual's designee, within thirty (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.

To request a retroactive authorization, hospital will submit to Optum clinical documentation for the whole stay via mail (**Optum Public Sector Utilization Management, PO BOX 601370, San Diego, CA 92160-1370**) with ALL the below required items:

- A letter explaining the reason why the request is being submitted retroactively
- Admit and discharge dates of the stay and client demographic information
- Proof of San Diego Medi-Cal eligibility covering the dates of service
- Chart notes for the entire stay

Complete TAR(s) or claim forms which clearly outline dates of services requested as acute and dates requested as administrative.

Processing TARS

Within fourteen (14) calendar days of receipt of the completed TAR from the provider, Optum

Utilization Management staff reconciles the information on the TAR with clinical information obtained during admission and concurrent/prospective review and submits the completed and approved TAR to the fiscal intermediary for payment processing via certified mail. A copy is forwarded to the provider. The provider may appeal non- authorization by following the appeals procedure described in the *Clinical Appeals* section of this handbook.

TAR Timelines

The following timelines are Title 9 requirements for submission of TARs.

- Provider must submit TAR to Optum: Within fourteen (14) calendar days of client discharge.
- Provider must submit a separate TAR to Optum: When ninety-nine (99) calendar days of continuous service are provided to a client and if the hospital stay will exceed that period of time.

Note**:** TARs submitted for review after the timelines specified above must include the medical record along with an explanation of why the TAR is being submitted late. TARs submitted late (Retro TARs) without a reasonable explanation may be denied administratively**.**

Eligibility

Providers must use the state operated Point of Service (POS) verification system to check a client's current San Diego Medi-Cal eligibility to meet the State standards.

At fee-for-service-hospitals, the client's Medi-Cal number is either verified by swiping their card through a POS reader or by checking the POS web site. A POS machine strip with the verification is printed out and must be attached to the TAR.

Medi-Cal as Secondary Insurance

When the primary insurance is Medicare, and it is apparent that Medicare coverage will expire within five (5) days, then concurrent review and TARs submission will be conducted in the same manner as if Medi- Cal was primary. Please note that although reviews will occur within five (5) days of Medicare expiration, payment authorization must be based on information presented at the time Medicare coverage expires.

Should the hospital discover after discharge that a client had Medi-Cal coverage as secondary coverage, the hospital is to submit:

- Complete TAR or claim form; and
- Verification of San Diego Medi-Cal for the dates of service;
- Complete medical record; and

- Written explanation of why the request is being submitted late.

Send this documentation to:

Optum Utilization Management
PO Box 601370
San Diego, CA 92160-1370

Optum will review the documentation for medical necessity, complete the TAR and submit it to the fiscal intermediary for processing.

12. Denials and Notice of Adverse Benefit Determination

Clinical Denials:

Clinical denials are based on Medical Necessity Criteria and the medical records submitted during the Utilization Management process. It is therefore in the provider's best interest to ensure that documentation is complete and accurate so that Optum staff may make a timely and appropriate authorization decision. All clinical denials are reviewed by a psychiatrist.

Notice of Adverse Benefit Determination (NOABD):

When Optum faxes an NOABD to the client in the hospital, it is the responsibility of the hospital staff assigned to the client to present the NOABD to the client and explain his/her rights and options.

13. Clinical Appeals

There are times when providers disagree with an authorization determination rendered by Optum. Providers are encouraged to communicate concerns regarding authorization decisions to Optum. Optum is committed to responding in an objective and timely manner. Optum will attempt to resolve the issue informally through direct discussion with a provider; however, if the problem is not resolved to the satisfaction of the provider, a formal appeal process is available.

A. Provider Appeals Process

The provider appeal process is governed by California Code of Regulations, Title 9, Chapter 11, Section 1850.315 *Provider Appeal Process* and 1850.320 *Provider Appeals to the Department*. Please contact the **Optum Provider Line at 1-800-798-2254**, option 3, if you have any questions regarding the process.

B. Expedited Review/Informal Appeal

The BHP encourages informal resolution of disagreements regarding treatment issues through direct contact with Optum. If an Optum Medical Director or Associate Medical Director denies a hospital's authorization request, Optum will work with the treating provider(s) to develop a plan of care. For example, Optum may provide discharge placement suggestions that may qualify for administrative days. Hospital may choose to do an Expedited/Informal Appeal Review if they disagree with the authorization denial. Services and payment for services shall not be discontinued until the beneficiary's treating provider(s) has been notified of Optum's decision and a care plan has been agreed upon by the treating provider(s) that is appropriate for the medical and behavioral health needs of the beneficiary.

Expedited/Informal Appeal Review

An Expedited/Informal Appeal Review of a denial/non-authorization may be requested by the attending physician or the treating provider at the hospital. To request such a review, the following circumstances apply:

1. The beneficiary must still be inpatient at the psychiatric facility. If the beneficiary has discharged from the facility, the Expedited/Informal Appeal Review is invalid, and the facility may utilize the formal appeal process.

2. The attending physician or the treating provider may submit to Optum complete information and supporting documentation for Expedited/Informal Appeal Review within two (2) business days of the date on the notification of denial/non-authorization. If Expedited/Informal Appeal request is received by Optum beyond two (2) business days, request is invalid and the facility may utilize the formal appeal process.

3. Only **one (1)** Expedited/Informal Appeal Review can be submitted per denied

authorization request. The facility may utilize the formal appeal process in the event that a second denial is issued.

4. Once an Optum Medical Director or Associate Medical Director has reviewed the request and supporting documentation for Inpatient Medical Necessity criteria, a determination to uphold or overturn the denied authorization request is made.

5. The UM clinician shall notify the hospital of the determination within two (2) business days of the date request was received. Denial of an authorization request and consultation between the treating provider(s) and Optum may result in one of the following outcomes:

    a. Optum and the treating provider(s) agree the beneficiary shall continue inpatient treatment at specified level of care, and the denial is reversed.

    b. Optum and the treating provider(s) agree to discharge the beneficiary from the inpatient level of care, and a plan of care is established prior to the beneficiary transitioning to services at another level of care.

    c. Optum and the treating provider(s) agree to discharge orders and plan of care is established; however, appropriate outpatient or step-down level of care bed is not available AND the beneficiary remains in the hospital, on administrative day level of care.

    d. If Optum suggests an alternate plan of care for beneficiary discharge (such as providing step-down options that qualify for administrative days), and the treating provider(s) do not agree on a plan of care, the beneficiary, or the treating provider on behalf of the beneficiary, may informally or formally appeal the decision to Optum. See "*Non-Authorization of Reimbursement for Psychiatric Inpatient Hospital Services*" letter for detailed instructions on the formal appeal process.

C. In-Network Appeals

Level I Appeal

A provider may appeal a denied or modified request for payment authorization. The written appeal is submitted to Optum within ninety (90) days of the date of receipt of the non-approval of payment. The following must be submitted to request a Level I appeal:

1. A written request for a review of the denied request for payment authorization, including a summary of the reasons why the services should have been authorized.

2. Clinical records including all relevant documents that support the medical necessity of services provided and/or documentation supporting allegations of timeliness, if at issue.

3. A copy of the denied treatment authorization request (TAR).

4. Provider's name, address, and telephone number. Signature of the authorized provider representative.

The appeal request may be submitted via mail, fax, or secure e-mail to the following:

Optum
Attn: Quality Improvement
PO Box 601370
San Diego, CA 92160-1370
Fax: 844-897-5479
SDQI@optum.com

Incomplete appeal requests and appeal requests beyond the submission timeframe are rejected. Complete and timely appeal requests are reviewed by a psychiatrist not involved in the initial denial or modification of the request for payment authorization. The provider receives a written decision within sixty (60) days of Optum receiving the request.

If the denied request for payment authorization is overturned, the provider submits a revised treatment authorization request (TAR) within thirty (30) days from the date on the written decision. Please include a copy of the appeal decision letter with the new TAR.

If the denied request for payment authorization is upheld, the provider is notified of any right to submit an appeal to the California Department of Health Care Services (Level II appeal).
Level II Appeal

When a Level I appeal of a denied or modified treatment authorization request is upheld, the provider may submit an appeal to the California Department of Health Care Services (DHCS). The provider submits a written appeal, along with supporting documentation, within thirty (30) days from the date on the Level I appeal outcome letter. Supporting documentation may include but is not limited to:

1. Clinical records supporting the existence of medical necessity, if at issue.

2. A summary of reasons why the request for payment authorization should have been approved.

3. Any clinical documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.

4. A contact name, address, and phone number.

Send the appeal request and supporting documentation to the following address:

Department of Health Care Services
Clinical Assurance Division, 2nd Level Mental Health TAR Appeals

1501 Capitol Avenue, Suite 71.3002, M.S. 4507
Sacramento, CA 95814
Phone: (916) 552-9100

The DHCS notifies Optum and the provider of receipt of a request for appeal within seven (7) days. The DHCS asks Optum for specific documentation supporting the decision to deny payment. Optum submits the required documentation to the DHCS within twenty-one (21) days of notification of the appeal or the DHCS finds the appeal in favor of the provider.

The DHCS has sixty (60) days from the receipt of the documentation from Optum to notify the provider and Optum in writing of the decision and its basis. At the election of the provider, if the DHCS does not respond within sixty (60) days from the postmark date of documentation from Optum, the appeal is deemed upheld.

If the DHCS upholds the original decision to deny reimbursement, a review fee is assessed to the provider (DM11 Letter #03-07). If the DHCS overturns a provider appeal, the provider is notified in writing with instructions to submit a new treatment authorization request (TAR) to Optum.

Administrative Denial Appeal

Should the facility disagree with an administrative denial of a retroactive authorization request, an appeal may be requested. The appeal request must be received by Optum within ninety (90) days of the date on the administrative denial notification.

To request an administrative denial appeal, submit the following to Optum:

1. A written request for a review of the administrative denial of the retroactive authorization request.

2. Documentation from the clinical record that supports submission criteria for retroactive authorization requests.

3. A copy of the denied treatment authorization request (TAR).

The appeal request may be submitted via mail, fax, or secure e-mail to the following:

Optum
Attn: Quality Improvement
PO Box 601370
San Diego, CA 92160-1370
Fax: 844-897-5479
SDQI@optum.com

The County of San Diego, HHSA, BHS Quality Management reviews the information and renders the final determination. The facility receives a written decision within thirty (30) days of receipt of the request. Should the administrative denial be overturned, Optum Utilization Management reviews the chart for medical necessity criteria.

D. Out-of-Network Appeals

Clinical Out-of-Network Appeal

A provider may appeal an out-of-network denied or modified request for payment authorization. The written appeal is submitted to Optum within ninety (90) days of the date of receipt of the non-approval of payment. The following must be submitted to request an out-of-network clinical appeal:

1. A written request for a review of the denied request for payment authorization, including a summary of the reasons why the services should have been authorized.

2. Clinical records including all relevant documents that support the medical necessity of services provided and/or documentation supporting allegations of timeliness, if at issue.

3. A copy of the denial letter.

4. Provider's name, address, and telephone number. Signature of the authorized provider representative

The appeal request may be submitted via mail, fax, or secure e-mail to the following:

Optum
Attn: Quality Improvement,
PO Box 601370
San Diego, CA 92160-1370
Fax: 844-897-5479
SDQI@optum.com

Incomplete appeal requests and appeal requests beyond the submission timeframe are rejected. Complete and timely appeal requests are reviewed by a psychiatrist not involved in the initial denial or modification of the request for payment authorization.

The provider receives a written decision within one hundred twenty (120) days of Optum receiving the request. If the denied request for payment authorization is overturned, the provider submits a revised UB-04 within thirty (30) days from the date on the written decision. Please include a copy of the appeal decision letter with the new UB-04.

There is no Level II appeal option for upheld out of network appeals.
Administrative Denial Out-of-Network Appeal

Should the facility disagree with an administrative denial of an out-of-network retroactive authorization request, an appeal may be requested. The appeal request must be received by Optum within ninety (90) days of the date on the administrative denial notification.

To request an administrative denial out-of-network appeal, submit the following to Optum:

1. A written request for a review of the administrative denial of the retroactive authorization request.

2. Documentation from the clinical record that support submission criteria for retroactive authorization requests.

3. A copy of the denial letter from Optum.

The appeal request may be submitted via mail, fax, or secure e-mail to the following:

Optum
Attn: Quality Improvement
PO Box 601370
San Diego, CA 92160-1370
Fax: 844-897-5479
SDQI@optum.com

The County of San Diego, HHSA, BHS Quality Management reviews the information and render the final determination. The facility receives a written decision within thirty (30) days of receipt of the request. Should the administrative denial be overturned, Optum Utilization Management reviews the chart for medical necessity criteria.

14. Using the County of San Diego Behavioral Health Service Management Information System (BHMIS)

To meet State and Federal reporting requirements and to facilitate coordination of client care, the County of San Diego uses the BH MIS client data recording system. BH MIS is used to register clients into the mental health system, to record service activities, and to update care coordination information. During the initial authorization process, Optum enters a limited set of information from inpatient providers about adult Medi- Cal hospital admissions into the BH MIS system within one business day of the admission. Hospital staff should check BH MIS, if possible, for information about clients' Outpatient Mental Health Services, and assigned Care Coordinator or Case Manager.

Training on the BH MIS system (SmartCare) is available to hospital staff upon request.
Please contact: QIMatters.hhsa@sdcounty.ca.gov

15. Coordination of Care

In accordance with State and Federal regulations, and within the guidelines of San Diego County Behavioral Health Services policies regarding confidentiality and release of information, hospital providers are expected to coordinate care with other healthcare and mental health providers who are also serving their clients. As clarified in Department of Mental Health Information Notice #04-07, information may be released without written permission when it will be used for diagnosis and treatment purposes, on an as needed basis. This allowance is based on Civil Code Section 56.10 which states that: *"A provider of healthcare or a healthcare services plan may disclose medical information to providers of healthcare, healthcare services plans, or other healthcare professional or facilities for purposes of diagnosis or treatment of the patient."*

A. Outpatient Care Coordination

Care Coordinator or Case Manager: Clients who are already involved or have recently been involved in the Specialty Mental Health Care System, in many cases, have a Care Coordinator. A Care Coordinator, such as a clinic therapist or an intensive case manager, is the person assigned to each individual client who is responsible for ensuring that the client receives all needed services. The Care Coordinator is responsible for integrating the client's treatment and care and assists the client in obtaining needed services both within and outside the organization. In order to coordinate care at the time of an inpatient admission, hospital staff should make an effort to obtain information regarding the client's assigned Care Coordinator. One method to accomplish this goal is to check the County's Mental Health Management Information System client data recording system. The goal is for the Care Coordinator to be contacted within forty-right (48) hours of admission to the inpatient setting, or as soon as possible.

The type of information the hospital staff may share with the Care Coordinator should include, but not be limited to:

- Date of admission;
- Circumstances of admission;
- Medication, and any changes in medication;
- Notification of any certification hearings or plans regarding Conservatorship;
- Discharge planning and/or discharge plan;
- Date planned discharge;
- Notification of client leaving hospital Against Medical Advice (AMA).

In order to ensure that the client will receive continuity of care between providers of all services, the Care Coordinator will interact with hospital staff by participating in the following ways:

Communicating with hospital staff about client's treatment;

- Reviewing the discharge plan with hospital staff and assisting with the discharge plan when appropriate;

- Assisting to ensure that the client is seen by a mental health care professional within seventy-two (72) hours of discharge from the hospital.

B. Transitional Services

1. Transition Team: Adult/Older Adult

The Transition Team (**619-683-3100**), operated by Telecare Corporation, under contract with the Mental Health Plan, provides a clinical review of all adult/older adult Medi-Cal recipients admitted to Medi-Cal contract hospitals. This review occurs within three (3) working days of notification that an individual was admitted to an acute care psychiatric unit. For Medi-Cal clients with a Conservator, Care Coordinator or Case Manager, the Transition Team is not needed. For Medi-Cal clients without such support, the Transition Team will make contact directly with the client and offer short-term case management services. Participation is voluntary.

The Transition Team will maintain a clinical case management record for each client who is enrolled. The goals of Transition Team services are to aid in the re-stabilization of clients in the community (following an acute psychiatric hospitalization) and to facilitate a smooth, rapid transition to requested community resources. Together, the client and Transition Team Case Manager develop an Individual Service Plan, and the Case Manager monitors the client's progress in the hospital, supports hospital discharge planning, and promotes linkage of the client with aftercare resources. The team will provide services and support, as necessary, to achieve the client's treatment plan goals and objectives. Transition Team services are short- term and dependent upon the requests and needs of the individual client. Upon completion of Transition Team services, clients may choose to link with Care Coordinators, Case Managers or other community providers, or choose not to participate in additional mental health services.

2. Transitional Services Program: Children/Adolescents

The Crisis Action and Connection (CAC) program (**619-591-5740** or **619-591- 5744**), operated by New Alternatives, Inc, under contract with the Mental Health Plan, provides qualifying children and adolescents a smooth and rapid transition/diversion from an inpatient psychiatric hospital and/or Emergency Screening Unit (ESU) to the community. The program focuses on diverting children and adolescents from inpatient psychiatric care and/or aids in the stabilization process following inpatient psychiatric care. The CAC program accomplishes these goals by promoting the utilization of appropriate community resources and continuity of care within the behavioral health system as well as providing post-hospitalization linkage for families to community resources to help prevent the need for re-hospitalization. These services are short-term and transitional in nature until the child/adolescent is connected to behavioral health services within their community. All clients are assessed within five (5) working days from the date of referral.

C. Discharge Planning

In order to facilitate continued treatment and prevent re-admission, discharge plans shall be completed for all clients being discharged from an acute level of care. Planning for discharge shall begin on the day of admission. Discharge planning shall include:

- Attempting contact with the client's Care Coordinator within forty-eight (48) hours of admission;
- Coordinating with the Short-Term Transition Team if no Care Coordinator is identified
- Contacting the Regional Center for appropriate clients;
- Planning for appropriate living arrangements for the client upon discharge;
- Planning for discharge to the appropriate level of care, including organizational, residential, or outpatient providers;
- Consideration of prior failures and successes of the client in an effort to design an effective discharge plan;
- Contacting an outpatient provider and requesting an appointment for providers and programs that schedule appointments (such as children's programs) to be scheduled for the client as soon as possible, or a referral to a walk-in program, with the targeted goal that the client is seen within three (3) business days of the client's discharge from the facility;
- Requesting a Release of Information (ROI) from the client to facilitate coordination of care between the acute setting and the outpatient provider (an ROI is not required for coordination, diagnosis or treatment purposes; however, it is a good practice and helps the client be more actively involved in their care);
- Required Model Care Coordination Plan (MCCP) elements of W&I Code § 5402.5;
- Sending fax to the referral program with the information about the client that has been referred in order to ensure that the program is aware that the client is coming;
- Identifying plan for client to obtain medications after discharge.

Optum Utilization Management staff review the discharge planning progress during the clinical record review process.

SB 1152 Hospital Patient Discharge Process: Homeless Patients Summary

Each hospital shall have a written discharge policy and process which requires that appropriate arrangements for post hospital care are made prior to discharge for those that are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

A. The patient shall be provided the opportunity to identify one family caregiver who may assist in posthospital care.

B. A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility and given to the patient and their legal representative prior to the

transfer.

C. A policy will be established to ensure each patient receives information regarding medication dispensed.

D. A hospital shall provide every patient anticipated to be in need of long-term care at the time of discharge with contact information for at least one public or non-profit agency for community- based long-term care options in the patient's county of residence and appropriate to the client's needs.

Each hospital shall include within its discharge policy a written homeless patient discharge planning policy and process, including information about the patient's housing status and individual discharge plan.

A. Unless transferred to another LHF, the policy is to identify a post discharge destination with priority given to identifying a sheltered destination with supportive services.

B. A social service agency, non-profit social service provider or governmental service provider that has agreed to accept the homeless patient.

The policy shall require that information regarding discharge or transfer be provided to the homeless patient in a culturally competent manner and in a language that is understood by the homeless patient.

This hospital shall document all of the following prior to discharging a homeless patient: Clinical stability for discharge, offering of a meal, appropriate clothing, follow up care, prescription, screening for infectious disease, vaccinations, medical screening (referral to health plan, primary care or another provider if necessary); screened for and provided assistance to enroll in, any affordable health insurance coverage for which he or she is eligible; transportation after discharge within 30 minutes travel time from the hospital.

A hospital shall develop a written plan for coordinating services and referrals for homeless patients with the county behavioral health agency, health care and social services agencies in the region, health care providers, and non-profit social services providers to assist with ensuing appropriate homeless patient discharge. The plan shall be updated annually and include:

A. A list of homeless shelters

B. Hospital procedures for homeless patient discharge referrals

C. The contact information for the homeless shelter's intake coordinator

D. Training protocolsfor discharge planning staff

E. Each hospital shall maintain a log of homeless patients discharged and the destinations to which they werereleased.

Refer to *California Hospital Association Discharge Planning Book* for further information.

Discharges of clients who leave the facility Against Medical Advice (AMA)

In the event a client wishes to leave the facility against medical advice, they should still be offered transportation, have their personal property returned, be offered assistance with setting up follow-up care/coordination with PCP and be offered the client satisfaction survey.

D. Coordination with Other Levels of Care

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

In accordance to CCR, Title 9, Chapter 1, Section 1810.310 (a)(1), providers are to provide the DHCS issued *Medi-Cal Services for Children and Young Adults: Early & Periodic Screening, Diagnosis & Treatment (EPSDT)* brochures, which includes information about accessing Therapeutic Behavioral Services (TBS) to Medi-Cal (MC) beneficiaries under twenty-one (21) years of age and their representative, **at the time of admission** to any of the following facilities: Specialized Treatment Program (STP), Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution of Mental Diseases (IMD), Rate Classification Level (RCL) 13-14 Foster Care Group Home or RCL 12 Foster Care Group Home. Providers shall document in the client chart that brochure was provided to the client/family/caregiver.

See the links to the EPSDT brochures : See the link to the EPSDT brochures: Medi-Cal for Kids and Teens Resource

Crisis Residential Services

Upon inpatient admission, or as a step-down plan, clients can be referred to Crisis Residential Services.

Clients who do not meet, or no longer meet, medically necessary criteria for inpatient services may be referred to a crisis residential facility if the following criteria are met:

- Be in psychiatric crisis too severe to be handled on an outpatient basis and have an Axis I diagnosis other than a substance-induced disorder. This includes individuals experiencing an acute life crisis, an acute phase of a chronic psychiatric disorder, or an acute psychiatric episode;
- Be capable of maintaining safety;
- Be voluntarily requesting services and willing to go to the crisis residential facility;
- Not be actively violent or in need of restraints (but may have a history of violence if currently able to control impulses);
- Be free from non-psychiatric medical conditions, which would require more than outpatient

medical care;

- Not have a substance abuse or substance dependence diagnosis, in absence of a mental health diagnosis;

- Be ambulatory as defined by Community Care Licensing (unless occupying room approved by Fire Department and Community Care licensing for non-ambulatory). Some facilities have waivers to admit non-ambulatory clients. "Ambulatory" is defined as: *the ability to exit the facility quickly without assistance from any person or device such as a cane, walker, or crutches;*

- Clients over fifty-nine (59) who are compatible with the current population will be accepted only upon approval by Community Care Licensing. All crisis residential facilities are able to routinely get approval to admit a limited number of individuals over age fifty-nine (59).

E. Referrals to County Funded Long-Term Care Services

The Behavioral Health Plan (BHP) contracts with Mental Health Rehabilitation Centers (MHRCs) and Special Treatment Programs (STPs), Skilled Nursing Facilities (SNF), SNF Patch, Neurobehavioral Health Patch, and Specialized Residential Treatment facilities to meet the needs of San Diego residents who require the most intensive, secure, twenty- four (24) hour settings. The BHP also manages the care of San Diego residents placed in out-of-county IMDs and/or State Hospitals.

General Admission Criteria

- Admission criteria for San Diego County funded Long Term Care, along with other forms necessary and helpful for the request process, may be found at optumsandiego.com> "BHS Provider resources" > "Long Term Care" > "*COUNTY LTC ADMISSION AND CONCURRENT REVIEW CRITERIA*".

Referral Process

Complete Long Term Care referrals may be faxed to the Optum Long-Term Care team at **888-687-2515**. Questions may be directed to the Long-Term Care Provider Line at (**800) 798-2254** option #3, then option #5. The Optum Long-Term Care team will review requests with the Optum Medical Director who will determine the referral's appropriateness.

F. Interface with Medi-Cal Managed Care Health Plans

Note*:* The information presented in the following section is in accordance with the Memorandum of Understanding (MOU) between County of San Diego Health and Human Services Agency Local Behavioral Health Plan (BHP) and the Medi-Cal Managed Care Plans.
HMO Medi-Cal Beneficiaries

Over fifty percent (50%) of Medi-Cal beneficiaries are enrolled in one of the Health Maintenance

Organizations (HMOs) that are part of Healthy San Diego. To help facilitate communication and coordinate physical and mental health services, Healthy San Diego has prepared a Physical and Mental Health Coordination Form and Guidelines for its use. Each HMO has contracts with specific pharmacies and laboratories. Providers need to be aware of which pharmacy or laboratory is associated with the HMO serving the client for whom they are prescribing medication or lab tests in order to refer the client to the appropriate pharmacy or lab. Providers prescribing lab tests may refer the client back to his or her Primary Care Physician (PCP) for these services. The client's HMO enrollment card also may have a phone number that providers and clients can check in order to identify the contracted pharmacy or lab.

Physical Health Services While in A Psychiatric Hospital

The client's Healthy San Diego HMO will cover and pay for the initial health history and physical assessment required upon admission to a psychiatric inpatient hospital. The client's HMO is also responsible for any additional or on-going medically necessary physical health consultations and treatments. The BHP contracted psychiatrist is responsible for obtaining the psychiatric history upon admission, and for ordering routine laboratory services. If the psychiatrist identifies a physical health problem, he or she contacts the client's HMO to request an evaluation of the problem. If the psychiatrist determines further laboratory or other ancillary services are needed, the contracted facility must obtain the necessary authorizations from the HMO. The client's HMO contracted providers are to provide these services, unless the BPH contracted facility obtains prior authorization from the HMO to use a provider not contracted with the client's HMO.

Transfers from Psychiatric Hospital to Medical Hospital

Psychiatric hospitals may transfer a client to a medical hospital to address a client's medical problems. The psychiatric hospital must consult with appropriate HMO staff to arrange transfer from a psychiatric hospital to an HMO contracted hospital if it is determined that the client requires physical health-based treatment. The Optum Medical Director and the HMO Medical Director shall resolve any disputes regarding transfers.

Non-Emergency Medical Transportation

Healthy San Diego HMOs cover medically necessary non-emergency medical transportation services for Plan members. HMO members who call the Access and Crisis Line for medical transportation are referred to the Member Services Department of their HMO to arrange for such services.

G. Beneficiaries Not Enrolled in Medi-Cal Managed Care Health Plans

For those clients who are not members of a Healthy San Diego HMO, physical health services provided in a psychiatric hospital are reimbursed by Medi-Cal.

H. Authorization for Transfer between Hospitals

Medi-Cal clients may be transferred from one hospital to another or from one floor to another within the same hospital, according to the following guidelines:

- Medical necessity criteria is clearly established for the client
- Referring hospital may contact Optum to request an authorization to reduce the potential for transferring a client who no longer meets medical necessity
- The referring hospital shall arrange for transportation to the receiving hospital.
- The receiving hospital/floor shall meet the following conditions:
    - Have a bed available to receive the client;
    - Have an attending physician available for the client;
    - Be willing to accept the clinical information of the referring hospital/floor or be willing to conduct a new assessment of the client within twenty- four (24) hours of admission.

These authorization conditions apply equally for:

a. Psychiatric to psychiatric hospital transfer;
b. Medical to psychiatric hospital transfer;
c. Medical floor to psychiatric floor transfer within the same hospital.

Optum licensed clinical staff will provide authorization to the receiving hospital/floor if the above conditions are met. Please note: When there is a transfer between hospitals, once the client has been admitted to the second hospital that hospital will then be responsible for obtaining any further authorizations.

I. Authorization Process for the Emergency Psychiatric Unit (EPU) of the San Diego County

Psychiatric Hospital and for ReceivingHospitals

When a client has been assessed in the EPU as requiring inpatient hospitalization and is insured, the EPU staff will seek an available bed for that client in the Lanterman-Petris-Short (LPS) unit of a participating hospital. If the client is a Medi-Cal recipient, the receiving hospital follows the same admission procedure they would for any requests for reimbursement for acute care as well as for subsequent days. If the client is a Medicare A&B recipient, the EPU will confirm this status and inform the receiving hospital. Private insurance carriers are contacted by the receiving hospital for authorization.

For Sending Hospitals

If a client is assessed in a hospital Emergency Room as needing inpatient care and is uninsured, the facility faxes a completed San Diego County Psychiatric Hospital (SDCPH) Request for Transfer Form to SDCPH, along with other standard referral material. SDCPH acknowledges the receipt of the request within one (1) hour, and gives a preliminary standing based on established criteria. The SDCPH staff manages and prioritizes the referrals, accepting clients who are medically stable and otherwise appropriate, as bed space allows.

16. Beneficiary Rights

San Diego County Behavioral Health Services is committed to protecting client's rights in accordance with State and Federal Regulations and County policy. Violations of clients' rights will be responded to appropriately.

A. Confidentiality

Maintaining the confidentiality of client and family information is of vital importance, not only to meet legal mandates, but also as a fundamental trust inherent in the sensitive nature of the services provided through the MHP.

B. Beneficiary Handbooks

Providers are required to inform every client during their admission that the Beneficiary Handbook is available and can be accessed in their preferred threshold language. The handbook is titled: *Integrated MHP and DMC-ODS Member Handbook*. The beneficiary handbooks contain a description of the services available through the MHP, a description of the required process for obtaining services, a description of the MHP problem resolution process, including the complaint resolution and grievance and appeal processes (Appendix I) and a description of the beneficiary's right to request a State fair hearing. Guides are written by the State with updates by the MHP. They are available for download and printing at www.optumsandiego.com in the SMH & DMC-ODS *Beneficiary* tab. Providers should have copies of the Beneficiary Handbooks available in all of the current threshold languages, document that they were offered to each client, and provide them to the client as applicable.

Clients must also receive a copy of the *Behavioral Health Member Quick Guide to Specialty Mental Health services* and *Drug Medi-Cal Organized Delivery System for Adult, Older Adult and Children* in the available threshold languages.

All clients also must receive a copy of the *State Handbook, Rights for Individuals in Mental Health Facilities*. This handbook deals with rights of persons both voluntarily and involuntarily admitted, discussing the role of the Patient Rights Advocate, rights that cannot be denied, rights that can be denied with good cause, medical treatment and the right to refuse it, and informed consent for medication. These handbooks should be provided to clients in the available threshold languages. The State Handbooks in the available threshold languages are located on the JFS Website. The County MHS contracts with Jewish Family Service for the Patient Advocacy Program (**1-800-479-2233**) to assist clients with grievances and appeals. The Patient Advocacy Program distributes an informing brochure for clients called "*Seclusion & Restraint: Answers to Your Questions*."

C. Translation Service Availability

According to Title 9 and Title IV, Civil Rights Act of 1964, interpreter services shall be available to beneficiaries and families in threshold and non-threshold languages if requested or if the need is determined to assist in the delivery of specialty mental health services. It is not the standard of

practice to rely on family members for translation services. Providers are required to ensure that rights, notifications, advisements, and treatment information and services are communicated in a language and modality accessible to the client. (WIC, §5325) Providers are required to have Limited English Proficiency (LEP) posters posted in all the available threshold languages.

D. Client Grievances and Appeals

Clients may contact Jewish Family Service, the Patient Advocacy Program at **1-800-479-2233**, if they are dissatisfied with any aspect of inpatient services, they receive under the MHP.

It is the provider's responsibility to inform clients regarding their right to file a grievance or an appeal to express dissatisfaction with MHP services without negative consequences of any kind. Providers are required by Title 9 to post Grievance and Appeal posters (in English and the designated threshold languages which are Spanish, Vietnamese, Arabic, Tagalog, Persian, Korean, Somali, and Chinese for San Diego County) in a visible area to ensure clients are advised of their rights. Title 9 requires brochures, grievance forms and pre-addressed/stamped envelopes are easily accessible to both clients and provider staff in the threshold languages without the need of a verbal or written request by the client. Copies of the Grievance and Appeal posters and brochures may be obtained completing the MHP and DMC-ODS Beneficiary Materials Order Form located on the Optum website > *Beneficiary* tab.

Clients may file an appeal of an action taken by the Behavioral Health Plan (BHP) such as any of the following:

a. A denial or modification of services,

b. A reduction, suspension or termination of a previously authorized services,

c. A denial, in whole or part, of payment for a service,

d. Failure to provide services in a timely manner (within 1 hour for emergency care).

If a client wishes to file an appeal, the provider should inform them that they should contact the Patient Advocacy Program at **1-800-479-2233**.

If the standard resolution process for an appeal could, in the opinion of the client, the BHP, JFS Patient Advocacy Program jeopardize the client's life, health or ability to attain, maintain, or regain maximum function, the client has the right to file an Expedited Appeal. Expedited Appeals may be filed for any of the reason listed above but must resolved within three (3) working days (*Appendix I*).

Inpatient providers are required by Title 9 to maintain a log in which all client or family concerns or grievances are entered. Concerns may be expressed verbally or in writing. The log must include the following elements:

a. Complainant's name
b. Date the grievance was received
c. Name of person logging the grievance

d. Nature of the grievance
e. Nature of the grievance resolution
f. Date of resolution

The BHP may request a copy of a provider's Grievance Log at any time.

E. Client Right to Request a State Fair Hearing

Clients have the right to request a State Fair Hearing any time before, no later than one hundred and twenty (120) calendar days from the date of the BHP's written appeal resolution, after the completion of the beneficiary problem resolution process, whether or not the client uses the problem resolution process and whether or not the client has received a Notice of Adverse Benefit Determination. Providers are required to inform their clients or the clients' conservators/legal guardians of these rights.

F. Client Right to Have an Advance Health Care Directive

All new clients must be provided with the information regarding the right to have an Advance Health Care Directive at their first face-to-face contact for services. This procedure applies to emancipated minors and clients eighteen (18) years and older. Generally, Advance Directives addresses how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for himself/herself. The BHP provides an informational brochure on Advance Directives, available in the threshold languages. They are available for download and printing at www.optumsandiego.com in the *Beneficiary* tab.

G. Title 42 CFR Section 438.100 – Addressing Beneficiary's Rights

1. General rule. The State must ensure that

    i. Each MCO and PIHP has written policies regarding the enrollee rights specified in this section; and

    ii. Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

2. Specific rights

    i. Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of section 438.100.

    ii. An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights:
        a. Receive information in accordance with 42 CFR §438.10.

b. Be treated with respect and with due consideration for his or her dignity and privacy.

c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in 42 CFR §438.10(f)(6)(xii).

d. Participate in decisions regarding his or her health care, including the right to refuse treatment.

e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

f. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526.

g. An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with 42 CFR§438.206 through §438.210.

3. Free exercise of rights. The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, or PCCM and its providers or the State agency treat the enrollee.

4. Compliance with other Federal and State laws. The State must ensure that each MCO, PIHP, PAHP, and PCCM complies with any other applicable Federal and State laws (such as: title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; and Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality).

5. Hospital facilities must complete a Firearm Prohibition Form and inform individuals who are subject to a lifetime ban on gun ownership due to involuntary admission (5151) into a locked designated facility due to DTS or DTO and who have a previous admission in the past year, but the facility can no longer submit the Patient Notification of Firearm Prohibition and Right to Hearing form BOF 4009C on behalf of the client.

17. Quality Improvement

Site reviews will be conducted tri-annually. Requirements are based on State standards for Medi-Cal certification. On-site reviews shall occur during normal business hours with at least seventy-two (72) hours prior notice; except unannounced on-site reviews and requests for information may be made in those exceptional situations where arrangement of an appointment beforehand is clearly not possible or clearly inappropriate due to the nature of the intended visit.

Providers are required to adhere to all applicable Federal, State, and County regulations, policies and statutes, including Title 9 and Department of Health Care Services (DHCS, formerly DMH) Letters and Notices. Relevant Letters published in 2004 included but are not limited to:

- DMH Letter 04-04, which requires hospitals to provide EPSDT and TBS notices to full scope individuals eighteen (18) to twenty- one (21) admitted with an emergency psychiatric condition.

- DMH Information Notice 04-05, which discusses the *Emily Q. v. Bonta* Appeal settlement and criteria special service eligibility for those ages twenty-one (21) to twenty- five (25).

Providers are required to offer each client a satisfaction survey. The client can decline to complete one, but there should be documentation that one was offered to each client.

All County and contracted providers are required to report critical incidents involving clients in active treatment or whose discharge from services has been thirty (30) days or less. Required reports shall be sent to the Behavioral Health Services (BHS) Quality Assurance (QA) Unit that will review, investigate as necessary, and monitor trends. BHS-QA designated staff will communicate with program Contracting Officer's Representatives (CORs) and Behavioral Health Services (BHS) management staff as needed on all reported serious incidents. The provider shall also be responsible for reporting critical incidents to the appropriate authorities (*Appendix J*).

All behavioral health providers are required to adhere to cultural competence standards. The QA staff will look for elements of cultural competence in program orientations, staffing, charting and/or trainings during site reviews.

Reports Required: All Lanterman-Petris-Short (LPS) facilities are required by the State DHCS to submit the following reports to County Mental Health Services Quality Improvement Unit, using the State forms Appendices:

- *Denial of Rights/Seclusion and Restraint (S&R) Monthly Report* (DHCS 1804)—if there are no instances of denied rights in a quarter, hospitals must submit a report saying this (*Appendix K*). Should be submitted to BHS QA Unit by the 10th day following the reporting month. An exception is made to the last reporting month of the quarter (September, December, March, and June), the Denial of Rights/S&R Monthly Reports can be included with the quarterly LPS data report submissions due by the 15th day following the reporting period.

- *Convulsive Treatment Administered (ECT)* (DHCS 1011)—to include Outpatient ECTs (*Appendix M*).

- *SB 929 - LPS Report* – **(**Combined: DHCS-1008 - Services Provided to Persons Detained in Jail Facilities; DHCS-1009 - Conservatorships Established by the Superior Court; and DHCS-1010 –Involuntary Detention-Treatment). LPS Facilities are reminded that each person who is on a 5150 is to be counted in the unit or facility where the specific detention was initiated to avoid duplicate reporting. A person who initially is admitted to a unit within a facility and is subsequently transferred to another unit within the same facility or to another facility for the same treatment episode while being held under the same W&I Code section is to be counted only once.

In addition to the LPS data reports, LPS facilities are to provide an explanation if there were any factors that occurred during the reporting period that may explain the difference between current fiscal year/quarter in comparison to previous reported quarter. These factors may include facility construction, decrease in beds, shortage of staffing availability, significant increases in patient acuity, etc.

LPS Facilities are to submit the reports via email to the QA Analyst team Lorena.Gonzalez-Fabiny@sdcounty.ca.gov Facilities may also fax in the reports to (619) 236-1953 attention QA Analyst team. If faxing, the facility must email the QA Analysts to notify they will be faxed in

Quarterly Reporting Schedule

- Quarter 1 (July 1 through September 30) Submit by October 15th
- Quarter 2 (October 1 through December 31) Submit by January 15th
- Quarter 3 (January 1 through March 31) Submit by April 15th
- Quarter 4 (April 1 through June 30) Submit by July 15th

The QA designee will complete the Denial of Rights - County Summary (DHCS 1805) Form using the data obtained from form DHCS 1804 reports submitted by each LPS facility. Once all the LPS data is provided to BHS by the facilities, the BHS QA designee must submit all the quarterly LPS data from the SB 929 LPS Reports (combined 1008, 1009, 1010), Denial of Rights-County Summary DHCS 1805, and ECT DHCS 1011 to DHCS by the 30th of the month following the reporting period.

18. Quality of Care Standards

Psychiatric inpatient providers shall be committed to providing dignified care and treatment to individuals who struggle with mental illness and substance abuse. Providers shall strive to restore the client to optimal functioning in the shortest amount of time and in the least restrictive and most comfortable environment possible. Providers will involve the client's natural support system and include them in the clients' treatment planning and care. Providers shall understand that it is common for people with mental illness to experience stigma and barriers to social integration and shall be committed to eliminating stigma and to promoting the fullest recovery for each individual.

Psychiatric inpatient Providers shall abide by their respective discipline's guidelines such as those noted on the following websites. *Appendix N* includes other helpful websites.

- CA Psychiatric Association - - www.calpsych.org
- American Psychiatric Nurses Association- CA Chapterwww.apnaca.org
- National Association of Social Workers- CA- www.naswca.org
- CA Association of Marriage and Family Therapists- www.camft.org
- California Psychological Association- www.cpapsych.org

Inpatient Treatment for Children and Adolescents

BHS supports the use of inpatient services for children and adolescents and recommends that inpatient facilities follow quality of care guidelines such as those published by the Association of Child and Adolescent Psychiatric Nurses, and the American Academy of Child and Adolescent Psychiatry. The following are examples of quality guidelines for facilities providing child or adolescent inpatient treatment:

- Treatment program should be under the direction of a fully trained and properly qualified child and adolescent psychiatrist.

- Decisions for admitting and treating children and adolescents in an inpatient setting must be very carefully considered. This would include the diagnosis of a psychiatric disorder as defined by the most recent version of the DSM and criteria for inpatient psychiatric hospitalization such as those described in the American Academy for Child and adolescent Psychiatry's Guidelines for Treatment, Quality Assurance, and Peer Review.

- Children and adolescents and their families shall have an opportunity to explain their perception of the behaviors and symptoms that prompted the admission

- Treatment plans must be individualized based on the assessment of the client's biological, psychological and social needs.

- The child or adolescent and their family should be encouraged to participate voluntarily in the decision for admissions, treatment and discharge planning.

- When additional treatment is determined to be necessary, a written mental health treatment plan is completed which identifies the least restrictive placement alternative in which the minor can receive the necessary treatment.

- Care should be coordinated with the child or adolescent's other healthcare providers

- Prescriptions should be based on individual characteristics, such as culture, ethnicity, gender, religious beliefs, and age Responsible party may not limit the minor's exercise of rights including phone calls and visitors

Appendix A: Procedure for Voluntary Electroconvulsive Treatment (ECT)

(including any client under Guardianship or LPS conservatorship 18 years of age of older)

I. The client's outpatient or inpatient treating psychiatrist:

1. Determines the need for electroconvulsive treatment (ECT) based on community standard guidelines:
   (usually moderate to severe primary affective disorder):

   - Not responsive to less intensive forms of treatment, or
   - When the client is unable to tolerate other forms of treatment, or
   - When the client's psychiatric illness is so severe that relief of symptoms is medically urgent and documents this in the client's medical record.

2. Prepares a written supplement to the standard consent form (Form DHCS 1800 (MH 300) containing details pertaining to the particular client (This supplemented form must specify a maximum number of treatments over a maximum period not to exceed thirty (30) days.).This signed documentation includes clinical reasons for the procedure, and a statement that all reasonable treatment modalities have been carefully considered, that the treatment is definitely indicated and is the least drastic alternative for the client at this time .

3. Determines that in his/her opinion this client is capable of written informed consent: Written informed consent requires that a person knowingly and intelligently, without duress or coercion, clearly and expressly manifests consent to the treating psychiatrist and in writing on the standard consent form. A person is incapable of written informed consent if he/she cannot understand or intelligently act on the information given.

4. Requests that a Board Eligible or Board-Certified Psychiatrist (or Neurologist) reviews the treatment proposal relative to the client's ability to give written informed consent for ECT. If this consulting psychiatrist finds that the client is not able to give written informed consent, the procedure for involuntary ECT may be considered by the treating psychiatrist. If this consulting psychiatrist agrees that the client is able to give written informed consent, then he/she documents this finding on the form entitled, "*Consulting Psychiatrist's Statement–Electroconvulsive Treatment for Voluntary Patients*" [Form HHSA:MHS-195 (02/00)].

5. The client's treating psychiatrist presents the ECT consent form to the client, explains it in detail, and presents the same information to another party at the client's request (family member, friend, or guarding may also review the consent form at the client's request and with the client's consent), and documents these explanations in the treatment record with the date and time the form and explanation were presented. The LPS Conservator, if one is

currently appointed, shall be fully informed regarding ECT proposed for the Conservatee.

II. Client gives written informed consent for ECT after a minimum delay of twenty- four (24) hours following the procedure described in I.5.

III. For clients under guardianship or on LPS Conservatorship (or being involuntarily detained in a hospital for psychiatric treatment), the client's Attorney or Court Appointed Public Defender must agree to the client's capacity to give written informed consent and that he/she has done so, and documents this in the client's treatment record (Counsel may be appointed by the client, or Court must be petitioned to appoint the Public Defender as a precedent to a decision regarding ECT). If Counsel disagrees with the client's ability to give written informed consent, procedure for involuntary ECT may be considered by the client's treating psychiatrist.

IV. The treating psychiatrist refers the client to the psychiatrist performing ECT (If ECT is not to be given by the treating psychiatrist), and treatment is scheduled. All steps and evaluations are to be fully documented in the client's treatment record. All pertinent documentation and medical evaluation results, including completed informed consent, must be provided to the facility where the ECT is to be given (If more treatments are required than were authorized in the initial informed consent, the procedure must be reinitiated beginning with step I.1).

V. The consenting party may withdraw Informed Consent for ECT at any time prior to treatment.

VI. If ECT is to be paid from the Mental Health budget for indigent care, then prior authorization is required from the Administrative Organization Medical Director or the Local Mental Health Director (or his/her designee). This authorization is contingent on meeting the criteria for indigent services (UMDAP) and clinical considerations relevant to Utilization Management.

If ECT is to be paid for by specialty mental health Medi-Cal funds, then prior authorization is required from the Administrative Service Organization Medical Director or the Local Mental Health Director (or designee). This authorization is contingent on clinical considerations relevant to Utilization Management under Medi-Cal regulations. It is expected that all alternate client resources and entitlements will be utilized for ECT and the required medical evaluation prior to authorizing the utilization of County specialty mental health resources.

VII. Outpatient ECT may be approved under the following circumstances:

1. The client has begun ECT on an inpatient basis and requires continuing treatments, but no longer requires inpatient care, **or**

2. The client is in outpatient who requires ECT but does not meet criteria for inpatient admission, **and**

3. The client has sufficient community support for safe outpatient ECT. Support may be provided by the client's personal resources (such as family and friends) or may be arranged by the treating psychiatrist or treatment team, such as home health services, if available.

Appendix B: Consultant Psychiatrist's Statement – Electroconvulsive Treatment for Voluntary Clients

Consultant Psychiatrist's Statement – Electroconvulsive Treatment for Voluntary Clients

I, the undersigned Psychiatrist, have reviewed the treatment record of _____,
(Client)

which include the psychiatric history and Examination by_____MD, and
(Treating Psychiatrist)

specific statements by _____, MD, indicating this client's competence
(Treating Psychiatrist)

to consent to electroconvulsive treatment as defined in Welfare and Institutions Code 5326.5 as follows: Written informed consent requires that a person "knowingly and intelligently, without duress or coercion, clearly and expressly manifests consent to the proposed therapy to the treating physician and in writing on the standard consent form."

Based on my personal examination of the client, and my review of the client's treatment record, I agree with the opinion and recommendation of this client's treating psychiatrist, that is client is competent to consent to electroconvulsive treatment.

Date:_____
Consultant Psychiatrist:_____

HHSA: MHS – 195 (06/2016)

County of San Diego
Health and Human Services Agency
Behavioral Health Services

Appendix C: Electroconvulsive Treatment (ECT), Informed Consent Form

State of California- Health and Human Services Agency Department of Health Care Services

ELECTROCONVULSIVE TREATMENT (ECT) INFORMED CONSENT FORM

DO NOT SIGN THIS FORM UNTIL YOU HAVE ALL THE INFORMATION YOU DESIRE CONCERNING ELECTROCONVULSIVE TREATMENT (ECT).

The nature and seriousness of my mental Condition, for which ECT is being recommended, is:_____

RECOMMENDATION: I understand that ECT involves passage of an electrical stimulus across my brain for a few seconds, sufficient to induce a seizure. In my case the treatments will probably be given_____times per week for _____weeks, not to exceed a total of _____treatments and not to exceed 30 days from the first treatment. Additional treatments cannot be given without my written consent.

Reasonable alternative treatments (such as psychotherapy and/or medication) have been considered and are not presently recommended by my doctor because:

_____

IMPROVEMENT: I understand that ECT may end or reduce depression, agitation and disturbing thoughts. In my case there may be permanent improvement, no improvement, or the improvement may last only a few months. Without this treatment my condition may improve, worsen or continue with little or no change.

SIDE EFFECTS AND RISKS: I understand there is a division of opinion as to the effectiveness of this treatment as well as uncertainty as to how this procedure works.

I also understand this treatment may have brief side effects: headaches, muscle soreness and confusion.

There may be some memory loss which could last less than an hour or there may be a permanent spotty memory loss. Memory loss and confusion may be lessened by the use of unilateral (one-sided) electrical brain stimulation rather than bilateral (two-sided) stimulation.

Anesthesia and muscle relaxants will be used during these treatments to prevent accidental injury. Oxygen will be administered to minimize the small risk of heart, lung, brain malfunction or death as a result of the anesthesia or treatment procedures.

My physician states I have the following medical condition(s) which increase the risk in my case, as follows:_____

I HAVE THE RIGHT TO ACCEPT OR REFUSE THIS TREATMENT. IF I CONSENT, I HAVE THE RIGHT TO REVOKE MY CONSENT FOR ANY REASON AT ANY TIME PRIOR TO OR BETWEEN TREATMENTS.

Dr. _____ has explained the above information to my satisfaction. At least 24 hours have elapsed since the above information was explained to me. I have carefully read this form or had it read to me and understand it and the information given to me.

I HEREBY CONSENT TO ECT _____
Signature Date and Time

_____
Witness Signature

DHCS 1800 (05/19)

Appendix D: Electroconvulsive Treatment (ECT), Informed Consent Form (Spanish)

State of California - Health and Human Services Agency Department of Health Care Services

ELECTROCONVULSIVE TREATMENT (ECT), INFORMED CONSENT FORM

NO FIRME ESTE FORMULARIO SINO HASTA QUE TENGA TODA LA INFORMACION QUE DESEA CON RESPECTO AL TRATAMIENTO ELECTROCONVULSIVO (ECT – *ELECTROCONVULSIVE TREATMENT).*

La naturaleza y gravedad de mi estado mental para el cual se ha recomendado el ECT, es

_____

RECOMENDACION: Entiendo que el ECT es el proceso de pasar estimulación (corriente) eléctrica a través del cerebro por unos segundos de modo adecuado para producir una convulsión. En mi caso, es posible que los tratamientos se me darán_____veces por semana durantesemanas, que no excedan de un total de_____ tratamientos y sin que transcurran más de 30 días del primer tratamiento. No se me darán tratamientos adicionales sin mi consentimiento por escrito. Se han considerado otros métodos de tratamiento y alternativas (tales como sicoterapia y/o medicamentos) y, al presente, mi doctor no los recomienda porque

MEJORAMIENTO: Entiendo que el ECT puede acabar con o reducir Ia depresión, agitación y pensamientos inquietantes. En mi caso, es posible que Ia mejoría sea permanente; que no haya mejoria, o que Ia mejoría dure sólo unos cuantos meses. Sin este tratamiento, mi estado puede mejorar, empeorar o continuar con un ligera cambio o sin cambio alguno.

RIESGOS Y EFECTOS SECUNDARIOS: Entiendo que hay división de opiniones en Io que respecta a Ia eficacia de este tratamiento así como dudas de cómo funciona este procedimiento. Entiendo, igualmente, que este tratamiento puede tener efectos secundarios breves: dolores de cabeza, dolencia de los músculos y confusión.

Puede haber pérdida de Ia memoria que puede durar menos de una hora o es posible que resulte una pérdida de Ia memoria esporádica permanentemente. La pérdida de Ia memoria y Ia confusión pueden aminorarse con el uso unilateral (de un sólo lado) de estimulaciones (corrientes) eléctricas en el cerebro, en vez de recibir Ia estimulación (corriente) de forma bilateral (en los dos lados).

Durante estos tratamientos se utilizarán anestesia y relajantes musculares para evitar lesiones a daños accidentales. Se administrará oxigeno para reducir al mínimo el riesgo pequeño que existe de que pudiera ocurrir un malfuncionamiento del corazón, pulmón, o cerebro o inclusive Ia muerte, como resultado de Ia anestesia o el tratamiento.

Mi doctor indica que yo tengo las siguientes condiciones que aumentarán los riesgos en ml caso:

_____

TENGO EL DERECHO DE ACEPTAR O RECHAZAR ESTE TRATAMIENTO. SI DOY MI CONSENTIMIENTO, TENGO EL DERECHO DE REVOCAR ESTE CONSENTIMIENTO POR CUALQUIER RAZON, Y EN CUALQUIER TIEMPO ANTES DE, O ENTRE TRATAMIENTOS.

El doctor_____me ha explicado Ia infarmación que aparece arriba a mi satisfacción. Por Io menos han transcurrido 24 horas desde que Ia información arriba mencionada me fue explicada. He leido cuidadosamente, o se me ha leído este formulario y Io entiendo así como Ia información que se me ha proporcionado.

POR LA PRESENTE DOY Ml CONSENTIMIENTO PARA ECT

_____ _____

Firma Fecha y hora Firma del testigo

DHCS 1800 SP (05/19)

Appendix E: Procedure for Involuntary Electroconvulsive Treatment (ECT)

(Including Any Client Under Guardianship or LPS Conservatorship 18 Years of Age or Older)

I. The client's outpatient or inpatient treating psychiatrist:

1. Determines the need for electroconvulsive treatment (ECT) based on community standard guidelines and documents this in the client's medical record:
   (usually severe primary affective disorder, psychotic catatonia):

   - Not responsive to less intensive forms of treatment, or
   - When the client is unable to tolerate other forms of treatment, or
   - When the client's psychiatric illness is so severe that relief of symptoms is medically urgent.)

2. Prepares a written supplement to the standard consent form containing details pertaining to the client. (This supplemented form must specify a maximum number of treatments over a maximum period not to exceed thirty (30) days.) This signed documentation includes clinical reasons for the procedure, and a statement that all reasonable treatment modalities have been carefully considered, that the treatment is indicated and is the least drastic alternative for this client at this time.

3. Determines that in his/her opinion this client is incapable of written informed consent: Written informed consent requires that a person knowingly and intelligently, without duress or coercion, clearly and expressly manifests consent to the treating psychiatrist and in writing on the standard ECT consent form. A person is incapable of written informed consent if he/she cannot understand or intelligently act on the information given.

4. Requests that a Review Committee of two board-eligible or board-certified Psychiatrists (or Neurologist) reviews the treatment proposal; committee members may not be personally involved in the client's treatment. Requests go to the treating facility, either inpatient or outpatient, for committee members. The review committee will include one (1) physician appointed by the treatment facility and one (1) shall be appointed by the BHS Director (WIC 5326.7). Both committee members must review the medical record and at least one must personally examine the client. If both members of the committee agree the proposed ECT is appropriate and necessary, both document that finding in the treatment record and complete form entitles, "*Review Committee – Electroconvulsive Treatment for Involuntary Patients*" [Form HHSA:MHS-195 (02/00)]. (If one disagrees with the proposed ECT, do not proceed.)

5. Have a petition filed with the Superior Court; the Court holds evidentiary hearing within three (3) business days to determine client's capacity; client attends hearing with Legal

Counsel (The client may appoint Counsel or the Court may be petitioned to appoint the Public Defender as a precedent to a decision regarding ECT).

II. The Superior Court finds the client incapable of written informed consent. A responsible relative, guardian, or Lanterman-Petris-Short Conservator of Person reviews recommendation of treating psychiatrist and makes election for ECT. This responsible person may also refuse consent or may later withdraw consent on behalf of the client. (If the Court finds the client competent to give informed consent for ECT, do not proceed).

The treating psychiatrist refers the client to the psychiatrist who will perform ECT, if the ECT is not to be given by the treating psychiatrist. Medical evaluation is documented as required by the facility policy, informed consent is confirmed, and treatment is scheduled. All steps are to be fully documented in the client's treatment record. All pertinent documentation and medical evaluation results, including completed informed consent, must be provided to the facility where the ECT is to be given (*If more treatments are required than were authorized in the above steps, the procedure must be reinitiated beginning with step I.1*).

III. The consenting party may withdraw Informed Consent for ECT at any time prior to treatment.

IV. If ECT is to be paid from the Mental Health budget for indigent care, then prior authorization is required from the Administrative Service Organization Medical Director or Local Mental Health Director (or designee). This authorization is contingent on meeting the criteria for indigent services (UMDAP) and clinical considerations relevant to Utilization Management

If ECT is to be paid for by specialty mental health Medi-Cal funds, then prior authorization is required from the Administrative Service Organization Medical Director or the Local Mental Health Director (or designee). This authorization is contingent on clinical considerations relevant to Utilization Management under Medi-Cal regulations.

It is expected that all alternate client resources and entitlements will be utilized for ECT and the required medical evaluation prior to authorizing the utilization of County specialty mental health resources.

V. Outpatient ECT may be approved under the following circumstances:

1. The client has begun ECT on an inpatient basis and requires continuing treatments, but no longer requires inpatient care, **or**

2. The client is in outpatient who requires ECT but does not meet criteria for inpatient admission, **and**

3. The client has sufficient community support for safe outpatient ECT. Support may be provided by the client's personal resources (such, as family and friends) or may be arranged by the treating psychiatrist or treatment team, such as home health services, if available.

Appendix F: Review Committee- Electroconvulsive Treatment (ECT) for Involuntary Clients

Review Committee – Electroconvulsive Treatment for Involuntary Clients

We, the undersigned Psychiatrists, have reviewed the treatment record of _____,
(Client)

which include the psychiatric history and examination by_____,MD, and specific
(Treating Psychiatrist)

statements by _____, MD, indicating the reason for the choice
(Treating Psychiatrist)

of this treatment procedure. All reasonable treatment modalities have been carefully considered, and electroconvulsive treatment is indicated and is the least drastic alternative available for this client at this time.

Based on a personal examination of the client and/or my review of the client's medical record (one Review Committee member only), we agree with the opinion and recommendation of the client's treating psychiatrist that electroconvulsive treatment is the treatment of choice for the welfare of this client and that this client is not able to give informed consent for this procedure.

Date:_____ Consultant Psychiatrist:_____
(Appointed by facility)

Date:_____ Consultant Psychiatrist:_____
(Approved by Behavioral Health Services Director)

HHSA: MHS – 195 (06/2016)

County of San Diego
Health and Human Services
Agency Behavioral Health
Service

Appendix G: Involuntary Electroconvulsive Treatment (ECT) Review Committee Physician Appointment Request

Involuntary Electroconvulsive Treatment (ECT) Review Committee
Physician Appointment Request

Name of Physician Requesting Appointment: _____

Program/Facility Name: _____

Medical Director's Name: _____

To be appointed by the County of San Diego BHS Director for placement on an Involuntary Electroconvulsive Treatment Review Committee, please complete the signed attestation below by the requesting physician and Medical Director and email the complete form along with the physician's CV to the BHS ECT Lead at BHSContactUs.HHSA@sdcounty.ca.gov

---

Attestation

I, the above referenced Physician requesting appointment, attest to the following:

Please initial below	
	I have reviewed and will maintain compliance with California Welfare and Institutions Code (WIC) Section 5326.7.

_____ _____
Physician Signature Date

I, the above referenced Medical Director, attest to the following:

Please initial below	
	Involuntary ECT policies and procedures at the program/facility referenced above maintains compliance with California Welfare and Institutions Code (WIC) Section 5326.7.
	The physician requesting appointment is a board-certified or board-eligible psychiatrist or neurologist.
	If there is any change to the licensure status, professional privileges, or any restriction that may affect the qualifications of this physician appointment, I agree to immediately notify the BHS ECT Lead at BHSContactUs.HHSA@sdcounty.ca.gov

_____ _____
Medical Director's Signature Date

Appendix I: Beneficiary and Client Problem Resolution Policy and Process

I. Beneficiary and Client Problem Resolution Policy

In its commitment to honoring mental health consumer rights, the County of San Diego shall maintain a beneficiary and client problem resolution process, in compliance with State and Federal regulations, which provides a quality, impartial, and effective process for resolving consumer problems encountered while accessing or receiving mental health services. All County-operated and contracted providers shall be required by contract to cooperate with the problem resolution process as described herein. The full and timely cooperation of the provider shall be considered essential in honoring the client's right to an efficient problem resolution.

A. Process

San Diego County Mental Health Services is committed to providing a quality, impartial, and effective process for resolving consumer complaints encountered while accessing or receiving mental health services. The process is designed to:

- Provide easy access
- Support the rights of individuals
- Be action-oriented
- Provide timely resolution
- Provide effective resolution at the lowest level
- Improve the quality of services for all consumers in the population

While the consumer is encouraged to present problems directly to the provider for resolution, when a satisfactory resolution cannot be achieved, one or more of the processes below may be used:

1. Grievance process

2. Appeal process (in response to an "action" as defined as: denying or limiting authorization of a requested service, including the type or level or service; reducing, suspending, or terminating a previously authorized service, denying, in whole or in part, payment for a service; failing to provide services in a timely manner, as determined by the Behavioral Health Plan (BHP) or; failing to act within the timeframes for disposition of standard grievances, the resolution of standard appeals or the resolution of expedited appeals.)

3. Expedited Appeal process (available in certain limited circumstances)

4. State Fair Hearing process--available to Medi-Cal beneficiaries who have filed an appeal through the County Behavioral Health Program (BHP) process and are dissatisfied with the resolution. The State Fair Hearing is also for clients whose grievance or appeal was not resolved timely in the BHP process (including an extension if permission was given), or no permission for an extension was given. In this instance, clients are not required to wait until the completion of the County BHP process to do so.

The Mental Health Problem Resolution process covers Medi-Cal beneficiaries, Severely

Emotionally Disabled (SED) certified children through the Healthy Families program, and persons without Medi-Cal funds receiving County-funded mental health services. It is designed to meet the regulations in CCR Title 9, Division 1, Chapter 11, Subchapter 5, Section 1850.205 and 42 CFR Subpart F, Part 438.400. The procedures relating to children and youth served under AB 3632/2726 legislation will take precedence over this document. By law, Welfare and Institution (WI) Code WI 10950, the State Fair Hearing process, is only available to a Medi-Cal beneficiary.

B. Objectives

1. To provide the consumer with a process for independent resolution of grievances and appeals.

2. To protect the rights of consumers receiving mental health services, including the right to:

    - Be treated with dignity and respect,
    - Be treated with due consideration for his or her privacy,
    - Receive information on available treatment options in a manner appropriate to his or her condition and ability to understand,
    - Participate in decisions regarding his or her mental health care, including the right to refuse treatment,
    - Be free from any form of unnecessary restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,
    - Request a copy of his or her medical records, and to request that an additional statement amending or correcting the information be included, and
    - Freely exercise these rights without adverse effects in the way providers treat him or her.

3. To protect the rights of consumers during grievance and appeal processes.

4. To assist individuals in accessing medically necessary, high quality, consumer-centered mental health services and education.

5. To respond to consumer concerns in a linguistically appropriate, culturally competent and timely manner.

6. To provide education regarding, and easy access to, the grievance and appeal process through widely available informational brochures, posters, and self-addressed/stamped envelopes as well as grievance and appeal forms located at all provider sites in all available threshold languages.

C. *Beneficiary and Client Rights During the Grievance and Appeal Process*

1. Consumer concerns shall be responded to in a linguistically appropriate, culturally competent and timely manner.

2. Clients' rights and confidentiality shall be protected at all stages of the grievance and appeal process by all providers and advocates involved.

3. Consumers shall be informed of their right to contact the Jewish Family Service (JFS) Patient Advocacy Program regarding problems at inpatient and residential mental health facilities or the Consumer Center for Health Education and Advocacy (CCHEA) for problems with outpatient and all other mental health services, at any time for assistance in resolving a grievance or appeal. Medi-Cal beneficiaries shall also be informed of their right to request a State Fair Hearing.

4. Consumers of the BHP and persons seeking services shall be informed of the process for resolution of grievances and appeals. This includes information about the availability of the JFS Patient Advocacy Program and CCHEA, the programs that currently are contracted with the BHP to assist consumers with problem resolution, at the consumer's request. The information shall be available in the threshold languages and shall be given to the client at the point of intake to Behavioral Health Plan services, and upon request during the provision of services. Continuing clients must be provided with the information annually. Providers shall document the provision of this information.

5. The client may authorize another person or persons to act on his/her behalf. A client may select a provider as his or her representative in the appeal process. His or her representative, or the legal representative of a deceased client's estate, shall be allowed to be included as parties to an appeal.

6. A support person chosen by the client, such as family member, friend or other advocate may accompany them to any meetings or hearings regarding a grievance or appeal.

7. The client and/or his or her representative may examine the case file, including documents or records considered during the grievance or appeal process.

8. Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance or appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to file a grievance or appeal.

9. Advocates shall treat clients, their chosen support persons, and all providers with courtesy and respect throughout the grievance resolution process.

    - Providers shall participate fully and in a timely manner in order to honor the client's right to an efficient, effective problem resolution process.

- Medi-Cal beneficiaries, who have appealed through the BHP Beneficiary Problem Resolution process and are dissatisfied with the resolution, have the right to request an impartial review in the form of a State Fair Hearing within 120 calendar days of the decision whether or not the client received a Notice of Adverse Benefit Determination (NOABD). At a State Fair Hearing, a client has the opportunity to present his or her concerns to an administrative law judge for a ruling. (See *Section VIII* for more information on the State Fair Hearings.)

- Clients who are Medi-Cal beneficiaries and who have a grievance or appeal which has not been resolved by the BHP within mandated timelines, and no client permission for an extension has been granted, may request a State Fair Hearing. They need not wait until the end of the County process before making the request.

- Quality of care issues identified as a result of the grievance and appeal process shall be reviewed by the BHP and the Quality Review Council for implementation of system changes, as appropriate.

D. *Client and Beneficiary Notification*

1. Consumers shall be informed in a clear and concise way of the process for reporting and resolving grievances and appeals. This includes information on how to contact JFS Patient Advocacy . The information shall be available in the threshold languages and shall be given to the client at the point of intake to a program and, as appropriate, during the provision of services. Continuing clients must be provided with the information annually, and providers will document these efforts.

2. Notices in all available threshold languages describing mental health rights, as well as the grievance and appeal procedures, shall be posted in prominent locations in public and staff areas, including waiting areas of the provider location. Brochures with this information will also be available in these areas in the County's threshold languages.

3. Grievance/Appeal forms and self-addressed/stamped envelopes must be available in all threshold languages for consumers at all provider sites in a visible location, without the consumer having to make a written or verbal request to anyone. This includes common areas of both locked and unlocked behavioral health units.

4. JFS Patient Advocacy Program shall have interpreter services and toll-free numbers with adequate TDD/TTY, available at a minimum during normal business hours.

5. Under certain circumstances, when the BHP denies any authorization for payment request from a provider to continue specialty mental health services to a Medi-Cal beneficiary, the BHP must provide the Medi-Cal beneficiary with a Notice of Adverse Benefit Determination (NOABD), which informs the beneficiary of his or her right to request a State Fair Hearing, and the right to contact a representative from JFS.

II. Informal Problem Resolution (available to all mental health clients)

Consumers are encouraged to seek problem resolution at the provider level by speaking or writing informally to the therapist, case manager, facility staff, or other person involved in their care. Often this is the quickest way to both make the provider aware of the client's issue, as well as come to a satisfactory resolution.

However, no consumer shall be required to take the matter directly to the provider unless he or she chooses.

In addition to, or instead of bringing the issue directly to the individual provider, consumers may work directly with the supervisor or Program Director, who shall make efforts to resolve it. In attempting to reach resolution, and consistent with confidentiality requirements, the appropriate supervisor or Program Director shall utilize whatever information, resources and/or contacts the consumer agrees to.

III. Grievance Process (available to all mental health clients)

Any consumer of mental health services may express dissatisfaction with mental health services or their administration by filing a grievance through JFS Patient Advocacy (for inpatient, CSU and residential services) or the Consumer Center for Health Education and Advocacy (for outpatient and all other mental health services).

IV. Grievance Procedures

At any time, the consumer chooses, the consumer may contact JFS Patient Advocacy, as appropriate. JFS Patient Advocacy shall work to resolve the issue according to the following steps:

1. Client contacts JFS Patient Advocacy Program for issues relating to inpatient and other twenty- four (24) hour-care programs, or CCHEA for issues relating to outpatient, day treatment and all other services, either orally or in writing, to file a grievance. A grievance is defined as an expression of dissatisfaction about anything other than an "action" (see *Section IV* for complete definition.).

   Note: If the client's concern is in regard to an "action" as defined, the issue is considered an "appeal" (see *Section X* for Definition) not a grievance. See "*Appeal Process*" *in Section V* below for procedure.

2. CCHEA or JFS Patient Advocacy Program logs the grievance within one (1) business day of receipt. The log shall include:
   - client name or other identifier,
   - date the grievance was received,

- date it was logged,
- the nature of the grievance,
- provider name,
- whether or not the issue concerns a child.

The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. The log content pertaining to the client shall be summarized in writing, if the client requests it.

3. CCHEA or JFS Patient Advocacy Program provides the client a written acknowledgement of receipt of the grievance postmarked within five (5) calendar days.

4. CCHEA or JFS Patient Advocacy Program shall contact the provider involved in the grievance within two (2) business days of receipt of the client's written permission to represent the client.

5. CCHEA or JFS Patient Advocacy Program investigates the grievance.

    - CCHEA or JFS shall ensure the person who makes the final determination of the grievance resolution has had no prior or current involvement in the grievance determination.

    - In cases where the CCHEA or JFS staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the MHP QA Unit about conflict of interest of issues.

    - The client's confidentiality shall be safeguarded per all applicable laws.

6. If the grievance is about a clinical issue, the decision maker must be a mental health professional with the appropriate clinical expertise in treating the client's condition.

7. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's grievance, CCHEA or JFS Patient Advocacy staff will often find it necessary to discuss the issue with the providers involved, either in person or by phone at various points in the process. The expectation is that CCHEA or JFS and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

    If a case should arise in which CCHEA or JFS and the provider are unable to reach a mutually agreeable resolution to the grievance within the required timeframe as stated below, CCHEA or JFS shall make a finding based on the facts as they are known. The grievance disposition letter shall include this finding. The letter may include a request that the provider write a Plan of Correction to be submitted by the provider directly to the BHP Director or designee. CCHEA or JFS may also choose to include what they believe to be equitable, enforceable suggestions or recommendations to the provider for resolution of

the matter. Notification of the resolution shall go out to all parties as described below.

8. CCHEA or JFS Patient Advocacy Program shall notify the client in writing regarding the disposition of the grievance within the timeframe for resolution stated below. The notice shall include:

    - the date
    - the resolution

    A copy of the grievance resolution letter will be sent to the provider and the QA Unit at the time the letter is sent to the client.

    Timelines for grievance dispositions cannot exceed thirty (30) calendar days from the date of receipt of the grievance. Timeliness of grievance resolution is an important issue for consumers. If CCHEA or JFS staff is unable to meet the timeframe described herein, the staff person shall issue a *Notice of Adverse Benefit Determination for Timely Access* (NOABD-Timely Access) to the beneficiary informing them of their rights. A copy of the NOABD shall be sent to the QA Unit. Clients whose grievances are not completed according to mandated timelines, and have not given permission for an extension, may request a State Fair Hearing. They need not wait until the end of the County process to make this request.

9. CCHEA or JFS Patient Advocacy Program shall record in the log, the final disposition of the grievance, and date the decision was sent to the client, or reason there has not been a final disposition of the grievance.

10. Providers who do not successfully resolve the grievance with the advocacy organization during the grievance process shall receive two letters from CCHEA or JFS. One is a copy of the disposition sent to the client, that includes a request for Plan of Correction, and the other is a letter requesting that the provider write a Plan of Correction and submit it within ten (10) working days directly to:

    Grievance Plan of Correction
    Quality Management Unit
    P.O. Box 85524, Mail Stop P531G
    Camino Del Rio South
    San Diego, CA 92186-5524

    The Plan of Correction letter to the provider (not the grievance disposition letter) may include CCHEA's or JFS's suggestions of what the Plan of Correction could include. Responsibility for reviewing the Plan of Correction and monitoring its implementation rests with the BHP. The monitoring of any provider's Plan of Correction and handling of any provider's request for administrative review shall be performed by the BHP directly with the provider.
    In the event that a provider disagrees with the findings of the grievance investigation as decided by the advocacy organization and does not agree to write a Plan of Correction, the provider may choose instead to write a request for administrative review by the BHP. This request shall be submitted directly by the provider to the BHP Director or designee within

ten (10) business days of receipt of the grievance disposition. The provider must include rationale and evidence to support the provider's position that the disposition of the grievance is faulty and/or that no Plan of Correction is indicated.

Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing a grievance.

Grievance Process Timeline

STEP	ACTION	TIMELINE
1	Grievance Filed by client	Filing date
2	Grievance Logged	One (1) business day from grievance filing
3	Written Acknowledgement to client	Five (5) calendar days from grievance filing
4	Provider Contact	Within two (2) business days from client's written permission to represent
5	Clinical Consultant review, if applicable	Within thirty (30) day total timeframe
6	Grievance Disposition	Thirty (30) days from filing date
7	Provider Plan of Correction (if needed)	Ten (10) business days from disposition date
8	Request for Administrative Review	Ten (10) business days from receipt of the grievance disposition

V. Appeal Process- (available to Medi-Cal Beneficiaries only)

The appeal procedure begins when a Medi-Cal beneficiary contacts JFS Patient Advocacy Program (for issues relating to inpatient and other twenty- four (24) hour care program) or CCHEA (for issues relating to outpatient, day treatment and all other services) to file an appeal to review an "action."

An "action" is defined by 42 Code of Federal Regulations as occurring when the BHP does at least one (1) of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Delays completion of the BHP appeals process within the mandated timeframe, without client permission for an extension.

In San Diego County this is relevant only for inpatient, day treatment, and outpatient services provided by fee-for-service providers, as these are currently the only services for which an authorization is required. Clients wishing to have a review of a clinical decision made by an individual provider, not the BHP or its administrative services organization, may use the grievance process.

The BHP is required to provide *Aid Paid Pending* for beneficiaries who request continued services, and have made a timely request for an appeal:

- within ten (10) days of the date the NOABD was mailed, or
- within ten (10) days of the date the NOABD was personally given to the beneficiary, or
- before the effective date of the service change, whichever is later.

The BHP must ensure that benefits are continued while the appeal is pending, if the beneficiary so requests. The beneficiary must have:

- an existing service authorization which has not lapsed, and the service is being terminated, reduced, or denied for renewal by the BHP, or
- been receiving specialty mental health services under an 'exempt pattern of care' (see *Section X- Definitions*).

The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved, or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, whichever is earliest.

Federal regulations require beneficiaries to file an appeal within sixty (60) calendar days from the date on the NOABD. The BHP shall adopt the 60-calendar day timeframe in accordance with the federal regulations. Beneficiaries must also exhaust the Plan's appeal process prior to requesting a State hearing. A beneficiary, or provider and/or authorized representative, may request an appeal either orally or in writing. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.

VI. Appeal Procedures

1. The client may file the appeal orally or in writing. If the appeal is oral, the client is required to follow up with a signed, written appeal. The client shall be provided with assistance in completing the written appeal, if requested. The date of the oral appeal begins the appeal resolution timeframe, regardless of when the follow-up, written appeal was signed. The client may present evidence in person or in writing.

2. CCHEA or JFS Patient Advocacy Program, as appropriate, determines whether the appeal meets the criteria for expedited appeal and, if so, follows the expedited appeal process as stated in *Section VI* below.

3. CCHEA or Patient Advocacy Program logs the appeal within one (1) business day of receipt. The log shall include the:

    - client name or other identifier,
    - date the appeal was received,
    - date the appeal was logged,
    - nature of the appeal,
    - the provider involved,
    - and whether the issue concerns a child.

    The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. If the client requests to see the log, CCHEA or JFS will summarize in writing the content pertaining to the client.

4. CCHEA or JFS shall acknowledge, in writing, receipt of the appeal within five (5) calendar days.

5. CCHEA or JFS shall contact the provider within two (2) business days of receipt of the client's written authorization to represent the client.

6. CCHEA or JFS Patient Advocacy Program shall notify the QA Unit within three (3) business days of any appeal filed.

7. CCHEA or JFS evaluates the appeal and:

    - Ensures that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.

    - Safeguards the client's confidentiality per all applicable laws.

    In cases where the CCHEA or JFS staff member has another existing relationship with the client or provider, that contractor's Program Director shall reassign the case or consult with the BHP QA Unit about conflict of interest of issues.

8. If the appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.

9. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential in honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's appeal, CCHEA or JFS staff will often find it necessary to discuss the issue with the providers involved and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or JFS, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious

ways to address and resolve the client's issue.

If CCHEA or JFS denies the appeal, or if the appeal is granted but is not an appeal of one of the actions listed in Item #10 below, proceed to item #12.

10. If CCHEA or JFS believes that there is sufficient merit to grant an appeal regarding an action that:

    A. denied or limited authorization of a requested service, including the type or level of service,

    B. reduced, suspended or terminated a previously authorized service, or

    C. denied, in whole or in part, payment for a service, CCHEA or JFS shall do the following within twenty (20) calendar days of the date the appeal was filed:

        a. notify the BHP Director or designee in writing of details of the appeal and the specific, supported rationale for why it should be granted, and

        b. provide copies to the BHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes, and other materials including an accurate representation of the provider's position regarding the appeal.

11. The BHP Director or designee shall return a decision on the appeal to the advocacy organization within ten (10) calendar days of receipt of the above.

12. CCHEA or JFS shall notify the beneficiary in writing regarding the disposition of the appeal within the timeframe for resolution stated below. The notice shall include**:**

    - the date,
    - the resolution,
    - and if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary, information regarding:
        - the right to request a State Fair Hearing within ninety (90) days of notice of the decision,
        - how to request a State Fair Hearing, and
        - the beneficiary's right to request services while the hearing is pending and how to make that request for continued services.
        - A copy of the appeal resolution letter will be sent to the provider and the Quality Assurance (QA) Unit at the time the letter is sent to the client.

13. Appeals must be resolved within thirty (30) calendar days from the date of receipt of the appeal. Timeliness of appeal resolution is an important issue for consumers. If an extension is required, CCHEA or JFS Patient Advocacy Program will contact the client to discuss an extension, document clearly in the file the extenuating circumstances for the extension, and the date the client was contacted and agreed to an extension.

14. If CCHEA or Patient Advocacy staff is unable to meet the timeframe described herein, they are required to issue an NOABD-Timely Access to Medi-Cal beneficiaries only. A copy shall be sent to the QA Unit. CCHEA or JFS Patient Advocacy Program shall record in the log the final disposition of the appeal, and the date the decision was sent to the client, or the reason for no final disposition of the appeal.

15. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

    Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

Appeals Process Timeline

VIII. Expediated Appeal Process—available to Medi-Cal beneficiaries only

When a client files an oral or written appeal to review an action (as previously defined) and use of the standard appeal resolution process could, in the opinion of the client, the BHP, or CCHEA or JFS

STEP	ACTION	TIMELINE
1	Appeal Filed by Client	File Date
2	Appeal Logged	One (1) business day from appeal
3	Expedited Appeal Criteria?	Go to Section VII
4	Written Acknowledgement of appeal to client	Five (5) calendar days from receipt of appeal
5	Provider Contact	Two (2) business days from client's written permission to represent
6	Clinical Consultant Review, if applicable	As soon as possible
7	Notify QA Unit	Three (3) business days of appeal filing
8	Advocacy Organization Recommends Denying Appeal	See #10 for timelines
9	Advocacy Organization Recommends Granting the Appeal, and Notifies BHP Director in Writing with Supporting Documentation	Within twenty (20) calendar days from date appeal was filed
10	BHP Director Makes Decision on the Appeal	Within ten (10) calendar days from receipt of appeal.
11	Appeal Resolution	Thirty (30) calendar days from receipt of appeal

Patient Advocacy program staff, jeopardize the client's life, health or ability to attain, maintain, or regain maximum function, the expedited appeal process will be implemented instead.

IX. Expediated Appeal Procedures

1. The client may file the expedited appeal orally or in writing.

2. The CCHEA or JFS Patient Advocacy Program logs the expedited appeal within one working day of receipt. The log shall include the:

   - client name or other identifier,
   - date appeal was received,
   - date the appeal was logged,
   - nature of the appeal,
   - provider involved,
   - and whether the issue concerns a child.

3. The log is to be maintained in a confidential location at CCHEA or JFS Patient Advocacy. If the client requests to see the log, the advocacy agency will summarize in writing the content pertaining to the client.

4. CCHEA or JFS Patient Advocacy Program provides the client a written acknowledgement of receipt of the expedited appeal within two (2) working days.

5. CCHEA or JFS Patient Advocacy Program shall notify the QA Unit immediately of any expedited appeal filed. CCHEA or JFS Patient Advocacy Program shall contact the provider as soon as possible but not to exceed two (2) business days.

6. The client or his or her representative may present evidence in person or in writing.

7. CCHEA or JFS Patient Advocacy Program evaluates the expedited appeal.

   - They shall ensure that the person who determines the final resolution of the appeal has had no decision-making involvement in any prior level of review.

   - The client's confidentiality shall be safeguarded per all applicable laws.

8. If the expedited appeal is about a clinical issue, the decision-maker must also be a mental health professional with the appropriate clinical expertise in treating the client's condition.

9. If, in the opinion of CCHEA or JFS Patient Advocacy Program, the appeal does not meet the criteria for the expedited appeal process that has been requested, CCHEA or JFS Patient Advocacy program staff shall:

- Obtain agreement of the MHP to deny the use of the expedited appeal process and to treat the appeal as a standard appeal instead.

- Transfer the appeal to the timeframe for standard appeal resolution (above), and

- Make reasonable efforts to give the client prompt oral notice of the denial of the expedited process and follow up within two (2) calendar days with a written notice. A copy of the letter shall be sent to QA.

10. All County-operated programs and contracted providers are required by contract to cooperate with the problem resolution process as it is described herein. The full participation and timely cooperation of the provider are essential to honoring the client's right to an efficient, effective problem resolution process. During the resolution of the client's expedited appeal, CCHEA or JFS staff will often find it necessary to discuss the issue with the providers involved, and the Administrative Service Organization (ASO), either in person or by phone at various points in the process. The expectation is that CCHEA or JFS, the ASO, and the provider will cooperate with each other to find mutually agreeable and expeditious ways to address and resolve the client's issue.

    If CCHEA or JFS denies the expedited appeal, or if the expedited appeal is granted but is not an appeal of one of the actions listed in item #12 below, *proceed to item #14*.

11. If the advocacy organization believes that there is sufficient merit to grant an expedited appeal regarding an action that:

    - denied or limited authorization of a requested service, including the type or level of service,

    - reduced, suspended or terminated a previously authorized service, or

    - denied, in whole or in part, payment for a service, the advocacy organization shall do the following within two (2) business days of the date the appeal was filed:

        - notify the BHP Director or designee in writing of details of the expedited appeal and the specific, supported rationale for why it should be granted, and

        - provide copies to the BHP Director or designee of all relevant medical records, the clinical consultant's evaluation, case notes,

and other materials including an accurate representation of the provider's position regarding the expedited appeal.

12. The BHP Director or designee shall return a decision on the expedited appeal to the advocacy organization within one (1) business day of receipt of the above.

13. CCHEA or JFS Patient Advocacy Program shall make a reasonable effort to notify the client orally of the expedited appeal resolution decision as soon as possible. In addition, they shall notify the client in writing within the timeframe for resolution stated below, regarding the results of the expedited appeal. The notice shall include:

    - the date,
    - the resolution,
    - and only if the decision is not wholly in favor of the client AND the client is a Medi-Cal beneficiary
    - information regarding the right to request an expedited State Fair Hearing
    - information on how to request continued services (aid paid pending) while the hearing is pending.
    - A copy of the appeal resolution letter will be sent to the provider and the QA Unit at the same time the letter is sent to the client.

14. Expedited appeals must be resolved, and the client must be notified in writing within three (3) business days from the date of receipt of the expedited appeal.

15. If CCHEA or JFS staff is unable to meet the timeframe described herein, they shall issue an NOABD-Timely Access to the beneficiary. A copy shall be sent to the QA Unit.

16. CCHEA or JFS Patient Advocacy Program shall record in the log the final disposition of the expedited appeal, and the date the decision was sent to the client, or reason there has not been a final disposition of the expedited appeal.

17. If the decision of the appeal process reverses a decision to deny services, those services shall be promptly provided.

    Reminder: Providers shall not subject a client to any discrimination or any other penalty of any kind for filing an appeal.

Expediated Appeals Process Timeline

STEP	ACTION	TIMELINE
1	Expedited Appeal Filed by client	File Date
2	Expedited Appeal Criteria? If not, obtain MHP agreement and treat as regular appeal.	If no, notify client in two (2) calendar days in writing
3	Expedited Appeal Logged	One (1) business day from appeal receipt
4	Written Acknowledgement of appeal to client	Two (2) business days from receipt of appeal
5	Provider Contact	Two (2) business days from client's written permission to represent
6	Notify QA Unit	Immediately
7	Advocacy Organization recommends denying appeal	See #10 above for timelines
8	Advocacy Organization recommends granting the appeal, and notifies BHP Director in writing with supporting documentation.	Within two (2) business days from date appeal was filed
9	BHP Director makes decision on the appeal	Within one (1) business day from receipt of notification from the advocacy organization
10	Appeal Resolution	Three (3) business days from receipt of appeal

X. State Fair Hearing —available to Medi-Cal beneficiaries only, who are not receiving services through the Department of Education

A. A State Fair Hearing is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal beneficiary is required to exhaust the BHP's problem resolution process above prior to requesting a State Fair Hearing. Only a Medi-Cal beneficiary may request a state hearing:

- within ninety (90) days after the completion of the BHP beneficiary problem resolution process, whether or not the client received a Notice of Adverse Benefit Determination (NOABD), or
- when the grievance or appeal has not been resolved within mandated timelines, and who gave no permission for an extension. The beneficiary does not need to wait for the end of the BHP Problem Resolution process.

A Medi-Cal beneficiary may request a State Fair Hearing by writing to or calling the State Fair Hearings Division of the California Department of Social Services at **1(800) 952-5253,** or by

contacting CCHEA or JFS Patient Advocacy Program for assistance.

Children and youth receiving mental health services under AB 3632/2726 legislation through the Department of Education should use that Department's Grievance and Appeals process.

B. When the BHP QA Unit has been notified by the State Fair Hearings Division that an appeal or state fair hearing has been scheduled, the QA Unit shall:

1. Contact the client or his or her advocate, investigate the problem, and try to resolve the issue before the matter goes to State Fair Hearing. In cases where a successful resolution of the matter is not reached, the client proceeds to a hearing.

2. Attend the hearing to represent the BHP position.

3. Require that County-operated and/or contracted providers involved in the matter assist in the preparation of a position paper for the hearing, and/or may be requested to attend the hearing as a witness in the case.

4. The BHP is required to provide *Aid Paid Pending* for beneficiaries who ~~want~~ request continued services while awaiting a Hearing, have met the Aid Paid Pending criteria per CCR, Title 22, Section 51014.2 summarized below, and have made a timely request for a fair hearing:

    - within ten (10) days of the date the NOABD was mailed, or
    - within ten (10) days of the date the NOABD was personally given to the beneficiary, or
    - before the effective date of the service change, <u>whichever is later</u>.

5. The beneficiary must have:

    - an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the BHP, or
    - been receiving specialty mental health services under an 'exempt pattern of care' (see *Section XII- Definitions*).

6. The benefits will stay the same until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal or state fair hearing is otherwise withdrawn or closed, <u>whichever is earliest</u>.

7. After a judge has heard a case, he or she forwards the decision to the BHP QA Unit. In the event that the case is not resolved in the BHP's favor, the QA Unit staff shall communicate the decision and any actions to be implemented, to the BHP Program Monitors to oversee implementation of the resolution by the County- operated and/or

contracted providers.

Please note: A beneficiary may file an appeal or state fair hearing whether or not a Notice of Adverse Benefit Determination (NOABD) has been issued.

XI. Monitoring Grievances and Appeals

The BHP QA Unit shall be responsible for monitoring grievances and appeals, identifying issues and making recommendations for needed system improvement.

A. Procedures

1. The BHP QA Unit shall review the files of CCHEA and JFS Patient Advocacy program periodically and as frequently as needed in order to monitor timely adherence to the policy and procedures outlined herein and ensure that consumer rights under this process are protected to the fullest extent.

2. On a monthly basis, by the 5th calendar day of the following month, JFS Patient Advocacy Program and CCHEA shall submit their logs of all grievances and appeals for the previous calendar month, to the BHP QA Unit. The logs shall specify whether each item is a grievance, appeal, or expedited appeal. They shall include the:

    - client name or other identifier
    - date the grievance or appeal was filed,
    - date logged
    - nature of the grievance or appeal
    - provider involved,
    - and whether the issue concerns a child.

3. For those grievances and appeals that have been resolved, the log shall note the final disposition of the grievance or appeal, and the date the decision was sent to the client.

4. The BHP QA Unit will keep centralized records of monitoring grievances and appeals, including the nature of the grievance/appeal, as well as track outcomes of appeals that were referred to other entities including State Fair Hearings. Trends will be identified and referred to the Quality Review Council, BHP Director, and/or Mental Health Board for recommendations or action as needed. The BHP QA Unit shall submit a grievance and appeal log to the State Department of Mental Health annually.

B. Handling Complaint Clusters

CCHEA and JFS Patient Advocacy shall report to the QA Unit complaint clusters about any one provider or therapist occurring in a period of several weeks or months, immediately upon discovery. Background information and copies of client documentation shall be provided to the QA Unit also.

1. The QA Unit will investigate all such complaint clusters.

2. Findings will be reported to the BHP Director.

XII. Definitions

ASO: Administrative Service Organization contracted by HHSA to provide Managed Care Administrative functions.

Action: As defined by 42 Code of Federal Regulations (CFR) an action occurs when the Mental Health Plan (MHP) does at least one of the following:

- Denies or limits authorization of a requested service, including the type or level of service;
- Reduces, suspends, or terminates a previously authorized service;
- Denies, in whole or in part, payment for a service;
- Fails to provide services in a timely manner, as determined by the MHP or;
- Fails to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

Appeal: A request for review of an action (as action is defined above).

Beneficiary: A client who is Medi-Cal eligible and currently requesting or receiving specialty mental health services paid for under the County's Medi-Cal Managed Care Plan.

Client: Any individual currently receiving mental health services from the County BHS system, regardless of funding source.

Consumer Center for Health Education and Advocacy (CCHEA) :CCHEA is an BHP contractor currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems with outpatient and all other non-residential mental health services; and to provide patient advocacy services which include information and education on client rights and individual assistance for mental health clients with problems accessing/maintaining services in the community.

Consumer: Any individual who is currently requesting or receiving specialty mental health services, regardless of the individual's funding source and/or has received such services in the past and/or the persons authorized to act on his/her behalf. (This includes family members and any other person(s) designated by the client as his/her support system.)

Grievance: An expression of dissatisfaction about any matter other than an action (as action is defined).

Grievance and Appeal Process: A process for the purpose of attempting to resolve consumer problems regarding specialty mental health services.

Mental Health Plan (MHP): County of San Diego, Health & Human Services Agency, Mental Health Services.

Notice of Adverse Benefit Determination (NOABD): A notice sent to Medi-Cal beneficiaries to inform them of a decision regarding denial, reduction, or termination of requested services and their rights for appeal if they disagree with the decision.

- NOABD-Denial of Authorization Notice: The BHP denies a request for service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. This notice used for denied residential services. .

- NOABD- Delivery System Notice: The BHP determined that the beneficiary does not meet the criteria to be eligible for specialty mental health services through the BHP. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health or other services

- NOABD- Modification Notice: The BHP modifies or limits a provider's request for a service , including reductions in frequency and/or duration of services, and approval of alternative treatments and services.

- NOABD- Termination Notice: The BHP terminates, reduces, or suspends a previously authorized service.

- NOABD- Timely Access Notice: When there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service.

- NOABD- Authorization Delay Notice: When there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When the BHP extends the timeframes to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted when there is a need for additional information from the beneficiary or provide, when the extension is in the beneficiary's interest.

- NOABD- Financial Liability Notice: The BHP denies a beneficiary's request to dispute financial liability, including cost- sharing and other beneficiary financial liabilities.

- NOABD- Payment Denial Notice: The BHP denies, in whole or in part, for any reason, a

provider's request for payment for a service that has already been delivered to a beneficiary.

Patients' Rights Advocate: The persons designated under Welfare and Institutions Code, Section 5500 et seq. to protect the rights of all recipients of specialty mental health services. The Patients' Rights Advocate "shall have no direct or indirect clinical or administrative responsibility for any recipient of Medi-Cal Managed Care Services and shall have no other responsibilities that would otherwise compromise his or her ability to advocate on behalf of specialty mental health beneficiaries."

JFS Patient Advocacy Program staff currently serves as the Patients' Rights Advocate for acute inpatient and other twenty- four (24) hour residential services, and CCHEA staff serves as the Patients' Rights Advocate for outpatient, day treatment, and all other services.

Quality Assurance (QA) Program: The Quality Assurance Program is a unit within HHSA Behavioral Health Services whose duties include monitoring and oversight of the Grievance and Appeal Process.

State Fair Hearing: A formal hearing before an administrative law judge, requested by a Medi-Cal beneficiary and conducted by the State Department of Social Services as described in Welfare and Institutions Code, Section 10950, and Federal Regulations Subpart E, Section 431.200 et seq.

Jewish Family Service (JFS) Patient Advocacy Program: The Jewish Family Service Patient Advocacy Program is an agency currently designated by the Local Mental Health Director to fulfill two roles: to operate the County's Grievance and Appeal process for client problems in acute care hospitals and residential services; and to provide patient advocacy services which include information and education on patient rights and individual client assistance in resolving problems with possible violations of patient's rights.

Appendix J: Incident Reporting (IR)

Incident Reporting

An incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community shall be reported to the BHS Health Plan Organization Quality Assurance Unit. There are two types of reportable incidents, 1) Critical Incidents are reported to the BHS QA Unit and 2) Non-Critical Incidents which are reported via an online submission form that report directly to the program's Contracting Officer Representative (COR) and reviewed by the Quality Assurance Unit.

All providers are required to report critical incidents involving clients in active treatment or whose discharge from services has been thirty (30) days or less. Required reports shall be sent to the QA Unit who will review, investigate as necessary, and monitor trends. The QA team will communicate with program's COR and BHS Management. The provider shall also be responsible for reporting critical incidents to the appropriate authorities, when warranted.

The following LPS designated facility types will have additional reporting requirements per the California Department of Health Care Services (DHCS) guidelines:

- Crisis Stabilization Unit (CSU)
- Jail LPS units;
- and designated facilities that are approved by the DHCS under subsection (b)(2)(H) of Section 3 that are not required to report critical incidents to a licensing over oversight authority.

Additional guidelines for the above facilities will be outlined below under the section titled "*Additional Reporting Guidelines for Crisis Stabilization Units, Jail LPS Units, and designated facilities"*.

Critical Incidents

A Critical incident is the most severe type. Counties are required to implement procedures for reporting incidents related to health and safety issues and develop mechanisms to monitor appropriate and timely interventions of incidents that raise quality of care concerns. Critical Incident categories are related to significant clinical health, safety, and risk concerns.

The Critical Incident Report must be submitted to the QA Unit within twenty – four (24) hours of knowledge of incident completed in full. This can be sent to the QI Matters inbox via secure email or faxed to the secure QA fax at **619-236-1953**. The Critical Incident report form can be found on the Optum Site > SMH & DMC-ODS Health Plans Page > '*Incident Reporting'* Tab.

Additionally, this is also where the Critical Incident Reporting FAQ & Tip Sheet can be found for any questions you may have regarding filling out the form. Consultation with QI Matters may also be provided at any time through emailing **qimatters.hhsa@sdcounty.ca.gov**

After review of the incident, QA may request a corrective action plan. QA is responsible for working with the provider to specify and monitor the recommended corrective action plan.

The client medical record shall not be accessed by unauthorized staff not involved in the incident. All program staff will maintain confidentiality about client and the critical incident. The critical incident should not be the subject of casual conversation among staff. A CIR is never to be filed in the client's medical record. A Critical Incident Report shall be kept in a separate secured confidential file.

As a reminder, the LPS BOX under "program type" MUST BE checked to indicate that this is an LPS program.

Critical Incident Categories

Critical Incidents are categorized as the following:

- Death/Pending (Pending CME investigation)
- Death/Natural Causes (Confirmed)
- Death/Overdose (Confirmed)
- Death/Suicide (Confirmed)
- Death/Homicide (Confirmed)
- Suicide Attempt
- Non-Fatal Overdose
- Medication Error
- Alleged abuse/inappropriate behavior by staff
- Injurious assault by a client resulting in hospitalization
- Critical Injury on site (MH/SUD related)
- Adverse Media/Social Media Incident (only; no leading incident)

Any incident that does not fall within these categories will be reported as a **Non-Critical Incident**.

QA Unit shall monitor critical incidents and issue reports to the Quality Review Committee and other identified stakeholders as indicated.

CIR Category Definitions:

- Death/Pending (Pending CME investigation) would be chosen for instances of client death in which the actual reason for death is not yet confirmed. The subsequent 'Confirmed' reasons for client death should only be chosen when the actual reason for death is known by the Program.

- CIRs are not required for deaths that are a natural occurrence. Instead, the program shall maintain a Natural Death Log that QA will review during the Medi-Cal recertification site visit. However, if a death that is a natural occurrence happens on a program's premises an CIR is required.

- Serious allegations of or confirmed inappropriate staff (includes volunteers, interns) behavior such as sexual relations with a client, client/staff boundary issues, financial

exploitation of a client, and/or physical or verbal abuse of a client

- Medication error in prescription or distribution resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.

- Critical injury is defined as injury to a client where the injury is directly related to the client's mental health or substance use functioning and/or symptoms. Critical injury means any injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, limb, organ, or of mental faculty (i.e., fracture, loss of consciousness), or requiring medical intervention, including but not limited to hospitalization, surgery, transportation via ambulance, or physical rehabilitation. Any injury not falling in these categories and/or not related to client mental health or substance use Sxs would be reported under the Non-Critical Incident process.

- Non-Fatal Overdose- For Critical Incidents related to an overdose by an opioid or alcohol, the client must be provided an opportunity for a referral to Medication Assisted Treatment (MAT) if the client is not already receiving MAT services. Information on MAT programs can be access through the Provider Directory on the Optum website or by calling the Access and Crisis Line.

- Reports of Sexual Misconduct by a Healthcare Provider (SB 425, Business & Professions Code Section 805.8) Effective 1/1/20, a healthcare facility, health plan, or other entity that grants privileges or employs a healthcare professional must, within fifteen (15) days of receiving a written allegation of sexual abuse or sexual misconduct (inappropriate contact or communication of a sexual nature) against one of its healthcare providers, file a report with that professional's licensing board.

Critical Incident Reporting (CIR) Timelines

All providers are required to report critical incidents involving clients in active treatment or whose discharge from services has been thirty (30) days or less.

STEP	ACTION	TIMELINE
1	Program becomes aware of a Critical Incident	A Critical Incident Report must be sent to QA no later than **twenty-four (24)** hours from the incident notification. A Critical Incident that occurs on the weekend or holiday shall be reported in accordance with the procedure documented in the *Organizational Provider Operations Handbook (OPOH)* and *the Substance Use Disorder Provider Operations Handbook (SUDPOH)*.
2	Program manager or designee will immediately safeguard the client's medical record. Program manager shall	Immediately

	review chart as soon as possible.	
3	All critical incidents shall be investigated and reviewed by the program	Following submittance of CIR
4	The program shall submit a complete **Report of Findings (ROF)** **AND If necessary** complete a **Root Cause Analysis (RCA)** **OR** request an extension in the case of a client death/ pending CME.	Within thirty (30) days of knowledge of the incident. A critical incident that results in 1) a completed suicide or 2) an alleged client committed homicide will automatically trigger a chart review by the QA Unit and require the completion of a **Root Cause Analysis (RCA)**. The Action Items of the RCA shall be summarized and submitted to the QA unit with thirty (30) days of knowledge of the incident. In the case of a client death, there is an exception to the Report of Findings report being due to QA within thirty (30) days of knowledge of the incident when the program is waiting on the CME report. The provider must inform QA that the CME report is pending and request an extension.

Report of Findings

All critical incidents shall be investigated and reviewed by the program. The program shall submit a complete Report of Findings to QA within thirty (30) days of knowledge of the incident. In the case of a member death, there is an exception to the Report of Findings report being due to QA within thirty (30) days of knowledge of the incident when the program is waiting on the CME report. The provider must inform QA that the CME report is pending and request an extension.

Clients with multiple program assignments:

- In instances where an ROF is required for a Critical Incident and there are multiple program assignments, an ROF will be required for the primary client assignment and/or the Program where the critical incident took place. The primary assignment may be viewed in the EHR if the permissions have been granted. Any other client program assignments submitting a CIR for the same incident may require an ROF per QA or COR request.

- In instances where the RCA is required for a Critical Incident where a client has multiple program assignments, the RCA will only be required for the primary client assignment and/or the program where the critical incident requiring the RCA took place. An RCA for any other client assignments may be requested by QA or your COR as clinically indicated. The primary assignment may be viewed in the EHR if the permissions have been granted.

Non- Critical Incidents

A Non-Critical Incident is reported directly to your COR/Program Manager and to QA via an online submission form within twenty-four (24) hours of knowledge of the incident. A Non-Critical Incident is defined as an adverse incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community that does not meet the criteria of a critical incident. Any incident that represents "adverse deviation from usual program processes for providing behavioral health care" and not falling into the Critical Incident categories will be considered Non-Critical Incident. Previously, these incidents were classified as 'Unusual Occurrences' or may have been reported as a 'Serious Incident Report Level 2

As a reminder, the "LPS Designated Facility" radio button MUST BE selected to indicate that this is an LPS program.

Note: Protected Health Information (PHI) should not be shared when completing a N-CIR submission, this will require a Privacy Incident Report (PIR) to be completed.

Non- Critical Incident Categories

Non-Critical Incidents may include but are not limited to:

- AWOL
- Contract/Policy violations by staff (unethical behavior)
- Loss or theft of medication from the Facility
- Physical Restraints (prone/supine)
- Tarasoff Reporting
- Non-critical injury onsite
- Adverse Police/PERT Involvement onsite
- Property destruction onsite
- Other

A program may be asked at any time to complete a **Report of Findings** for a Non-Critical Incident by the program COR or Quality Assurance Unit.

Non-Critical Incident Reporting Process

- Timelines: All providers are required to report non-critical incidents involving clients in active treatment or whose discharge from services has been thirty (30) days or less. A NCIR report must be sent to QA no later than **twenty-four (24)** hours from program becoming aware of the incident.

- Non-Critical Incidents are reported via and online submission form that can be found HERE and on the Optum Site under the SMHS & DMC-ODS Health Plans Page under the "*Incident Reporting*" Tab.

- Do **NOT** include PHI within the online submission form—This includes client first and last names, HER numbers, or any other Protected Health Information.

- Ensure correct spelling for CORs email information as this will be submitted to them directly through the application, non-submission based on incorrect contact or spelling information will not be tolerated.

- Please review the **Non-Critical FAQ/Tip Sheet** posted on Optum for additional information for submission of Non-Critical Incidents and completion of the form.

- Consultation may be requested by emailing QI Matters. If an incident is submitted as a Non-Critical Incident that meets criteria for a Critical Incident, your program will be contacted by your COR or QA staff, and the appropriate submission must occur

Additional Reporting Guidelines for Crisis Stabilization Units, Jail LPS Units, and designated facilities

Please note that the following guidelines are ONLY for facilities that are approved by the DHCS under subsection (b)(2)(H)

For these facilities, please select the box/ radio button titled **"LPS Designated Facility"** under "Program Type" on the CIR, NCIR and ROF forms.

Additional Critical Incident Categories:

- Physical or sexual assault on program premises where client is the victim or perpetrator.

- Alleged abuse/inappropriate behavior by staff towards patient/s.
    - *Alleged Abuse is defined as maltreatment, sexual maltreatment, financial maltreatment, sexual exploitation, sex trafficking, solicitation, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering, or deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.*

- Suspected criminal acts on the premises, by or against patient/s
    - *All incidents that involve suspected criminal acts must be reported to local law enforcement as soon as possible, and in no case later than twenty- four (24) hours after the act.*

- Death of patient/Natural causes (Confirmed)

- Patient suicide attempt

Additional Non-Critical Incident Categories:

- Cases of communicable disease reportable under section 25-of title 17 of California Code of Regulations.
- Poisonings
- Fires on premises
- Death of an employee, or visitor for unnatural causes
- Physical or sexual assault on employees or visitors on program premises.
- Actual or threatened walkout by staff, or other curtailment of services or interruption of essential services provided by the facility.
- Suspected criminal acts on the premises by or against patients, employees or visitors.
    - Suspected criminal acts on the premises by an employee against a patient would be considered a *Critical Incident Report*. Suspected criminal acts on the premises by client involving Mental health or Substance use related symptoms would be considered a Critical Incident Report.
- Physical injury is onsite to any person (not including patient) which, consistent with good medical and professional practice, would require treatment by a physician.
- Any other occurrence that threatens the welfare, safety, security, or health of patients, staff, or visitors.

If you are unable to find a matching incident heading type on the "Non Critical Incident Report", please select "Other" as the incident type. The Non-Critical Incident Report submission is not secure, please leave out all PHI including name, medical record number or any other identifiable information.

- Remember to select the "Send me a copy of my responses" option at the end of the Non-Critical Incident form to retain a copy of your report. Facilities must retain all Critical Incident Reports and Non-Critical Incident Reports for at least one year from the date of the occurrence.

San Diego County BHS shall provide the DHCS LPS team with a report of its resolution of the investigation, including any corrective action plans and supporting documentation within thirty (30) calendar days of concluding the investigation.

LPS Incident Reporting Crosswalk

Please note that for **ANY** of the below categories if there is media involvement, the Incident is **automatically a CIR**.

Reportable UO	**CIR / NCIR**	**CIR/NCIR Category**	**Notes**
Cases of communicable disease	NCIR	Other	N/A
Poisonings	NCIR*	Other	*Possible CIR depending on circumstances (i.e. attempted homicide)
Fires	NCIR	Property destruction onsite Other	Category dependent on details of events
Physical injury to any person which... would require treatment by a physician.	CIR/ NCIR*	Critical Injury Onsite Injurious assault by a client resulting in hospitalization Non-Critical Injury Onsite	*Possible CIR depending on severity of the injury or if the injury was directly related to MH/SUD symptoms.
Death of an employee/ visitor - unnatural causes	NCIR*	Other	*Possible CIR if death was purposely caused by a client (i.e. Injurious Assault by a Client resulting in Hospitalization)
Death of a patient - unnatural causes	CIR	Death /Pending Death/Overdose Death/Suicide Death/Homicide	Category dependent on details of events
Physical assault on employees / visitors.	CIR/NCIR	Injurious assault by a client resulting in hospitalization Critical Injury on site,	Possible CIR depending on severity of assault
Sexual assault on employees / visitors.	CIR/NCIR	Critical Injury on site Injurious assault by a client resulting in hospitalization) Other	Possible CIR depending on severity of assault
Physical / sexual assault on patients	CIR/NCIR	Alleged abuse/inappropriate behavior by staff Injurious assault by a client resulting in hospitalization	Dependent on severity of assault

		Critical Injury on site Non-critical injury onsite	
All instances of patient abuse	CIR/NCIR	Alleged abuse/inappropriate behavior by staff Contract/Policy violations by staff (unethical behavior) Non-critical injury onsite Other	Dependent on the severity and nature of the abuse
Actual or threatened walkout by staff/ other curtailment of services / interruption of essential services	NCIR	Other	N/A
Suspected criminal acts on the premises, by or against patients /employees / visitors.	NCIR*	Other	Possible CIR depending on nature of the act: Suspected criminal acts on the premises **by an employee against a client** would be considered a Critical Incident Report. (i.e. Alleged abuse/inappropriate behavior by staff) **All incidents that involve suspected criminal acts must be reported to local law enforcement as soon as possible, and in no case later than 24 hours after the act.**
Any other occurrence that threatens the welfare, safety, security, or health of patients, staff, or visitors.	NCIR*	Other	Possible CIR depending on the circumstance. Please refer to the Inpatient Operations Manual or consult with QI Matters at: qimatters.hhsa@sdcounty.ca.gov

Appendix K: Denial of Rights/ Seclusion and Restraint Monthly Report- DHCS 1804

Denial of Rights/Seclusion and Restraint Monthly Report Form.pdf

Denial of Rights/ Seclusion and Restraint Monthly Report- DHCS 1804

State of California - Health and Human Services Agency — Department of Health Care Services

DENIAL OF RIGHTS/SECLUSION AND RESTRAINT MONTHLY REPORT

(See Instructions on Reverse Side)

Month:
Year:

Facility: Program/Ward: County: San Diego

Name, Title and Telephone Number Of Person Preparing Report: Date of Report:

A	B	C Number of Days Denied Each Right or Days in Seclusion/Restraint									
Patient's I.D.	No. of Days In Facility	1	2	3	4	5	6	7	8	9	10
D. Total No. of Patients in 1-10		0	0	0	0	0	0	0	0	0	0	0

ONLY THE FOLLOWING RIGHTS MAY BE DENIED FOR GOOD CAUSE:

1. Right to wear one's own personal possessions WIC 5325 (a)
2. Right to keep & use one's own personal possessions WIC 5325 (a)
3. Right to keep and be allowed to spend a reasonable sum of one's own money for canteen expenses and small purchases WIC 5325
4. Right to have access to individual storage space for one's private use WIC 5325 (c)
5. Right to see visitors each day WIC 5325 (d)
6. Right to have reasonable access to telephones, both to make and receive confidential calls or to have such calls made for them WIC 5325 (d)
7. Right to have ready access to letter writing materials, including stamps WIC 5325 (e)
8. Right to mail and receive unopened correspondence WIC 5325 (f)

RESTRICTIONS IMPOSED

9. Seclusions (isolation of an involuntary patient in a locked room)
10. Restraints (any physical device used to immobilize the patient because of behavioral problems.)

DHCS 1804 (06/2013) Page 1 of 2

Reporting Instructions for DHCS 1804

COLUMN A: Patient's I.D. or Hospital Number

- Each patient who has been denied a right or placed in seclusion/restrain by the facility during the reporting month must be listed on this form by I.D. or hospital number.

COLUMN B: Number of Days in Facility this Month

- Enter each patient's total days in the facility for the month.

COLUMN C: Number of Days Denied Each Right or Days in Seclusion/Restraint

- Enter in Columns 1 through 10 the number of days each patient was denied a right or placed in seclusion/restraint.

ROW D: Totals – Number of Patients Denied Each Right

- Enter in Row D, 1 through 10, the total number of patients denied each right or placed in seclusion/restraints.
    - (Do not count the numbers in the boxes to achieve Row D, as the number of patients, not days, is needed.)

RESTRICTIONS IMPOSED

- Seclusion and restraints MUST be reported and documented because these actions imply the denial of other specific patients' rights, such as the right of access to the telephone.
- These implied denials need not be documented in the patient's chart and should not be reported on this form.
- When the exercise of a particular right is specifically requested by the patient, however, and denied by the staff while the patient is in restraint or seclusion, the denial of that right MUST be documented in the patient's record and reported on this form.
- SUBMIT TO: The Quality Improvement Unit, County of San Diego Mental Health Services by the 10th of the month following the end of the quarter. An aggregated report will be submitted by the local Mental Health Director to appropriate State offices.

Appendix M: Convulsive Treatments Administered- Quarterly Report- DHCS 1011

Quarterly Report for Convulsive Treatments and Psychosurgery Administered- DHCS 1011

Quarterly Report for Convulsive Treatments and Psychosurgery Administered- DHCS 1011

State of California
Health and Human Services Agency

RESET FORM

Department of Health Care Services

QUARTERLY REPORT FOR CONVULSIVE TREATMENTS AND PSYCHOSURGERY ADMINISTERED

County	Reporting Facility or Doctor	Report Date

For Quarter Ending	Number of Patients Treated by Major Source of Payment Source of	Private:	3rd Party:
		Public:	Other:

SECTION 1 — NUMBER OF PATIENTS RECEIVING TREATMENT

PATIENT DISTRIBUTION / PATIENT TYPE	AGE								GENDER					RACE								
	12-15	16-17	18-24	25-44	45-64	65+	Unknown	Totals	Male	Female	Non-Binary	Not Disclosed	Totals	White	Black	Hispanic	Asian	American Indian	Filipino	Other	Not Disclosed	Totals
Voluntary Patient-*With Informed Consent*																						
Voluntary Patient-*Not Capable of Informed Consent*																						
Involuntary Patient-With *Informed Consent*																						
Involuntary Patient-*Not Capable of Informed Consent*																						
TOTALS																						

SECTION 2 — TOTAL TREATMENTS GIVEN

Convulsive Treatments	

SECTION 3 — COMPLICATIONS ATTRIBUTABLE TO TREATMENT

Cardiac Arrest - *Nonfatal*	
Memory Loss - *Reported*	
Fractures	
Apnea	
Death–*No Coroner Report*	
Death–*With Coroner Report*	
TOTALS	

Reporting Instructions for DHCS 1011

1. Complete all heading items

    - Note: *Under "Number of Patients Treated by Major Source of Payment"*, enter the number of patients given Convulsive Therapy Treatments according to their Major Source of Payment for Treatment. Categorize Source of Payment into one of the following types: (a) Private, (b) Public (including but not limited to Medicare, Medi-Cal, and Short-Doyle), (c) Third Party Payor, (d) Other (Specify).

2. SECTION 1: "NUMBER OF PATIENTS RECEIVING TREATMENT"

    A. For each Patient Type (i.e., Voluntary Patient – With Informed Consent, Voluntary Patient – Not Capable of Informed consent)

    - *Involuntary Patient – With Informed consent, and *Involuntary Patient – Not capable of Informed Consent) indicate the number of patients receiving treatment during the report quarter by age group, sex, and race. The PDF form will automatically total the columns and rows. (If totals do not match, verify data posting.) *Involuntary patients include patients under guardianship or conservatorship*

3. SECTION 2: "TOTAL TREATMENTS GIVEN"

    A. Enter the total number of treatments given during the report quarter for all Patient Types by age group, sex, and race. The Excel spreadsheet will automatically total the row. (If totals do not match, verify data posting.)

4. SECTION 3: "COMPLICATIONS ATTRIBUTABLE TO TREATMENT"

    A. For each type of complication, enter the number of complications attributable to Convulsive Therapy Treatments that occurred by age group, sex, and race of the patient. The PDF form will automatically total the columns and rows. (**If totals do not match, verify data posting.)**

    B. Complications to be reported:

        a. Non-fatal cardiac arrests or arrhythmias, which required resuscitative efforts.

        b. Memory loss reported by the patient extending more than 3 months following the completion of the course of treatment (when reporting memory loss subsequent to a course of treatment which was reported on a previous quarterly report, designate separately with an asterisk).

        c. Fractures, with a medical diagnosis of the fracture accompanying quarterly.

        d. Apnea persisting twenty (20) minutes or more after initiation of treatment.

e. Deaths which 1) occur during or within first twenty-four (24) hours after a treatment; or 2) occur subsequently but are attributable to the treatment. All deaths in the first category shall be reported to the coroner and the coroner's report shall accompany the quarterly report. In all cases in which an autopsy is performed, the autopsy report shall also accompany the quarterly report.

The required accompanying reports in c) and e) above shall observe the confidentiality requirements of section 5328 of the Welfare and Institutions Code (W&I Code).

5. SECTION 4: "EXCESSIVE TREATMENT"

   A. Indicate the number of patients by age group, sex, and race who receive more than 15 treatments within a 30-day period during the quarter or who received more than 30 treatments within the immediately preceding one year. Attach documentation of the prior approval. The PDF form will automatically total the row. (If totals do not match, verify data posting.)

6. **REPORTS must be submitted to the County Mental Health Director as indicated in the lower right corner on the front of this form by the 15th of the month following the completion of the quarter.**

7. **THE COUNTY MENTAL HEALTH DIRECTOR shall email, fax, or mail the accumulated quarterly reports by the last day of the month, following the end of the quarter to:**

Email Address: **MHData@dhcs.ca.gov**
Fax Number: **(916) 324-0993**

Mailing Address: **DEPARTMENT OF HEALTH CARE SERVICES**
Mental Health Licensing Section,
Licensing Branch 2 Licensing and Certification Division
P.O. Box 997413, MS 2800
Sacramento, CA 95899-7413

NOTE: W&I Code section 5326.9 addresses violations of the laws governing the denials of rights. If you need assistance preparing this report, please call the Department of Health Care Services at **(916) 323-1864** or email **MHData@dhcs.ca.gov.**

Appendix N: Mental Health Websites

The following websites can be accessed for additional information:

- County of San Diego, Health & Human Services Agency: http://www.sdcounty.ca.gov
- State of California Department of Health Care Services: www.dhcs.ca.gov
- Medi-Cal Website: www.medi-cal.ca.gov
- Optum: www.Optumsandiego.com
- State of California Office of Patient Advocate: www.opa.ca.gov
- State of California Department of Managed Health Care: www.dmhc.ca.gov
- National Alliance of Mentally Ill: www.nami.org
- ARC of San Diego www.arc-sd.com

Appendix O: Medical Record Content Requirements

1. Mental status exam and psychiatric history are documented within 24 hours of admission. The history includes: previous treatment dates, providers, therapeutic interventions and responses, relevant family information, relevant results of lab tests (if applicable) and consultation reports (if applicable).

2. Initial diagnosis or suspected mental health diagnosis meets established medical criteria for acute inpatient admission:

    a. Danger to self, others or property;

    b. Prevents the member from providing for, or utilizing, food, clothing, shelter, personal safety, or necessary medical care.

    c. Presents a severe risk to the member's physical health

    d. Represents a recent, significant deterioration in ability to function;

    e. Unable to receive care at lower level.

3. Diagnosis is consistent with documented symptoms;

4. Treatment plan is consistent with diagnosis;

5. Therapeutic intervention is consistent with treatment plan;

6. Discharge plan is consistent with treatment plan;

7. Consent for medication treatment form is dated and signed by client;

8. Documented mental health diagnosis or suspected mental health diagnosis;

9. Documentation of 5150 (including appropriate form) is in chart, if applicable;

10. Documentation of 5270 (including appropriate form) is in chart, if applicable

11. Documentation that the client has signed a Release of Information (ROI) to his/her Primary Physician for the hospital discharge summary;

12. Cultural factors, including client's ethnicity/cultural background and primary language, are documented at admission;

13. If a readmission, how treatment plan addresses contributing problems leading to recurrence.

14. Relevant physical health conditions reported by client are prominently identified and

updated as appropriate;

15. Client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities, is clearly documented;

16. Documentation includes past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed, and over-the-counter drugs;

17. Transfer to administrative days is documented;

18. Active placement efforts for clients on administrative days are documented;

19. Discharge planning for clients on administrative days is documented;

20. Provision made for translation and/or interpretive services for non-English speaking clients and/or for clients needing sign language assistance is documented;

21. Client's response to offer of an interpreter or sign language assistance is documented;

22. Discharge diagnoses are documented;

23. Model Care Coordination Plan is documented;

24. Final discharge plan documents referral for outpatient medication management follow-up appointment;

25. Final discharge plan for clients with primary diagnosis of substance abuse/chemical dependency documents recommendations for chemical dependency services;

26. Other community support/agency/outpatient service referrals are documented;

27. Current and recommended living arrangements are documented;

28. Progress notes document reaction to treatment, problems and interventions;

29. Each order and note is signed and dated;

30. Client's referral back to primary care physician is documented;

31. Client's referral back to psychiatrist and/or therapist for outpatient care is documented.

Appendix P: Glossary

Beneficiary: Any person certified as eligible under the Medi-Cal Program according to Section 51001. Title 22, California Code of Regulations.

Consolidation: Term used by the state to describe shifting Medicaid dollars to the local (County) level for capitation and distribution.

Contract Hospital: A provider of psychiatric inpatient hospital services, which is certified by the State Department of Health Services, and has a contract with a specific Mental Health Plan to provide Medi-Cal psychiatric inpatient hospital services to eligible beneficiaries.

County of Beneficiary: The county is currently responsible for determining eligibility for Medi-Cal applicants or beneficiaries in accordance with Section 50120. Title 22, California Code of Regulations.

Fee For Service Medi-Cal (FFSMC): California's Medi-Cal program provides reimbursement on a per procedure basis for a broad array of health and limited mental health services provided to individuals who are eligible for Medi-Cal.

Fiscal Intermediary: The entity which has contracted with the State Department of Health Services to perform services for the Medi-Cal program pursuant to Section 14104.3 of the Welfare and Institutions Code.

Gatekeeper: Term for an organizational function which:

- Coordinates and assesses patient service needs.
- Monitors services rendered to assure that only needed services are provided.
- Identifies health practices and behaviors of target populations.
- Creates a fixed point of responsibility
- Reduces service overlap and redundancy

Hospital: An institution, including a psychiatric health facility, which meets the requirements of Section 51207, Title 22, California Code of Regulations.

Implementation Plan for Psychiatric Inpatient Hospital Services: A written description submitted to the State Department of Health Care Services (DHCS by the Mental Health Plan (MHP), and approved by the DHCS, which specifies the procedures which will be used by a prospective MHP to provide psychiatric inpatient hospital services.

Inpatient Hospital Services: See "*Psychiatric Inpatient Hospital Services*" definition.

Lanterman-Petris-Short (LPS): Persons designated by San Diego County who may take or cause to be taken, mentally disordered person(s) into custody and place him/her in a facility designated by the County and approved by the State DHCS as a Facility for seventy-two (72) hour Treatment and

Evaluation.

Local Mental Health Care Plan (Plan): The term used to denote the local managed mental health care plan administrator. The Plans will be responsible for offering an array of mental health services to all eligible Medi-Cal beneficiaries.

Managed Care: A new paradigm funding approach that combines clinical services and administrative methods in an integrated and coordinated way to provide timely access to care in a cost effective manner. Emphasis on prevention and early care reduce usage of more expensive methods of treatment.

Medi-Cal: California's Medicaid Program.

Medically Necessary: A service or treatment that is appropriate and consistent with diagnosis, and that, in accordance with accepted standards of practice in the mental health community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member's condition or the quality of care rendered.

Mental Health Carve Out: It has been determined at the state level that the local County Mental Health Departments will design and develop a managed mental health care system separate from the local County Departments of Health. However, a clear mental health and physical health interface for integrating service delivery must be included in the design.

Behavioral Health Plan (BHP): An entity which enters into an agreement with the State DHCS to provide beneficiaries with psychiatric inpatient hospital services. An BHP may be a county, counties acting jointly or another governmental or non-governmental entity.

BHP Authorization for Payment: The initial process in which reimbursement for services provided by an acute psychiatric inpatient hospital to a beneficiary is authorized in writing by the BHP. In addition to the BHP authorization for payment, the claim must meet additional Medi-Cal requirements prior to payment.

Provider: A hospital, whether a Fee For Service/Medi-Cal or a Short Doyle/Medi-Cal provider, which provides psychiatric inpatient hospital services to beneficiaries.

Psychiatric Inpatient Hospital Services: Both acute psychiatric inpatient hospital services and administrative day services provided in a general acute care hospital, a free-standing psychiatric hospital or a psychiatric health facility that is certified as a hospital. A free-standing psychiatric hospital or psychiatric health facility that is larger than sixteen (16) beds may only be reimbursed for beneficiaries sixty-five (65) years of age and over and for persons less than twenty-one (21) years of age. If the person was receiving such services prior to his/her twenty- first birthday and he/she continues without interruption to require and receive such services, the eligibility for services continues to the date he/she no longer requires such services or, if earlier, his/her twenty second birthday.