L. PRACTICE GUIDELINES

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

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

Co-Occurring Disorder Population

- Co-occurring disorders (COD) are defined as the occurrence of a combination of any mental health condition and substance use (SUD). The significant co-morbidity of SUD and mental illness (typically reported as 40% - 80% depending on study characteristics and population) and the growing body of research associating poorer outcomes with a lack of targeted treatment efforts have highlighted the importance of addressing the unique needs of this population. Integrated treatment coordinates mental health and substance use interventions to treat the whole person more effectively. As such, integrated care broadly refers to the process of ensuring that treatment interventions for COD are combined within a primary treatment relationship or service setting. Research has generally supported that the ideal approach toward treatment for CODs is to address all conditions simultaneously, as opposed to addressing the mental health condition and SUD separately and in a silo of separate treatment approaches.

  When providers have staff who possess the skills and training to adequately address the needs of the COD population within their scope of practice, integrated care is best provided inhouse. It is the expectation that all programs be, at a minimum, Co-Occurring Capable with the goal of becoming Co-Occurring Enhanced.

Medi-Cal Transformation Initiative for Co-Occurring Treatment Disorders

- The Medi-Cal Transformation initiative seeks to reduce or eliminate barriers to treatment for clients with co-occurring disorders. Therefore, services provided in the presence of co-occurring disorders will be reimbursable when a medically necessary service is documented.

- Specialty mental health program providers must still deliver covered specialty mental health services at sites that have specialty mental health certifications, and contracted DMC-ODS providers must still deliver covered DMC-ODS services at sites that are at DMC certified. Department of Health Care Services is not removing all distinctions between the two programs or allowing specialty mental health providers to automatically bill for DMC services or DMC-ODS providers to bill for specialty mental health services.

- Programs must also provide linkage to the system of care that meets the client's primary needs. The County of San Diego is in process of developing policy and procedure for billing and linkage for clients with co-occurring disorders and will be communicated in coming months.

- Clients with co-occurring mental health and substance use issues are common in the public mental health system and present with complex needs. Consequently, the presence of substance use should be explored with all clients and caretakers as part of routine screening at the point of initial evaluation, as well as during the course of ongoing treatment

- **For adult clients** with serious mental illness who meet eligibility criteria, integrated treatment of a co-occurring substance use disorder and the mental health diagnosis.

    - (Note: If a diagnosis is undetermined at the time of assessment, services will be reimbursable with the use of Z03.89 until the diagnosis is established) is nationally recognized as evidenced based practice.

- **For children/youth clients** Be aware that some children in San Diego have been identified as beginning to use substances as early as age 6 and this must be assessed.

    - (Note: If a diagnosis is undetermined at the time of assessment, services will be reimbursable with the use of Z03.89 until the diagnosis is established), particularly in high-risk family situations. Additionally, children and youth may be impacted by substance use or abuse on the part of their caretakers.

- When serving adults, children, adolescents, or their families that meet the criteria for co-occurring disorders these guidelines are to be implemented:

- Document on the Admission Checklist that the client and/or family was given a copy of your program's Welcoming Statement, that outlines the programs capacity to address co-occurring needs as well as physical health needs, including tobacco use.

- Include substance use and abuse issues in your initial screening, assessment and assessment updates, included on the Behavioral Health Assessment. In addition, use any screening tools that may be adopted or required. For beneficiaries under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the assessment domain requirements.

- If both types of disorders are indicated for the client at diagnostic levels, list the mental health diagnosis or Z03.89 Deferred Diagnosis as the primary disorder and the substance use diagnosis as the secondary disorder. This indicates that the mental health diagnosis will be the primary focus of treatment, not necessarily that the mental health disorder is the more important disorder or the cause of the substance use.

- **For all clients** who do not meet the criteria for access to Specialty Mental Health services, but do have an identified substance use issue, the provider will make appropriate services referrals and document actions taken.

- Treatment services and documentation shall focus on the primary mental health diagnosis and the identified functional impairment(s). Treatment planning should deal with the substance use issue, either by referral or direct treatment. The co-occurring substance use issue may be integrated into the client's problem list and service may be provided in relation to how it impacts the functional impairment related to the mental health diagnosis.

- Documentation of treatment services and interventions must meet the federal and W&I Code 14184.402 requirements if mental health services are to be claimed to Medi-Cal. Progress notes should be carefully stated to remain within Medi-Cal guidelines. If the substance use concerns a collateral person, the progress note must focus on the impact of the substance use on the identified client. In most instances, it is preferable to approach the substance use in the context of the mental health disorder and create an integrated note and treatment regime.

- It is not appropriate to exclude a client from services solely because of the presence of a substance use disorder or a current state of intoxication. This decision should be made based on the client's accessibility for treatment, as well as client and provider safety concerns.

Medically Necessary Specialty Mental Health Services for Child/Youth

- For beneficiaries under age 21, a service is medically necessary if it meets criteria of Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct and ameliorate mental illness or condition discovered by a screening service, despite if such services are covered under the State Plan.

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

- Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria below.

- If a member under age 21 meets the criteria as described in (1), the member meets criteria to access SMHS. It is not necessary to establish that they also meet criteria in (2).:

    - (1) The member has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following:

        - Scoring in the high-risk range under a trauma screening tool approved by the department,
        - Involvement in the child welfare system (open child welfare or prevention services case),
        - Juvenile justice involvement (has ever been detained or committed to a juvenile justice facility or is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency),
        - Experiencing homelessness (Literally homeless, imminent risk of homelessness, unaccompanied youth under 25 who qualify as homeless under other Federal statues, fleeing/attempting to flee domestic violence)

OR

- The member meets both of the following requirements in a) and b) below:
    a. The member has at least one of the following:
        - A significant impairment
        - A reasonable probability of significant deterioration in an important area of life functioning
        - A reasonable probability a child will not progress developmentally as appropriate
        - A need for specialty mental health services, regardless of impairment, that are not included in the mental health benefits that a Medi-Cal managed care plan is required to provide.

AND

b. The member's condition as described in subparagraph (2) above is due to one of the following:
    - A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and

the Internal Statistical Classification of Diseases and Related Health Problems
- A suspected mental disorder that has not yet been diagnosed
- Significant trauma placing the member at risk of a future mental health condition, based on the assessment of a licensed mental health professional

- This criterion shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

    - Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.
    - The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.
    - The member has a co-occurring substance use disorder.

- For more information, please reference DHCS Behavioral Health Information Notice BH IN 25-020 which provides guidance on screening and Transition of Care tools; BHIN 21-073 which addresses criteria for member access to SMHS, medical necessity and other coverage requirements and BHIN 22-011 '*No Wrong Door for Mental Health* 'Policy.

Documentation Guidelines when the Electronic Health Record (EHR) is Unavailable

- Programs are expected to adhere to County and Medi-Cal Documentation standards. There may be occasions when the EHR is temporarily out of operation causing delays or a potential work stoppage. When an unplanned disruption occurs, programs will receive an email alert from the CalMHSA Helpdesk with the following guidelines:

    - Consider the circumstances and apply best judgement to determine if it is prudent to use paper methods for documentation of services.

    - Review UCRM to determine if the documentation/data is required to be entered manually into the EHR or can be scanned into the EHR/maintained in paper format in the Hybrid Chart. Paper **billing records** should be given to administrative staff for later entry in the EHR. Services may be claimed **after** documentation on paper notes or signature in the EHR.

    - It is strongly recommended that programs Save and Sign documentation as soon as possible within the stated timelines, in order to avoid risk of late entry and being out of compliance.

  - Continued problems with the EHR should be reported directly to the CalMHSA Helpdesk.

- Questions about the documentation process may be sent to: QImatters.hhsa@sdcounty.ca.gov.

Dual Diagnosis Capable Programs

- It is the expectation that all programs be, at a minimum, Co-Occurring Capable. Certain programs within the HHSA/BHS system are certified as Dual Diagnosis Enhanced. These certifications refer to program and staff competence with clients with co-occurring disorders.

- In general, Dual Diagnosis Capable programs will welcome clients with both types of diagnosis, make an assessment that accounts for both disorders, and may provide treatment for the substance use within the context of the mental health treatment.

- Enhanced programs will be able to provide comprehensive, integrated treatment for both disorders. Following are the characteristics of Dual Diagnosis Capable Mental Health Programs when fully developed:

  - Welcomes people with active substance use

  - Policies and procedures address dual assessment, treatment and discharge planning

  - Assessment includes integrated mental health/substance abuse history, substance diagnosis, and phase-specific needs

  - Treatment plan: 2 primary problems/goals

  - Discharge plan identifies substance specific skills

  - Staff competencies: assessment, motivational enhancement, treatment planning continuity of engagement

  - Continuous integrated case management/phase-specific groups provided: standard staffing levels

Education on MAT as Alternative to Pain Management Training

- Effective January 1, 2019, a 12-hour continuing education course on MAT (Medication Assisted Treatment) and treating opiate-dependent patients may be taken as a condition of licensure by the Medical Board of California (MBC) as an alternative to the mandated 12-hour course on treating terminally ill and dying patients.

Drug Formulary for HHSA Mental Health Services

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

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

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

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

- For all initial prescriptions, consideration should be given to prescribing generic medication rather than brand name medication unless there is superior efficacy for the brand name medication, or the side-effect profile favors the brand name medication.

- Providers shall follow the requirements for preparing a Treatment Authorization Request (TAR) as stated in the Medi-Cal Drug Formulary.

    - County-operated programs shall send TARs to the County Pharmacy for any non-formulary medication

    - Contractor operated programs shall develop an internal review and approval process for dispensing non-formulary medication for both Medi-Cal and non-Medi-Cal eligible clients

- There shall be an appeal process for TARs that are not accepted.

Monitoring Psychotropic Medications

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

Informed Consent

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

- Instead, facilities must maintain written consent records that contain **both** of the following:
  1. A notation that information about informed consent to antipsychotic medications has been discussed with the patient; **and**
  2. A notation that the patient understands the nature and effects of antipsychotic medications, and consents to the administration of those medications.

- The minimum requirement going forward is to include the above notations within the medical record progress note(s) when prescribing, adding or adjusting antipsychotic or psychotropic medications.

- Providers may choose to continue using the Informed Consent for Psychotropic Medications form to document that they have reviewed consent and the nature and effects of antipsychotic or psychotropic medications however, use of this form is not monitored as part of the medical record review and patient signature is not a requirement.

SB184 does not supersede JV-220 requirements for dependent youth or youth in an out-of-home placement.

Antipsychotic Medications

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

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

Clinical Advisory on Monitoring Antipsychotic Medications

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

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

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

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

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

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

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

- Refer to Clozapine REMS Program for monitoring Clozaril.

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

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

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

- Patients with a history of a clinically significant low white blood cell count (WBC) or a drug-induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and discontinuation of medication should be considered at the first sign of a clinically significant decline in WBC in the absence of other causative factors (package insert).

Naloxone for Risk of Overdose

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

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

Children Youth and Families

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

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

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

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

- The Department of Social Services (CDSS), in collaboration with stakeholders, developed measures to track youth in foster care who received a paid claim for psychotropic medication from the California Department of Health Care Services. These measures will be publicly posted with a goal of improving the health and well-being of youth in care. Those measures include select Healthcare Effectiveness Data and Information Set (HEDIS) measures and Child

Welfare Psychotropic Medication Measures. County of San Diego providers shall be familiar with these measures as they shall serve as the guideline for provision of care locally to all youth. For recommended monitoring parameters please check *Appendix L- L.1* in the OPOH.

Monitoring Controlled Substance Prescriptions

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

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