QUALITY MANAGEMENT PLAN

FY2021-22

COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

CONDADO DE SANTA CRUZ
Salud Mental y Tratamiento del Uso de Sustancias
PARA NIÑOS Y ADULTOS

OVERVIEW

The Santa Cruz County Behavioral Health Services (BHS) Quality Improvement (QI) Work Plan and the Quality Management (QM) Plan serve as the foundation of our continuous efforts to improve the quality of treatment and services provided to our beneficiaries. The QM and QI Work Plan is an integrative service delivery model in which leadership and staff value BHS operational excellence and sustainable quality of care. The QI Work Plan outlines the structure and process by which the Mental Health Plan (MHP) & Drug Medi-Cal (DMC-ODS) delivers, monitors and evaluates services, integrates quality improvement activities throughout the organization and promotes collaboration through various activities with partner agencies.

In 2020, BHS' leadership, MHP and DMC-ODS community service partners, and workforce representatives participated in discussions and activities, facilitated by the BHS Quality Improvement Director, to identify universally shared values that will support and anchor our collective service and operational decisions and improvement areas. BHS included in the process review of the County of Santa Cruz and the Health Service Agency Division's values as well as Trauma Transform's Trauma-Informed System Guiding Principles. BHS and valued stakeholders identified five (5) values-based areas that are now being incorporated into operational governing, service delivery practices and overall monitoring and improvement initiatives.

Inclusion & Engagement	Cultural humility & responsiveness ● Human connection and relationship ● Universal dignity, respect, kindness, and compassion ● Offerings of support and gratitude ● Transparency and collective communication ● Timely accessibility ● Inclusion of client voice/choice ● Dependability
Operational Excellence & Service Stewardship	Excellent effective care and customer service delivery ● Adaptability ● Ethics ● Responsibility ● Accountability ● Innovation ● Utilize outcomes to improve care, support program decisions and share with other healthcare providers and the greater community.
Targeted Treatment & Evidence-Based Services	Trauma-informed care ● Individualized "Voice & Choice" care ● Targeted Health ● Clinical quality & fidelity to EB practices ● Utilize data outcome to inform decisions ● Workforce Training
Equity & Sustainability	Promote resiliency and recovery (personal/social/environmental/economic) ● Collective impact ● Equity for All ● Justice ● Integrity ● Collaboration ● Holding hope & Eliminating stigma ● Positivity ● Capacity building
Safety	For all who provide and receive services from SCCBHS, including staff, clients, contractors, partners, stakeholders, and our community at large. Safety includes physical, emotional and self-care when at county facilities, remote work setting and/or in community

QUALITY MANAGEMENT (QM) PROGRAM REQUIRED ELEMENTS

The QM Program's describes required qualitative outcome activities for the populations serviced within the MHP and DMC-ODS networks as guided federal and state regulations, including the Code of Federal Regulations Title 42, California Code of Regulations Title 9, California Welfare and Institutions Code, CA Bills/laws, as well as DHCS' relevant MHP/DMC-ODS agreement requirements and performance measures. These QM activities are performed by Quality Improvement team in partnership with MHP and/or DMC-ODS departments to ensure compliance and promote department and BHS agency quality improvement initiatives. According to the California State Department of Health Care Services (DHCS), the Quality Management (QM) Program clearly defines the BHS QM Program's structure and elements, assigned responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The QM Program shall be evaluated annually and updated as necessary per Title 9, CCR, Section 1810.440(a)(6) and Title 42 CFR, Section 438.240(e).

QUALITY MANAGEMENT (QM) PROGRAM DESCRIPTION

The QM Program aims to continuously improve all aspects of service delivery through monitoring and analyzing data, modifying practices and developing initiatives to measure and improve services provided by the BHS network. The QM Program shall include active participation by practitioners and providers, QI licensed staff, BHS staff, as well as beneficiaries and family members in the planning, design and execution of the QM Program and QI Work Plan, as described in Title 9 CCR, Section 1810.440(a)(2)(A-C). The QM program is responsible for monitoring the MHP's and DMC-ODS' effectiveness and for providing support to all areas of MHP/DMC-ODS operations by conducting performance monitoring activities which include, but are not limited to utilization management, utilization review, provider appeals, credentialing and monitoring, fraud prevention monitoring, network adequacy, resolution of beneficiary grievances, and analysis of beneficiary and system outcomes. There shall be a minimum of four active Performance Improvement Projects (PIPs) that include two MHP and two DMC-ODS improvement areas that focus on: a clinical area and a non-clinical area for each benefit.

The QM Program shall:

- Conduct performance monitoring activities throughout its operations.
- Activities shall include but not be limited to;
  - Access to services, including timeliness and cultural and demographic capacity
  - Safety and Effectiveness of Care, including medication practices
  - Coordination of Care
  - Service Satisfaction
  - Quality of Care
  - Workforce Development
- Implement mechanisms beneficiary and system outcomes
  - utilization management/utilization review
  - provider appeals
  - credentialing and monitoring

- resolution of beneficiary grievances and appeals
- ensuring continuity and coordination of care with other health care providers
- coordinate with human services agencies, probation and emergency safety units
- coordinate with community safety stakeholders and consumer outreach
- coordinate integrative care for co-morbidity beneficiary needs
- develop mechanisms to detect both underutilization of services and overutilization of services,
- implement mechanisms to monitor the safety and effectiveness of medication practices
- implement mechanisms to address meaningful clinical issues affecting beneficiaries system-wide
- implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns

I. ORGANIZATION OF SERVICES

Behavioral Health Access to Care:

The Santa Cruz County BHS Access Team is the main point of entry for adults/older adults who are seeking mental health and is an entry point for substance use disorder (SUD) treatment services. The Access Team shall serve as one of the points of entry into the Children's System of Care for children with an emotional disturbance. The MHP Children's System of Care has established additional BHS and Community-Based Organization (CBO) entry points, herein referred to as "gate", to operate a no wrong door approach.

Toll Free Number

The Access Team will respond to calls coming in on the BHS toll-free number from individuals seeking mental health and/or SUD treatment services during normal working hours. Persons requesting services from the Access Team during normal working hours will initially speak to clerical staff who will then greet them in English or Spanish depending on the caller's preference. The Access Team functions will be covered after hours, weekends and holidays by the Santa Cruz Answering Service and Mental Health/SUD staff on call (for those beneficiaries already receiving services). Requests for information and referrals may originate from a community agency, primary care physician, or family member. However, requests for services will usually come from beneficiaries and/or legal guardian/representative.
The Access Team will maintain the County Electronic Health Record's (EHR) Service Request and Disposition Log of all requests for Specialty Mental Health and Drug Medi-Cal Services. (Policy 2102: Access Triage, Screening and Assessment has detailed description of Access Log requirements.) DMC-ODS has a number of contractor entry points and also enter all requests in the County EHR's Service Request and Disposition Log.

The Access Team and Children's SOC Gates are the point of authorization for Managed Care Specialty Mental Health Services for Santa Cruz County Medi-Cal beneficiaries. These Access team members are licensed/registered/waivered clinicians. Drug Medi-Cal services may be initiated at the County Access Team or DMC certified contract agencies.

Medi-Cal beneficiaries will receive the Medi-Cal Specialty Mental Health Services Handbook or Drug Medi-Cal Organized Delivery System Beneficiary Handbook and appropriate Provider Directory at their initial contact for planned services. This information is also posted on the Behavioral Health Client Information webpage: https://www.santacruzhealth.org/HSAHome/HSADivisions/BehavioralHealth/ClientInformation.aspx

Timely Access to Services

The MHP & DMC-ODS will respond to service requests timely and according to managed care timely access standards for routine, specialty and urgency request needs. Identified routine non-specialty requests by beneficiaries or legal guardian will be offered a first appointment within 10 business days; a specialty psychiatry request within 15 business days and NTP/OTP requests within 3 business days.

Urgent service requests by beneficiaries or legal guardian to be delivered within 48 hours for services not requiring an authorization and within 96 hours for prior-authorization requests. During normal working hours this authorization process will be conducted by the Access team for MHP adult services, Children's BHS staff for children and youth, and by BHS SUD staff for DMC-ODS services. For requests that do not require prior authorization, contracted MHP and DMC-ODS network providers will ensure timely access to urgent care**.** After hours, weekends or holidays urgent care response will be conducted by the Crisis Stabilization Program for MHP. DMC-ODS Medi-Cal beneficiaries will be referred to nearest Emergency Dept or Withdrawal Management Services if appropriate.

Emergency Services

The Access team will transfer psychiatric emergency calls to the Telecare Crisis Stabilization Program regardless of insurance or ability to pay. Medi-Cal beneficiaries residing outside of Santa Cruz County who request urgent or other services will be directed to the MHP in the Host County. The Access team will contact the local MHP for assistance with locating a provider.

Services shall be provided in-person by Mobile Emergency Response Team (MERT(Y)) licensed/licensed eligible staff in response to notification by county emergency rooms and Santa Cruz County Juvenile Hall that an adult or youth needs a psychiatric assessment to determine whether or not he/she meets 72 hour involuntary psychiatric hold criteria between the hours of 8:00am to 5:00pm Monday through Friday, excluding weekends and holidays. Telecare Crisis Stabilization Program will perform evaluations for psychiatric inpatient services for youth 24/7.

Foster Care Youth Service Authorization

For children/youth Santa Cruz County MHP Medi-Cal beneficiaries who are in out of county foster care homes or are beneficiaries of another county who have been placed in Santa Cruz, the MHP will follow DHCS guidelines in MHSUDS Info Notice 17-032. For youth in KinGAP or Aid to Adoptive Parents aid codes, the MHP will utilize the Service Authorization Requests (SAR) to approve mental health services upon request from the host county. The MHP will also initiate SAR's for Santa Cruz County beneficiaries in KinGAP or Aid to Adoptive Parents aid codes placed out of county who need mental health services.

BHS Service Eligibility

The Access Team will use regulatory guidance for determining eligibility for BHS services. For MHP, the sources are the state Medi-Cal Specialty Mental Health outpatient criteria for medical necessity as identified in MHSUDS Information Notice 17-004 and MHSUDS Information Notice 16-051 regarding use of DSM 5 and PDD diagnostic categories. A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present. In addition, MHP will use MHSUD Info Notice 18-053 for all included Outpatient Diagnostic Categories.

MHP Impairment criteria must also be met:

1. A significant impairment in an important area of life functioning, or
2. A probability of significant deterioration in an important area of life functioning, or
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate.

And intervention related criteria that includes all 1, 2 and 3 below:

1. The focus of proposed intervention is to address the condition identified in impairment criteria above, and
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate, and
3. The condition would not be responsive to physical healthcare-based treatment.

For DMC-ODS, Access Entry Gates will use the state DMC-ODS ASAM level of care criteria and inclusive diagnosis categories to determine medical necessity of care needs and adequate service delivery.

DESCRIPTION OF DMC-ODS SERVICES

Drug Medi-Cal-Organized Delivery System

BHS' approach to substance use disorder (SUD) treatment is harm reduction. The County and Community providers focus on delivery services from this clinical perspective to support a beneficiary's continued motivation and engagement in recovery progress. Drug Medi-Cal-Organized Delivery System (DMC-ODS) offers substance use disorder treatment services to Medi-Cal beneficiaries. DMC-ODS substance use treatment services shall be available for Santa Cruz County Medi-Cal beneficiaries who meet medical necessity criteria.

ASAM Criteria

The American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services is the foundational guide for determining medical necessity, level of care services and the continuum of care model of the DMC-ODS program.

Medical Necessity
Medical Necessity means those substance use treatment services that are reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness or injury consistent with 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1

a. Medical necessity for an adult (age 21 or older) is determined using the following criteria:
    i) Must receive at least one (1) diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) for Substance-Related and Addictive Disorders (Except: Tobacco-Related Disorders and Non-Substance Related Disorders).
    ii) Must meet the American Society of Addiction Medicine (ASAM) Criteria definition of medical necessity for services based on the ASAM Criteria, including level of care needs.

b. Medical necessity for youth (under the age 21) is determined using the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT, Medi-Cal beneficiaries under the age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health concerns that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS Pilot overrides any EPSDT requirements. Medical necessity for youth (under the age 21) is determined using the following criteria:
    i) The adolescent individual must be assessed to be at risk for developing a SUD; and
    ii) The adolescent individual must meet the ASAM adolescent treatment criteria; and
    iii) Must receive at least one (1) diagnosis from the Diagnostic and Statistical Manual of Mental Disorder (DSM-5) for Substance-Related and Addictive Disorders (Except: Tobacco-Related Disorders and Non-Substance Related Disorders).

c. Medical necessity shall be evaluated by a LPHA for each beneficiary receiving DMC-ODS services throughout treatment based on the ASAM Assessment level of care criteria. When a beneficiary receives services at the same level of care, continuing services shall be reviewed no sooner than 5 months and no later than 6 months by the Medical Director, licensed physician or LPHA to determine clinical appropriateness and authorization.

Entry Gate
Point of entry for Drug Medi-Cal eligible beneficiaries seeking DMC-ODS substance use disorder services. All DMC-ODS network providers are identified Entry Gates.

DMC-ODS Level of Care Service Programs
All qualified DMC-ODS beneficiaries, adults and children/youth, shall have access to medically necessary services in level of care, type, frequency and duration based on the initial ASAM results, and indicated progress through reassessments. ASAM level of care services include:

- Withdrawal Management - ASAM level 3.2 or 1.0
- Residential Treatment - ASAM levels of 3.1, 3.3 and 3.5

- Intensive Outpatient Services – ASAM level 2.1, up to 9 hours for adults and 6 hours for youth per week
- Outpatient Services – ASAM level 1.0
- OTP/NTP Services – ASAM level 1.0
- Perinatal Services available at all levels
- Medication Assisted Treatment (MAT) Services – ASAM 1.0

In alliance with the DMC-ODS regulations and as a BHS QM practice, the BHS Quality Improvement team shall conduct annual monitoring of each DMC-ODS entity provider and their service programs to ensure compliance if such regulations and assist technical assistance as need to support their coming into compliance for any identified deficiencies.

Qualified Service Providers
All DMC-ODS Medi-Cal beneficiary services shall be performed by a DMC certified Program with qualified DMC-ODS staff based on licensure, certification and registration recognized under California State scope of practice statutes. All qualified staff shall be trained in ASAM Criteria prior to delivering services.

Qualified staff include:

a. Certified and Registered SUD Counselors
    i. Staff must adhere to all requirements in the CCR, Title 9, Chapter 8.
    ii. Staff must be registered or certified by one of the DHCS recognized certification agencies.
        (1) California Consortium of Addiction Programs and Professionals
        (2) California Association of DUI Treatment Programs

b. Licensed Practitioner of the Healing Arts (LPHA)
    i. Physician (MD, DO)
    ii. Nurse Practitioner (NP)
    iii. Physician Assistant (PA)
    iv. Registered Nurse (RN)
    v. Registered Pharmacist (RPh)
    vi. Licensed Clinical Psychologist (LCP)
    vii. Licensed Clinical Social Worker (LCSW)
    viii. Licensed Marriage and Family Therapist (LMFT)
    ix. Licensed Professional clinical Counselor (LPCC)
    x. License-eligible practitioners working under the supervision of licensed clinicians (such as ASW, AMF, APCC)

Planned Service
Planned SUD treatment services are interventions directed toward achieving the individual's goal and desired outcomes, as described in the Treatment Plan. DMC-ODS planned services include:

- Outpatient: Individual counseling, including client education services, group counseling, family therapy, collateral services, case management services, physician consultation,

recovery Services- individual counseling, recovery services – group counseling, and recovery services – recovery monitoring/substance abuse assistance;
- Intensive Outpatient Treatment services, which includes the listed outpatient services according to the individualized treatment plan;
- Residential Treatment services, which includes at least 20 hours of clinical treatment services a week as well as case management and recovery services;
- Ambulatory Withdrawal Management, Residential Withdrawal Management and/or Medication Assisted Treatment services as indicated on the client's treatment plan.

Unplanned Services
Unplanned SUD treatment services include:
- Clinical assessments, including ASAM and medical assessments (medical necessity evaluation),
- Treatment plan and discharge plan development,
- Targeted case management before treatment plan development, and
- Crisis intervention services.

Coordination of Care Services
SUD treatment providers shall provide coordination of care services when needed.
- Treating provider shall support beneficiaries with referrals and linkage services with physical health care providers, mental health providers and other community-based resources,
- Treating provider shall coordinate with NTP/OTP or MAT providers for additional SUD services as needed.

Recovery Services
- SUD providers shall provide recovery services when medically necessary after completing their course of treatment.
- Recovery services shall be utilized when the beneficiary is triggered, has relapsed or simply as a preventative measure to prevent relapse.
- Recovery services shall be provided as indicated in the beneficiary's assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process

DESCRIPTION OF MENTAL HEALTH PLAN (MHP) SERVICES

ADULT/OLDER ADULT SERVICES

The Mission of the MHP Adult/Older Adult Team is to implement programs and provide services that assist consumers with a severe psychiatric condition and co-occurring medical disorder to develop the skills, acquire the supports and resources necessary to succeed in directing their own lives and participating fully as possible as members of the community.

The wishes and needs of persons with a severe psychiatric condition are paramount in the

planning, operating and evaluation of mental health care. Family members and significant others shall be consulted, with the individual's consent, in their role as important providers of resources and support. Services shall be based on a person's choice as much as possible. Services shall be built upon the assets and strengths of each individual to maintain a sense of empowerment, dignity and self-esteem providing the greatest opportunities for meeting their goals. The Adult Mental Health System shall incorporate consumer self-help approaches and allow persons the opportunity for self- determination. Individuals with psychiatric disabilities shall be encouraged to set their own goals and be involved in the planning of service delivery and policy making.

Families shall be provided with assistance to maximize their ability to support persons with psychiatric disabilities. Family involvement, involvement with significant others and support systems shall be promoted and included in treatment planning, where it does not conflict with an individual's desire for privacy. Services shall be available, accessible and appropriate for members with different ethnicities.

Persons with a severe psychiatric condition shall be encouraged to use natural support systems in the community whenever possible. They shall be integrated into their community's usual living, working, learning and leisure activities. The Adult Mental Health System shall assist persons with psychiatric disabilities to obtain the full range of benefits to which they are entitled.

Mechanisms shall be in place to ensure continuity of care and coordination of care throughout the Adult Mental Health System. This system shall appear, as much as possible, to be seamless for consumers and families receiving services throughout various levels of care. The Mental Health System shall manage resources and be accountable for measurable outcomes. This system of care is designed to provide a single point of responsibility and accountability. Finally, the system of care places an emphasis on the relationship between an individual and the members of their service team. Every effort is made to support this core relationship, reducing fragmentation of services.

Two intake sites have been identified for adults in Santa Cruz County: North County Mental Health and South County Mental Health via the Access Team.

For all new clients the first contact with these intake sites is defined as the "key point of contact". Each intake site will utilize the same screening criteria and standards and adhere to all relevant regulations regarding access, eligibility, beneficiary protections and cultural competence. These sites will distribute informing materials to Medi-Cal beneficiaries.

The admission process begins with the completion of a face-to-face assessment by a member of the Access Team. This comprehensive clinical assessment is inclusive of elements required in the DHCS contract with the MHP. If the individual meets medical necessity for System of Care Services (determined to have a major mental illness together with significant functional impairment), the Access clinician will make a referral to a service team.

Once the determination is made that the individual does meet medical necessity criteria for

System of Care, the individual will then be assigned to a service delivery team. A team member will be the designated Care Coordinator and a Treatment Plan will be developed with the individual within sixty days from the opening to County LE by Access.

The referral process by which individuals are assigned to specific teams involves determining whether or not they meet the Level of Care Criteria for the type of team, as well as the particular criteria established for a specific team within the care levels (see directly below).

Level of Care Criteria:

1) Adult Mental Health & Residential Teams

Individuals assigned to one of these teams must exhibit:

- Difficulty in meeting life's demands and functioning independently
- Risk of increased functional impairment without support
- Risk or history of at least one inpatient psychiatric hospitalization
- Need for case management services to support activities of daily living and/or
- Be an LPS conservatee

County Recovery and South County Adult Mental Health Service Teams

These are general service, mental health teams that provide the full array of services, including individual rehabilitation counseling, therapy (provided by licensed therapists), crisis intervention and case management/brokerage. The County Teams also provide bilingual and bicultural mental health services to Spanish speaking individuals and/or their families.

Residential Programs

The County Mental Health Housing Council selects candidates referred by care coordinators for Adult Residential Care facilities. Clients referred to these residential teams do not require intensive services and have been deemed stable for this level of care by the current Coordinator and Residential staff.

Mental health services provided include case management and brokerage services, crisis intervention and rehabilitation services. County mental health staff will provide WIC 5150 interventions as needed. Medi-Cal beneficiaries who require individual psychotherapy may be referred to a County therapist.

Front Street and Willowbrook staff may serve as the Care Coordinators for the residents of their facility. If residents leave either facility, Care Coordination will be determined by the County/Contract Team Supervisors/Managers. Wheelock Adult Residential is located in South County providing similar services as Front Street and Willowbrook.

In addition, there are other short-term residential programs:

- Eldorado Residential provides step-down services from inpatient care.
- Telos Crisis Residential providing diversion from inpatient care.
- Casa Pacific provides services to clients with dual diagnosis.

- Opal Cliff provides services to individuals needing less intensive structure.

Two Full Service Partnership (FSP) Teams (TAY & MOST)

Individuals assigned to one of these teams must exhibit:

- Severe inability to meet life's demands and function independently
- High risk or history of multiple inpatient psychiatric hospitalizations or incarcerations due to mental health condition
- Intensive case management needed to support activities of daily living and/or
- Need for highly individualized services

These teams are characterized by the:

- Staff's assertive, pro-active approach with clients towards the aim of community integration
- Ninety (90%) percent of each team should be comprised of Medi-Cal beneficiaries or Indigent (County Responsible) clients
- For TAY be under age 25
- For MOST be involved with criminal justice system and be on formal probation with specific mental health terms.

Transition Age Youth (TAY) Team

This team provides services to individuals aged 18-24 meeting basic FSP criteria who would not be better served by another team. The typical sources of referral are from in-patient units where the young adult has often been placed after experiencing an initial psychiatric episode and from SED (Seriously Emotionally Disturbed) Children's Mental Health treatment programs after the young person is no longer eligible for services, due to their age and/or special treatment needs.

a. Intensive Services — Individuals referred to this team require more intensive mental health services than can be provided by other adult teams. Services are provided within a developmental context that often involves extensive family work.

b. Special Services — Individual therapy and EPSDT services are provided by licensed therapists assigned to this team. In addition, TAY are screened for appropriateness for the specialized Prevention, Recovery in Early Psychosis (PREP) treatment program.

MOST Team

This team is a Forensic Assertive Community Treatment program (FACT) that combines an evidence-based program of wrap around mental health services inclusive of case management, psychiatry, psychotherapy and employment skill development with additional supports specific to the criminal justice system involvement such as probation, court discharge planning and disposition, liaison relationships with law enforcement. Consumer participants of the MOST team are provided with intensive behavioral health and probation monitoring and intervention. Service provision occurs multiple times per week by a member of the

multidisciplinary team.

ACT Team
This team provides intensive wrap-around case management services for consumers who are returning to the community from locked psychiatric care. The majority of consumers on this team are under LPS conservatorship and the goal is to support their psychiatric stabilization, successful transition back into the community, increase independent living skills and decrease the need for locked care. The case managers have small caseloads so they can provide the intensive supports and safety nets in a timely and responsive manner.

All services will be provided, authorized and/or monitored by the Service Team. The Service Team will be the central unit of service delivery. Teams will share crisis responsibilities for clients assigned to them. Crisis availability by a team member will rotate to provide 24 hour a day, 7 day a week access by individuals to their team. In this way crisis intervention will be provided by persons having some primary relationship with the individual client to provide better management of service utilization and respond quickly to problems as they occur.

It is County policy to require team notification of an individual's use of or need for urgent/emergency mental health services 24 hours a day, 7 days a week to ensure adequate support is offered to the individual related to the crisis at hand.

Intra-Team Transfers will also occur where an individual previously receiving only medication services requires other services beyond the scope of usual psychiatric services. In such instances the team psychiatrist will consult with the team supervisor/manager. The team supervisor/manager will direct assignment of the new Coordinator and minimally a progress note should summarize the conference findings including the effective date and endorsement of any new planned services. ANSA is a tool used to evaluate client strengths and needs to assist in determining appropriateness of services. This tool is used at intake and every 6 months thereafter to monitor progress.

Contract providers offer pre-vocational/educational programs as well as short-term residential programs supported housing and Wellness Centers in both North & South County. In addition, the adult system provides residential “step-down” from the inpatient Psychiatric Health Facility as well as Crisis Residential Services and Crisis Stabilization Services to prevent hospitalization.

CHILDREN'S SERVICES

Santa Cruz County Children’s Mental Health Services has been an active interagency System of Care since 1989. The subsequent years have provided an ongoing context for interagency and community collaboration, needs identification, and system improvement.
These partnerships include Probation, Social Services, Substance Use Disorders, Education, and Community partners.

Throughout Children’s Mental Health Services, there is a commitment to integrate the key areas

of Cultural Awareness, Family Partnerships, Dual Diagnosis Substance Use expertise/needs across the partnerships. Special attention is also paid to addressing Early Mental Health needs of children 0-5, and the needs of transition-age youth aging out of the foster care system. Finally, there is a commitment to improve and expand service access in each of the Children's partnership areas.

Santa Cruz County Children's Mental Health provides targeted System of Care services in conjunction with interagency partners and contract providers who provide System of Care and/or EPSDT mental health services. All services are provided in order to:

a. Maintain children in their homes whenever possible
b. Place children in the least restrictive yet clinically appropriate setting when out of home placement is required
c. Reduce the number and costs of group home and hospital placements by:
    1) Providing appropriate alternative services
    2) Maintaining family involvement
    3) Providing individualized, community-based services
    4) Interagency collaboration
    5) Coordinated services delivery
d. Reduce juvenile justice recidivism
e. Maintain school attendance and increase benefit from education
f. Develop and maintain a professional family partnership
g. Provide culturally aware services
h. Use evaluation to shape policy and become accountable to families, taxpayers and legislators

Children's Mental Health and contract agencies shall provide mental health services to children, youth and families who meet medical necessity criteria for EPSDT Medi-Cal services. In addition, Children's System of Care (SOC) services shall be provided to those children who meet the target population definition for these services, as defined below.

<u>Medical Necessity for EPSDT</u>
Child/adolescent who has an eligible diagnosis and condition that can be ameliorated with mental health treatment.

<u>Target Population for Children's SOC</u>:
Child/adolescent who meets Medical Necessity for EPSDT criteria and is at imminent risk of out of home placement or a higher level of care, as defined in WIC Section 5600.3(a)(2) or eligible Special Education students referred by local school districts as determined by Education Code Section 56026(c)(4) and U.S. Government Code Section 7572.

<u>Children's Access Gates</u>
Children may access mental health services from the following programs or services:

a. The Access Team

b. Parents/Legal Guardians
c. Social Services
d. Juvenile Probation
e. Community Based Organizations
f. Special Education
j. Primary Care

Requests for Children's mental health services will adhere to the same logging protocols as those for adult clients requesting services.

Interagency Referrals

Requests for Children's mental health services that are referred from Special Education, Social Services, or Juvenile Probation will follow regulations outlined in Memorandums of Understanding (MOUs) established with these agencies.

Interagency Placement Committee Requests

Requests for services that are generated from interagency placement committees will be routed by a Children's Mental Health Committee member via an intake form to a treatment team supervisor; and

Individuals are referred to one of several Children's Mental Health treatment teams (see below for descriptions) based upon the Access Gate through which they entered and a determination of eligibility for services.

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Children's Teams and Service Programs

a. Probation Programs

A variety of providers respond to direct requests for mental health services from Juvenile Probation to determine the most appropriate level of care and reduce risk of incarceration or out of home placement.

1. Wraparound Program seeks to strengthen families so that youth who are at imminent risk for out of home placement may continue living at home, with their families and in their communities. By using innovative and non-traditional approaches to case planning and service delivery, families become central to all decision-making and professional services support the family's vision for success. Family Solutions is a partnership between the Probation Department, Children's Behavioral Health, and the Family Partnership Program.

2. Juvenile Hall BHS provides crisis, assessment, brief treatment and mental health/substance use education for youth detained in Juvenile Hall.

b. Social Service Programs

A variety of programs assess any court dependent (WIC 300) child referred by a Human Services Agency (HSD) social worker to determine the level of mental health services required by the child in order to maintain his/her present placement.

1) County Provided Services
   - Supportive Intervention Services for children/youth under 18 years of age who have been placed into foster care or STRTP's, or are at imminent risk of placement. Family reunification is an important goal, as well as maintaining foster home placement stability.
   - Supportive Adolescent Services are for youth between the ages of 14 and 21 years of age. The goal of this program is for youth to reconnect with family, develop independent living skills, community supports, and prepare for transition to adulthood.

2) Contract Services
   - Transition-age Services for Foster Youth focuses on assisting with housing and related support services for social service and probation youth aging out of the system.
   - Parents Center provides counseling to children & families referred from social services, as well as by the community.
   - Families Together is a multi-agency, multi-disciplinary team of services providers helping families at risk for child abuse and neglect in Santa Cruz County.

c. <u>Community Programs</u>

A variety of mental health & substance use out-patient services, which function as early intervention and/or "step-down" from more intensive system of care services.

1) County Provided Services
   - Community Gate offers intensive outpatient and wraparound services for youth with moderate to serious emotional disturbances who are at risk of out of home placement.

2) Contract Services
   - Family Partnership Program is a parent-run program (operated by the Volunteer Bureau) which provides peer support, education, services and advocacy for families within our system of care.
   - Youth Services (EPSDT) provides a variety of mental health and substance use outpatient services, which function as early intervention and/or "step-down" from more intensive system of care services. These also include:
     - Encompass Community Services provides youth counseling services helps students establish a positive change and healthy and lifestyle.
     - Pajaro Valley Parent & Student Assistance (PVPSA) Services provides counseling services to students in the Pajaro school district, as well as probation-related services.
   - Managed Care Panel Providers offer specialized treatment not available from

County or Contract organizational providers. These include neuro-psychological testing, eating disorder treatment and services in non-threshold languages such as ASL.

d. School Treatment Programs

Intensive and regular outpatient services are provided to eligible Special Education students referred by local school districts.

Services are provided as part of several Special Day Classrooms for emotionally disturbed (ED) students operated by the the Pajaro Valley Unified School District. Additional services are provided to eligible students at their home schools.

Need for Increased Level of Care

The level of care of a client may change and need to be re-evaluated when a community-based partner is coordinating care and the level of need significantly increases (i.e. multiple hospitalizations, initiation of a psychotic process or complex, multiple agency involvement), the care may be reviewed for re-assignment to a more appropriate County Mental Health based treatment team.

Children and youth who meet the criteria for Enhanced Services are those who have more intensive needs and require medically necessary mental health services in his/her own home, a family setting or the most home-like setting appropriate in order to meet his/her needs for safety, permanence and well-being. They are referred for the following services:

IHBS (Intensive Home-Based Services)

Intensive Home-Based Services are individualized, strength-based interventions designed to help the child/youth build skills necessary for successful functioning and/or improve the family's ability to help the child/youth successfully function in the home and community.

ICC (Intensive Care Coordination)

Intensive Care Coordination is an intensive form of Targeted Case Management intended to link beneficiaries to services provided by other child-serving systems, to facilitate teaming, and to coordinate mental health care. The ICC Coordinator serves as single point of responsibility to ensure medically necessary services are accessed, coordination and delivered in a strengths-based, individualized, and culturally and linguistically relevant manner guided by family/child voiced choice and needs.

CFT (Child and Family Team)

Child and Family Team includes the child or youth, family members, professionals, natural community supports, and other individuals identified by the family who are invested in the child, youth, and family's success. In addition to participation of involved public agency representatives, the composition of the team is driven by family members' preferences. The individuals on the team work together to identify each family member's strengths and needs, based on relevant life domains, to develop a child, youth, and family-centered case plan. The plan articulates specific strategies for achieving the child, youth, and/or family's goals based on addressing identified needs and building on or developing functional strengths.

STRTP (Short-term residential therapeutic program)
Facility licensed by the California Department of Social Services (CDSS) to provide an integrated program of high quality, therapeutic interventions and 24-hour supervision on a short-term basis for children who have complex and severe needs.

CANS (Child & Adolescent Needs & Strengths)
CANS is a tool used to evaluate client strengths and needs to assist in targeting services to child/family needs to support wellness. This tool is used at intake and every 6 months thereafter to monitor progress. Results of CANS are shared with Child Welfare to avoid duplication and ensure coordination of care.

Role of the Care Coordinator
The Coordinator is a mental health staff person designated by the system to take primary responsibility for services delivered to the child/adolescent including the family/caregiver. The Coordinator's role is to assist the child/adolescent in attaining his/her identified goals, provide and coordinate treatment services, monitor the overall delivery of service and the child/adolescent's progress, and behaviors. This staff person will ensure initiation and completion of the assessment process, ensure linkage to behavioral health and community programs, coordinate planned services including the development of a Treatment Plan.

TBS (Therapeutic Behavioral Services)
The MHP shall provide TBS as an EPSDT supplemental one-to-one mental health service for children and youth (under 21 years of age) with serious emotional problems who are full scope Medi-Cal eligible and meet medical necessity criteria.
Any service provider, family member or legal guardian associated with the client can request TBS services and submit a referral. All referral requests will be directed to the TBS Coordinator who is responsible for authorizing or denying TBS services within 3 days. (See Policy & Procedure 2461).

II. DESCRIPTION OF BEHAVIORAL HEALTH RECORDS SYSTEM

The Medical Record System documents the care process and is a critical communication tool between staff as well as supporting medical necessity and billing. All programs providing mental health services under Santa Cruz County Mental Health Plan and all Drug Medi-Cal providers will use the county electronic medical record, Avatar.

Paper mental health records will continue to be stored in a secure chart room and file cabinet until they are purged and destroyed according to regulatory timelines. Information from the chart is only released with written consent of the client or legal guardian unless permitted by state or federal regulation.

A. ***THE COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT INCLUDES:***

- Relevant physical health conditions reported by the client shall be prominently identified and updated as appropriate.

- Presenting problems and relevant conditions affecting the client's physical health, mental health and SUD status shall be documented, for example: living situation, daily activities, and social support.
- Client strengths in achieving client plan goals.
- High risk behaviors that present a danger to client or others shall be prominently documented and updated as appropriate.
- Medications that have been prescribed by psychiatrists including dosages of each medication, dates of initial prescriptions and refills, and documentation of informed consent for medications.
- Client self report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities shall be clearly documented.
- A mental health history, including: previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information and relevant results of relevant lab tests and consultation reports.
- For children and adolescents, pre-natal and perinatal events and complete developmental history shall be documented.
- Past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the counter drugs.
- A relevant mental status examination.
- An ICD-10 and current DSM diagnosis consistent with the presenting problems, history, mental status evaluation and/or other assessment data.

Dated signature of assessor and approval by a Licensed Practitioner of the Healing Arts as needed. The Assessment is completed by the end of the Intake Period.

B. THE TREATMENT PLAN INCLUDES:

1. Client problem(s) identified in the assessment.
2. Goals addressing problem(s). For DMC-ODS, include related ASAM Dimension and severity level
3. Measurable/observable objectives with baseline to achieve individual's goals.
4. Service provider interventions, with frequency and duration, to assist individual's goal achievement.
5. For DMC-ODS, target date for completion of Goal Action items/objectives
6. Client/or legal guardian signature (if no signature the date of an explanatory note is referenced).
7. For DMC-ODS, the name and electronic signature of the Primary SUD Counselor. Counselor may sign only once if also is a LPHA
8. Dated electronic signature of Service Provider with job title/license and LPHA (if Service Provider is not).

In addition, the LPHA signed Treatment/Service Plan is due by the end of the Intake Period. For MHP treatment plan may also be completed within sixty days of opening to the Legal Entity. For DMC-ODS, the Treatment Plan shall be completed no later than the 30-day Assessment period. For MHP, it must be updated annually according to the authorization period or as new problems, goals, objectives or interventions are provided. The client's strengths, challenges, supports and language preference (as well as family language

preference for minors) will also be documented. The Client Treatment/Service Plan is used to identify and coordinate all care provided to an individual.

The Crisis Residential Program must have service/treatment plan completed within 5 days business days of admission.

For DMC-ODS, the Treatment Plan must be updated within 90 days of the initially signed treatment plan.

C. *THE PROGRESS NOTES INCLUDE:* (Will vary according to type of service provided)

1. Date of Service
2. Type of Service
3. Duration of Service. For DMC-ODS, the Service Start and End time must be documented.
4. Location of Service
5. Identification of the goals/objectives addressed
6. Description, in a DIRP (data, intervention, response, and plan) format, of what was attempted and/or accomplished toward the client's goals and objectives, or what was medically necessary at the time the service was delivered, client response to intervention and plan for follow-up, and noted status of goal progress
7. Electronic signature and title/license of service provider.

For Medication Monitoring each note must follow E & M guidelines for each CPT Service Code and also include:

a) Service date
b) Individual's response to medication
c) Any side effects
d) Medication adherence

III. DESCRIPTION OF UTILIZATION REVIEW PROGRAM

A. *APPROVAL OF MHP SERVICES:*

1. The Access Team performing the initial assessment to determine medical necessity will authorize System of Care Mental Health Services.
2. Day Treatment Intensive and Day Rehabilitation must be authorized by licensed County Mental Health staff. DTI will be authorized for 3-month intervals and DTR will be authorized for 6-month intervals.
3. TBS Services will be authorized by the County TBS Coordinator.
4. ICC and IHBS Services will be authorized by the County ICC and IHBS Coordinator.
5. The Manager responsible for Managed Care or their designee will authorize Medi-Cal Managed Care Panel Provider visits, including ECT, eating disorder and psychological testing prior authorizations as needed
6. Crisis and Adult Residential prior authorization will be authorized by the

County Acute Care Manager or authorized delegates. Ongoing current review will be authorized by County QI staff.

7. Inpatient psychiatric hospitalization care will be initially and concurrently authorized by County MHP delegate, Beacon Health Options.
8. UR Specialists will provide retro reviews of acute psychiatric inpatient care and, in consultation with the UR Psychiatrist, authorize or deny payment according to state medical necessity guidelines and concurrent review outcomes.

B. ***APPROVAL OF DMC-ODS SERVICES:***

1. The Access Team and DMC-ODs Gate provider performing the initial ASAM screening and/or assessment to determine medical necessity will authorize DMC-ODS Services.
2. Residential Prior Authorization: County SUD staff will authorize residential treatment services for DMC-ODS within 24 hours of request from provider.

C. ***REVIEW OF SERVICES:***

1. Utilization Review activities will be conducted for ten percent (10%) of the annual unduplicated number of Individuals receiving Medi-Cal funded Specialty Mental Health Services beyond two months; and DMC-ODS Services within two months.
2. The Utilization Review form will include the Standard Reasons for Disallowance. Reimbursement received by the County will be returned to the State for any disallowances found through the review process.
3. Clinical and System issues identified in the UR process shall be referred to the Quality Improvement Steering Committee for in-depth review and appropriate action.
4. For DMC-ODS, persons performing Utilization Review shall be Qualified Mental Health Professionals or certified/registered DMC-ODS providers. Administrative staff will determine high users of SUD services through a Report for Drug Medi-Cal High Utilization Clients or a Service Activity Report. Administrative staff will review a yearly list of beneficiaries reviewed to ensure that all SUD service clinicians are reviewed at least once per year.
   No more than fifteen client names (or 5%) are selected from these reports for each audit review meeting. Sequestered clients (those not permitting sharing of PHI) will be reviewed by County UR staff with the Legal Entity.

D. ***QUALITY IMPROVEMENT PROGRAM MANAGER***

There will be one Quality Improvement Program Manager, title known as Quality Improvement Director, for the County and all providers. This person shall report to the Director of Behavioral Health Services. The Quality Improvement Program Manager shall supervise all Utilization Review Specialists. This person will chair the Quality Improvement Steering Committee that will initiate and update the QI Work Plan, maintain documentation of committee meetings and supervise Quality Improvement activities such as reviews of service quality, grievances, appeals, provider credentialing and sentinel events.

The Quality Improvement Program Manager and QI department delegates shall provide the first level appeal to hospital providers, participates in the development of Practice Guidelines and Performance Improvement Projects.

E. ***QUALITY IMPROVEMENT UTILIZATION REVIEW COMMITTEES***

There are three Quality Improvement Utilization Review Committees to focus on the quality of clinical care; one for Children, one for Adult/Older Adult clients and DMC-ODS. DMC-ODS records that are sequestered will have separate on-site meetings. All will be chaired and supervised by a licensed Utilization Review Specialist designated by the Quality Improvement Program Manager. The committees will each meet once a month to review chart documentation to support medical necessity and billing requirements. The committees will be comprised of licensed, registered/certified/waivered or MHRS staff from county and contractor organizations. A provider, client, or family member may also request a chart review of services.

F. ***UTILIZATION REVIEW SAMPLE SIZE AND ACTIVITIES***

The Utilization Review (UR) Committees will meet on a regular basis to review documentation of services delivered to high-risk clients, by a selection of providers and a random sample.

The Mental Health committees will annually review 10% of the unduplicated Medi-Cal beneficiaries served. For DMC-ODS No more than fifteen client names (or 5%) are selected from these reports for each audit review meeting.

- Mental Health UR Specialists will determine high users of service by printing a caseload report of high cost service utilizers. The UR Specialists will analyze reports to ensure that all clinicians are reviewed at least once per year.
- Ten (10) client names are selected from these reports for each meeting and a 3-month time period is selected that shows the services billed in the designated timeframe.

For DMC-ODS, the Administrative staff will determine high users of SUD services through a Report for Drug Medi-Cal High Utilization Clients or a Service Activity Report. Administrative staff will review a yearly list of beneficiaries reviewed to ensure that all SUD service clinicians are reviewed at least once per year. A one-two month calendar range is selected from which to run the Service Activity Report that shows the services billed in the designated timeframe.

G. ***PROCESS FOR UTILIZATION REVIEW***

All high risk and random sample charts assigned to Utilization Reviewers shall also be assigned for Medication Monitoring. Medication Monitoring Review will be performed by a medical professional designated by County Chief of Psychiatry. The Utilization Review Forms, that include the Standard Reasons for Disallowances, shall be utilized by reviewers to document review activities. Additional comments, which relate to the level and quality of care, shall be included on the form. The disallowances identified by the reviewers will be documented on the form and sent to the clinical staff providing services, and their supervisor for review and appeal purposes. The UR Specialist will assemble UR records related to disallowances after the review and then forward them

to Patient Accounting. A record of disallowances is maintained by Patient Accounting. In addition, all organizational contracts stipulate that state disallowances will be deducted from payments made by county to the contractor.

Unusual service patterns and significant quality of care issues are brought to the attention of the Quality Improvement Steering Committee.

H. ***REVERSING CHARGES FOR DISALLOWANCES***

The Medical Billing Technician or QI administrative staff checks the Error Report to ensure that the UR denials have not already been refunded.
In July of the second year following the end of the Fiscal Year, a Short-Doyle/Medi-Cal Reconciliation amount is determined. The Reconciliation amount is based on data contained on the UR Spreadsheet for each Fiscal Year. DMC-ODS follows similar principles. These figures are sent to the SCCBH Fiscal Unit in order to make federal and state adjustments for previously submitted claims.

V. THE QUALITY IMPROVEMENT PROGRAM

A. ***GOAL OF PROGRAM***

The goal of the Quality Improvement Program is to evaluate, objectively and systematically, the quality and effectiveness of services, pursue opportunities to improve services to individuals and families by eliciting input from individuals and families served as well as providers. It is also responsible for the dissemination of this information to Behavioral Health Services Management to insure utilization in policy and program planning.

B. ***QUALITY IMPROVEMENT COMMITTEES***

In addition to the three Quality Improvement Utilization Review Committees, there is a Quality Improvement Steering Committee that meets quarterly to review progress on the QI Work Plan goals and develop a revised plan annually. It also reviews issues brought up in quality of care investigations such as Sentinel Events, reviews Performance Improvement Projects, Practice Guidelines, Grievances, and Performance Outcomes including beneficiary satisfaction and recommends policies and follow-up actions. The committee is comprised of representatives from Child & Adult Mental Health Services, Contractor Representative, SUD Program, Quality Improvement, Fiscal, Data and Support Services, Training & Cultural Awareness Coordinator, Chief of Psychiatry or designee, consumer and family representatives. Recommendations from the committee are forwarded to the Director.

C. ***OTHER ISSUES TO BE REVIEWED BY QUALITY IMPROVEMENT COMMITTEE***

Recommendations from Sentinel Event Reviews will be shared with the QI Steering Committee. Other clinical care issues can be referred to the QI Steering Committee by a staff member, contract provider, client, or family member. The recommendations for changes at an individual or system level will be documented and forwarded to the Director, the QI Program Manager, and other clinical or supervisory staff as indicated. It

is expected these recommendations will be implemented by appropriate staff unless there is an appeal.

D. ***QUALITY IMPROVEMENT REVIEWS***

Any instance, where medical necessity, the level or quality of care is questioned, shall be documented in a Sentinel Event Reporting From and sent to the appropriate QI Committee for an in-depth review. The program staff providing services shall be notified of the committee meeting date, time and place. A record of individual attendees shall be maintained. The issue of concern to shall be documented along with Committee recommendations.

If problems identified are systemic rather than based on individual clinical decisions, these shall be put into writing and sent to the Director and the QI Steering Committee for further discussion and disposition.

E. ***ONGOING CLIENT SATISFACTION***

Surveys in Spanish and English are available in all clinic sites for client satisfaction (How Are We Doing?). These are confidential and are reviewed by the QI staff. Specially targeted client satisfaction and family surveys shall be performed as directed by DHCS. BHS has implemented additional opportunities for immediate feedback/satisfaction survey by installing “Happy or Not” survey kiosks in each BHS clinic lobby to capture beneficiary post-services experiences. The identification of additional beneficiary input/feedback opportunities is a QI Work Plan focus area.

VI. MEDICATION MONITORING - PEER REVIEW

A. *POLICY STATEMENT*

The Medication Monitoring - Peer Review process is to assure that medications are provided appropriately, safely and effectively where medications are prescribed, including monitoring metabolic functioning for both adults and children/youth. The Chief of Psychiatry, as the principle Medication - Peer Reviewer, will supervise and oversee the Medication - Peer review Monitoring Process.

The Chief of Psychiatry will submit quarterly reports related to Medication and Peer Prescription Monitoring activities to the Quality Improvement Committee.

There are also accompanying procedures addressing the service delivery staff and individuals receiving care. Individual clients, families and legal guardians will receive appropriate training and information about prescribed medications. In addition, there are policies and procedures for reporting unexpected drug reactions, which will be reviewed in the monitoring process. Indicators and thresholds are based on the American Psychiatric Association's Peer Review Manual and other accepted clinical guidelines. The procedure specifies how medical records are to be reviewed and the number of charts to be reviewed quarterly.

This Medication Monitoring - Peer Review function is also performed in conjunction with the Quality Improvement Committee, under the supervision of the Chief of Psychiatry.

As principle Medication Reviewer, the Chief, or a designated psychiatrist, will receive referrals to review possible deviations from established policies and procedures and will supervise any Psychiatric Nurse Practitioners, Registered Nurses, Licensed Vocational Nurses, Psychiatric Technicians or Medical Technicians involved in Medication Monitoring activities regarding any possible practice deviations. The Chief will be informed of all possible deviations from standard practices and procedures in the Division and he/she, or an Associate Psychiatric Medical Director, will directly be responsible for supervision of any Psychiatrists.

B. *CURRENT GOALS*

The current goal is to establish a performance baseline of medication prescribing practices by the medical staff (psychiatrists and psychiatric nurse practitioners). The secondary goal is to use the data from this baseline to make future improvements in the overall prescriptive practices and quality of care in the department and maintain a sustained Medication Monitoring - Peer Review program in the division along the outlined guidelines.

C. *REQUIREMENTS*

The Mental Health Medication Monitoring - Peer Review program will screen an annual sampling of at least five percent (5%) of the unduplicated number of Medi-Cal beneficiaries receiving services beyond two months. Charts will be randomly or specifically selected by the Psychiatry Program Coordinator and QI Utilization Review Specialist and assigned by the Chief of Psychiatry to designated "Medication Reviewers" for review. At least two charts of each psychiatrist/psychiatric nurse provider will be reviewed annually.

The QI Utilization Review Committees (Adult & Child) review the charts and all services utilized during a three-month review period that are non-psychiatry. This will include all populations obtaining all types of Medi-Cal reimbursable services in all the various modes of care.

For DMC-ODS, a qualified medical professional County staff, designated by Chief of Psychiatry, will perform an addiction medication management peer review, when indicated, to ensure compliance with medication monitoring procedures. Providers will not review their own records.

D. *MEDICATION MONITORING PLAN:*

1. Coordination. As part of the Quality Management Program of Santa Cruz County Specialty Mental Health Services and DMC-ODS, the Quality Improvement Program Manager is responsible for arranging with the Chief of Psychiatry for Medication Monitoring/Peer Review to be supervised by a Psychiatrist (Medication Reviewer), who is either the Chief or a designee of the Chief.

2. Standards and Criteria. The Chief of Psychiatry, as supervisor of the Medication Monitoring Program, shall be a member of the Quality Improvement Committee. For care reviews standards he/she will primarily utilize the criteria of the American

Psychiatric Association's Practice Guidelines, along with current professional literature and community standards. Screening criteria regarding drug prescription doses will be based on community standards and the generally agreed upon maximum daily doses for a particular medication in a given age group. The Chief of Psychiatry and members of the psychiatric staff are responsible for annually reviewing and approving the guidelines for medication treatment in the Division.

Peer review of the prescriptive practices of Psychiatrists or Certified Nurse Practitioners shall by performed only by staff who themselves have prescriptive privileges in the Division, principally Psychiatrists, and are also designated by the Chief of Psychiatry. This level of review is to be used for both random sampling of persons in treatment; those referred for care review, charts undergoing Utilization Review and other records of clinical concern or focused review.

The screening and/or in-depth reviews shall monitor medications for at least the following:

a. Evidence of informed patient consent/refusal.
b. Appropriateness of the medication(s) prescribed.
c. Appropriateness of the dosage levels prescribed.
d. Appropriateness of the duration of medication use.
e. Evidence of adverse reactions, interactions, effects and side effects.
f. Evidence of actions taken as a result of e. above.
g. Evidence of compliance or non-compliance with care.
h. Evidence of degree of response to treatment and evidence of effective. response to treatment for justification of sustained use of medication.
i. Evidence of appropriate laboratory and metabolic monitoring for side effects know to be caused by prescribed medication.
j. Evidence of monitoring for medication related movement disorders.
k. Substance use.

The record shall document information about medications provided to clients that allows for informed consent to medication treatment. The treating psychiatrist/psychiatric nurse practitioner is the primary person responsible for educating the client about medications, including their purpose, effects, side effects, benefits, alternative treatments, potential for interactions with other medications, potential for abuse and dependence, and possible adverse reactions.

Referrals for medication treatment review regarding concerns about specific client care by a staff clinician are initiated by sending a memo (or email) addressed to the Chief of Psychiatry.

3. Client Population for Medication Monitoring. All client records for all Short-Doyle/Medi-Cal (SD/MC) reimbursable services for children, adults and older adults, whether delivered by County or contractor are subject to sampling for screening and/or in-depth review of Psychotropic medication and prescribing practices. Annually a sample of individual records of Short-Doyle/Medi-Cal clients shall be selected for review, totaling a minimum 5% of the annual unduplicated number of these individuals receiving services. At least two charts of each psychiatrist/nurse practitioner provider

are reviewed annually. The Quality Improvement staff using the monthly computer-generated reports will select the clients.

Review Processes:

a. A Medication Reviewer will perform a *Medication Monitoring Screening Review* on all SD/MC clients assigned to Utilization Review.

b. The Medication Reviewer shall utilize the established Medication Monitoring Chart Review Form to detect deviations from the accepted standards and criteria of Psychopharmacological practice.

c. the Medication Reviewer and the Quality Improvement Committee (QIC) will perform *Variation Reviews* on referrals to the Chief of Psychiatry.

The Chief of Psychiatry, or a designee, is responsible for follow-up with the treating psychiatrist/psychiatric nurse practitioner regarding the advisory findings and recommendations of the Committee, documented by submission of a copy of the reviewing form by the treating psychiatrist with notation that the deficiencies were corrected. Significant deviations from care or patterns of unusual prescriptive practices are to be brought by the Medication Reviewer to the attention of the Chief of Psychiatry, the QI Program Manager and the Behavioral Health Director for discussion with the treating psychiatrist/nurse practitioner.

Appeals of the findings by the Review Process are to be directed to the Quality Improvement Committee for resolution.

Confidentiality and Anonymity:

Clients' ID numbers and physician staff numbers shall be used in reports and on review forms to preserve confidentiality and anonymity as much as possible.

The Quality Improvement Committee may receive reports of problematic client care and may, on occasion, need to know the names of clients, physicians and reviewers and have access to records. To maintain confidentiality and anonymity insofar as possible, all persons maintaining records concerning Medication Monitoring activities shall store these records separately from client's charts in a secure place and shall not provide such confidential information to any unauthorized individual.

Approval of the Medication Monitoring Plan:

Any changes in the Santa Cruz County Behavioral Health Services Medication Monitoring/Peer Review Plan will require the approval of the Psychiatric staff, the Quality Improvement Program Manager, the Chief of Psychiatry, the Behavioral Health Director and the State Department of Health Care Services.

VII. APPEAL PROCESS

Any program or service provider who wishes to appeal a Utilization Review decision shall put their appeal in writing with documentation as to the reason for the appeal.

Appeals of Utilization Review decisions shall be submitted to the appropriate Children's, Adult's or DMC-ODS Quality Improvement UR Committees. Appeals of decisions made

by either of the Committees shall be resubmitted to the Quality Improvement Committee with additional documentation in support of the Appeal. All appeals and the results shall be documented in the minutes.

Managed Care Provider Appeals shall be reviewed by the Program Manager or designee and a NOABD shall be issued for denial or reduction of requested or existing services.

Hospital Appeals of denied psychiatric inpatient days shall be reviewed by the Quality Improvement Program Manager and/or Chief of Psychiatry or designee as the first level reconsideration. The hospital will be referred to DHCS for further appeals should the original decision be upheld