Mental Health and Recovery Services (MHRS)

Adult and Older Adult Physicians Manual and Practice Guidelines

2023

Approval	Signatures	Date
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SECTION I – Psychiatrist Scheduling, Evaluation & Peer Monitoring

Psychiatrist Scheduling

The psychiatrist's schedule is primarily by appointment, with time set aside for urgent / emergency evaluations. The psychiatrist also determines when the beneficiary/client is to return, and most beneficiaries/clients are seen monthly but may be seen more frequently as needed. With the introduction of the electronic records system, psychiatrists may also schedule beneficiary/client appointments themselves.

Schedules may vary based on the needs of the clinic, but in general, staff will use the following guidelines in scheduling:

- 30 minutes at the beginning of the day for 'set up'—labeled as "Protected Time" on the schedule. This would typically involve brief review of the charts for the day (labs / additional info needed), phone calls, setting up the computer, messages, coordinating care with staff, etc.
- 30 minutes at the end of the day for 'finishing up'—also labeled as "Protected Time" on the schedule. This would typically involve charting that was not finished earlier, phone calls, reviewing / signing charts, etc.
- 30 minutes to one hour on some days for team meetings, staff meetings, or training. However, emergencies in the clinic would take priority if needed.
- Up to two new evaluations (intakes) may be scheduled per day. These will typically be scheduled for 90 minutes. If you are notified in advance by a Plan Coordinator of increased complexity, need for medical coordination, extenuating issues (family involvement / language needs), then block additional time as needed.
- Follow-up visits--most of what makes up a routine daily schedule. These will typically be for an average of ½ hour per beneficiary/client per month. Occasionally, for complex cases, longer or more frequent appointments are needed.
- 30 minutes to one hour on some days for urgent beneficiaries/clients or 'covering' appointments for other psychiatrists in the clinic, temporary medication refills (TMR's), intensive follow-up or unscheduled visits.

Appointments for beneficiaries/clients in Orange County clinics are part of the way a system operates, but the beneficiaries/clients may not always follow this process. In the Rehabilitation Model, there may be many reasons for no shows or lateness. The Psychiatrist can notify the Plan Coordinator if this occurs regularly. Plan development in this case includes understanding the reason for attendance difficulties and trying to jointly arrive at a plan to manage this while also providing appropriate care and treatment.

Evaluation of Psychiatrist's Performance and Role of the Clinic Service Chief

The Health Care Agency's Psychiatrist Job Description states the following,

> "...performs highly specialized medical and psychiatric services in the Community Mental Health program and engages in the prevention, diagnosis and treatment of mental health problems...has knowledge of principles and practices of modern medicine and psychiatry and highly specialized techniques, procedures and equipment used in psychiatry...prepares comprehensive and concise records and reports; and maintain effective relationships with beneficiaries/clients, staff and other agencies"

The APA's Community Mental Health Psychiatrist Practice Guidelines are in synchrony when it states, "The staff Psychiatrist has authority and responsibility for *psychiatric* services of the (clinic) assigned to him / her by the Medical Director, or, when appropriate by the CEO *(i.e., the Service Chief)*."

The Service Chief manages the day-to-day business and operations of the clinic. The Psychiatrist provides medication and behavioral health services to beneficiaries/clients—often taking the role of the clinical lead on treatment teams. Although the psychiatric services and medical judgment are the essence of the Psychiatrist's role, the Service Chief evaluates the Psychiatrist regarding the following:

Quantity:	Amount and timeliness of clinical service
Quality:	Accuracy, neatness, thoroughness
Habits:	Following regulations, safety, punctuality and attendance
Relations:	With staff and beneficiaries/clients (working with service team)
Adaptability:	Performance in new situations, change in nature of service
Progress:	Learning, self-improvement, relevant CME and training activities

Peer Medication Monitoring Process for Psychiatrists / Quality Improvement

Psychiatrists' charts will be reviewed by other clinic psychiatrists as part of the standard clinic process for medication monitoring. Every fiscal year, each outpatient clinic and contract clinic site provides an estimate of the Medi-Cal caseload and 5% (or at least 10) of these charts are pulled for medication monitoring. The quantifying terms are:

- ❑ Not Applicable
- ❑ Yes, In Compliance
- ❑ Partially Compliant
- ❑ Not Clear
- ❑ Not Compliant

The purpose, method and regulatory requirements for medication monitoring continue to be reviewed with Psychiatrists and Service Chiefs. Psychiatrists perform the chart review within a reasonable amount of time, approximately 15 minutes for an uncomplicated review and completion of the medication monitoring form. This time frame is related to the general standard that a Psychiatrist, other than the

treating psychiatrist, should be able to rapidly find relevant clinical information in the chart to treat or manage the beneficiary/client safely and effectively.

Feedback: This method was also intended to give feedback at several places in the loop. The back of the medication monitoring form continues to facilitate individual case feedback with subsequent opportunity for clinical improvement for that case.

Example of Quality Improvement Form, Page 1

☐ Random Selection Monitoring ☐ Problem Case Monitoring (e.g.) _____

Clinic or Site: _____ Treating Psychiatrist: _____

Beneficiary/Client Name: _____ Age: _____ Current EOC: _____

The standard for documentation is: The treating psychiatrist and covering psychiatrist should be able to find relevant clinical information in the chart within the last year to manage the beneficiary/client safely and effectively. The reviewer should answer the following questions after examining the last twelve months of documentation (or more if appropriate). The reviewer should indicate "Not Clear" if unable to answer a question "N/A," "Yes," "No," or "Partial."

Selected Quality Improvement Items for Current Year

	N/A	Yes	No	Partial	Not Clear
1) Psychiatric diagnoses clearly affirmed or changed in last 12 months' progress notes? (Standard: *Diagnoses should be addressed in physician progress notes at least yearly, and a diagnosis change should be preceded by subjective and objective information, including DSM 5 criteria.*)	☐	☐	☐	☐	☐
Psych DX(s): _____ _____ _____ _____					
2) Are vital signs, laboratory, & metabolic data regularly considered and documented? (Standard: *Laboratory tests and vital signs are part of assessment of symptoms and medication effects and should be monitored regularly as appropriate related to beneficiary/client condition, regimen, and response. If atypical antipsychotics are prescribed, it is recommended that BMI is checked at least quarterly, while blood pressure, fasting blood sugar, and lipids should be checked at least annually.*)	☐	☐	☐	☐	☐
3) Is there documentation in the chart of care coordination with the PCP? (Standard: *Medical issues can contribute to psychiatric symptoms and should be treated by a PCP. The psychiatrist and PCP should communicate about medical concerns that could affect psychiatric management.*)	☐	☐	☐	☐	☐
4) Are medical conditions considered in the assessment and treatment plan? (Standard: *Medical conditions should be considered when evaluating psychiatric symptoms and, if applicable, medication choice.*)	☐	☐	☐	☐	☐
Medical DX(s): _____ _____ _____ _____					
5) Do all prescribed psychotropic medications have a medication consent form with all fields completed? (Standard: *Consent form should be completed in its' entirety for each prescribed medication with the exception of Narcan/naloxone. Consent duration range must include a specific end-date.*)	☐	☐	☐	☐	☐
Current Medications: (include dose, route, frequency) _____ _____ _____ _____					
6) Is (are) medication(s) maintaining or improving the beneficiary/client level of function? (Standard: *Reduction in impairments should be apparent to a covering or new psychiatrist.*)	☐	☐	☐	☐	☐
7) Is the justification of more than one medication in same category documented? (Standard: *The psychiatrist should document the rationale for prescribing multiple medications in the same therapeutic drug class and discuss any additional risks with the beneficiary/client.*)	☐	☐	☐	☐	☐
8) Is consideration of a differential diagnosis (including SUD) documented in the medical record? (Standard: *Consideration of medical, developmental, and/or substance-related factors should be documented in the medical record and considered when determining the cause of symptoms and appropriate medications for treatment.*)	☐	☐	☐	☐	☐

SECTION II – Psychiatric Services - Pharmacy, Laboratory, Medical Referral

Prescription Security for Medications

With the implementation of California AB2789 in January 2022, all providers are required to use a secure, electronic health record (EHR) system to transmit prescriptions for both controlled and non-controlled medications to pharmacies. Allowable exceptions are listed within the bill, and they include temporary system failure of the EHR. However, in these circumstances of system outage, the Psychiatrist must document in the beneficiaries/client record the reason(s) for why an electronic prescription was not transmitted and a paper prescription or telephone order to the pharmacy was utilized instead.

Institutional Security Prescriptions are used by new Psychiatrists until pre-printed scripts are ordered and received—and again with passage of AB2789, these secure prescription pads are only used with rare, allowable exceptions such as an EHR system outage. Although the Medical Director's name and license information is pre-printed at the top of the script, the prescribing Psychiatrists must also write in their name, license and DEA number on each prescription that they write.

Samples - Acquisition, Storage, Use, and Disposal of Medications

The Health Care Agency / Mental Health and Recovery Services P&P 07.03.04 *Outpatient Clinic Medication Rooms – Receipt, Storage, Administration, Disposal and Accountability of Medication* addresses medication storage. Some important elements of the policy include:

Medication samples intended for use by MHRS beneficiaries/clients will only be provided if specifically requested by an authorized MHRS psychiatrist.

Each time a psychiatrist or nurse receives, dispenses, or removes for destruction expired sample prescription medications, the MD or nurse shall document this on an official Medication Log. (see next page)

Contact the RN at each clinic for access to the sample medication storage.

The reasons for which a MHRS psychiatrist may choose to furnish sample medications include, but may not be limited to:

1) Initiating a medication that is to be titrated.

2) Initiating a medication for which the effectiveness for that beneficiary/client is still being determined.

3) Initiating a medication that will be used only briefly.

4) Initiating or continuing a medication for which the samples provide a safe effective financial alternative to a prescription.

5) Initiating a medication that is to begin immediately.

6) Enhancing beneficiary/client understanding of the use of the medication.

7) Continuing a medication for a brief period of time when a medication has been lost.

The use of samples shall be recorded in the chart, similarly to any prescription, AND in the Sample Log.

Medication samples shall only be furnished by a psychiatrist in the package provided by the manufacturer, which has the medication name, strength, quantity, expiration date. Additional information written on the package with a label should include beneficiary/client's name and directions for use.

Psychiatrists shall bring expired sample medications, and unused medications received from a beneficiary/client to the medication room for subsequent disposal.

OC health CARE AGENCY

COUNTY OF ORANGE, CALIFORNIA
HCA BEHAVIORAL HEALTH SERVICES

RECORD OF MEDICATION
RECEIPT, STORAGE, ADMINISTRATION, & DISPOSAL

Clinic Name & Address: ______________________

Do not leave any items blank. Either cross out or indicate NA

RECEIPT (Copy of receipts from Pharmacy or Drug Mfg kept in a binder or with Medication Log in the medication room for 3 years)						ADMINISTRATION / DISPENSING (See individual patient chart/EHR for clinical record)					DISPOSAL(DESTROYED)/ RETURN (Copy of receipts kept either in a binder or behind this form in the medication room for 3 years)				
Date Ordered	Date Received And Exp. Date	Medication/ Amt (Strength and Qty) (Lot # or Pt name)	Name of Issuing Pharmacy or PAP (Drug Mfg)	Type	Initial	Date & Time	Amount	Dosage	Route of Administration/ Pick up	Signature	Date	Prescription #	Amt medication Destroyed / Returned	Type	Signatures (Two witnesses required)
				☐Sample ☐Patient Specific ☐Patient Returned										☐Waste pick up ☐Return ☐Finished	
				☐Sample ☐Patient Specific ☐Patient Returned										☐Waste pick up ☐Return ☐Finished	
				☐Sample ☐Patient Specific ☐Patient Returned										☐Waste pick up ☐Return ☐Finished	
				☐Sample ☐Patient Specific ☐Patient Returned										☐Waste pick up ☐Return ☐Finished	
				☐Sample ☐Patient Specific ☐Patient Returned										☐Waste pick up ☐Return ☐Finished	

F346-710 Rev. (2/18)

Keep medication log for 3 years from the last entry

Prescribing Formularies

The beneficiary/client's chart identifies funding source and determines which formulary to use. The majority of beneficiaries/clients are either Unfunded/Self-pay (with no 3rd party payor) or have Medi-Cal/CalOptima, however, a few have Medicare Part-D & Medicare Advantage Orgs (Medi-Medi).

The formulary for Medi-Cal/CalOptima clients is consolidated under the California Medi-Cal Rx system, and a link to the formulary is found below:

https://medi-calrx.dhcs.ca.gov/home/cdl/

Prescribing for Unfunded County Beneficiaries/Clients

If the beneficiary/client does not have Medi-Cal, or it is 'in-process', then the ProCare Pharmacy Benefits Manager (PBM) will cover the prescription. Most pharmacies in the County can bill to ProCare. However, prescriptions must be on the ProCare (County) formulary in order to be covered automatically. If the medication is not on the formulary or if dosage recommendations are exceeded, then the medical staff (nurse or psychiatrist) will need to complete an initial 30-day **Prior Authorization Request (PAR)** and an **internal County Treatment Authorization Request (TAR)** for medication approval after 30 days. Completed internal TARs are given to MHRS office staff who will enter the initial 30-day PAR into the PBM and then e-mail the TAR to our QMS Office Coordination Team (bhsirisfrontofficesupport@ochca.com).

The internal County TAR form can be found at:
https://bhsehrinfo.ochca.com/office-support-info/pharmacy-process-and-forms/

The County Medication Formulary is accessed through the website below:
https://www.ochealthinfo.com/page/formulary

Prescribing for Medi-Cal/CalOptima Beneficiaries/Clients

On January 7, 2019, Governor Gavin Newsom issued Executive Order (EO) N-01-19 for achieving cost savings for drug purchases made by the state. A key component of EO N-01-19 requires that the Department of Health Care Services (DHCS) transition all Medi-Cal pharmacy services from Managed Care (MC) to fee-for-service. The Medi-Cal pharmacy benefits and services administered by DHCS in the fee-for-service delivery system are identified collectively as "**Medi-Cal Rx.**" Some of the benefits of transitioning pharmacy services from MC to fee-for-service include:

- Standardize the Medi-Cal pharmacy benefit statewide, under one delivery system.
- Improve access to pharmacy services with a pharmacy network that includes the vast majority of the state's pharmacies.
- Apply statewide utilization management protocols to all outpatient drugs.
- Strengthen California's ability to negotiate state supplemental drug rebates with pharmaceutical manufacturers.

Medi-Cal Rx was implemented on January 1st, 2021.

The Medi-Cal Rx Formulary can be found here:

https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf

Please consult the formulary prior to prescribing medication for a beneficiary/client to be sure that the medication(s) are covered. If necessary, a prior authorization may be completed by one of the methods listed here:

https://medi-calrx.dhcs.ca.gov/provider/forms/

Please also factor in processing and review time of a prior authorization when considering a beneficiary's/client's need to access medications in a timely or urgent basis.

Prescribers should typically provide ONLY one month medication supply at a time. Refills (30 days + 1 refill etc.) generally only considered for special circumstances.

Medication Consents

A Psychiatric medication consent form should be completed at the first prescriber face-to-face appointment for any MHRS medication prescribed. The only exception is Narcan (naloxone), which does not require a medication consent form.

In accordance with the California Welfare and Institutions Code 5326.2 and HCA MHRS Policy and Procedure 02.04.02 regarding Psychiatric Medication Consent Forms, the following information is required to constitute voluntary informed consent and must be explained to the beneficiary/client in a clear and explicit manner:

- Reason for medication, such as diagnoses, symptoms, and/or behaviors
- Name, dosage, frequency, route, and duration of the proposed medication
- Anticipated benefits of the medication
- Possible risks and side effects that may occur after short-term and long-term treatment
- Reasonable alternative treatments
- Beneficiary's/Client's right to refuse the medication and withdraw the consent at any time

Additional considerations for medications consents include the following:

- May have more than one medication listed, but all meds listed must be consented on the same day of that particular form.
- Future medications require a new consent.
- Medication dose range should be listed lowest to highest—including frequency (per day, etc.)
- Reason for medication could be written as "for mood" or "for psychosis" as examples.
- Anticipated duration must be estimated and listed as a specific, initial timeframe of treatment, for example "up to 3 years." Non-specific durations like "Indefinitely" or "TBD" or "1 year or

more" cannot be listed. The maximum duration of a medication consent should not exceed 3 years. The provider should consider a new medication consent once the initial, estimated timeframe of treatment is exceeded.

- Signatures and dates are required. If it is not possible to obtain a signature, the provider should document the reason on the medication consent form and that verbal informed consent was obtained.
- If beneficiary/client has a conservator, the conservator must sign.

THIS MUST BE COMPLETED FOR ALL MHRS MEDICATIONS PRESCRIBED (except Naloxone)

"CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328"

health CARE AGENCY

PSYCHIATRIC MEDICATION CONSENT **DOB:** _____

Client Name _____ **MRN Number** _____

I acknowledge that I have discussed with my (or my child's) prescriber my (or his/her) prescription of psychiatric medication(s) specified in this consent form, the reason(s) for taking such medication(s), and reasonable alternative treatment(s) available.

The REASON(S) diagnosis(es), symptoms and/or behaviors for taking the following psychiatric medication(s) are:

_____

_____

_____

***All side effects indicated below could happen after either short term or long term (> 3 months) of medication treatment. Best effort is made here to address notable or likely side effects, but not all possible side effects could be listed or even predicted. It is important to always inform your prescriber as soon as possible any side effects that occur.**

☐ **Potential side effects that are of common concerns to all drugs**: allergic reactions, nausea, vomiting, headache, dizziness, fatigue, dry mouth, constipation, diarrhea, weight change, change in sleep and alertness, movement disorder, sexual dysfunction, birth defect, **and when the medication use is >3months:** osteoporosis, tardive dyskinesia, liver/kidney dysfunction, blood disorders; and ones below that are associated with a particular category of medication:

☐ **Antipsychotic (name, daily min/max dose, frequency range, route, duration)** _____

_____

_____

Additional possible side effects: increased blood sugar/lipids, blurred vision, restlessness, tremor, stiff muscles, neuroleptic malignant syndrome (high fever, rigidity, delirium, circulatory and respiratory collapse), seizures, irregular heart rhythm, increased risk of stroke and death in the elderly with dementia; **treatment >3months:** diabetes, metabolic syndrome, decreased blood cells, **tardive dyskinesia (involuntary movements of the head, neck, limbs which may be irreversible and may appear after medications have been discontinued).** Other side effects (specify if after >3 months treatment): _____

☐ **Antidepressant (name, daily min/max dose, frequency range, route, duration)** _____

_____

_____

Additional possible side effects: blurred vision, urinary retention, seizures, blood pressure dysregulation, irregular heart rhythm, **mood changes, irritability, violence, suicidal thoughts and behavior (especially in youth); treatment >3months:** sexual dysfunction, metabolic syndrome, tardive dyskinesia. Other side effects (specify if after >3 months treatment): _____

_____

☐ **Antianxiety/Hypnotic (name, daily min/max dose, frequency range, route, duration)** _____

_____

_____

Additional possible side effects: trouble concentrating, confusion, clumsiness, loss of inhibition, adverse synergistic effect with alcohol and other drugs, including opioid analgesics; **treatment >3months:** tolerance/dependency, addiction. Other side effects (specify if after>3 months treatment): _____

_____

_____

_____ (client/legal guardian's initials)

☐ **Mood Stabilizer (name, daily min/max dose, frequency range, route, duration)** _____
_____
_____
Additional possible side effects: serious rash/mucosal blister, potentially life-threatening, confusion, liver/pancreas dysfunction, decreased blood cell, birth defects; **treatment >3months:** hyponatremia, ovarian problems (valproic acid). Other side effects (specify if after >3 months treatment): _____

☐ **Lithium (daily min/max dose, frequency range, route, duration)** _____
Additional possible side effects: thirst, increased urination, tremors, birth defects; **treatment >3months:** acne, thyroid disorder, kidney failure. Other side effects (specify if after >3 months treatment): _____

☐ **Attention Deficit Hyperactivity Disorder Medication (name, daily min/max dose, frequency range, route, duration)** _____
_____
Additional possible side effects: decreased appetite/growth, restlessness, blood pressure/heart rhythm dysregulation. **Atomoxetine:** rare liver injury with possible jaundice, abdominal pain, dark urine, flu-like symptoms. **Stimulants:** psychosis, suicidal ideation, aggression, sudden unexplained death, primarily with (undetected) underlying cardiac structural abnormalities; **treatment >3months:** tolerance/dependency, addiction. Other side effects (specify if after >3 months treatment):_____
_____

☐ **Anti-Parkinson Medication** (name, daily min/max dose, frequency range, route, duration) _____
_____
Additional possible side effects: blurred vision, mental dulling, and trouble urinating; **treatment >3months:** sexual dysfunction, glaucoma, bowel dilation. Other side effects (specify if after >3 months treatment):
_____

☐ **Other Psychiatric Medication (name, daily min/max dose, frequency range, route, duration)**
_____
_____
Possible side effects (specify if after >3 months treatment): _____
_____

I have been informed of reasonable ALTERNATIVE TREATMENT(S) listed below and the likelihood of improving or not improving without the above medication(s) (this must be completed): _____
_____

Other topics we discussed:

1. Possible drug interactions that may occur with other medications and drugs. I agree to notify my/my child's prescriber regarding any medication(s), or changes in medication(s), prescribed by other prescriber(s), and regarding use, or changes in use, of over-the-counter drugs or natural/herbal supplements.

2. Potential medication risk to an unborn baby or a new born being breast fed, and I have told my/my child's prescriber whether I am/my child is currently pregnant or breast feeding. I agree to inform my prescriber if there is any possibility or intention of my/my child's becoming pregnant or doing breast feeding.

_____ (client/legal guardian's initials)

3. Because they alter the mind, **alcohol and/or recreational/street/illicit drugs should be avoided**. They can also cause dangerous interactions and can adversely affect the intended actions of prescribed medications.

4. I am/my child is aware that medications can impair the ability to drive or operate equipment. I/my child should avoid driving or using heavy machinery until I know/my child knows how the medication(s) prescribed could affect me/my child. I take responsibility for maintaining the safety of myself/my child, and the safety of others.

5. I agree/my child agrees to take/administer the medication(s) as prescribed and, especially when starting meds or during changing doses, to watch for and contact my/my child's prescriber about any unusual or adverse effects. Emergency/911 will be contacted if adverse effects are serious.

6. Discontinuing medications, especially abruptly, can cause serious adverse effects. I agree to discuss stopping medications with my/my child's prescriber before doing so, and to follow medical advice about safely tapering medications if intending to discontinue medications.

7. The medication(s) is/are selected based on best evidence supported by clinical literatures, guidelines, and expert opinions, even though sometimes a particular medication might not have U. S. Food and Drug Administration approval for the use(s) and dose range discussed.

Acknowledgement and Agreement

I acknowledge that the above topics were covered to my satisfaction, and that I have consented to, and accepted the risks of treatment with the medication(s) indicated in this form. I also understand that I have the **right to refuse** this/these medication(s) and that it/they cannot be administered to me/my child without my consent. I may seek further information at any time that I wish, and I **may withdraw my consent** to treatment with the above medication(s) at **any time** by stating my intention to my/my child's prescriber. I certify with my signature that I have legal authority to sign this consent and that the relationship listed is valid and legal.

Client (or Parent or Legal Guardian/ Conservator) Signature Date

Print Name if not client/ Legal Relationship

Prescriber Signature Date

Prescriber Print Name/Credentials CA Medical License #

Name of Clinic

Clinic Address

Laboratory Services

Laboratory services are provided by a contract through UC Irvine with phlebotomists who come out to MHRS clinics to perform lab draws for blood and urine. The front office staff at each clinic has the current schedule of when the phlebotomist comes for lab draws (usually for 60 minutes, 2-3 times per week). Same day results can be available by phone or requesting a FAX of results. If the lab test is a send-out, then results may take longer.

The laboratory requisitions (and requests for EKGs, see below) are completed by the psychiatrist in the EHR, and the system will generate a lab requisition form to print at the front office once the front office staff activates the order. The Psychiatrist reviews the purpose of the laboratory tests with the beneficiary/client and gives the beneficiary/client directions to return to clinic at the scheduled time slots. Standing orders (e.g., weekly or bi-weekly CBCs for clozapine monitoring) can be ordered as a "recurring order" in EHR.

If the EHR system is down, OR if a lab test is required that is not available in the EHR for ordering ('off-panel'), paper requisition forms are available and please follow the directions below

Be sure to write the **Pt Name, Sex, DOB, Medical Record Number (MRN)** on the form. Additionally, please circle **<M>** or **<F>,** *(without the age and sex, the lab is not able to include normal values on the report, since some of the "normal" values vary with age and sex).*
For proper billing, the diagnosis(es) must also be entered. Enter an ICD-10 / DSM V text diagnosis and numeric code in the appropriate fields.
Print the **Psychiatrist's first and last name**. (The laboratory will only be able to attach the psychiatrist's license, NPI and UPIN number from the data bank if the full name is clear.)
-If the client is Unfunded/Self-Pay, check the box **'Bill to HCA'**. -For beneficiaries/clients with Medi-Cal or Medicare, list the **Medi-Cal** or **Medicare #** in the appropriate fields. -If the beneficiary/client has another 3rd -party payor, check the box, **Bill to Insurance**. If there is another 3rd -party insurance payor other than Medicare or Medi-Cal, then the front office staff will have to attach a copy of the insurance card or enter all of the insurance billing information.
Sign the section under **Psychiatrist Acknowledgement and Certification** to indicate that the tests are medically necessary, and that if the tests are ordered for purposes of screening on a beneficiary/client with Medicare, the potential for denial of payment has been explained to the beneficiary/client who has signed an ABN. The **ABN portion applies only to beneficiaries/clients with Medicare**. In general, this should not be an issue. When laboratory tests are ordered in the clinics, it is always done as part of the assessment of biological causes of the beneficiary/client's mental, emotional, or behavioral symptoms, OR to evaluate for contraindications or precautions in prescribing medications, OR to evaluate for side-effects from the use of medications.

For EKG's, the order is placed through the EHR, or in the event that the system is down, the same lab form mentioned above and displayed on the next page is used. EKGs are performed by technicians from UC Irvine on-site at the clinic during business hours, and they may be scheduled by calling Dependable Dispatch at 1-888-705-9992. For EKGs, a strip is immediately left onsite at the clinic, and another copy of the strip is sent to a cardiologist for review and interpretation. After cardiologist review, an interpretation/signature of review is then faxed back to the clinic for scanning into the beneficiary/client chart.

With the recent launch of the electronic lab interface, most lab results from UC Irvine will return directly into the beneficiary/client's electronic chart. However, for any report of lab or EKG results that is faxed back to the clinic or provided to MHRS from another outside provider, the Psychiatrist should review the results as soon as possible, then initial and date that the results have been reviewed prior to scanning into the EHR. If any action is indicated or if there is an interpretation that is relevant, the Psychiatrist should indicate this on the printout so that later clinicians or reviewers can understand the beneficiary/client's care up to this point.

County of Orange Health Care Agency – Mental Health and Recovery Services

Laboratory Request Form Sample

HCA3 (rev 05 12)

UCI Pathology Services / UC Irvine Medical Center
101 City Drive South, Rt. 38, Orange, CA 92868
TOLL FREE: 1-888-UCI-LABS (1-888-824-5227) <1> FAX: 714-456-2200
Edwin S. Monuki, M.D., Ph.D., Laboratory Director & Associates
www.pathology.uci.edu

Clinic Address: 2035 E. Ball Road
Anaheim

☐ STAT ☐ PHONE:_____

☐ ROUTINE ☐ FAX:_____

PATIENT INFORMATION (Please print or affix patient label)		ACCOUNT INFORMATION	
NAME	SEX M F	ACCOUNT NAME: Anaheim – MH	ACCOUNT CODE: BHD-
DATE OF BIRTH	PATIENT ID/CHART	UCI Label	

DIAGNOSIS INFORMATION		PHYSICIAN INFORMATION
DIAGNOSES: Diagnosis verbiage or list all applicable ICD-9 codes using highest specificity code	ICD9 CODE(S): Or write in next to individual tests	Ordering physician name/license#

BILL TO: ☐ HCA ☐ INSURANCE (attach copy of card and include all billing information)

BILLING INFORMATION

☐ MEDI-CAL ☐ MEDI-CARE
(Attach copy of card and complete info below)

Medicare does not pay for screening tests nor will they pay for tests that are not medically necessary. If Medicare is likely to deny payment for one or more of the requested tests, then the Advanced Beneficiary Notice (ABN) must be explained to the patient and the patient or responsible party must sign.

ABN obtained? YES ☐

PHYSICIAN ACKNOWLEDGEMENT AND CERTIFICATION

The undersigned physician acknowledges that: 1. The tests ordered are medically necessary, 2. If tests are ordered for the purposes of screening, the likelihood of denial of payments has been explained to the patient who has signed the Advanced Beneficiary Notice and agreed to be personally and financially responsible for payment of denied tests.

Physician's Signature:_____

MEDI-CAL/MEDICARE NO.

PATIENT SOCIAL SECURITY NO.

ORDERING PHYSICIAN UPIN AND LICENSE NO.

SPECIMEN INFORMATION

DATE COLLECTED: _____ TIME COLLECTED: _____ SPECIMEN TYPE (circle types): SERUM PLASMA WHOLE BLOOD URINE OTHER:_____

Serum tubes (gold) required unless otherwise indicated — **TESTS (check in column or list in space below)** — Tube types listed below (L, B, etc.)

Chemistry Panels				**Urine Testing**				**Chemistry continued**			
	Electrolyte Panel	LG	80051	ELECPN		Urinalysis with Microscopic	U	81000	UAW		Cholesterol	LG	82465	CHOL
	Basic Metabolic Panel	LG	80048	BMPAN		Urine Culture	U	Mult	CULURI		Cortisol	R	82533	CORTIS
	Compr Metabolic Panel	LG	80053	CMPAN		Rapid Drug Screen	U	80100	RDSC		Creatinine	LG	82565	CREAT
	Hepatic Function Panel	LG	80076	HFP		Pregnancy, Urine	U	81025	PREG		Folate	R	82746	FOLATE
	Lipid Screen	LG + R	83701	LIPSCR	**Infectious Disease**						Iron	LG	83540	IRON
HematologyTesting						Hepatitis A Ab, IgM	G	86709	HAVGM		Iron Panel (Iron, TIBC, IronSat)	R	mult	FEPANL
	A1C Glycated Hemoglobin	L	83036	A1C		Hepatitis B Surface Ab	G	86706	HBSAB		Lead	L	83655	LEADBL
	CBC with Differential	L	85025	CBCWID		Hepatitis B Surface Ag	G	87340	HBSAG		Potassium	LG	84132	K
	Differential (Includes WBC)	L	85048	DIFF		Hepatitis B Core Ab	G	86704	HBCORE		Pregnancy, Beta HCG	LG	84702	BHCG
	Reticulocyte Count	L	85045	RETIC		Hepatitis C Ab	G	86803	HCV		TIBC	LG	84466	TIBCT
	Sedimentation Rate	L	85651	ESR		Hepatitis Panel (Acute)	G	80074	AHP		Urea Nitrogen (BUN)	LG	84520	BUN
						Syphilis Ab Screen	G	86780	SERSAS		Vitamin B12	LG	82607	VITB12
Thyroid Testing					**Chemistry Testing**						Vitamin D, 25 hydroxy	R	82306	VITD
	T3, Total	R	84480	T3		Alcohol	LG	82055	ALCOHL	**Therapeutic Drugs**				
	T3 Free	R	84479	FREET3		Amylase	LG	82150	AMY		Carbamazepine	R	80156	CARBAM
	T4, Total	R	84436	T4		BUN	LG	84520	BUN		Clozaril (Clozapine) Level	R	80299	CLOZ
	TSH	R	84443	TSH		Calcium	LG	82310	CA		Dilantin	R	80185	DILNTN
						GGT	LG	82977	GGT		Lithium	R	80178	LITH
											Valproic Acid	R	80164	VALP

L = Lavender R = Red LG = Light Green DG = Dark Green B = Light Blue G = Grey U = Urine O = Other

Additional Tests

For EKG and X-ray services, contact Practical Sleep Solutions at 949-222-0102

PANEL Components - PLEASE ORDER PANELS BY CHECKING ABOVE
(Individual tests may be ordered separately if desired.)

Electrolytes	Basic Metabolic		Comprehensive Metabolic		Acute Hepatitis	Hepatic Function	Rapid Drug Screen	
ELECPN	BMPAN		CMPAN		AHP	HFP	RDSC	
80051	80048		80053		80074	80076	80100 x 10	
Sodium Potassium Chloride Carbon Dioxide	Sodium Potassium Chloride CO_2	Creatinine Glucose BUN Calcium	Sodium Potassium Chloride Carbon Dioxide Creatinine Glucose BUN	Albumin Alkaline Phos Bilirubin, total Calcium ALT (SGPT) AST (SGOT) Protein, total	Hepatitis A Ab, IgM Hepatitis B surface Ag Hepatitis B core Ab, IgM Hepatitis C Ab	Albumin Alkaline Phos Bilirubin, direct Bilirubin, total ALT (SGPT) AST (SGOT) Protein, total	Alcohol Amphetamines Barbiturates Benzodiazepines Cocaine	Methadone Opiates Propoxyphene Phencyclidine Tetrahydro-cannabinol

Medical Services

If a beneficiary/client has other non-psychiatric medical conditions, it is advised that the Plan Coordinator obtain a signed release of information for the chart that allows the Psychiatrist and treatment team to have communication with other professionals providing medical treatment. The potential for medication interactions, physical conditions affecting psychiatric conditions, or psychiatric conditions affecting physical conditions is always present.

If the Psychiatrist suspects or detects a significant medical condition, then the Plan Coordinator or RN can assist with the appropriate referral.

- For the beneficiary/client who has an HMO or insurance company, the referral will be driven by this system.
- For the beneficiary/client who has CalOptima (Medi-Cal), the CalOptima medical managed care plan (there are more than ten) will determine whom the beneficiary/client should see. Many CalOptima beneficiaries/clients will have **CalOptima Direct,** which allows those individuals to see any CalOptima (Medi-Cal) provider for non-psychiatric medical care.
- For the unfunded client, the Plan Coordinator or RN should link the client with medical services for low or no-cost in the community. The relative constraints on resources for medical evaluation and treatment for the unfunded client should not discourage clinic staff and MDs from medically appropriate screening labs or linkage to low-cost medical resources. Indeed, this may be a part of a more meaningful linkage for ongoing health care.

Behavioral Health/ PCP Coordination of Care

Coordination of Care with a beneficiary/client's **Primary Care Psychiatrist (PCP)** is an essential aspect of providing comprehensive and integrated care for our beneficiaries/clients. We are also encouraged to coordinate with other treating providers at contracted agencies or community providers, and we provide discharge summary information when a beneficiary/client leaves our care and is transitioned to another Behavioral Health provider.

The EHR has an electronically generated **Continuity of Care Document (CCD)** that may be used to provide a summary of the beneficiary's/client's care to another provider when we are coordinating care for a beneficiary/client, or when transitioning care to a provider outside of HCA.

> An **Authorization to Disclose (ATD)** is still recommended for coordination of care purposes. Check the client's **Clinical Documents** folder to see if an ATD or any restrictions regarding releasing information are on file before releasing beneficiary/client information.

As part of opening a beneficiary/client for services, beneficiaries/clients should be asked whether they have a Primary Care Psychiatrist (PCP). If beneficiaries/clients do not have a PCP, they should be referred and linked with one. There are fields on the BH Biopsychosocial Evaluation Forms to document the beneficiary's/client's PCP status.

The first 60 days of care are also the appropriate time for a Continuity of Care Document (CCD) to be produced and sent to the beneficiary's/client's PCP, to establish coordination of care communication with the PCP.

The **Behavioral Health Nurse (RN)** will have the primary responsibility for generating the CCD and forwarding this document to the PCP. **Psychiatrists** and **Nurse Practitioners** may also run the CCD as needed from within the EHR.

In summary, a **Continuity of Care Document (CCD)** is a set of demographics, clinical and administrative information about a beneficiary/client's healthcare. It provides an efficient means for sending pertinent data about a beneficiary/client to another healthcare provider.

The CCD provides the following information (please see next page for an example):

- **Beneficiary/client Name** - *Most recently entered in Registration*
- **Demographics: Gender, DOB, Primary Language. Race, Ethnicity** - *Most recently entered in Registration*
- **Vital Signs** - *Most recently entered in Vital fields from any form*
- **Problem List** - *Current active Problems (aka Diagnoses)*
- **Allergies** – *Current, active allergies or NKA, and/or NKMA*
- **Medications** - *Active Medications: Prescribed and Documented by History*
- **Tobacco Smoking Status** - *Most recently entered in the field from any form*
- **Tobacco Cessation Education** - *Most recently entered in the field from any form*
- **Results** - *Appears blank for now. In the future this will include UCI Lab Results*
- **Date Document Created** – *Displays the date the CCD was generated*
- **Encounter Date** – *Date of the FIN / encounter used to generate the CCD*
- ***Care Team Members*** -- *This information is not available now, but will be added on the enhanced version, which we hope to release soon*

BHS Care Summary / Continuity of Care Document

Max Zztest

Gender: Male | DOB: MAY 23, 1991 | Language: English | Race: White | Ethnicity: Lebanese
Medical Record Number (MRN): 1000746732

Vital Signs

		Date Provider
BMI (kg/m2):	31	10/25/17 15:42 Weidhaas, Susan E
Weight (lb):	175	10/25/17 15:42 Weidhaas, Susan E
Height (in):	63	10/25/17 15:42 Weidhaas, Susan E
Waist Circumference (in):		
Sitting Systolic BP (mmHg):	110	10/25/17 15:42 Weidhaas, Susan E
Sitting Diastolic BP (mmHg):	80	10/25/17 15:42 Weidhaas, Susan E
Sitting Pulse (bpm):	75	10/25/17 15:42 Weidhaas, Susan E
Standing Systolic BP (mmHg):		
Standing Diastolic BP (mmHg):		
Standing Pulse (bpm):		
Respiration (br/min):	20	10/25/17 15:42 Weidhaas, Susan E
Temperature (DegF):	98	10/25/17 15:42 Weidhaas, Susan E

Problem List

Condition	Status
Major depressive disorder, recurrent, moderate (Confirmed)	Active
Post-traumatic stress disorder, acute (Confirmed)	Active

Allergies, Adverse Reactions, Alerts

Substance	Reaction	Severity	Status
ZyPREXA			Active

Medications

diphenhydrAMINE (diphenhydrAMINE 25 mg oral tablet)
25 mg = 1 tab(s), Oral, Once a day (at bedtime), for insomnia, # 30 tab(s), 0 Refill(s) ----------
Start Date: 10/25/2017
Stop Date:
Status: Documented

FLUoxetine (PROzac 20 mg oral capsule)
20 mg = 1 cap(s), Oral, Daily, # 30 cap(s), 0 Refill(s), Do Not Route, called to pharmacy (Rx) ----------
Start Date: 10/25/2017
Stop Date:
Status: Prescribed

Results

No data available for this section

Social History

Light tobacco smoker
Tobacco Cessation Counseling, Tobacco Cessation Pamphlet Given

Details

Document Created: JAN 31, 2018
Encounter FIN: 100012689582
Encounter Date: SEP 16, 2016

SECTION III - Psychiatric Services – Evaluation, Follow-up, Team Meetings

Initial & Follow up Evaluations

Initial Evaluations

Psychiatric Initial Evaluations are typically scheduled for 90 minutes and average 2 per day for a full-time MD. "Psychiatric evaluation" suggests that in addition to assessing the need for medication, there will also be:

A) Further assessment recommendations for active substance abuse and medical problems.
B) Consideration of complex social / family / cultural stressors.
C) Consideration of MHRS clinic "medical necessity".
D) Initial treatment recommendations including medication(s).

Nature of Evaluation Clarified

Not every beneficiary/client scheduled for initial evaluation with a psychiatrist will necessarily need long-term treatment at the level of care for severe/persistent mental illness (SPMI) or meet 'medical necessity' in our MHRS clinics. As part of the evaluation, this need may be assessed and determined across the initial or first several appointments. If the treatment team determines that a beneficiary/client does not need SPMI level of care or meet medical necessity, the Plan Coordinator may assist in linkage to other appropriate services and resources.

The Clinic Evaluation is the Cornerstone of Community Behavioral Health Care

In community behavioral health, some individuals may never be admitted to a hospital setting, or if they are, it may only be for crisis stabilization. This means that the diagnostic work-ups and comprehensive treatment plans mostly occur in the outpatient clinic setting. Extensive chart reviews, unusual circumstances, written reports / coordination of care with other outside providers, and immediate interventions involving the treatment team may require longer appointment times or rescheduling another follow-up to continue the initial evaluation.

When other comprehensive inpatient or outpatient records exist, these should be requested and entered into the current clinic medical record. Diagnostic assessment and determination of treatment efficacy depends on the establishment and review of the long-term record.

Follow-Up Evaluations

Scheduled Visit / Follow-up Visits

Psychiatric follow-ups typically average one, 30-minute appointment with the MD per month and are for individuals:

A) With SPMI who have engaged in care and are either in the **"rehabilitative"** or **"recovery"** phase.
B) With their 1st episode of mental illness, and education & illness management counseling is a part of each visit.
C) With a serious mental illness requiring case management.

Urgent or Intensive Visits & Unscheduled Services

May be 30-60 minutes in length. These visits may be scheduled same day for individuals requiring urgent services:

A) With a recent hospital discharge.
B) Seeing another clinic MD who is not at the clinic that day, and the beneficiary/client may be "urgent".
C) With SMPI who are not engaged in treatment and need frequent contacts to form a relationship
   a. May be resistant to having a mental illness/impairments, needing treatment, etc.
   b. May have active substance abuse, medical problems, or complex social/family/cultural stressors.
D) With infrequently seen diagnoses.
E) Requiring team discussions, hospital liaisons and primary care communication.
F) With SPMI who have missed a scheduled follow up and the team has agreed the individual is at imminent risk of further deterioration in an important area of life functioning.

Bi-monthly Scheduled Visit / Follow-up Visits

Typically average 30 minutes every two months. Scheduled follow-ups of this frequency are typically for individuals:

A) With SMPI who need psychiatric medication in **"recovery"** to prevent a recurrence of significant deterioration in an important area of life functioning, AND who may be in the process of linkage to a lower level of care.

Crisis Evaluations, Consultations, and Specialty Evaluations

Crisis Evaluations / Evaluation for Hospitalization (5150)

If a psychiatrist determines that a beneficiary/client who came in for a scheduled visit is not safe to leave the clinic unless acute interventions can be arranged, then other members of the team (Service Chief, Plan Coordinator, or clinic OD) should be contacted to further assess what interventions are necessary. If intensive follow-up as an outpatient is not adequate, then voluntary or involuntary psychiatric hospitalization may be the least restrictive intervention.

Consultations (Within Clinic)

A psychiatrist may meet with a beneficiary/client of another MHRS psychiatrist for several reasons. This should be communicated before the meeting, and if it is not clear, the psychiatrist should discuss with the team what is the intent, (e.g., "covering", "consult", "evaluate & assume care", etc.).

If the intent is to "cover" or provide services in the absence of the treating psychiatrist, then after providing services, direct the beneficiary/client back to the original psychiatrist in a supportive manner. Also, assist the Plan Coordinator with 'unexpressed' needs with the beneficiary/client, as time permits. This may evolve into a *consultation.*

If the intent is to assume care, clarify if this is a beneficiary/client request, MD request, or clinic request. This information will help with the transition. Occasionally, the request may not clinically be in the beneficiary/client's best interest, and this should be resolved within the clinic team members.

Consultations (Outside of Clinic)

Psychiatrists or other agencies may request a psychiatric or mental health consult for a beneficiary/client who may not end up meeting ongoing medical necessity for clinic services at MHRS. The reason for consult should be communicated before the assessment appointment, and if it is not clear, the psychiatrist should discuss with the team what is the intent, (e.g., "what is the consultation question", "what is needed for management by the outside agency", etc.).

Conservatorship Evaluations & Reassessments for Conservatorship

When a beneficiary/client maintains a significant level of impairment secondary to a severe or persistent mental illness, the clinic psychiatrist may make an application to pursue or continue an LPS conservatorship. The Plan Coordinator often has additional information on impairments in function and may also recommend continuation of LPS conservatorship. These assessments require the evaluation and signature of TWO clinic psychiatrists.

Annual Reevaluations and Transfer Summaries

Annually or whenever a significant change in the beneficiary/client condition has occurred, the psychiatrist should document a comprehensive or extended evaluation in the chart. This would also take place prior to a planned transfer so that a continuation of the diagnostic work-up or assessment of treatment efficacy can effectively continue.

Disability Evaluations for SSI / SSDI

A Social Security Disability Evaluation is completed with objective history or findings to establish the presence of an illness for 12 months, or with sufficient evidence to predict that it will last 12 months or more. The MHRS clinic staff does not make the decision on **SSDI** versus **SSI, but may make recommendations on whether or not the beneficiary/client should be their own payee.**

These benefits are often referred to as "entitlements", and in this context, they refer to necessities for living in the community. Frequently, one of the steps along the road to recovery is an appropriate disability evaluation that can allow the individual to access Social Security, Medi-Cal, or other funding. This in turn allows access to medications, medical services, housing, and other components of recovery.

One third of SSI benefits in the U.S. are given for mental illness disabilities. Descriptions are listed below:

I. Social Security Disability Insurance (SSDI) Benefits: (1956):

These are benefits paid to individuals who have worked a certain number of years or have paid into the SSA disability fund or became disabled while on their parents' Social Security as a dependent. There is no cap at present. Medical Necessity is the only limitation.

- Medicare Part A (hospital only) two years after application.
- Medicare Part B (psychiatrist & laboratory fees) two years after application.
- Medicare Part A and Part B do not cover outpatient pharmacy costs.
- An application for SSI also occurs, and if approved, would cover outpatient pharmacy costs and health care in the Medi-Cal system.

II. Supplemental Security Income (SSI) Benefits: (1972):

If the beneficiary/client has no income or it is very low, these are benefits paid to individuals who have not worked a certain number of years and have not paid into the SSA disability fund.

III. Combined SSD & SSI:

In these situations, the individual would have Medicare and Medi-Cal for their medical care.

SSI-OR Tips: Effective Documentation for Disability

Five KEY AREAS on progress notes!!!

****SSI-OR Tips/interpretation-To be used for SSI-OR training only **For complete understanding refer to SSA literature/requirements****

- Social Security disability is an administrative/legal decision (**not a medical decision!!!**) Burden of Proof is on claimant!
- Social Security definition of disability: unable to work (any job) at SGA ($1040 per month) lasting or expected over 1 yr
- SSA criteria requires current, objective medical evidence of signs, symptoms...and examples of function that clearly show if beneficiary/client can/cannot do a "simple repetitive task" on a sustained basis (i.e.: push groc carts, stack boxes)
- **Current progress notes are considered "Mental Status Exams"- used by SSA to determine disability.**
- Important to consistently document signs/symptoms + examples of NON-function preventing work (i.e.: "**cannot** leave house approx 1-2 days per wk" "**cannot consistently** complete tasks" "requires reminders") for current evidence

IMPORTANT EVIDENCE: 5 KEY AREAS of evidence on progress notes

1. **6 mo current Medication compliance:** Need sufficient evidence if better w/medication.... or still unable to work

***IF not compliant OR missing appts**: possibly not be enough evidence to determine response to medication. Important to document **IF** due to Mental Illness: **IE: "Missed appts/meds due to mental illness + inability to adhere to schedule"**

2. **3 mos Sobriety:** Need evidence that substance is not material. (If no substance ...is person be able to work??)
   (Important to provide enough objective evidence that substance not material.
   IE "Sober since approx 3 mos - except 2 brief relapses 1 day each"
3. **Symptoms:** What are the **current symptoms that prevent work (a simple task 8 hrs a day- on an ongoing basis)??**
   - ☐ Poor memory/poor concentration (**can beneficiary/client remember/concentrate 8 hrs per day 5 days per week??**)
   - ☐ Poor judgment/Poor insight
   - ☐ Mood swings
   - ☐ Hallucinations/disorganized thoughts/delusions
   - ☐ Easily confused/overwhelmed
   - ☐ Poor impulse control/ poor emotional control: antagonistic, argumentative
4. **Functional Limitations: Recommend** at least **2 current OBJECTIVE EXAMPLES "per progress note"**
   re what person cannot do on a consistent basis to show if they can sustain activity on a "simple repetitive task job

IE: Common Functional Limitations	**Objective Examples (help prove disability !!)**
Cannot consistently follow instructions	Forgets what he's doing, makes mistakes, easily overwhelmed, doesn't finish
Cannot consistently complete tasks	C/c reminded ct 3 times to call housing for appt - overwhelmed, still not started
Cannot consistently keep appts	Confused/forgets appts - or shows up without appts due to mental illness
Cannot consistently follow a schedule	Starts projects for about 2 weeks then does not follow: dropped class 3rd time
Cannot independently manage medications	Requires mother to give him the medication to make sure he takes it
Requires supervision	No longer allowed to cook - forgets to turn off stove, walks away - burns food
Requires prompting/reminders w/chores, etc	Wife reminds husband to take out trash, go for a walk
Cannot get along/respond appropriately	Walks into clinic without appt, demanding, yelling "I need meds changed!"
Cannot get along/respond appropriately	Family refuses to allow beneficiary/client to visit - due to uncontrolled arguments/yelling
Unable to perform tasks independently	Requires mother to take her to shopping/appts, or gets confused/lost/panics
Unable to leave the house approx 1-2 days per wk	Husband tries to prompt her to go out - but stays in room
Unable to follow through on treatment goal	Attempting groups 2 times per wk, only able to follow through 1x, even w/help
Unable to independently manage ADLs	Requires reminders to change clothes, eat and shower

5. **CONTEXT/Clarification for "subjective or apparent improvement": Need to** clarify statements that may **"appear"** beneficiary/client functioning better than actuality. **Objectively show** if person can/cannot do a "simple repetitive task ongoing!

IE: Situation	**Clarification helps show "actual" level of function!!**
"Stable on meds	**however, still** cannot get out of bed approx 1-2 days per week"
"Getting better	**however, still** cannot complete tasks on a consistent, scheduled basis"
"Going to school	**however,** 1 online class and already failing"
"Pt states looking for work...	**however** not able to follow through"
"Helps with chores	**however,** mother still has to remind him"

Situation _____ **Clarification** _____

Mental Disorder Questionnaire (MDQ) for SSI / SSDI

When the treating clinical team feels the determination of **SSI / SSDI** disability is an important part of the recovery process for individuals with Serious Persistent Mental Illnesses (SPMI), the individual or the Plan Coordinator assisting the individual start the process by filling out the online or the 8-page paper form (SSA-3368). Subsequently, the office of Disability Determination Services (**DDS**) in LA will send the clinic a 5-pg Mental Disorder Questionnaire (**MDQ**).

DDS case examiners and medical consultants will use the MDQ along with other information to complete a 14-page Psychiatric Review Technique Form (**PRTF**) to organize findings and make the disability determination more objective, rather than solely based on stated history and mental status examination. The clinic's completion of the MDQ is a key in the objective data used by the DDS, therefore it is important that the MDQ address the **TWO objective areas** in the PRTF:

Objective Area #1 - DSM signs & symptoms

The DDS examiners will find evidence of a mental disorder **ONLY** if the appropriate DSM signs & symptoms are listed on the ***MDQ Pgs. 1 – 3 Sections 1 – 5***. Typically, in a mental health clinic these would be psychotic, affective, anxiety, or somatoform disorders.

Objective Area #2 - Impairment examples

The DDS examiners will find evidence of a serious impairment **ONLY** if examples are given of the beneficiary/client's **current** inability to function independently, appropriately, effectively, and on a sustained basis in three areas. The DDS examiners must be able to conclude that there is "**marked**" for at least two, or "**very marked**" for one, of the following:

1) Examples of restriction of activities of daily living should be listed on the ***MDQ Pg. 3 Sec 6A Present Daily Activities.*** Even though one may be able to do a wide range of activities of daily living (cleaning, shopping, cooking, taking public transportation, paying bills, maintaining one's residence, grooming, hygiene, etc.), "**marked**" limitation may be found if there are serious difficulties performing them without direct supervision, or in a suitable manner, or on a consistent, useful, routine basis, or without undue interruptions or distractions.

2) Examples of difficulty in maintaining social functioning should be listed on the ***MDQ Pg. 4 Sec 6B Present Social Function.*** Impairments may include a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, or social isolation. However, even if a person is tolerated by local storekeepers, despite being highly antagonistic, uncooperative or hostile, the person may have "**marked**" limitation in social functioning since that behavior is not acceptable in other social contexts (e.g., responding appropriately to people in authority like supervisors, and cooperating with co-workers).

3) Examples of deficiencies of concentration, persistence or pace should be listed on ***MDQ Pg. 4 Sec 6C Concentration and Task Completion.*** While best observed in work settings, these may be assessed through clinical examination. The beneficiary/client may be able to complete simple tasks in the clinic, but still have marked limitation if the tasks cannot be completed without extra

supervision or assistance, or in accordance with quality and accuracy standards, or without unreasonably long or frequent rest periods, or without undue interruptions or distractions.

4) Examples of episodes of decompensation should be listed on ***MDQ Pg. 1 Sec 3 Past History of Mental Disorder.*** For this impairment, the DDS examiners are looking for three or more examples of temporary increases in symptoms or signs typically requiring an increased treatment or a less stressful situation. They may be inferred from medical records showing a significant alteration in medication or the need for a more structured psychological support system.

HOWEVER, If the **current** impairment severity for **psychotic or affective disorders in Area #2** above is not clear (e.g., responded to treatments, relative providing total care, etc.), then the MDQ must document the beneficiary/client has had persistent signs and symptoms as in one of the three following:

1) Examples of episodes of decompensation should be listed on ***MDQ Pg. 1 Sec 3 Past History of Mental Disorder***. In this case, the examples should be at least **two years duration** with repeated, extended episodes of decompensation. Typically, this means three episodes per year and each must last for at least 2 weeks. However, more frequent episodes of shorter duration, or less frequent longer episodes also applies.

2) Examples of residual disease should be listed on ***MDQ Pg. 1 Sec 3 Past History of Mental Disorder***. In this case, at least **two years duration** of residual disease with marginal adjustment to the extent that even a little increase in mental demands or change in environment would result in deterioration.

3) Examples of inability to function should be listed on ***MDQ Pg. 2 Sec 4 Family, Social, Environmental History***. In this case, at least **one year** of inability to function outside of highly supportive living arrangement with an indication of continued need for same.

Or, for an **anxiety disorder in #2** then beneficiary/client must have:

1) Examples of inability to function should be listed on ***MDQ Pg. 2 Sec 4 Family, Social, Environmental History***. In this case, at least **one year** of complete inability to function independently outside of the area of one's home.

Lastly, if beneficiary/client is using / abusing drugs or alcohol it is necessary to clarify if the team believes that the drug or alcohol use is not a material factor significant to the disability.

SECTION IV – Coding & Billing

Please find below a summary of the CPT codes most commonly used by Psychiatrists in MHRS.

Medication Services Charge Description	CPT
Established Patient Office Visit w/ Prob Focus Hx & Exam Straight Forward Decision Making or **10 - 19 minutes** (99212, SF 60)	99212
Established Patient Office Visit w/ Expanded Prob Focused Hx & Exam, Low Decision Making or **20 - 29 minutes** (99213, SF 60)	99213
Established Patient Office Visit w/ Detailed Hx & Exam, Moderate Decision Making or **30 - 39 minutes** (99214, SF 60)	99214
Established Patient Office Visit w/ Comprehensive Hx & Exam, High Decision Making or **40 - 54 minutes** (99215, SF 60)	99215

Note that CPT **99215 is used even if a service appointment (most often an Initial Evaluation) is **greater than 54 minutes.**

Additional codes that are used less often include the following:

- **Temporary Medication Refill (TMR)** services, when billable can be coded as **90899-8** (Comprehensive Medication Service w/ or w/out Patient Present)
- **Non-Compliant Chart Services** must always be coded as **90899-109** (Comprehensive Medication Services-Non Compliant)

For additional information on coding and billing, please refer to the BEHAVIORAL HEALTH PROVIDER HANDBOOK CODING MANUAL AND DOCUMENTATION GUIDELINES (Version 11, Updated Nov 2020) published by the Quality Management Services (formerly called Authority & Quality Improvement Services (AQIS)) Department at HCA. This manual can be found at the following website, accessed on County network computers:

SECTION V - Documentation / Treatment Plans / Co-Occurring Disorders / Special Circumstances

Charting for Clinical Effectiveness - General

The general standard is that a 'covering' psychiatrist (as well as the treating psychiatrist) should be able to find relevant clinical information in the chart (within the last 12 months) to treat or manage the beneficiary/client safely and effectively.

1) The progress note should specify if the beneficiary/client was or was not present and also reference any family or other people present for the appointment who may have provided collateral.
2) Completely list medications prescribed, samples given, labs ordered / results, vital signs, no shows. Also, please document medications that the beneficiary/client is taking from outside providers (like PCPs) to the best that you can determine. Plan Coordinators and clinic RNs can assist with obtaining records from PCPs and other providers.

Diagnoses

Diagnoses need to be on every progress note. It is important that all diagnoses on the chart agree, and that criteria to support the diagnosis are documented within that note. If the psychiatrist determines that the Plan Coordinator has a different diagnosis, then that should be discussed with the PC and treatment team.

Psychiatrists and other mental health professionals use the most current Diagnostic & Statistical Manual (DSM-5) for clinical diagnostic purposes. Insurance companies require the use of the International Classification of Diseases (ICD-10). The ICD-10 uses alphanumeric codes to describe a particular illness, a medical condition or disease, or even signs and symptoms. The DSM, if used to the highest level of specificity possible, should be consistent with the ICD-10 codes. The AQIS department can provide DSM5/ICD-10 crosswalks that can assist the clinician with this process.

Documentation of Medical Necessity

Beneficiaries/clients must have "medical necessity" or "service necessity" to receive clinic-based Specialty Mental Health Services. This means that the diagnosis of mental illness alone is not sufficient to allow state and federal reimbursement (Short-Doyle / Medi-Cal) for the County's services. The Intake Counselor (IC) is responsible for evaluating and then documenting in the chart the presence or absence of medical necessity. Psychiatrists should also assist with supporting medical necessity in their documentation.

While it seems that the presence of a diagnosis of a severe or persistent mental illness (SPMI) should be sufficient, the initial and follow-up medication services progress notes should reflect the following if the findings are present:

- Symptoms and signs (and severity) required to make a DSM diagnosis.
- Ideation, intent, threats, or an act of harm to self, others or property.
- Impairment secondary to the above in maintaining living arrangements, productive daily activities, social relationships or health.
- In the absence of above, evidence that the individual has a psychiatric history of recurring illness or impairment that will recur without ongoing services.

Clinical reasoning of medical necessity for ongoing treatment might be something like,

"Pt's <SYMPTOM or IMPAIRMENT> is improving in response to the <INTERVENTION or TREATMENT>, OR

"Pt's <SYMPTOM or IMPAIRMENT> are better, but are at risk for significant deterioration without the <INTERVENTION or TREATMENT>.

Although this information is sometimes not apparent in the MD's office, it is possible this information may come from the Plan Coordinator, another person familiar with the beneficiary/client, or previous records. The source of the information should be noted in the progress note.

If the Plan Coordinator's initial evaluation has been completed in the chart, you can look at the "Community Functioning Evaluation" (CFE) within the BH Assessment note for further information.

Documentation of Psychiatrist's Initial Evaluation (Biopsychosocial)

Some documentation can be shortened if a clear reference can be made to other documentation in the chart. This may include the Plan Coordinator's initial evaluation / Psychosocial, the Client Self-Report, the Community Functioning Evaluation (CFE), the Care Plan or outside records that have been obtained.

Documentation of Psychiatrist's Follow up Appointments

Record any narrative that is important, including discussion of this beneficiary/client's case with others assisting in medication services. Also recommended are the following:

- Treatment circumstances "35 y/o male here for follow up treatment for *(dx or sx)*"
- Medication effectiveness, side effects (including TD assessment), compliance.
- Medical Necessity - refer to ***Medical Necessity*** on previous page for format.

Documentation of Care Plan Evaluations

Medicare Hospital Manual Chapter II - Coverage of Hospital Services *Outpatient Hospital Psychiatric Services 230.5 states,* "Services must be supervised and periodically evaluated by a psychiatrist to determine the extent to which treatment goals are being realized." This is also the opinion that HCA has received from outside consultants. The clinic psychiatrist should be involved in the Care Plan development via discussion with the Plan Coordinator.

As part of the clinic's initial evaluation, the Care Plan is developed by the treatment team, including the beneficiary/client and the psychiatrist. Frequently, the Plan Coordinator incorporates the team input into the Care Plan, and they are ultimately responsible for completing this document. At least one of the nine problems must be listed on each subsequent progress note while the beneficiary/client is receiving care in our system.

Care Plans for Board & Care Beneficiaries/clients

Board & care psychiatrists cannot sign the Care Plan, as they are not a member of the team, and thus Medicare beneficiaries/clients' treatment plans require a signature by a clinic psychiatrist. In this case, a face-to-face visit and information from the B&C / other outside treating psychiatrist is recommended for the clinic psychiatrist to participate in the clinic's Care Plan process.

Recovery Based Treatment Planning

For many cases in which the beneficiary/client is engaged in treatment, the Care Plan may seem to be documentation of treatment that is obviously indicated. For other cases in which the beneficiary/client is not engaged, or on the opposite end of the continuum as the beneficiary/client is in "recovery" phase (but without resources to continue outside of the clinic), the Care Plan is more difficult to formulate. In the latter cases, the Care Plan may focus the clinic's work, engage the beneficiary/client, or set endpoints for clinic treatment.

Documentation – Addendums, and Corrections

Referring to Plan Coordinator notes

Plan Coordinator progress notes contain valuable information. Sometimes there will be history, or other details, which are used in the psychiatrist's medical decision making. It is acceptable to write, "please see PC's note date __/__/__ regarding _____". Alternatively, the information can be written in the psychiatrist's note.

Addendums & Reviewer requests for additional clinical information needed to support CPT code:

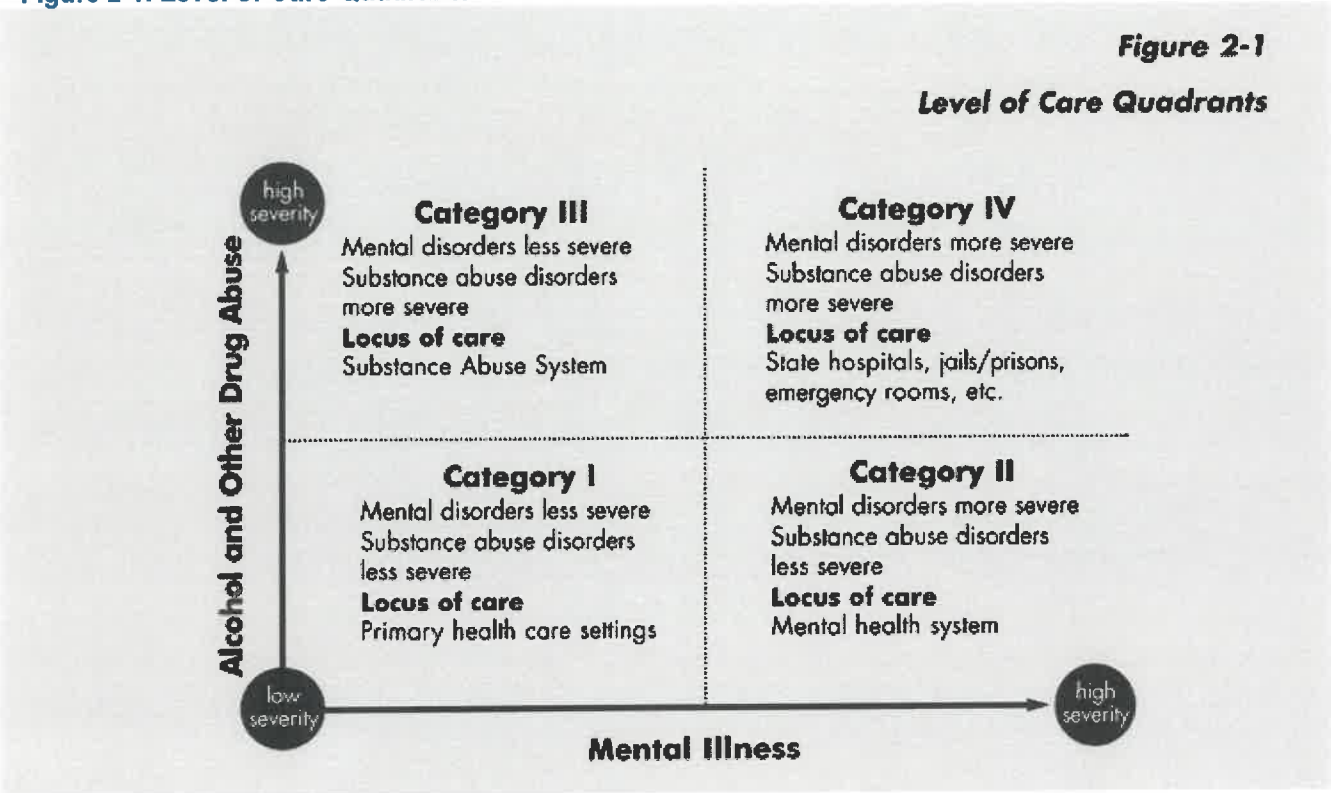
1) Label "Addendum" and list the date of the addendum.
2) Provide reason info needed and additional information to support CPT, i.e., what service you provided to support CPT code selected
3) No billing for requested corrections or addendums

Documentation / Coding for Unscheduled Services

1) 90899-8 medication services – temporary medication refills (TMRs), contacts with pharmacy or other medication services that may not involve direct contact with the beneficiary/client.
2) 90899-6 mental health service - PC / team discussion, Initial Care Plan, or Care Plan, if note includes 'intake exam, MHRS evaluation, and lab testing necessary'
3) 90899-1 case management – Initial Care Plan, or Care Plan, or form completion / signing **(clinic)**, 'communication or coordination'.

SAMHSA TIP 42. Substance Abuse Treatment for Persons with Co-Occurring Disorders

Figure 2-1. Level of Care Quadrants



Quadrant I: This quadrant includes individuals with low severity substance abuse and low severity mental disorders. These low severity individuals can be accommodated in intermediate outpatient settings of either mental health or chemical dependency programs, with consultation or collaboration between settings if needed. Alternatively, some individuals will be identified and managed in primary care settings with consultation from mental health and/or substance abuse treatment providers.

Quadrant II: This quadrant includes individuals with high severity mental disorders who are usually identified as priority beneficiaries/clients within the mental health system and who also have low severity substance use disorders (e.g., substance dependence in remission or partial remission). These individuals ordinarily receive continuing care in the mental health system and are likely to be well served in a variety of intermediate level mental health programs using integrated case management.

Quadrant III: This quadrant includes individuals who have severe substance use disorders and low or moderate severity mental disorders. They are generally well accommodated in intermediate level substance abuse treatment programs. In some cases, there is a need for coordination and collaboration with affiliated mental health programs to provide ongoing treatment of the mental disorders.

Quadrant IV: Quadrant IV is divided into two subgroups. One subgroup includes individuals with serious and persistent mental illness (SPMI) who also have severe and unstable substance use

disorders. The other subgroup includes individuals with severe and unstable substance use disorders and severe and unstable behavioral health problems (e.g., violence, suicidality) who do not (yet) meet criteria for SPMI. These individuals require intensive, comprehensive, and integrated services for both their substance use and mental disorders. The locus of treatment can be specialized residential substance abuse treatment programs such as modified therapeutic communities in State hospitals, jails, or even in settings that provide acute care such as emergency rooms (see chapter 7 for an example in an emergency room setting).

Two Axis Continuums of Dual Diagnoses

Dual Diagnosis or Co-occurring Disorders are probably best conceptualized as a spectrum or "continuum" of disorders as illustrated on the two-axis continuum on the next page. A treatment team will function better if all members of the team seek to reliably determine in which quadrant the client currently is.

Ψ **Vertical Axis - Medical Necessity for BHS outpatient AMHS or ADAS 01 Outpatient Services**
(Face to face evaluation or several evaluations over a short period of time may be needed to determine this)

1) With a GAF greater than 60 (61-70 Some mild symptoms OR some impairment in social, occupational function), the assessment and management of dual diagnosis issues are different than in the Specialty Mental Health Services. Perhaps the biggest difference is that Specialty Mental Health Services are tasked with providing a "safety net" for individuals who are denied private sector service for a variety of reasons such as non-compliance, dangerousness, and financial reasons.

   With a GAF of 41 – 60 (51-60 Moderate symptoms OR moderate impairment in social, occupational function and 41-50 Serious symptoms OR serious impairment in social, occupational function), patients have medical necessity (e.g. impairment) just sufficient to warrant BHS AMHS or ADAS 01 services.

2) With a GAF of 21 - 40 (31-40 Impaired reality testing OR major impairment in social, occupational function21-30 Impaired communication and judgment OR inability to function in almost all areas), patients have substantial medical necessity, but are still stable enough to be managed in "outpatient services".

   With a GAF less than 20 (11-20 some danger of hurting self or others OR gross impairment in communication), the assessment and management of dual diagnosis issues are also different than in the community mental health setting. The biggest difference is that Community (Specialty) Mental Health Services are tasked with providing a "least restrictive" level of care for individuals who may be "high-utilizers" of other social and financial resources in the county and state, yet abstinence by containment is not available.

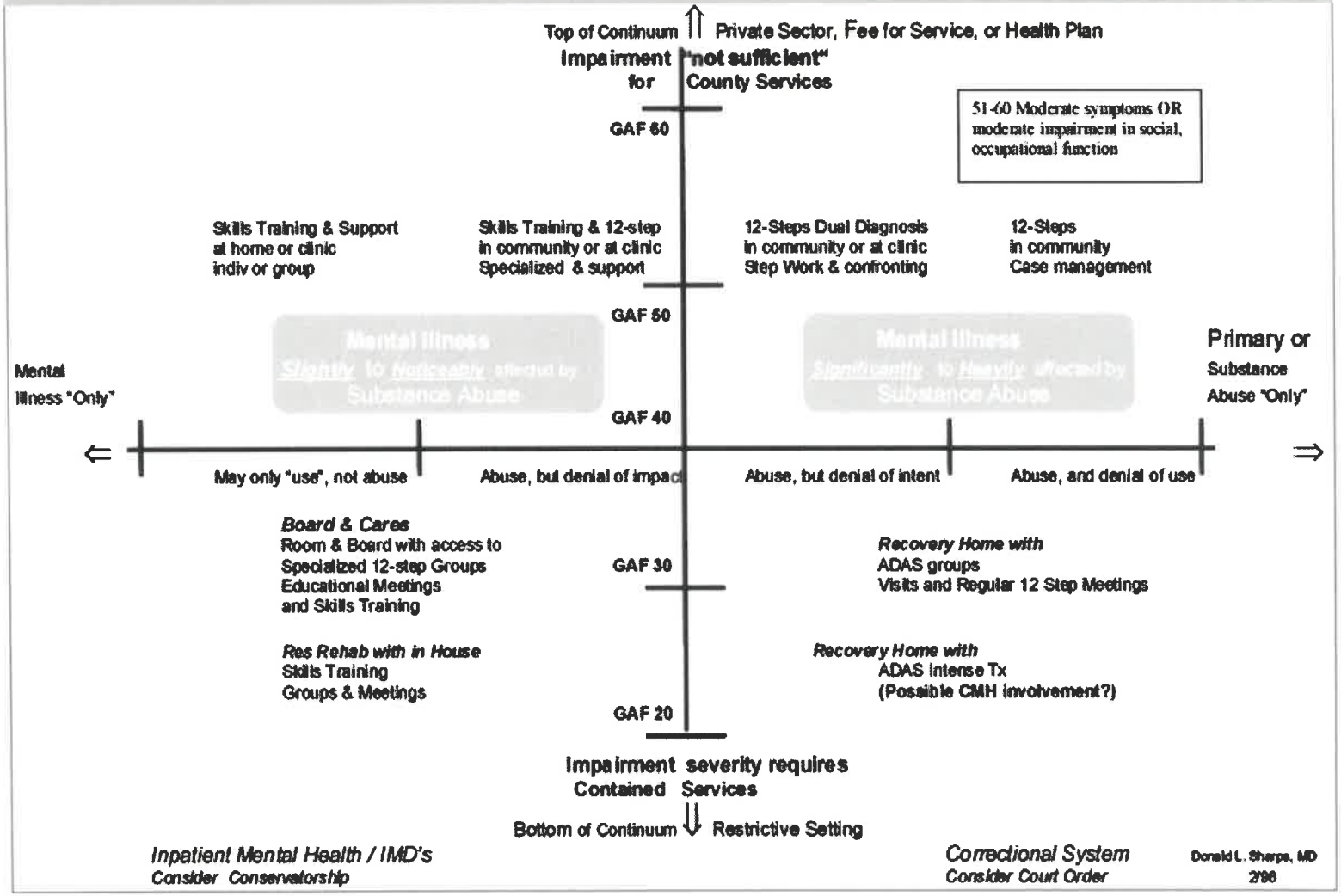
Ψ **Horizontal Axis** – After medical necessity determined, it still takes time and communication to sort

1) The left end of the horizontal continuum addresses patients who very clearly have a predominant or preexisting mental illness.
2) The right end addresses patients who have psychiatric impairment during their predominant behavior pattern of substance abuse or dependence.

Donald L. Sharpe, MD

Two Axis Continuum of Dual Diagnosis in *Specialty Mental Health*

Donald L. Sharps, M.D. 1/98



SECTION VI – Community Mental Health in Orange County - Managed Care & The Mental Health Plan

Managed Care and OC's Mental Health Plan (MHP)

Since 1995, Orange County HCA's Behavioral Health Service has been a managed MHP in a contract with the state and is responsible for provision of specialty mental health (SMH) care in a managed care model of service delivery for Medi-Cal beneficiaries either directly or through contract providers. Individuals without Medi-Cal also receive the same SMH care services, but the state does not provide additional reimbursement to the county for those services.

Timeline of CMH funding in OC HCA MHRS

1957 - California passed legislation creating the Short-Doyle Program, wherein counties were required to ensure delivery of mental health services utilizing a system of county operated and contract providers. (Coinciding with beginning of deinstitutionalization)

1965 - United States congress passed:

1) Title XVIII, Medicare legislation for some disabled individuals & persons 65 years of age and over, &
2) Title XIX, the Medicaid legislation that provided federal matching funds to states that implemented a comprehensive health care system for the poor under the administration of a single state agency.

1966 - California implemented the Medi-Cal program, based on the provisions of Title XIX. Mental health services for which there was federal reimbursement included:

1) Psychiatric inpatient hospital services
2) Nursing facility care
3) Professional services provided by psychiatrists and psychologists.

Services were provided under a fee for service reimbursement arrangement with rates set by the Dept of Health Services (DHS). This system came to be known as Fee for Service Medi-Cal (FFS/MC)

1971 - Legislation in California added Short-Doyle community mental health services into the scope of benefits of the Medi-Cal program enabling counties to obtain federal matching funds on their costs of providing certain mental health services to persons eligible for Medi-Cal. These Short Doyle Medi-Cal (SD/MC) services consisted of:

1) Inpatient hospital services delivered in acute care hospitals
2) Individual, group or family therapy delivered in outpatient or clinic settings
3) Various partial day or day treatment programs.

Two current community MH features were added in subsequent years:

1988 - Targeted Case Management was added via a state plan amendment (SPA) to the SD/MC array of services. Case management emphasized that individuals with serious persistent illness needed much more than treatment.

1993 - Rehabilitation Option was added which further emphasized a full range of services that emphasized allowing the individual to remain at the least restrictive level of care. These additions broadened the scope of benefits, the range of personnel who could provide services and the location where services could be provided.

Consolidation and Managed Care

The plan to consolidate the two Medi-Cal funding streams for mental health services was designed to provide a cost containment strategy that would allow maximum benefit for its expenditures and would allow for increased access to specialty mental health services within the same level of funding.

Access to services was a critical concern for the Health Care Financing Administration (HCFA) in evaluating the state's plans for delivery of managed health care for the Medi-Cal population.

The decision was made to "carve out" specialty mental health services from the rest of Medi-Cal managed "medical" care. Thus, a distinction was made between specialty mental health care (those services requiring the services of a specialist in mental health) and general mental health care needs (those needs which could be met by a general health care practitioner).

A "freedom of choice" waiver from HCFA allowed California to have a single plan model whereby beneficiaries in need of specialty mental health services have one plan available in each county as opposed to the more traditional managed care model of a choice of at least two plans in each locality from which beneficiaries may choose.

1995 - The Medi-Cal Specialty Mental Health Services Consolidation program began with county mental health departments taking on responsibility for authorization and payment of all Medi-Cal covered psychiatric inpatient hospital services for beneficiaries in the county. Consolidation operates under a federal freedom of choice "waiver" originally approved in May 1995.

1997 - OC Mental Health Plan (MHP) began a contract with PacifiCare Behavioral Health (PBH) to assume the county's new MHP responsibility for FFS outpatient specialty mental health professional services, in addition to responsibility of OC clinics to provide rehabilitative mental health and targeted case management services. These PBH "providers" replaced the previous fee-for-service Medi-Cal providers.

Freedom of choice waiver renewed in September 1997 for an additional two years. A request to renew the program for an additional two years was submitted to the Health Care Financing Administration (HCFA) in June 1999.

State Medi-Cal Funding for OC MHRS

1) MHPs receive a fixed annual allocation of state general funds (SGFs) based on the historical cost of services formerly provided through the FFS/MC system.

2) MHPs receive uncapped SGFs for services provided to Medi-Cal beneficiaries under 21 for outpatient specialty mental health services above a baseline expenditure level.

3) MHPs also receive ***realignment funds,*** which have funded SD/MC services since 1991. These funds made up of revenues from sales tax and vehicle licensure fees are collected by the state and transferred by the state to each county. All of these funds may be used as the state Medicaid match for claiming federal matching funds that make up a little over 51 percent of the funding for mental health services.

Reimbursement under the SD/MC program is primarily based on allowable costs or negotiated rates approved by DHCS, up to a statewide maximum allowance.

SECTION VII – Rehabilitation Model & Recovery Model

"Deinstitutionalization" began 50 years ago. The Community Mental Health Act of 1963 began the creation of community mental health as it is today. There are two notable points.

First, Community Mental Health Centers are also a "safety net", which requires care for individuals who may not directly request services. Society and laws (*parens patriae)* infer that these individuals' behaviors are a request for help that the individuals are not capable of making for themselves.

Secondly, and perhaps the bigger point for California, was the implementation of the Rehabilitation Model in the early 1990's. A decade later, this has evolved into a Recovery model. This was accompanied by the beginning of managed care for Medi-Cal occurred in the mid–1990's. This is described in the last section in this reference.

In order to address the relationship of psychiatry and rehabilitation, in 1998, Rodrigo Munoz, MD, president of the American Psychiatric Association (APA), invited the American Association of Community Psychiatrists (AACP) to identify important concerns challenging psychiatry in addressing its relationship to psychosocial rehabilitation. The AACP has composed a set of principles to guide psychiatry's relationship with psychosocial rehabilitation.

American Association of Community Psychiatrists' Five Organizing Precepts:

1. Psychosocial rehabilitation has been defined as "a therapeutic approach that encourages a mentally ill person to develop his or her fullest capacities through learning and environmental supports"
2. Psychiatrists must engage and then build relationships with mental health consumers and, in collaboration with other professionals, help their beneficiaries/clients articulate and accomplish their personal goals.
3. Psychiatrists should employ a biopsychosocial model to guide the categorization of goals and to understand their interaction.
4. Psychiatrists often assume leadership roles, while engaging in goal planning among professionals. Given this, psychiatrists should utilize their leadership opportunities to maximize the visibility of rehabilitation as a therapeutic modality.
5. The components of rehabilitative goals lie on a spectrum from traditional services to nontraditional community resources. Traditional psychiatric tools, like diagnosis, psychopharmacology, psychotherapy, inpatient hospitalization, and health evaluation are discrete interventions within the rehabilitative paradigm. While grounding their work in science, psychiatrists working with beneficiaries/clients with severe psychiatric disorders must understand how to coordinate these interventions with the creative use of other resources in pursuit of enhancing functioning, fostering hope, and helping a person create meaningful identity. Examples of these resources are vocational

and social skills training, treatment of co-occurring chemical dependency, specialized housing, peer support mechanisms, and healing modalities that derive from cultural values and spiritual concerns.

Recovery and MHSA transformation:

MHRS Adult Acute and Recovery (from HCA April 2005 Business Plan -Appendix B)

Adult Acute Services provides outpatient crisis stabilization and resolution, hospital diversion and inpatient access management through coordinated services of the Outpatient, Acute Inpatient and Managed Care sections of Adult Mental Health. Such services include crisis intervention and evaluation in the community and a 23-hour evaluation and treatment unit; assessment, medication management; individual and group therapy, as well as family services at County-operated Clinics.

Adult Recovery Services provides mental health services to beneficiaries/clients in intermediate and long-term care facilities and beneficiaries/clients receiving outpatient services in contracted programs. Such services include short-term episodic outpatient treatment, longer term rehabilitative and recovery services, residential rehabilitation programs, and supportive housing services.

From AACP Guidelines for Recovery Services

Behavioral health problems and services have been viewed variably by those giving and receiving the services. Many have considered those delivering the services as autocratic and paternalistic. Professional helpers have viewed those with mental illness as disabled and they have been oriented to care for such people as individuals with perpetual needs. From this perspective, they have assumed positions of power in the relationships they have shared with consumers. In most service systems, programs are developed to meet the needs of a prototypical beneficiary/client. Program elements are often rigidly defined to attend to that prototype. Consumers have been expected to fit into these services, whether they match their needs precisely, or not. The assumption that one size can fit all has not been a successful approach to service planning.

Professionals have been trained to think in terms of chronic, unremitting or even deteriorating disabilities in their beneficiaries/clients with severe mental illness. Even in the addiction field, where many recovery concepts originated, the professional culture has generally maintained an authoritarian posture. Little hope has been offered for a return to a productive, respected place in the community, outside of highly prescriptive and restrictive parameters. Service users have reported feeling humiliated, demeaned, and devalued by their experiences within these systems. Some have developed profound hostility and mistrust towards the systems that were meant to help them. This has frequently left service users confused and alienated, cut off from hope and meaning in their lives.

Today many consumers of behavioral health services have adopted recovery perspectives. These concepts have been used in some quarters for many years, but interest in them has become widespread relatively recently. Although recovery has been variably defined, most conceptualizations recognize that recovery is a highly personal process and one that continues throughout a person's life. Most definitions include several elements from the list below:

- hope and faith
- self-management and autonomy
- restoration and personal growth
- tolerance and forgiveness
- adaptability and capacity to change
- personal responsibility and productivity
- peer support and community life
- dignity and self-respect
- acceptance and self-awareness
- universal applicability

The emergence of recovery models have occurred, in part, through the organizations and advocacy developed in the consumer movement. Part of this new perspective on the course of behavioral health disorders has been a re-examination of the relationship between the user of services, the service system, and the professionals working in that system. This has stimulated service systems and professionals to examine themselves and to consider how they can best meet the emerging needs of persons who require services. The transformation of systems from a paternalistic illness oriented perspective to collaborative autonomy enhancing approaches represents a major cultural shift in service delivery.

SECTION VIII – Selected Regulations for CMH Psychiatrists' Reference

General Information

Providing direct medical services and being able to provide comprehensive medical direction in a community mental health clinic requires psychiatrists to know or be aware of laws and regulations, which affect the practice of psychiatry. These are numerous and include, but are not limited to: Medical Necessity, Medical supervision, Involuntary Treatment, Confidentiality, Informed Consent, Staffing, Billing, Duty to Warn, Child Abuse, Elder Abuse, Spousal Abuse, and Sexual contact with previous therapist.

The California legislature creates statutes or laws. California regulations (called 'Titles') are rules passed by one of the state Agencies with that area of responsibility. Typically, they parallel a statute.

Below is a list of sources for obtaining detailed information regarding these Statutes and Regulations

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California ***Statute*** Law consists of **29 codes**, covering various subject areas. Web site is:

http://www.Leginfo.ca.gov/calaw.html

A few of the 29 Codes that have regulations pertinent to mental health are:

- **Business and Professions Code**
- **Civil Code**
- **Government Code**
- **Health and Safety Code**
- **Penal Code**
- **Welfare and Institution's Code**

Many California ***Regulations*** are found in the **27 Titles**. The web site to access these is:

http://www.oal.ca.gov/

The titles that have regulations pertinent to mental health are

Title 2. Administration

Title 5. Education

Title 9. Rehabilitative and Developmental Services **(Following pages describe in more detail)**

Title 16. Professional and Vocational Regulations

Title 22. Social Security (NOT "THE SS" - rather includes licensing of healthcare facilities)

The ***Code of Federal Regulations*** (CFR) is a codification of the general and permanent rules published in the *Federal Register* by the Executive departments and agencies of the Federal Government. Web site is:

http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR

The CFR is divided into ***50 titles,*** which represent broad areas subject to Federal regulation. Each title is divided into chapters, which usually bear the name of the issuing agency.

Each chapter is further subdivided into parts covering specific regulatory areas. Large parts may be subdivided into subparts. All parts are organized in sections, and most citations to the CFR will be provided at the section level.

In contrast, the *Federal Register* (FR) is the publication in which regulations are published as they are developed and refined and finalized, while. The *CFR* is the publication in which final regulations are compiled and arranged by subject.

The *FR* is published every business day and the *CFR* is completely re-published every four years, with all the changes in the intervening years included in the new version. However, electronic access now allows changes to both the *FR* and *CFR* are added as quickly as possible.

California Title IX Rehab & Developmental Services – Clinic Requirement & Medical Necessity

Division 1 Department of Mental Health

Chapter 3 Community MH Services Under the Short-Doyle Act

Article 11. Requirements for Outpatient Services

680. Basic Requirements

Outpatient services in Local Mental Health Services shall include:

(a) Minimum Professional Staff. Outpatient services shall be under the direction of a person who qualifies under Section 623, Section 624, Section 625, Section 626, Section 627, Section 628, Section 629, Section 630. In addition to the director, the minimum professional staff shall include a psychiatrist, psychologist, and social worker, except that under special circumstances the Department may authorize the operation of an outpatient service with less personnel. In addition, the staff may include qualified registered nurses and other professional disciplines.

A psychiatrist must assume medical responsibility as defined in Section 622, and be present at least half-time during which the services are provided except that under special circumstance the Department may modify this requirement.

In developmental disabilities and substance abuse programs a physician other than a psychiatrist may be substituted when this would be more appropriate to the treatment needs of the beneficiary/client upon approval of the Department.

(b) Availability of Service. Outpatient services shall be reasonably available and accessible.

(c) Care and Staffing. A program of outpatient services should provide for continuity of care and flexibility of staffing to meet the needs of the individual beneficiaries/clients.

(d) **Integration of Staff Services.** The services of the various professional disciplines shall be integrated through regular staff meetings and other conferences for joint planning and evaluation of treatment.

1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty MH Services

(a) The following mental necessity criteria determine Medi-Cal **reimbursement** for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specially provided.

b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders
(B) Disruptive Behavior and Attention Deficit Disorders
(C) Feeding and Eating Disorders of Infancy or Early Childhood
(D) Elimination Disorders
(E) Other Disorders of Infancy, Childhood, or Adolescence
(F) Schizophrenia and Other Psychotic Disorders
(G) Mood Disorders
(H) Anxiety Disorders
(I) Somatoform Disorders
(J) Factitious Disorders
(K) Dissociative Disorders
(L) Paraphilia Disorders
(M) Gender Identity Disorders
(N) Eating Disorders
(O) Impulse Control Disorder
(P) Adjustment Disorders
(Q) Personality Disorders, except Antisocial Personality Disorder
(R) Medication-Induced Movement Disorders related to other included diagnoses

(2) Must have **at least one** of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

(A) A **significant impairment in an important area of life functioning**

(B) A probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet **each of the intervention criteria** listed below:

(A) The focus of the proposed intervention is to address the condition identified in (2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or

2. **Prevent significant deterioration in an important area of life functioning**, or

3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

1810._ _ _. Types of Services in Short-Doyle Specialty MH Services

1) §1810.249. Targeted Case Management

- Assist to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services ***(including placement)***
- May include communication, coordination, and referral; monitoring service delivery to ensure access to service and the service delivery system; monitoring of progress; and plan development

2) §1810.227. Mental Health Services

- Individual/group therapies or interventions to provide reduction of mental disability and *improvement or maintenance* of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency
- May include assessment, plan development, therapy, rehabilitation and collateral
- **Assessment** - limited to an intake exam, MH evaluation, physical examination, and lab testing necessary for the eval and treatment of the pt's MH needs

3) §1810.225. Medication Support Services

- Prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. May include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary

4) §1810.209. Crisis Intervention

- Assessment, collateral, therapy, & other services (lasting < 24 hrs) to or on behalf of a beneficiary which requires more timely response than a regularly scheduled visit

1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpt Hospital Services

(a)For Medi-Cal reimbursement for an admission to a psychiatric inpatient hospital, the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:
Personality Disorders

(1) Essentially a diagnosis listed in 1830.205, and
(2) A beneficiary must have both (A) and (B):
(A) Cannot be safely treated at a lower level of care; and
(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to indications in either 1 or 2 below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):
   a. Represent a current danger to self or others, or significant property destruction.
   b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
   c. Present a severe risk to the beneficiary's physical health.
   d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

   a. Further psychiatric evaluation.
   b. Medication treatment.
   c. Other treatment that can reasonably be provided only if the beneficiary/client is hospitalized.

(b) Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:

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

(c) An acute beneficiary/client shall be considered stable when no deterioration of the beneficiary/client's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the beneficiary/client from the hospital.

Business & Profession Code (Division 2. Healing Arts) - Prescribing

Section 2241 – prescribing without a good faith medical exam.

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in ***Section 4022*** without a good faith prior examination and medical indication therefor, constitutes unprofessional conduct.

> 4022. "Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use, except veterinary drugs that are labeled as such, and includes the following: (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import. (b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a ____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device. (c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist **serving in the absence of the beneficiary/client's physician** and surgeon or podiatrist, as the case may be, provided such drugs were prescribed, dispensed, or furnished only as necessary **to maintain the beneficiary/client until the return of his or her practitioner, but in any case, no longer than 72 hours**.

(2) The licensee transmitted the order for such drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility

(A) if such practitioner had consulted with such registered nurse or licensed vocational nurse who had reviewed the beneficiary/client's records and

(B) if such practitioner was designated as the practitioner to serve in the absence of the beneficiary/client's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner **serving in the absence of the beneficiary/client's physician** and surgeon or podiatrist, as the case may be, and was in **possession of or had utilized the beneficiary/client's records** and ordered the renewal of a medically indicated prescription for an **amount not exceeding the original prescription in strength or amount or for more than one refilling**.

Section 4040 Prescription written by physician must have:

1) Beneficiary/client's name or names and address *(but doesn't require birth date)*
2) Medication's name and quantity and the directions for use
3) The date of issue
4) Physician's name *(and, if applicable, the nurse practitioner who functions pursuant to a standardized procedure)* address, and telephone number, *(doesn't specify if individual clinic address should be added or if the 515 Sycamore address is enough)*

5) Physician's license classification (i.e., "M.D." is sufficient, and it does not require license number)
6) Physician's *(and, if applicable, the nurse practitioner's)* DEA number, if a controlled substance is prescribed. (But HCA may be using DEA number to determine if MD is allowed to prescribe using HCA formulary

However, Section 4040(b) goes on to say that if the pharmacy has the license classification, DEA number, and phone number on file, it is not required to be on the Rx.

Section 4076 Prescription bottle must have:

(a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:
  (1) Except where the prescriber orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used.
  (2) The directions for the use of the drug.
  (3) The name of the beneficiary/client or beneficiaries/clients.
  (4) The name of the prescriber.
  (5) The date of issue.
  (6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.
  (7) The strength of the drug or drugs dispensed.
  (8) The quantity of the drug or drugs dispensed.
  (9) The expiration date of the effectiveness of the drug dispensed.
  (10) The condition for which the drug was prescribed if requested by the beneficiary/client and the condition is indicated on the prescription.
  (11) Description of medication **(new Jan 2006)**

Section 4077 Medication may be given to beneficiary/client by MD if...:

(a) Except as provided in subdivisions (b) and (c), no person shall dispense any dangerous drug upon prescription except in a container correctly labeled with the information required by Section 4076.
(b) Physicians, dentists, podiatrists, and veterinarians may personally ***furnish*** any dangerous drug prescribed by them to the beneficiary/client for whom prescribed, provided that the drug is properly labeled to show all information required in Section 4076 except the prescription number.

Section 4172 Storage of medication by MDs

A prescriber who dispenses drugs pursuant to Section 4170 shall store all drugs to be dispensed in an area that is secure. The Medical Board of California shall, by regulation, define the term "secure" for purposes of this section. (see Title XVI for definition *below - dls*)

Title XVI Professional & Vocational Regulations Section 1356.3 Storage of Drugs in MD's Office

Secure Area--Storage of Drugs in Physician's Offices

Division 13 Medical Board of California Chapter 1 Division of Licensing

Section 1356.3. Secure Area--Storage of Drugs in Physician's Offices

For purposes of section 4172 of the code, the phrase "area which is secure" means a locked storage area within a physician's office. The area shall be secure at all times. The keys to the locked storage area shall be available only to staff authorized by the physician to have access thereto.

Health & Safety Code Div. 10 Uniform Controlled Substance Act
Chap 4 Prescriptions

Article 1. Requirements of Prescriptions Sections 11150- 11180

Section 11164 Except as provided in Section 11167, no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

(a) Each prescription for a controlled substance classified in Schedule II, III, IV, or V, except as authorized by subdivision (b), shall be made on a controlled substance prescription form as specified in Section 11162.1 and shall meet the following requirements:
   (1) The prescription shall be signed and dated by the prescriber in ink and shall contain the prescriber's address and telephone number; the name of the person for whom the controlled substance is prescribed; and the name, quantity, strength, and directions for use of the controlled substance prescribed.
   (2) The prescription shall also contain the address of the person for whom the controlled substance is prescribed. If the prescriber does not specify this address on the prescription, the pharmacist filling the prescription or an employee acting under the direction of the pharmacist shall write or type the address on the prescription or maintain this information in a readily retrievable form in the pharmacy.

(b) (1) Any controlled substance classified in Schedule III, IV, or V may be dispensed upon an oral or electronically transmitted prescription, which shall be produced in hard copy form and signed and dated by the pharmacist filling the prescription or by any other person expressly authorized by provisions of the Business and Professions Code.
   (2) The date of issue of the prescription and all the information required for a written prescription by subdivision (a) shall be included in the written record of the prescription; the pharmacist need not include the address, telephone number, license classification, or federal registry number of the prescriber or the address of the beneficiary/client on the hard copy, if that information is readily retrievable in the pharmacy.
   (3) Pursuant to an authorization of the prescriber, any agent of the prescriber on behalf of the prescriber may orally or electronically transmit a prescription for a controlled substance classified in Schedule III, IV, or V, if in these cases the written record of the prescription required by this subdivision specifies the name of the agent of the prescriber transmitting the prescription.

(c) The use of commonly used abbreviations shall not invalidate an otherwise valid prescription.

(d) Notwithstanding any provision of subdivisions (a) and (b), prescriptions for a controlled substance classified in Schedule V may be for more than one person in the same family with the same medical need.

(e) This section shall become operative on January 1, 2005.

Section 11168

(a) The prescription book containing the prescriber's copies of prescriptions issued shall be retained by the prescriber, which shall be preserved for three years.

(b) This section shall remain in effect only until January 1, 2008, and as of that date is repealed.

Article 2 Prescriber's Record Sections 11190-11192

Section 11191. The record shall be preserved for three years.
Every person who violates any provision of this section is guilty of a misdemeanor.

Article 4. Refilling Prescriptions Sections 11200-11201

Section 11200

(a) No person shall dispense or refill a controlled substance prescription more than six months after the date thereof.

(b) No prescription for a Schedule III or IV substance may be refilled more than five times and in an amount, for all refills of that prescription taken together, exceeding a 120-day supply.

(c) No prescription for a Schedule II substance may be refilled.

Mandated Reporting for Mental Health Professionals

1) Elder Abuse Reporting

California Welfare & Institutions Code 15630 (b)(1) states that "any mandated reporter who, in his or her professional capacity",,, "has observed or has knowledge of an incident that reasonably appears to be physical abuse,,, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission,,, **SHALL REPORT** the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days,,," When working in a clinic setting, typically, the report shall be made to the adult protective services agency or the local law enforcement agency.

California Welfare & Institutions Code 15630 (b)(3) also states that "a mandated reporter,,, **SHALL NOT BE REQUIRED** to report,,," if the mandated reporter the mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred, and the elder who reports the abuse has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia, AND in the exercise of clinical judgment, the reporter reasonably believes that the abuse did not occur.

California Welfare & Institutions Code 15630 (d) allows that when two or more mandated reporters are present and jointly have knowledge or reasonably suspect that types of abuse of an elder or a dependent adult for which a report is or is not mandated have occurred, and when there is agreement among them, the **telephone report may be made by a member of the team selected by mutual agreement, and a single report may be made and signed by the selected member of the reporting team.** Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

2) Child Abuse Reporting

California Penal Code 11166 (a) states ,, any ,,, health practitioner,,, who has knowledge of or observes a child, in his or her professional capacity,,, whom he or she knows or reasonably suspects has been the **victim of** child abuse, **shall report** the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof within 36 hours of receiving the information concerning the incident. ,,,"**Reasonable suspicion**" means,,, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse.

California Penal Code 11166 (b) also states ,, any ,,, health practitioner,,, who has knowledge of or who reasonably suspects that **mental suffering** has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, **may report** the known or suspected instance of child abuse to a child protective agency.

California Penal Code 11166 (g) allows that when two or more persons, who are required to report, jointly have knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the **telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team**. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

3) Tarasoff Warning

The "duty to warn" law in California is several fold. "Tarasoff" is a legal precedent based on a 1976 California Supreme Court case that found that therapists have a duty to protect their beneficiaries/clients' potential victims. Subsequent to this court case, in 1986, the California Assembly passed Bill 1133 which created *Ca Civil Code Section 43.92.*

California Civil Code Section 43.92 (a) states "there shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to warn of and protect from a beneficiary/client's threatened violent behavior or failing to predict and warn of and protect from a beneficiary/client' s violent behavior except where the beneficiary/client has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims."

Paragraph (a) says a duty exists if a beneficiary/client ***(or family member*)*** has communicated to the psychotherapist:

1) a serious threat of physical violence
2) against a reasonably identifiable victim or victims

California Civil Code Section 43.92 (b) also states, "If there is a duty to warn and protect under the limited circumstances specified above, the duty shall be discharged by the psychotherapist making **reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency."**

Paragraph (b) says the duty to warn and protect is discharged by making reasonable efforts to communicate the threat to:

1) the victim or victims, ***AND***
2) to a law enforcement agency

After California Appellate Court case (Ewing v. Goldstein) in 2004, the **duty to warn has been expanded**. The Appellate Court concluded that the trial court too narrowly construed section 43.92, and a communication from a **family member** to a therapist, made for the purpose of advancing a beneficiary/client's therapy, is a "beneficiary/client communication" within the meaning of section 43.92.

4) Reporting to Disorders Characterized by Lapses of Consciousness to the DMV

Physicians may play two roles in reports to the California Department of Motor Vehicles. One role is that of mandated reporting and the other is assisting with probation monitoring.

California Health & Safety Code Section 103900(a) states that every physician **shall report** to Orange County's Health Agency (OCHCA) Communicable Disease Control (P.O. Box 6128, Santa Ana, CA 92706-0128 or Pony Address Bldg. 79) in writing, every beneficiary/client whom the physician has diagnosed as **having disorder characterized by lapses of consciousness (LOC).**

Reporting this in writing can use any format as long as it includes the beneficiary/client's name, age, and address. The OC Health Care agency has a Confidential Morbidity Report form that may be used. Alternatively, the DMV form 699 can be used to the send information to OCHCA Communicable Disease Control.

California Code of Regulations Title 17 Section 2806 states that disorders characterized by LOC involve:

1) A loss of consciousness or a marked reduction of alertness or responsiveness to external stimuli; AND
2) Inability to perform one or more activities of daily living; AND
3) The impairment of the sensory motor functions used to operate a motor vehicle

California Code of Regulations Title 17 Section 2808 states that sensory motor functions (SMF) means ability to integrate seeing, hearing, smelling, feeling, and reacting with physical movement, such as depressing the brake pedal of the car to stop the car from entering an intersection to avoid hitting a pedestrian.

California Code of Regulations Title 17 Section 2812 also states that a physician **shall not be required** to report if:

a) The beneficiary/client's SMF are impaired and beneficiary/client is unable to ever operate vehicle, or

b) The beneficiary/client states does not drive, and never intends to drive, or

c) The beneficiary/client's record shows a physician reported this, and the physician believes the beneficiary/client hasn't operated a vehicle

California Department of Motor Vehicles Form 699 is for:

1. For a family member to use to report to DMV
2. Psychiatrist would send to OCHCA Communicable Disease Control (if they use this form)
3. Clinicians, Care coordinators, nurses, Nurse practitioners and any non-psychiatrist clinical staff may not use form 699 as this may constitute a breach of confidentiality. However,

a) If the behavior poses imminent risk self/others, please call 911

b) Notify assigned PCP or refer to a PCP for evaluation if none assigned.

California Department of Motor Vehicles Form 326 is for Medical Probation Type II monitoring:

1) Placing a person on medical probation allows drivers with controlled epilepsy and other disorders characterized by a LOC to continue driving
2) Medical probation is only to be used when control of a LOC disorder has been achieved for at least three months
3) Medical probation Type II is for drivers who have achieved three to five months of control
4) The driver is required to authorize his/her treating physician to complete the Driver Medical Evaluation (form DS 326) and submit it to the department on a prescribed basis
5) Page 1 is beneficiary/client's, and page 2 & 3 are MD's

5) Domestic Violence Reporting

California Penal Code 11160 (Control of crimes and criminals) states that that "**Reports of Injuries**" (e.g., includes Domestic Violence) are required by telephone immediately or as soon as practically possible to the local law enforcement agency, followed by a written report within two working days if:

1) **Any health practitioner** who
2) Provides **medical services for a physical condition**[1] to a beneficiary/client
3) Whom the practitioner knows or **reasonably suspects**[2] was EITHER
    a. Shot by self or another, OR
    b. Suffering from any wound or other physical injury inflicted upon the person where the injury is **the result of assaultive or abusive conduct**[3]
        1) The county compliances understanding of that a county MH employee is not a mandated reporter because the employee 1) will not have seen ***physical evidence of injury*** caused by domestic violence, or 2) if there is 'physical evidence', it will not have been seen while providing medical services for the physical injury, and 3) will not have provided medical services to treat that physical condition.
        2) "**Reasonably suspects**" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect.
        3) "**Assaultive or abusive conduct**" shall include any of the following offenses: 1) Murder, 2) Manslaughter, 3) Mayhem, 4) Aggravated mayhem, 5) Torture, 6) Assault with intent to commit mayhem, rape, sodomy, or oral copulation, 7) Administering controlled substances or anesthetic to aid in commission of a

felony, 8) Battery, 9) Sexual battery, 10) Incest, 11) Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure, 12) Assault with a stun gun or taser, 13) Assault with a deadly weapon, firearm, assault weapon, or machinegun, or by means likely to produce great bodily injury, 14) Rape, 15) Spousal rape, 16) Procuring any female to have sex with another man, 17) Child abuse or endangerment, 18) Abuse of spouse or cohabitant, 19) Sodomy, 20) Lewd and lascivious acts with a child, 21) Oral copulation, 22) Sexual penetration, 23) Elder abuse, 24) An attempt to commit any crime specified in paragraphs (1) to (23), inclusive.

California Penal Code 11160 (e) allows that when two or more persons, who are required to report are present and jointly have knowledge of a known or suspected instance of **violence** that is required to be reported pursuant to this section, and when there is an agreement among these persons to report as a team, the team may select by mutual agreement a member of the team to make a report by telephone and a single written report, as required by subdivision (b). The written report shall be signed by the report has failed to do so shall thereafter make the report that the member designated to report has failed to do so shall thereafter make the report.

Welfare and Institutions Code – Bronzan-McCorquodale Act

DIVISION 5. Community Mental Health Services
PART 1. THE LANTERMAN-PETRIS-SHORT ACT
PART 1.5. CHILDREN'S CIVIL COMMITMENT AND MH TREATMENT ACT OF 1988
PART 2. THE BRONZAN-MCCORQUODALE ACT
Ch 1 Gen Provisions. Sections 5600 – 5623.5 (see also sections 5650 – 5772 in Chap's 2.5 – 4)

5600.1. The mission of CA's MH system shall be to:

- ✓ enable persons experiencing ***severe and disabling MI's and children with serious emotional disturbances*** to access services and programs that assist them to
  - better **control their illness**
  - **achieve their personal goals**
  - **develop skills** and supports leading to living the most constructive and satisfying lives

5600.2. ***To the extent resources are available***, CA public MH services include:

(a) Client-Centered Approach - individual goals, diverse needs, concerns, strengths, motivations
(b) Priority Target Populations - severe, disabling conditions have high priority
(c) Systems of Care - coordinated, integrated, and effective services organized in systems of care
(d) Outreach - accessible 24/7 in times of crisis & assertive outreach should be available
(e) Multiple Disabilities / Dual Dx
(f) Quality of Service - effective services based on measurable outcomes
(g) Cultural Competence
(h) Community Support - concept of community support
(i) Self-Help - promote the development and use of self-help groups by individuals with serious MI
(j) Outcome Measures - developed based on client-centered goals and outcomes
(k) Administration - efficient, timely, and cost-effective manner
(l) Research - cooperate with research centers on basic research into the nature and causes of MI's
(m) Education on MI - Consumer and family advocates for MH should be encouraged and assisted in informing the public about the nature of MI from their viewpoint and about the needs of consumers and families. MH professional organizations should be encouraged to disseminate the most recent research findings in the treatment and prevention of MI.

5600.3. To the extent resources are available CA public MH services include:

(b)(1), (2), & (3) Adults and older adults who have a serious mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to

maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time meeting **all of the following criteria**:

(A) MI, other than a substance use disorder or developmental disorder or acquired traumatic brain injury, unless that person also has a serious mental disorder

(B) Substantially impaired in independent living, social relationships, vocational skills, or physical condition, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms, or is likely to become so disabled as to require public assistance, services, or entitlements

(c) Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.

(d) Persons who need brief treatment as a result of a natural disaster or severe local emergency.

5600.4. CMH services to provide an array of treatment options, to the extent resources are available:

(a) Precrisis and Crisis Services - Immediate response to individuals in precrisis and crisis and to members of the individual's support system, on a 24-hour, seven-day-a-week basis

(b) Comprehensive Evaluation and Assessment - Includes, but is not limited to, evaluation and assessment of **physical and MH**, income support, housing, vocational training and employment, and social support services needs

(c) Individual Service Plan - Identification of the short- and long-term service needs of the individual, advocating for, and coordinating the provision of these services

(d) Medication Education and Management - Includes, but is not limited to, evaluation of the need for administration of, and education about, the risks and benefits associated with medication

(e) Case Management – Beneficiary/Client-specific services that assist beneficiaries/clients in gaining access to needed medical, social, educational, and other services

(f) Twenty-four Hour Treatment Services - crisis, transitional and long-term programs

(g) Rehabilitation and Support Services - Treatment and rehabilitation services designed to stabilize symptoms, and to develop, improve, and maintain the skills and supports necessary to live in the community. These services may be provided through various modes of services, including, but not limited to, individual and group counseling, day treatment programs, collateral contacts with friends and family, and peer counseling programs.

(h) Vocational Rehabilitation - Services which provide a range of vocational services to assist individuals to prepare for, obtain, and maintain employment

(i) Residential Services - Room and board and 24-hour care and supervision

(j) Services for Homeless Persons - Services designed to assist MI persons who are homeless, or at risk of being homeless, to secure housing and financial resources

(k) Group Services - two or more beneficiaries/clients at the same time

5604.

(a) (1) Each county shall have a MH board comprised of 50% consumers or families of consumers

(e) (1) No member shall be a county employee

(h) The MH board may be established as an advisory board or a commission

5604.2.

(a) The county MH board shall do all of the following:

(1) Review and evaluate the community's MH needs, services, facilities, and special problems
(2) Review any county agreements entered into
(3) Advise the governing body and MH director as to any aspect of the local MH program
(4) Review and approve the procedures ensure citizen and professional involvement in planning
(5) Submit an annual report to the governing body on MH system needs and performance
(6) Make recommendations on applicants for the appointment of a local director of MH services
(7) Review performance outcome data and communicate its findings to CA MH Planning Council
(8) This part does not limit the ability of the governing body to transfer additional duties or authority to a mental health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to beneficiaries/clients and on the local community.

5611.

(a) CA Director of MH shall establish a **Performance Outcome Committee**, to be comprised of representatives from the **PL 99-660 Planning Council** and the **CA Conf of Local MH Directors (now "CMHDA")**

(b) **Major MH professional organizations representing licensed clinicians** may participate as members of the committee at their own expense

5612.

(b) The **Performance Outcome Committee shall develop measures** in the following areas:

(1) Numbers of persons in identified target populations served.
(2) Estimated number of persons in identified target populations in need of services.
(3) Treatment plans development for members of the target population served.
(4) Treatment plan goals met.
(5) Stabilization of living arrangements.
(6) Reduction of law enforcement involvement and jail bookings.
(7) Increase in employment or education activities.
(8) Percentage of resources used to serve children and older adults.
(9) Number of beneficiaries/clients' rights advocates and their duties.
(10) Quality assurance activities for services, including peer review and medication management
(11) Identification of special projects, incentives, and prevention programs.

5614. (a)

Ca DHCS, in consultation with the Compliance Advisory Committee which shall have representatives from relevant stakeholders, including, but not limited to, local MH depts, local MH boards & commissions, private & community-based providers, consumers & family members of consumers, & advocates, shall **establish a protocol for ensuring that local MH departments meet statutory & regulatory requirements for the provision of publicly funded CMH services provided under this part**

5614.5.

(a) CA DHCS, in consultation with the Quality Improvement Committee, which shall include representatives of the California Behavioral Health Planning Council, local MH departments, consumers & families of consumers, & other stakeholders, shall establish & measure indicators of access & quality to provide the information needed to continuously improve the care provided in CA's public MH system.

(b) CA DHCS in consultation with the Quality Improvement Committee shall include specific indicators in all of the following areas:

(1) Structure

(2) **Access to care, appropriateness of care**, and the cost effectiveness of care

(3) Outcomes

5622.

(a) A licensed inpatient MH facility, shall, prior to the discharge of any beneficiary/client, prepare a written aftercare plan, which, to the extent known, shall specify:

(1) The nature of the illness and follow-up required
(2) Medications, including side effects and dosage schedules
(3) Expected course of recovery
(4) Recommendations regarding treatment that are relevant to the beneficiary/client's care
(5) Referrals to providers of medical and MH services
(6) Other relevant information

5623.5.

Commencing October 1, 1991, and to the extent resources are available, no county shall deny any person receiving services administered by the county MH program access to any medication which has been prescribed by the treating physician and approved by the federal Food and Drug Administration and the Medi-Cal program for use in the treatment of psychiatric illness.