UTILIZATION OF THE MEDI-CAL EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) BENEFIT

A Report to the Legislature in Response to the Supplemental Report of the 2001 Budget Act for Item 4440-101-0001 for the Department of Mental Health

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UTILIZATION OF THE MEDI-CAL EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) BENEFIT

EXECUTIVE SUMMARY

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit is a mandated component of the California Medi-Cal Program. Physical and mental health services are provided under EPSDT for full-scope Medi-Cal beneficiaries less than 21 years of age.

Since implementation of the EPSDT benefit in FY 94/95, growth in number of clients, amount of services provided and expenditures for the mental health portion of the benefit has been rapid. This reflects the broader definition of medical necessity under EPSDT to "correct or ameliorate illnesses and conditions," new state mandates for services such as Therapeutic Behavioral Services (TBS) and mandatory foster care assessments, and the relatively limited availability of funding for such children's services in the past.

In 2001, considering the cost of the EPSDT benefit and its continuing robust growth, members of the Legislature asked DMH to perform field audits of EPSDT-funded services provided by county mental health plans. Policymakers wished to be assured that sufficient EPSDT services were being provided to children and youth when medically necessary and in a cost-effective manner.

Currently, DMH has three major components of its effort to assure adequate, appropriate and cost-effective services under the EPSDT benefit:

- DMH EPSDT Fiscal Year (FY) 2000/01 Field Audits
- DMH Continuing EPSDT Oversight Activities
- New Targeted DMH Strategy to Monitor EPSDT Utilization - FY 2001/02 and Future Years

Field Audits - The Department of Mental Health (DMH) Program Compliance staff performed field audits of the EPSDT benefit during the first six months of Fiscal Year (FY) 2001/02. Charts of 150 EPSDT clients were selected at random in eleven county mental health plans. Auditors found presence of appropriate documentation of medical necessity in all of the charts examined. In the auditors' opinion, in 143 of the 150 charts, services provided to the client by the mental health plan were sufficient to meet the clients' needs. Auditors also identified a need for training of local staff in the area of chart notes and documentation.

Continuing Oversight Activities - For each of the last three fiscal years, DMH has evaluated statewide EPSDT expenditure data to identify county mental health plans that seemed to be particularly high or low utilizers of the EPSDT benefit. DMH staff contacted these counties for further explanations of their EPSDT utilization.

New Targeted Strategy – Beginning in FY 2001/02,DMH initiated more complex analyses of selected counties in order to obtain a clearer picture of utilization of the EPSDT benefit on the local level. This analysis investigates a variety of factors that affect EPSDT utilization and costs, such as county demographic information, severity and intensity data, availability of resources and outcome data. Counties selected for this in-depth analysis are counties whose FY 2000/01 paid claims total per unduplicated client was 20% or higher than FY 1999/00 and whose total of unduplicated clients had grown 4% or less during that same period

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At least preliminarily, it appears that during the initial years of EPSDT implementation, county mental health plans focused on increasing access to services for those EPSDT eligible children and youth who needed them, thus the number of clients served increased. As the program has matured, counties are finding that they need to increase the intensity of services to many of their young clients with the most severe emotional disturbances in order to achieve positive outcomes and to keep youth in their own homes, functioning in school and out of the juvenile justice system. This has resulted in higher paid claims per client in a number of counties that were unable to provide these levels of service prior to EPSDT.

UTILIZATION OF THE MEDI-CAL EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) BENEFIT

ISSUE STATEMENT

This report was prepared in response to the Supplemental Report of the 2001 Budget Act for Item 4440-101-0001 for the Department of Mental Health. It contained the following language:

> *"It is the intent of the Legislature that the Department of Mental Health (DMH) conduct field audits of the Mental Health Plans in regard to the services provided by those counties under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, or to incorporate an examination of issues related to the EPSDT benefit as part of any other audits conducted by DMH. The DMH shall include, but not be limited to, an examination of what it deems to be a representative sample of counties regarding (a) whether only medically necessary services are being provided to clients in a cost-effective manner and (b) whether sufficient services are being provided to those clients to meet the treatment goals and the requirements of EPSDT. The department shall report its findings in regard to the specialty mental health EPSDT benefit to the Joint Legislative Budget Committee and the budget committees of both houses of the Legislature by April 1, 2002."*

This report presents the findings of DMH field audits of the EPSDT benefit. In addition, it provides data and information about other analyses of EPSDT expenditures by DMH to determine if county mental health plans are appropriately utilizing these resources.

BACKGROUND

The EPSDT benefit has been a requirement of the Medicaid program since its inception in 1966. The federal Omnibus Budget Reconciliation Act of 1989 (OBRA '89) expanded the benefit, requiring state EPSDT programs to provide diagnostic and treatment services needed to "correct or ameliorate defects, physical and mental illnesses, and conditions discovered by screening services, whether or not such services were covered under the Medicaid State Plan." In 1995, in response to legal action, the California Department of Health Services (DHS) expanded the EPSDT benefit to full-scope Medi-Cal beneficiaries less than age 21.

In its implementation of the expanded EPSDT benefit, DHS recognized that county mental health departments had been the historic providers of mental health services to children and youth with serious emotional disturbances (SED). Accordingly, county mental health departments were determined to be the logical choice to provide the expanded EPSDT benefit to the SED population. When specialty mental health services were consolidated under a federal waiver in 1997-98, county mental health plans assumed the responsibility to provide these services to all Medi-Cal children and youth meeting the medical necessity criteria, in addition to the SED population already being served.

DHS developed an interagency agreement with DMH through which county mental health plans are reimbursed the entire non-federal share of cost for all EPSDT-eligible services in excess of the expenditures made by each county for such services during FY 1994/95. The funding agreement that implemented the EPSDT mental health benefit is subject to the annual state budgetary process.

Growth in number of clients, amount of services provided and expenditures for the mental health portion of the EPSDT benefit has been rapid. This reflects the broader definition of medical necessity to "correct or ameliorate," new state mandates for services such as TBS and mandatory foster care assessments, and the relatively limited availability of funding for such children's services in the past. Although actual growth rates vary in each fiscal year, the average annual growth rate for specialty mental health services provided by county mental health plans to this population from FY 1994/95 to FY 1999/00 was 29.7%. Actual statewide expenditures according to paid claims data available to date for FY 2000/01 were over $500 million for 2,687,475 average monthly eligibles.[12]

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[1] Average monthly eligible measurements count the unique number of persons eligible for Medi-Cal each month, adds these monthly totals and divides by twelve (12). A small proportion of these persons actually need and receive mental health services.

[2] Penetration rates provide information on the proportion of persons who receive one or more Medi-Cal mental health services out of the average monthly eligible population. It is obtained by dividing the number of unduplicated clients who actually received services by the average monthly eligible count

DMH has been carefully scrutinizing and refining its understanding of utilization of the EPSDT benefit by county mental health plans since it became available as a resource. Working closely with local mental health staff and other stakeholders, the Department has been implementing strategies to track local expenditures and penetration rates. These are compared to statewide and regional values. Any counties with outlying values have been followed up even more intensively.

In 2001, considering the cost of the EPSDT benefit and its continuing robust growth, members of the Legislature asked DMH to perform field audits of EPSDT-funded services provided by county mental health plans. Policymakers wished to be assured that sufficient EPSDT services were being provided to children and youth when medically necessary and in a cost-effective manner.

DMH determined the most cost-effective means of completing the EPSDT field audits was to incorporate them into the Medi-Cal program reviews performed by the DMH Program Compliance Division. The field audits were an excellent complement to the oversight strategies the DMH System of Care Division had already initiated.

Any discussion of EPSDT expenditures must include recognition of the complex situation faced by county mental health plans. The EPSDT benefit was designed to be a comprehensive set of services with a broad definition of medical necessity. Its purpose is to identify and correct illnesses and conditions early in the interests of curtailing more serious problems later in life. County mental health plans were instructed to implement this benefit along these very broad lines. At the same time, DMH monitors mental health plans for expenditures that appear to be higher or lower than the statewide average. The pressure to expand access and services while remaining cognizant of total spending, is perceived by some stakeholders as putting county mental health plans in a double bind.

The Department's continuing commitment is that children and youth meeting medical necessity criteria receive the mental health care they need to grow and develop consistent with federal and state requirements for EPSDT. At the same time, DMH wishes to work with counties to assure that the EPSDT resources expended to achieve this goal are used appropriately.

OBJECTIVE

The objective of this report is to provide the Legislature with current information about the following:

1. DMH EPSDT FY 2000/01 Field Audits
2. DMH Continuing EPSDT Oversight Activities
3. New Targeted DMH Strategy to Monitor EPSDT Utilization - FY 2001/02 and Future Years

STUDY METHODOLOGY

1. DMH EPSDT FY 2000/01 Field Audits

Process

DMH executive staff determined that integrating the EPSDT field audits with existing Medi-Cal reviews was the most cost-effective means to provide the information requested by the Legislature. The DMH Program Compliance Division has responsibility to ensure that county mental health plans comply with state and federal laws and regulations related to the Medi-Cal managed mental health care program. One of the ways in which the Division accomplishes this task is to perform on-site Medi-Cal program reviews. Each year the Program Compliance Division, with the assistance of various stakeholders on the Compliance Advisory Committee (CAC), develops a review protocol for the reviews in the following fiscal year. *(See Attachment A.)* All reviewers in the Medi-Cal Oversight North and South Units utilized the same protocol for reviews.

In the summer of 2001, Program Compliance staff, working with the CAC and other stakeholders, developed and added "Section J., Chart Review – Non-Hospital Services" to the existing Review Protocol for Consolidated Specialty Mental Health Services. *(See Attachment B.)* Section J. was designed to assess critical components of EPSDT services as documented in the beneficiary's chart. Specifically, using federal and state laws and regulations as a guide, Section J reviewed the following:

Question Number In Review Protocol	Component of Documentation
One and Two	Medical Necessity
Three	Assessment
Four	Client Plan
Five and Six	Progress Notes, Sufficiency of Services for Needs
Seven – Nine	Other Chart Documentation

A cross-section of large and small, urban and rural counties was selected in an attempt to capture information that would be representative of all county mental health plans. Because field audit results were due to the Legislature by April 1, 2002, counties were selected from those scheduled for the first six months of the FY 2001/02 review cycle. EPSDT chart reviews were performed in the following county mental health plans:

Alameda	Orange	San Luis Obispo
Kern	Placer	Shasta
Marin	Riverside	Tulare
Monterey	San Joaquin	

The number of charts to be reviewed was based on county size. This is the same process normally used for sample size for other chart reviews of non-hospital specialty mental health services. Charts examined varied from a minimum of 10 charts for smaller counties to 20 charts for the larger counties. Reviewers obtained a randomized sample of EPSDT beneficiary names and Medi-Cal numbers, along with a record of claims paid for that beneficiary, from the DMH Statistics and Data Analysis (SDA) Unit from claims paid during the review period, January 1 through March 31 of 2001. The chart reviewers themselves had no hand in the chart selection. *(See Attachment C.)*

Only DMH employees who are also licensed mental health professionals were utilized to perform the chart reviews. No licensed mental health professionals were available from among the Expert Pool of mental health clients and family members routinely utilized in review teams and therefore none were included as reviewers of the EPSDT charts. All reviewers abide by DMH Policy Directive Number 201, "Confidentiality of Patient Information*." (See Attachment D.)*

Standards

The Legislature directed DMH to review two aspects of EPSDT service provision:

(1) Whether only medically necessary services are being provided to clients in cost-effective manner.

(2) Whether sufficient services are being provided to those clients to meet the treatment goals and requirements of EPSDT.

In making these determinations, Program Compliance reviewers applied pertinent state and federal law and regulation in addition to their professional experience and expertise.

Medical Necessity

Section 1830.210, "Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age" delineates the standards that reviewers used in making their medical necessity determinations. *(See Attachment E.)* Further, reviewers considered Section 1905(r) of the Social Security Act which allows for "such other necessary health care, diagnostic services, treatment and other measures…to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." Reviewers examined a chart for documented evidence of medical necessity and then determined if the subsequent interventions are reasonable in light of the identified condition. Reviewers generally expected to find evidence of medical necessity among assessments, care plans and progress notes within the chart.

Cost-Effectiveness

Information available to field auditors included paid claims records for EPSDT beneficiaries for a specific county during a pre-determined three-month review period. Reviewers compared the paid claims for services for an individual beneficiary with the documentation in that beneficiary's chart. It should be noted that a selected beneficiary's paid claim records might not have reflected all billings submitted because they would not reflect any subsequent corrections or additions made to the initial billing.

Requirements for documentation standards are included as part of the managed care contract between DMH and the county mental health plans. *(See Attachment F.*) Reviewers are trained to focus special attention in chart reviews when there is an inconsistency between the record of paid claims and chart documentation such as the following:

1. A paid claim exists for a service but there is no corresponding chart note.

2. A paid claim exists for a time when the beneficiary was a resident of an Institution for Mental Disease (IMD) and therefore not eligible for the EPSDT benefit.

3. A paid claim exists for a service but the chart indicates a "no show" and no other documentation in the chart indicates additional service provision for that date.

4. A paid claim exists for a group service but the county mental health plan failed to divide the activity time correctly between those individuals receiving the service.

In addition to reviewing for these specific instances and for adherence to other requirements of the Documentation Standards, reviewers are trained to detect possible incidents of fraudulent billing practices. Specific procedures are in place to investigate such instances if and when they are identified.

Sufficiency of Services

Question Six of Section J. of the protocol asked the reviewer to indicate, based upon the overall findings, whether or not sufficient services were provided to meet the client plan goals and the requirements of EPSDT.

2. DMH Continuing EPSDT Oversight Activities

(NOTE: Oversight activities occur in the year after paid claims data are available for all of the previous fiscal year, e.g. FY 2000/01 activities analyze claims data from FY 1999/00.)

For each of the last three fiscal years, DMH has evaluated statewide EPSDT expenditure data to identify county mental health plans that seemed to be particularly high or low utilizers of the EPSDT benefit. A high utilizing county was a county mental health plan whose average claim per average monthly eligible was at least double the statewide average claim per average monthly eligible. A low utilizing county was a county in which the average claim per average monthly eligible was half or less of the statewide average claim per average monthly eligible. DMH also identified counties with decreases in penetration rate or decreased expenditures from the previous fiscal year. Oversight activities for FY 2000/01 and 2001/02 included counties with less than 50,000 in population.

Counties with outlying values were identified for further follow-up. DMH staff contacted these counties in writing and requested further information on county mental health plan utilization of the EPSDT benefit. If the additional information was still thought to be insufficient to justify EPSDT expenditures, counties were asked to submit a plan of action to make necessary corrections or to supply additional detail.

3. New Targeted DMH Strategy to Monitor EPSDT Utilization - FY 2001/02 and Future Years

One outcome of the oversight strategy DMH used during the last three fiscal years was the realization that EPSDT expenditures must be viewed through a variety of lenses over a period of several years. While average paid claims per average monthly eligible and penetration rate continue to be critical indices, there is such variability between county mental health plans in California that single variables can draw an inaccurate picture of EPSDT within any given county in any given year. Analysis of claims data and penetration rates among county mental health plans within a region can narrow the focus and reveal a clearer picture of counties with outlying values but still supplies a limited picture of individual county mental health plan performance.

EPSDT spending in any given county must be considered in context in order to be fully understood. DMH continues to refine its oversight strategies to obtain a clearer picture of utilization of the EPSDT benefit on the local level. These strategies recognize the fact that EPSDT is no longer a pilot project and, as a mature, on-going and relatively costly program, the Department's oversight must also become more sophisticated. Therefore, DMH will initiate more complex analysis of selected counties. These analyses, adjusted as necessary to reflect the individualized strategies appropriate to a given county, could include the following:

- Demographic data, including any significant changes in the Medi-Cal and indigent populations, foster care population and age and ethnic factors.

- Access data, including changes in numbers/patterns of young clients served by county mental health programs funded by Medi-Cal and other funding sources such as Realignment, Children's System of Care, Chapter 26.5 Special Education funds, Healthy Families, and CalWorks.

- Severity and intensity data, including diagnoses of youth served, type of service delivered (outpatient, day treatment, crisis, in-home services) and frequency and duration information.

- TBS utilization and average cost.

- Provider data, including changes in types of providers, such as Fee-For-Service providers, organizational providers, and residential providers.

- Outcome data, including changes in numbers of children in inpatient care, in foster care, in shelters and in juvenile facilities.

- Additional analysis of highest cost services and providers.

- Complaints/grievances filed.

- Availability of resources such as child psychiatrists and other mental health staff, low cost housing, and substance abuse treatment availability.

To select the counties that have the highest priority for further in-depth analysis, EPSDT unduplicated client counts and average paid claims per unduplicated clients for FY 2000/01 were used. Any county whose FY 2000/01 average paid claims per unduplicated client was 20% or higher than FY 1999/00 and whose total of unduplicated clients had grown 4% or less would be a candidate for additional analysis.

Other EPSDT Research Activity

The Center for Mental Health Services Research at the University of California, Berkeley is in preliminary phases of research entitled, "Public Mental Health Services for Youth: The Impact of EPSDT in California." This two-year study, funded by the California Healthcare Foundation, will examine county-level variation in the effects of a 1995 California EPSDT lawsuit on mental health access, utilization, expenditures and process of care. There will also be a one-year parallel study with the Caring for California Initiative (CCI) sponsored by DMH. This research will examine county-level variation in the effect of EPSDT expenditures on quality of care.

FINDINGS

1. DMH EPSDT FY 2000/01 Field Audits

The table, "EPSDT FIELD AUDIT FINDINGS"" on the next page summarizes the findings for the counties selected for review of EPSDT services. The table should be read in conjunction with Section J. of the Protocol in the Attachments Section since the numbered items in the left column of the table correspond to numbered items in Section J.

Notes to Summary Table

- The charts examined represent one percent or less of the total Medi-Cal population in any county reviewed and these results cannot be considered to be representative of the whole Medi-Cal population within any of the counties.

- The field auditors used a 90% compliance rate as a standard. Thus, if 90% of the charts met the criteria, the county received an "Ok" for that item. If less than 90% of the charts met the standard, the note in the table will be "No."

- Chart documentation has been and continues to be an area in which most counties require technical assistance. There were 227 instances in which field auditors could not locate notes to coincide with a paid claim. However, this represents a small percent of the paid claims for which substantiation was present. (The pool of services is very large for 150 clients receiving Medi-Cal services over a three-month period.)

- The asterisk (*) on items 4g. and 4h. designates the charts of clients who received Therapeutic Behavioral Services.

- The asterisk (*) On item 6. indicates the field auditor included a written note on the original survey summary form.

- The designation 'unk" means unknown.

EPSDT FIELD AUDIT FINDINGS

COUNTY	San Joaquin	San Luis Obispo	Alameda	Orange	Shasta	Monterey	Kern	Marin	Placer	Tulare	Riverside	TOTAL
# of charts reviewed	10	10	20	20	10	10	20	10	10	10	20	150
No note found	8	7	42	57	0	22	72	0	0	3	16	227
Beneficiary in IMD	0	0	0	0	0	0	0	0	0	0	2	2
No other document for "no show"	0	0	0	1	0	0	0	0	0	0	0	1
Group time divided incorrectly	0	0	0	0	0	0	0	0	0	0	5	5
1./2.Med.Nec.	Ok	Ok	Ok	Ok	Ok	Ok	Ok	Ok	Ok	Ok	Ok	0
3. Assessment	Ok	Ok	NO	Ok	Ok	Ok	Ok	NO	NO	Ok	Ok	3
4. PLAN												
4a. Goals	NO	Ok	Ok	NO	NO	NO	Ok	NO	NO	Ok	Ok	6
4b. Interventions	NO	Ok	NO	Ok	NO	Ok	Ok	NO	NO	Ok	Ok	5
4c. Duration	NO	Ok	NO	NO	NO	Ok	Ok	NO	NO	NO	Ok	7
4d. Legible	Ok	Ok	NO	Ok	NO	Ok	Ok	NO	NO	Ok	Ok	4
4e.Staff Sig.	Ok	Ok	NO	Ok	NO	Ok	Ok	Ok	Ok	Ok	Ok	2
4f.Client Sig.	NO	Ok	NO	Ok	NO	Ok	Ok	NO	NO	Ok	Ok	5
4g.TBS TB/S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	*N/A	N/A	*(1)
4h.TBS INT.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	*N/A	N/A	*(1)
5.PROGESS NOTES												
5a. Date	Ok	Ok	Ok	Ok	Ok	Ok	Ok	Ok	NO	Ok	Ok	1
5b.Encount.	NO	Ok	NO	Ok	Ok	Ok	Ok	NO	Ok	Ok	Ok	3
5c.Staff Sig.	Ok	Ok	NO	Ok	Ok	Ok	Ok	Ok	Ok	Ok	Ok	1
5d. Legible	NO	NO	Ok	Ok	NO	Ok	Ok	Ok	Ok	Ok	Ok	3
5e. Timely	NO	Ok	Ok	Ok	Ok	Ok	Ok	Ok	Ok	Ok	Ok	1
5f. TBS Int.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
OTHER												
7. Copy P.	unk	unk	unk	Ok	unk	Ok	Ok	unk	unk	unk	unk	
8. V/H Imp.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
9. CCP				2						2		
9a. Lang.	N/A	N/A	N/A	Ok	N/A	Ok	Ok	Ok	N/A	Ok	Ok	
9b.Response	N/A	N/A	N/A	Ok	N/A	Ok	Ok	Ok	N/A	Ok	Ok	
9c. Linking	N/A	N/A	N/A	Ok	N/A	Ok	Ok	Ok	N/A	Ok	Ok	
9d. Title 4	N/A	N/A	N/A	Ok	N/A	Ok	Ok	N/A	N/A	N/A	Ok	
6. Reviewer's opinion insufficient for needs	1	*3	1	1	0	0	0	0	0	0	1	7

2. DMH EPSDT Oversight Activities

Paid Claims Per Average Monthly Eligible

Paid claims per average monthly eligible has been a critical index in DMH EPSDT oversight activities in the last three years. Using the statewide average paid claim amount, DMH worked intensively with any county mental health plan whose paid claims per average monthly eligible were double or half the statewide rate. Starting in FY 2000/01, DMH included counties with less than 50,000 population in this examination. The table below shows how many counties have met this index in the last three years.

Number of County Mental Health Plans with At Least Double or Half the Statewide Rate of Paid Claims Per Average Monthly Eligible						
Fiscal Year	1998/99		1999/00		2000/01	
County Size**	Small	All Others	Small	All Others	Small	All Others
Double	NA	8	2	7	2	2
Half	NA	3	5	3	4	4

**Small County = A county with 50,000 or fewer in population

Generally the number of county mental health plans meeting the double/half criteria for EPSDT monitoring are decreasing.

Penetration Rates

DMH has also closely tracked penetration rates over the last three years. The table below shows the results of looking at county mental health plans for double or half the statewide penetration rate. In the last two fiscal years, DMH included counties with less than 50,000 in population.

Number of County Mental Health Plans with Double or Half the Statewide Penetration Rate						
Fiscal Year	1998/99		1999/00		2000/01	
County Size**	Small	All Others	Small	All Others	Small	All Others
Double	NA	6	4	1	4	1
Half	NA	3	2	0	3	0

**Small County = A county with 50,000 or fewer in population

Generally there has been less change in the counties appearing in these categories over time. DMH monitors closely counties that have experienced two consecutive years of decreases in penetration rates.

County Responses to DMH Follow-up

As DMH staff has worked with counties on EPSDT utilization issues, the reasons for high and low utilization are coming into clearer focus. Speaking generally, counties with higher paid claims per average monthly eligible or higher penetration rates cite the following reasons for their statistics:

- High cost of living in the local area
- Expansion of System of Care and TBS
- Large foster care populations requiring day treatment services
- Historically high levels of unmet needs for children and youth
- Service delivery via school sites
- Contention that comparison with a statewide rate is inappropriate and regional rates comparisons would be more equitable
- Low levels of inpatient placement

Counties with lower paid claims per average monthly eligible or low penetration rates most frequently attribute the rates to:

- Difficulties with staff turnover and recruitment
- Relatively few providers in more rural counties
- Incorrect claims processing
- Welfare reform
- Need for technical assistance

3. New Targeted DMH Strategy to Monitor EPSDT Utilization – FY 2001/02 and Future Years

The last three years have demonstrated decreasing variability in the range of high and low utilizing county mental health plans as determined by paid claims per average monthly eligible and penetration rates. Consistent with its strategy to obtain a clearer picture at the local level of factors that impact EPSDT utilization, DMH introduced another element to its data analysis. Responding to an apparent trend, DMH staff has begun to analyze county mental health plan performance on the basis of paid claims per unduplicated client. It appears that statewide, the number of new clients is increasing at a decreasing rate and clients are receiving more services.

DMH staff selected for individual follow-up those counties whose average paid clams per unduplicated client had grown by at least twenty percent in the last year while their increase in total unduplicated clients was 4% or less for the same time period. Upon follow-up, these counties attributed these changes in paid claims to the following:

- Provision of TBS
- Expanded utilization for day treatment for high-risk children and youth, especially in foster care group homes
- Full Implementation of Children's System of Care
- Improved case management
- Decreases in Medi-Cal eligible children and significant increases in services to non-Medi-Cal eligible children and youth
- Special initiatives and programs to keep children and youth out of the juvenile justice system
- More intensive services, including in-home services, designed to keep clients out of placement in more restrictive settings
- Planned wraparound services to multi-problem youth with multi-system involvement
- Commitment to fully serve clients already in the system

There was a surprising degree of consistency in the county mental health plan responses. Although DMH will continue with further analyses, county responses suggest the following hypotheses:

I. In earlier years, counties were focused on outreach and case finding. Attention has shifted to fully serving the clients who have been recruited into the system.

II. Counties have seen significant expansion in the percent of non-Medi-Cal eligible children and youth being served.

III. Collaboration initiated with other agencies through Children's System of Care activities has led to identification of multi-problem children with multi-agency involvement. These children require more intensive and therefore more costly services.

IV. There has been planned expansion of services to children in younger age groups, particularly high-risk children 0 - 7 years of age.

V. More focus has shifted to youth involved in the juvenile justice system.

VI. Following the model of TBS, staff has been encouraged to provide more intensive in-home services to avoid placing children and youth in out-of-home placements or more restrictive settings.

DMH is gathering further information and data to explore these hypotheses.

IMPLEMENTATION

DMH staff is currently in the process of completing the following tasks:

- Follow-up to EPSDT field audits, including Plans of Correction, disallowances and technical assistance and training.

- Intensive follow-up of those counties who have consistently been either at least double or half the statewide rates for paid claims per average monthly eligible.

- Intensive follow-up of those counties who have consistently been at either double or half the statewide rates for penetration.

- Intensive follow-up with counties who have had decreases in penetration rates for two consecutive years.

- Comprehensive analyses of those counties with twenty percent or higher increases in paid claims per unduplicated clients and increases of four percent or less in total unduplicated clients.

- Providing technical assistance to small counties in rural areas who require assistance to improve their EPSDT service delivery.

- Providing additional training on documentation standards.

- Quarterly follow-up with identified counties to track progress toward pre-established goals or gather additional information about performance. DMH staff tracking EPSDT service delivery at the county level will meet with the Deputy Director, Systems of Care and report findings on a quarterly basis.

- Focused reviews of county mental health plans that seem unable to make progress toward mutually established goals. DMH may also require these counties to perform formal quality studies to identify potential chronic problems within their service delivery system or develop Plans of Correction.

CONCLUSION

Field audits of the EPSDT benefit show that sufficient, medically necessary services were provided to eligible children and youth in eleven California counties. In addition, other oversight activities indicate that access has increased for children needing mental health services, and that more intensive and appropriate services are being provided to multi-problem youth with severe emotional disorders. These positive results are an excellent indicator of appropriate utilization of the EPSDT benefit at the local level. However, much still remains to be learned about other factors that impact utilization of EPSDT services. DMH will continue its oversight and research to ensure adequate services are provided, at the same time being mindful that scarce resources must be wisely spent.

ATTACHMENT A.

DEPARTMENT OF MENTAL HEALTH
COMPLIANCE ADVISORY COMMITTEE (CAC)
MEMBERSHIP LIST
(April 2002)

California Mental Health Planning Council:

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California Association of Social Rehabilitation Agencies:

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ATTACHMENT B.

SECTION J—MODIFIED FOR THE NON-HOSPITAL CHART REVIEW OF EPSDT SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
A. MEDICAL NECESSITY				
1.	Does the beneficiary meet all three of the following reimbursement criteria (1a., 1b., and 1c. below):			NOTE: Promote peer reviewer participation in review of charts • Review assessment(s), evaluation(s), and/or other documentation to support 1a, 1b, and 1c
1a.	The beneficiary has a DSM IV diagnosis contained in the CCR, Title 9, Chapter 11, Section 1830.205(b)(1)(A-R)?			• Is the beneficiary's diagnosis among the list of diagnoses in Section 1830.205(b)?
1b.	The beneficiary, as a result of a mental disorder listed in 1a, must have, at least, one of the following criteria (1, 2, or 3 below):			• Determine which condition(s) (1, 2, and/or 3) is the focus of treatment
	1. A significant impairment in an important area of life functioning?			NOTE: Definitions of "significant" at the discretion of the MHP
	2. A probability of significant deterioration in an important area of life functioning?			NOTE: Definitions of "probability" at the discretion of the MHP
	3. A probability the child will not progress developmentally as individually appropriate?			
1c.	Must meet each of the intervention criteria listed below (4 and 5):			NOTE: Only medically necessary services are to be provided
	4. The focus of the proposed intervention is to address the condition identified in no. 1b. above?			• Does the proposed intervention(s) focus on the condition(s) identified in no. 1b? • Review client plan for proposed intervention(s)

SECTION J—MODIFIED FOR THE NON-HOSPITAL CHART REVIEW OF EPSDT SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
	5. The expectation is that the proposed intervention will do, at least, one of the following (A., B., or C.): A. Significantly diminish the impairment? B. Prevent significant deterioration in an important area of life functioning? C. Allow the child to progress developmentally as individually appropriate? *CCR, Title 9, Chapter 11, Section 1830.205(b).*			• Can a connection be identified between the proposed intervention and the following: • Diminishing the impairment? • Preventing a significant deterioration? • Allowing a child to progress developmentally as individually appropriate? **DISALLOWANCE:** Criteria 1a not supported by documentation (For 1b and 1c, see Disallowance for question No. 2 below)
2.	Do beneficiaries under 21 years of age who do not meet the medical necessity criteria of no. 1b. and/or no. 1c. above still meet the medical necessity criteria per EPSDT (*CCR, Title 22, Section 51340[e][3])* eligibility when specialty mental health services are needed to correct or ameliorate a defect, mental illness, or condition? *CCR, Title 9, Chapter 11, Section 1830.210(a).*			NOTE: N/A if medical necessity established in no. 1 above • Can a connection be made between the diagnosis in 1a and the service(s) provided? **DISALLOWANCE:** Neither criteria 1b and 1c above were supported by documentation nor was the need for specialty mental health services to correct or ameliorate a defect, mental illness, or condition established

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
B. ASSESSMENT				

3.	Has an assessment been completed and, as appropriate, does it contain areas addressed in the MHP contract with the DMH?
	
	CCR, Title 9, Chapter 11, Section 1810.204; MHP Contract with DMH, Attachment C.
				NOTE: Assessment information need not be in a specific document or section of the chart
				
				• Review assessment(s), evaluation(s), and/or other documentation to support 1a, 1b, and 1c
				• Does the assessment(s) include the following elements, as appropriate?
				
				  • Physical health conditions reported by the client are prominently identified and updated
				  • Presenting problems and relevant conditions affecting physical and mental health status: i.e., living situation, daily activities, social support
				  • Client strengths in achieving client plan goals
				  • Special status situations and risks to client or others
				  • Medications, dosages, dates of initial prescription and refills, informed consent
				  • Allergies and adverse reactions, or lack of allergies/sensitivities
				  • Mental health history, previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information, lab tests, consultation reports
				  • For children and adolescents, pre-natal and perinatal events and complete developmental history
				  • Past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed and over-the-counter drugs
				
				OUT OF COMPLIANCE: NFP; no assessment has been completed

C. CLIENT PLAN

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
4.	Does the client's plan contain the following elements:			• Review the client plan
4a.	Specific, observable, or quantifiable goals?			
4b.	The proposed type(s) of intervention?			• Do the proposed interventions and goals focus on the condition identified in no. 1b or 2?
4c.	The proposed duration of the intervention(s)?			
4d.	Writing that is legible?			
4e.	A signature (or electronic equivalent) of, at least, one of the following: 1. A person providing the services(s)? 2. A person representing the MHP providing services? 3. When the plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category, one of the following must sign: A. A physician? B. A licensed/waivered psychologist? C. A licensed/registered/waivered social worker? D. A licensed/registered/waivered marriage and family therapist? E. A registered nurse?			• If necessary, ask for a list of staff, staff signatures, and staff licenses

SECTION J—MODIFIED FOR THE NON-HOSPITAL CHART REVIEW OF EPSDT SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
4f.	Documentation of the client's degree of participation and agreement with the client plan as evidenced by one of the following:			• Does the chart contain documentation of the client's degree of participation and agreement with the plan?
	When the client is a long-term client, as defined by the MHP, and the client is receiving more than one type of service from the MHP, the client's signature, or an explanation of why the signature could not be obtained, is documented on the plan?			• Describe how the MHP defines "long-term client" • Is the client a long-term client? • Is the client receiving more than one type of service? • Is there a client signature or explanation of why the signature could not be obtained documented on the plan?

	When the client is not a long-term beneficiary, examples of documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, the client signature on the plan, or a description of the client's participation and agreement in the progress notes?			• Is there reference to the client's participation and agreement in the body of the plan?
				  • OR, is there a client signature on the plan?
				  • OR, is there a description of the client's participation and agreement in the progress notes?

	CCR, Title 9, Chapter 11, Sections 1840.314 and 1819.440(c); MHP Contract with DMH, Attachment C; DMH Policy Letter No. 99-03.			**OUT OF COMPLIANCE**: NFP; no client plan has been completed; complete absence of 4a, b, or c; writing that is illegible; absence of signature for 4e or 4f

SECTION J—MODIFIED FOR THE NON-HOSPITAL CHART REVIEW OF EPSDT SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
	D. PROGRESS NOTES			
5.	Do progress notes document the following:			NOTE: Only medically necessary services are to be provided NOTE: Progress notes, in general, should reflect progress or lack of progress towards goals, or redirection towards other identified goals
5a.	The date services were provided?			
5b.	Client encounters, including clinical decisions and interventions?			NOTE: Interventions need only to correct or ameliorate a defect, mental illness, or condition • Do the interventions/client encounters focus on the condition identified in no. 1b or 2?
5c.	A signature (or electronic equivalent) of the staff providing the service with professional degree, license, or job title?			
5d.	Writing that is legible?			
5e.	Timeliness/frequency as following: 1. Every service contact for: A. Mental health services? B. Medical support services? C. Crisis intervention? 2. Daily for: A. Crisis residential? B. Crisis stabilization (1x23hr)?			

SECTION J—MODIFIED FOR THE NON-HOSPITAL CHART REVIEW OF EPSDT SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
5e.	3. Weekly for: A. Day treatment intensive? B. Day rehabilitation? C. Adult residential? 4. Other notes as following: A. Psychiatric health facility services: each shift? B. Targeted case management: every service contact, daily, or weekly summary? *CCR, Title 9, Chapter 11, Section 1810.440(c);* *MHP Contract with DMH, Attachment C;* *DMH Policy Letter No. 99-03.*			**OUT OF COMPLIANCE:** NFP; progress notes within the review period do not contain these elements
6.	Were sufficient services provided to meet the client plan goals and the requirements of EPSDT?	N/A. **For survey only**		NOTE: Conclusion to be based upon overall findings of this section NOTE: Client plan goals refers to the goals of this beneficiary NOTE: Requirements of EPSDT refers to entitlement requirements when medical necessity is met • If you believe insufficient services were provided, is there documentation that sufficient services were offered, but declined?

RE: OTHER CHART DOCUMENTATION

7.	Is there a process to notify the beneficiary that a copy of the client plan is available upon request? *CCR, Title 9, Chapter 11, Section 1810.110(a);* *MHP Contract with DMH, Attachment C.*			• Describe the procedure for obtaining client plan. **OUT OF COMPLIANCE:** NFP

SECTION J—MODIFIED FOR THE NON-HOSPITAL CHART REVIEW OF EPSDT SERVICES

	CRITERIA	IN COMPLIANCE Y	N	*INSTRUCTIONS TO REVIEWERS* COMMENTS
8.	When applicable, was information provided to beneficiaries with visual and hearing impairments? *CCR, Title 9, Chapter 11, Section 1810.110(a); DMH Information Notice No. 97-06, D.5; W&IC Sections 5600.2(e) and 5614(b)(5).*			• Evidence that beneficiaries with visual and/or hearing impairment were provided with information? **OUT OF COMPLIANCE:** NFP; no evidence that beneficiaries with visual and/or hearing impairment were provided with information based on MHP's IP or policy
9.	Regarding cultural/linguistic services:			NOTE: Coordinate findings with DMH system review process • Review CCP and charts
9a.	When applicable, is there documentation to show that services are available in a beneficiary's primary language as described in the MHP's CCP?			• Is there evidence beneficiaries are made aware of services available in their primary language?
9b.	When applicable, is there documentation of the response to offers of interpretive services as described in the MHP's CCP?			
9c.	When applicable, is there documentation of linking beneficiaries to culture-specific and/or linguistic services as described in the MHP's CCP?			
9d.	When applicable, is there compliance with Title VI of the Civil Rights Act prohibiting the expectation that families will provide interpreter services? *CCR, Title 9, Chapter 11, Sections 1810.410(a) and (d)(2); DMH Information Notice No. 97-14, Pages 13,14,and 18; Title VI, Civil Rights Act of 1964, (42 U.S.C., Section 2000d, 45 C.F.R., part 80).*			• When families provide interpreter services, is there documentation that other linguistic services were offered first, but the client preferred to provide a family interpreter? **OUT OF COMPLIANCE:** NFP

ATTACHMENT C.

Chart Samples for EPSDT Audits
Data Criteria and Random Sampling

A. Data Criteria

- Use Short-Doyle/Medi-Cal approved claims data
- Select desired county based on the county that submitted the claim
- Date of service is in 1/1/01 – 3/31/01

Process

1. Delete Inpatient Services.
2. Exclude Healthy Families claims and those with an approved aid code that begins with "9" from the analysis.
3. Keep Psychiatric Health Facilities, Residential, Day and Outpatient Services.
4. Keep Full-Scope aid codes. Delete all others, especially all minor consent aid codes.
5. If the beneficiary's county code is <01 or >58 the beneficiary's county code is set to equal the county submitting the claim.
6. Select clients between the ages of 0 and 21.

B. Random Sampling

The sample side for Los Angeles County is 80 clients; Alameda, Fresno, Kern, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco and Santa Clara counties are 20 and the remaining counties have a sample size of ten. The sample size refers to the number of unduplicated clients.

Once the sample size is determined, use SAS software for the random sampling. Use a random number generator (an SAS function) to assign a random number to each data record. The data is sorted in ascending order by the random number. Then take however many clients are needed for the sample size.

ATTACHMENT D.

CALIFORNIA DEPARTMENT OF MENTAL HEALTH

POLICY DIRECTIVE

Series: Effective Date: 07/30/93

Number: 201 Supersedes: New

Subject: CONFIDENTIALITY OF PATIENT INFORMATION

Directive: All Department of Mental Health (DMH) staff will protect the confidentiality of patient information.

Authority: By order of the Director, consistent with Welfare and Institutions (W & I) Code Section 5328 and Government Code Section 11152

Purpose: This directive sets forth policies and procedures for the handling of confidential patient information.

Confidential patient information is information which can be used by unauthorized persons to identify an individual patient. Such information includes, but is not limited to, names, fingerprints, social security numbers and photographs.

Method: Supervisors and managers will ensure that all staff are aware of the need to protect patient confidentiality. Staff who are new to DMH will be asked to sign the Department of Mental Health Oath of Confidentiality (Form 5473). Staff who do not sign Form 5473 are not absolved of the responsibility to protect the confidentiality of patient information in accordance with W & I Code Section 5328.

Confidential patient information is to be secured from access when DMH staff are not present. Office areas which house confidential patient information shall be locked when unattended.

Confidential patient information shall not be divulged to any person outside of DMH except as authorized by W & I Code Section 5328 or other provisions of law.

Efforts by unauthorized persons to obtain confidential information shall be reported immediately to the DMH Information Security Officer.

Unresolved questions concerning the authority of requesters to receive confidential patient information should be directed to the DMH Office of Legal Services.

Paper documents containing confidential patient information shall be stored out of sight when not in use. Computer video display terminals (VDT) showing confidential patient information shall be protected from view of persons not authorized to view such information. The intent is to protect confidential patient information from inadvertent disclosure to visitors, building maintenance people, custodians and others who do not have authority to view confidential patient information.

All computer systems which use confidential patient information will be protected from access by use of passwords, or equivalent devices which block access to unauthorized persons.

All documents which contain confidential patient information shall include the following admonishment:

Confidential information - California Welfare and Institutions Code Section 5328

All documents which contain confidential patient information shall be destroyed when they are ready to be discarded. Methods of destruction include tearing and shredding. Materials to be shredded shall be boxed and sealed and transported to a shred materials collection point. The Business Services Section shall designate collection points for shred materials and shall arrange for such materials to be shredded.

Several DMH office areas house confidential patient information . When people appear in these areas who are not known to have authorization, DMH staff should politely ask them to leave. Contact the State Police if they do not comply.

Data items which identify specific patients should be expunged from documents which are to be distributed outside of DMH. When it is essential that documents containing confidential patient information be distributed outside of DMH, staff shall ensure that recipients exercise procedures which preserve confidentiality in accordance with W & I Code Section 5328.

Work-at Home employees shall protect the confidentiality of patient information at the work-at home work site.

Work-at-Home employees shall not transport computer files or documents containing confidential patient information to their work-at-home work sites.

At their work-at-home site, work-at-home employees shall not store confidential patient information on computer media or in printed form.

All confidential patient information at the work-at-home work site, whether in printed form or appearing on VDT screens, shall be protected from the view of persons who are not authorized to view confidential patient information. Immediately after use, all printed materials which contain confidential patient information shall be destroyed.

/s/ Stephen W. Mayberg, Ph.D. July 30, 1993
Director Date
Department of Mental Health

ATTACHMENT E.

1830.210. Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age.

(a) For beneficiaries under 21 years of age who do not meet the medical necessity requirements of Section 1830.205(b)(2) and (3), medical necessity criteria for specialty mental health services covered by this subchapter shall be met when all of the following exist:

(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1).

(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and

(3) The requirements of Title 22, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT Supplemental Specialty Mental Health Service under this section if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this subchapter.

(c) The MHP shall not approve a request for specialty mental health services under this section in home and community based settings if the MHP determines than the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater that the total cost to the Med-Cal program in providing medically equivalent services at the appropriate level are available in a timely manner.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14132, and 14684, Welfare and Institutions Code, and Title 42, Section 1396d (r), United States Code.

ATTACHMENT F.

Documentation Standards For Client Records

The documentation standards are described below under key topics related to client care. All standards must be addressed in the client record; however, there is no requirement that the record have a specific document or section addressing these topics.

A. Assessments

1. The following areas will be included as appropriate as a part of a comprehensive client record.

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

2. Timeliness/Frequency Standard for Assessment

- The MHP will establish standards for timeliness and frequency for the above mentioned elements.

B. Client Plans

1. Client Plans will:

- have specific observable and/or specific quantifiable goals
- identify the proposed type(s) of intervention
- have a proposed duration of intervention(s)
- be signed (or electronic equivalent) by :
- the person providing the service(s), or
- a person representing a team or program providing services, or
- a person representing the MHP providing services
- when the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the above staff are not of the approved category,
  - a physician
  - a licensed/"waivered" psychologist
  - a licensed/registered/waivered social worker
  - a licensed/registered/waivered marriage and family therapist or
  - a registered nurse

- In addition,

- client plans will be consistent with the diagnoses, and the focus of intervention will be consistent with the client plan goals, and there will be documentation of the client's participation in and agreement with the plan. Examples of documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, client signature on the plan, or a description of the client's participation and agreement in progress notes.
- client signature on the plan will be used as the means by which the MHP documents the participation of the client
- when the client is a long term client as defined by the MHP, and
- the client is receiving more than one type of service from the MHP
- when the client's signature is required on the client plan and the client refuses or is unavailable for signature, the client plan will include a written explanation of the refusal or unavailability.
- the MHP will give a copy of the client plan to the client on request.

2. Timeliness/Frequency of Client Plan:

- Will be updated at least annually.
- The MHP will establish standards for timeliness and frequency for the individual elements of the client plan described in item 1.

C. Progress Notes

1. Items that must be contained in the client record related to the client's progress in treatment include:

- The client record will provide timely documentation of relevant aspects of client care
- Mental health staff/practitioners will use client records to document client encounters, including relevant clinical decisions and interventions
- All entries in the client record will include the signature of the person providing the service (or electronic equivalent); the person's professional degree, licensure or job title; and the relevant identification number, if applicable
- All entries will include the date services were provided
- The record will be legible
- The client record will document referrals to community resources and other agencies, when appropriate
- The client record will document follow-up care, or as appropriate, a discharge summary

2. Timeliness/Frequency of Progress Notes:

Progress notes will be documented at the frequency by type of service indicated below:

a. Every Service Contact

- Mental Health Services
- Medical Support Services
- Crisis Intervention

b. Daily

- Crisis Residential
- Crisis Stabilization (1x/23hr)

c. Weekly

- Day Treatment Intensive
- Day Rehabilitation
- Adult Residential

d. Other

- Psychiatric health facility services: notes on each shift
- Targeted Case Management: every service contact, daily, or weekly summary
- As determined by the MHP for other services.