City & County of San Francisco
Department of Public Health

Clinical Practice Guidelines on Evidence-Based and Best Practices for San Francisco Department of Public Health Behavioral Health Services System of Care

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San Franscisco Department of Public Health (SFDPH)
Behavioral Health Services (BHS)
Clinical Practice Guidelines on Evidence-Based and Best Practices

Introduction

The San Francisco Department of Public Health (SFDPH) protects and promotes the health of all San Franciscans through a comprehensive approach that includes assessing and researching community health, developing and enforcing health policies, preventing disease and injury, educating the public, and providing quality health services. SFDPH's vision is to ensure equal access to health services for all residents, including immigrants, the uninsured, Medi-Cal and Healthy San Francisco Members, and to address health disparities. The department is committed to creating a culture of equity and inclusion, which will improve the delivery of services to all San Franciscans. For more information about SFDPH, refer to https://www.sf.gov/departments--department-public-health.

Behavioral Health Services (BHS) Mission, Vision, and Who We Serve

SFDPH Behavioral Health Services (BHS) is committed to ensuring that our services are inclusive, equitable, accessible, culturally responsive, and sensitive.

- Our Vision: For all San Franciscans to experience mental and emotional well-being and participate meaningfully in the community across lifespans and generations.
- Our Mission: To provide equitable, effective substance use and mental health care and promote behavioral health and wellness among all San Franciscans.
- Who We Serve: We serve San Franciscans (children, youth, and adults) who are experiencing mental health and substance use disorders and have low incomes, are uninsured, and/or qualify for Medi-Cal.

For more information about SFDPH BHS, refer to https://www.sf.gov/departments--department-public-health--behavioral-health.

Purpose of the BHS Clinical Practice Guidelines

The purpose of this document is to provide a standardized framework for the delivery of mental health and substance use services at the SFDPH BHS. This document serves as a vital resource to guide system of care Leaders, Providers, Administrators, and Stakeholders in providing exceptional, evidence-based behavioral health (BH) services. By adhering to these standards, SFDPH is committed to ensuring that BH services are inclusive, equitable, accessible, culturally responsive, and sensitive to the needs of all San Franciscans.

Recommendations are grounded in published guidelines and do not prioritize treatments based on cost. These guidelines serve as a guide for clinical decision-making, but Providers and Members must collaborate to create individualized treatment plans tailored to each Member's unique needs, abilities, and circumstances. When providing clinical services, Providers must always consider the Member's culture and lived experiences, seek their feedback, and monitor their responses to interventions. This document embodies BHS' dedication to providing intentional and thoughtful evidence-based care and not intended to be exhaustive, prescriptive, or

definitive. BHS will continue to update and develop the guidelines and suggested best practices to meet the needs of Members and remain adherent to local, State, and Federal regulations.

The term "Provider" will be used throughout this document to refer to clinical staff who provides behavioral health services. The Provider may be licensed or licensed waivered as a Licensed Practitioner of the Healing Arts (LPHA). LPHAs can operate independently within their scope of practice. The Provider may also be a "non-LPHA," a service Provider who is not licensed but credentialed and experienced to provide specific behavioral health services within their scope of practice, and under the direction of a LPHA. The term "Program" will be used to refer to any program, clinic, and/or agency that provides clinical services. The term "Member" will be used to indicate anyone receiving behavioral health services at BHS.

BHS Advisory and Working Board

This guide was created in consultation and working collaboration with BHS System of Care (SOC) Leadership in Adult/Older Adults (AOA), Children, Youth, and Families (CYF), Transitional Age Youth (TAY), Substance Use Services (SUS), Clinical Informatics, BHS Compliance, BHS Quality Assurance/Quality Improvement (QA/QI), Quality Management Regulatory Affairs, BHS Chief Medical Officers, and the Medical Use Improvement Committee (MUIC).

The guidelines and practices set forth aligns with Behavioral Health Services Policies and Procedures | SF.gov and meets various Federal, State, and Local regulations to implement clinical practice guidelines that:

- Are evidence-based and consider the needs of all BHS Members.
- Are implemented in collaboration with network Providers. The guidelines will be disseminated through existing mechanisms to all affected Providers and, upon request, to Members and potential Members.
- Are aligned with the guidelines in the Program Utilization Review Quality Committee (PURQC) form, as well as other internal auditing, compliance, and reviews. See Appendix A: Program Utilization Review Quality Committee (PURQC) Form and Appendix B: PURQC Memo.

Governing Agency: Department of Health Care Services (DHCS)

The California Department of Health Care Services (DHCS) is the backbone of California's healthcare safety net, helping millions of Californians every day. DHCS' purpose is to provide equitable access to quality health care leading to a healthy California for all. As the cornerstone of California's health safety net, DHCS oversees Medicaid, mental health, and substance use services to ensure equitable access to quality care. See About Us | DHCS. for information regarding DHCS. DHCS has set forth standards of care through regulatory and performance requirements for Counties to meet to ensure that Members are receiving timely access to quality care that is grounded in evidence-based practices and that these principles are effectively operationalized by system Leaders and Providers. See BHIN 24-020 2024 Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans.

SF BHS Leadership are dedicated to upholding DHCS requirements through system performance, access and care continuity, and clinical quality and safety.

*System Performance

- Information Systems Capabilities Assessment Tool (ISCAT): Annual Survey to validate information system capabilities for performance measures and network adequacy reporting including data integration, system controls, and data file handling.
- Behavioral Health Accountability Set (BHAS): The BHAS is a set of performance measures used by DHCS to track the quality of care provided by County Behavioral Health Plans (BHPs), including Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS). See current BHAS performance measures at Medi-Cal Managed Care Accountability Sets.

*Access and Care Continuity

- Timeliness Metrics: Reporting and monitoring of time between initial requests to offered appointment and offered follow-up appointments, ensuring timely access from the moment a Member requests BHS services.
- Screening for Medical Necessity: Applying evidence-based diagnostic criteria at the first point of contact, we ensure that Members are matched with the appropriate level of care immediately, fulfilling DHCS requirements for clinical appropriateness.
- Continual Assessment: Monitoring the progression of client needs to ensure their Level of Care (LOC) remains appropriate, transitioning Members as their clinical profiles evolve.

*Clinical Quality and Safety

- Medication Monitoring: Performing systematic reviews of prescribing trends and medication efficacy, ensuring that pharmacological interventions align with the latest evidence-based prescribing practices.
- Member Experience: Client Satisfaction conducted annually through the Treatment Perception Survey (TPS) for substance use services and the Consumer Perception Survey (CPS) for mental health services.

External Quality Review (EQR)

As required by Title 42, Code of Federal Regulations, Part 438, Subpart E, DHCS contracts with an External Quality Review Organization (EQRO) to conduct reviews of Mental Health Plans (MHPs) and Drug-Medi-Cal Organized Delivery System (DMC-ODS). EQRO analyzes and evaluates information related to quality, timeliness, and access to Specialty Mental Health Services (SMHS) provided by California's MHPs, DMC-ODS and/or their subcontractors to Medi-Cal beneficiaries. The California EQRO is Health Services Advisory Group (HSAG). At the end of each review period, HSAG completes a comprehensive technical report that analyzes and evaluates aggregated information on healthcare services provided by BHPs during the review period.

Behavioral Health Accountability Set (BHAS)

Behavioral Health Plans must report on Behavioral Health Accountability Sets (BHAS) measures through the External Quality Review (EQR) process conducted through HSAG. This process evaluates County Behavioral Health Plans (BHPs) on specific performance metrics to ensure quality, accountability, and compliance with minimum performance level standards (MPLs). MPLs are typically set based on national Medicaid quality benchmarks, often aligning with the 25th percentile of national performance. County BHPs are contractually required to perform at or above the established MPL for each designated behavioral health measure. Key areas reviewed for mental health and substance use disorder services include follow-up care after emergencies,

screening rates, and follow-up treatment. In addition, the BHAS monitoring aligns with the national Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by NCQA. See Appendix C: Behavioral Health Accountability Set (BHSA) Measurement Year and HEDIS - NCQA.

Performance Improvement Project (PIP)

Performance Improvement Projects (PIPs) are a mandatory federal 42 CFR 438.330 requirement for behavioral health plans (BHPs) as part of the External Quality Review designed to demonstrate significant, sustained improvement in clinical care and non-clinical care areas. They ensure compliance with federal, state, and Medicaid standards by analyzing problems, implementing interventions, and validating outcomes. Two active, distinct PIPs—one clinical and one administrative—are required during an External Quality Review cycle for the MHP and DMC-ODS systems and reviewed by the EQRO annually, to enhance beneficiary health and service access.

California Advancing and Innovating Medi-Cal (C*al*AIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a statewide initiative led by DHCS to transform the Medi-Cal delivery system into a more integrated, equitable, and person-centered model. It replaced cost-based reimbursement with a Fee-for-Services (FFS) structure to transition toward value-based care and streamlines clinical documentation to prioritize direct patient care. Key components of CalAIM include Enhanced Case Management (ECM), Community Supports, Population Health Management, and Justice-Involved Initiative. The framework is to expand through BH-CONNECT, which focuses on evidence-based practices (EBPs) and transitional rent to support Members with the most significant behavioral health needs. See Medi-Cal Transformation and CalAIM 1115 and 1915(b) Waiver Renewals for more information.

Behavioral Health Services Act (BHSA)

The Behavioral Health Services Act (BHSA) replaces the Mental Health Services Act (MHSA) of 2004. BHSA reforms behavioral health care funding to prioritize services for people with the most significant mental health needs while adding the treatment of substance use disorders (SUD), expanding housing interventions, and increasing the behavioral health workforce. It also enhances oversight, transparency, and accountability at the state and local levels. Additionally, BHAS creates pathways to ensure equitable access to care by advancing equity and reducing disparities for individuals with behavioral health needs. It is one part of Proposition 1. The second part of Proposition 1, the Behavioral Health Bond, authorizes $6.4 billion in bonds to finance behavioral health treatment beds, supportive housing, community sites, and funding for housing veterans with behavioral health needs. See Mental Health Services Act (MHSA) and MHSA County Performance Outcomes for more information.

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) is a five-year (January 2025 to December 2029), $1.9 billion initiative under Medicaid Section 1115 demonstration and State Plan Amendments. BH-CONNECT expands access to timely, evidence-based behavioral health services for Medi-Cal Members with significant behavioral health needs. The initiative strengthens community-based care, supports workforce development, advances High Fidelity Wraparound, and expands evidence-based practices (EBPs), including Assertive Community Treatment (ACT), Forensic Assertive Community

Treatment (FACT), Coordinated Specialty Care for First Episode Psychosis (CSC-FEP), Individual Placement and Support Employment (IPS), Clubhouse, Community Health Worker (CHW), and family-based models like Functional Family Therapy (FFT), Multi-System Therapy (MST), Parent-Child Interaction Therapy (PCIT), and High Fidelity Wraparound (HFW). San Francisco County is aligning its behavioral health practice guidelines and initiatives with BH-CONNECT to support an integrated, whole-person continuum of care that strengthens access, quality, and care delivery. For more information, see BH-CONNECT for more information.

In addition to evidence-based practices, DHCS strives toward aligning with national standards and is incentivizing counties to strive towards National Committee for Quality Assurance (NCQA) Behavioral Health Accreditation. Prioritizing Quality Improvement (QI) and Population Health Management (PHM) standards measure performance outcomes based on the organization's clinical practice guidelines. See BHIN 25-006: Provision of BH-CONNECT Access, Reform and Outcomes Incentive Program for more information.

BHS Practice Guideline Values

SF BHS Leadership acknowledges that universal standards do not fully consider local community needs, especially in those communities that have experienced historical and institutional biases, racisms, and acts of harm inflicted by dominant cultures. SF BHS Leadership is fully committed to providing culturally congruent and linguistically competent services to our diverse communities in San Francisco. BHS Providers are encouraged to attend our BHS training courses on best practices and maintains the flexibility to provide safe, effective, and culturally attuned services.

The following sections supplement existing BHS policies such as the Cultural and Linguistic Humility Requirements for BHS 3.02-15, Translation Request Policy 3.02-23, Interpretation Request Policy 3.02-24, and Equity Learning Policy for BHS 2.06-22. These policies and guidelines can be found at Behavioral Health Services Policies and Procedures | SF.gov.

In addition to the importance of culturally congruent care, BHS recognizes the need for clinical and operational practices based on the values of trauma informed practices, harm reduction, recovery-oriented approach, and self-care.

General Guidelines for Culturally Congruent Care

To provide effective, person-centered care for culturally diverse populations, Providers must understand the Member's experience and help-seeking behaviors within their social and cultural context. Recognizing a Member's cultural and background is essential for delivering the highest quality of care. One useful tool is the DSM-5 Cultural Formulation Interview (CFI), a semi-structured, 16-item interview protocol to gather essential data that supports culturally sensitive diagnosis and treatment planning. For information on general best practices, see American Psychological Association (APA): APA Guidelines for Providers of Services to Ethnic, Linguistic, and Culturally Diverse Populations, National Association of Social Workers (NASW): Standards and Indicators for Cultural Competence in Social Work Practice, and California Association of Marriage and Family Therapists (CAMFT): Culturally Responsive Training.

Culturally and Linguistically Appropriate Service (CLAS) Standards

The Culturally and Linguistically Appropriate Service (CLAS) Standards are action steps to improve health equity by guiding organizations to provide effective, understandable, and respectful care, addressing cultural belief,

preferred languages, and health literacy. For more information regarding CLAS standard, see Implementing the National CLAS Standards for Communication and Language Assistance Services: Lessons from the Field.

Specific Guidelines for Patient Populations

American Psychological Association (APA) has best practice highlights for working with African American, Appalachian, Asian American, Latino, LGBTQ, Muslim, Indigenous, Refugee and Forced Displacement, and Women Members. See Psychiatry.org - Best Practice Highlights for Treating Diverse Patient Populations for APA best practice recommendations for the communities identified.

Trauma-Informed Practices

Trauma-Informed Care (TIC)

Trauma-informed Care (TIC) brings to the forefront the belief that trauma can pervasively affect a Member's well-being, including physical and mental health. TIC reinforces the importance of acquiring trauma-specific knowledge and skills to meet the specific needs of Members; of recognizing that individuals may be affected by trauma regardless of its acknowledgment; of understanding that trauma likely affects many people who are seeking behavioral health services; and of acknowledging that organizations and Providers can retraumatize individuals through standard or unexamined policies and practices. See Practical Guide for Implementing a Trauma-Informed Approach | SAMHSA for more information.

Trauma Informed System (TIS)

As a system, SFDPH recognizes that trauma is a pervasive, long-lasting public health issue that affects our workforce and systems. Like people, organizations are susceptible to trauma in ways that contribute to fragmentation, numbing, reactivity, and depersonalization. Trauma Informed Systems (TIS) work is based on the understanding that service delivery systems can inadvertently reinforce oppression and create harm. The TIS Initiative at SFDPH is an organizational change model to support organizations in nurturing and sustaining trauma-informed practices. Through TIS, healing environments are cultivated by increasing organizational resilience, improving workforce experience, and ultimately supporting organizations in responding to and reducing the impact of trauma. More information can be found at Office of Justice, Equity, Diversity, and Inclusion (JEDI) | SF.gov and Microsoft Word - TIS Program Overview 7-9-19.docx.

Harm Reduction/Recovery-Oriented Care

All Agencies funded by SFDPH must adhere SFDPH Harm Reduction Policy and adhere to a Declaration of Compliance where the agency must address in their program design and objectives how they will provide harm reduction treatment options, develop harm reduction guidelines in accordance with the Resolution of the SF Health Commission. In addition, SFDPH and Community Health Equity and Promotion Branch (CHEP) funds seven (7) Health Access Points (HAPs) focusing on the following communities: Latin/a/e/o/x, Trans Women, People Who Use Drugs (PWUD)/People Experiencing Homelessness (PEH), Gay/MSM, Asian & Pacific Islanders, Young Adults (18-24), Black/African Americans. The HAPs provide low-barrier clinical and community services in welcoming spaces, free from stigma. The goal is to ensure that all San Franciscans have equitable access to high-quality HCV, HIV, and STI prevention, care & treatment services, and harm reduction & overdose prevention services. Review Harm Reduction Training Institute (HRTI) | SF.gov , DPH-Policy-Overdose-Prevention-Policy-2022-update-3.pdf, and Health Access Point (HAP) – Home for more information.

Provider Self-Care

There are many reasons as to why a Provider took the educational and professional steps into the field of helping others. For some, they had received BH services or had a close family member who received services, for others, it was to provide help to others that they wished that they had. Regardless of the reason it is a difficult role to be in the service of others. Self-care plays an essential role in the longevity of a Provider in this profession to prevent burn out and compassion fatigue, to improve Member care and clinical decision making, and is both a personal and professional responsibility of the Provider. Please review the resources below and discuss the importance and need for self-care during supervision, as an agenda item during staff meetings, and with each other as colleagues.

Dear Mental Health Practitioners, Take Care of Yourselves: a Literature Review on Self-Care, APA Addressing Compassion Fatigue, Self-Care Plans For Therapists: Tips For Taking Care Of Mental Health | BetterHelp, Self-Care for Therapists: 5 Practical Daily Strategies, NASW Self-Care for Social Workers, APA Self-care Series, CAMFT Self-Care for Therapists, Compassion Fatigue and Self-care Resources for Crisis Counselors | CCP Toolkit | SAMHSA, Provider Self-Care Toolkit - PTSD: National Center for PTSD

Evidenced Based Practices (EBP)

BHS's practice guidelines for the use of evidence-based practices provide recommendations to improve the assessment, diagnosis, and treatment of behavioral health conditions for Members in San Francisco. The population served is primarily Black, Indigenous, and People of Color (BIPOC), including Latina/o/x/e, Black/African American, and Asian American, Native Hawaiian, and Pacific Islander communities. As such, these guidelines promote the use of evidence-based practices balanced with culturally responsive and equity-centered care. The vision is for equitable access to high-quality, effective, and culturally affirming behavioral healthcare leading to positive outcomes and addressing disparities.

General EBPs

BHS guidelines are informed by recommendations on evidence-based practices from national organizations including the American Psychological Association (APA), Substance Abuse and Mental Health Services Administration (SAMHSA), American Psychiatric Association, and the American Academy of Child and Adolescent Psychiatry (AACAP). However, issues around cultural relevance and barriers to engagement exist when applying evidence-based treatments. Augmenting them with culturally responsive and equity-centered approaches is vital for implementation success in minority communities.

Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy (CBT) is a structured, goal-oriented, short-term treatment that helps individuals develop coping skills to change unhelpful thoughts, emotions, and behaviors. It is based on the principle that thoughts, emotions, and behaviors are interconnected affect one another. In CBT, the Provider guides the Member to distinguish between thoughts and feelings, recognize how thoughts impact emotions, critically evaluate automatic thoughts and assumptions, and develop skills to notice, interrupt, and replace unhelpful thinking patterns. In addition, relaxation exercise and stress reduction techniques are often incorporated.

CBT is widely recognized as one of the most effective and well-researched forms of psychotherapy. It has been shown to help treat a range of mental health conditions, including depression, anxiety disorders, alcohol and

drug use problems, marital problems and eating disorders. Numerous research studies indicate that CBT significantly improves quality of life and overall functioning. See APA| What is Cognitive Behavioral Therapy? And Association for Behavioral and Cognitive Therapies| What is Cognitive Behavioral Therapy? for more information.

Motivational Interviewing (MI)

The heart of Motivational Interviewing (MI) is the ability to build partnership through conversation between Members and Providers rooted in compassion and respect, rather than being directive or inferring judgement. With MI, Providers can also identify the type of dialogue that will best match the Member's readiness for change and support treatment planning rooted in the Member's self-identified goals and motivations. MI is an important intervention because it centers on the Member as the expert of their own life and allows Members to provide information pertinent to their lived experiences and care in a way that is empowering. Motivational interviewing is used within programs across BHS Providers who work with various populations and across all ages. This therapeutic approach is useful in strengthening motivation for change, advancing treatment goals, and strengthening the therapeutic rapport. See 10 Motivational Interviewing Strategies for Deeper Patient Engagement in Care Management and Understanding Motivational Interviewing | Motivational Interviewing Network of Trainers (MINT) for more information about MI.

Psychoeducation

Psychoeducation combines therapeutic interventions such as Cognitive Behavior Therapy (CBT) with education. The basic goal is to provide the Member with knowledge about various facets of their illness and treatment options. Providing this education allows the Member to work together with the Provider for a better overall outcome. Psychoeducation can include information given verbally in a therapy session, handouts, guides, and homework tasks where Members are encouraged to discover information for themselves. BHS utilizes psychoeducation to support Members to better understand their mental health and/or substance use challenges while providing treatment options based on the Member's goals. Using psychoeducation can empower Members to make informed decisions about their illness and treatment, which often results in better outcomes. See Clinical Practice Guidelines for Psychoeducation in Psychiatric Disorders General Principles of Psychoeducation - PMC for more information.

Integrated Core Practice Model (ICPM)

The California Integrated Core Practice Model for Children, Youth, and Families 2024 (ICPM) is a guide for effective service delivery within the trauma-informed Children and Youth System of Care (CYSOC) mandated by AB 2083. The model emphasizes the importance of healing relationships, nurturing family, parents and caregivers, cultural appropriateness, and timely and accessible services for at-risk children and youth. ICPM is a strengths-based, needs-driven approach that brings together service Providers, natural supports, and the client/family to develop and implement a unified service plan. Key components include comprehensive assessment, intensive care coordination (ICC), child and family teaming (CFT), intensive home-based services (IHBS), and culturally relevant interventions. See The Integrated Core Practice Model from the California Department of Social Services (CDSS) for more information.

Relapse Prevention

Relapse Prevention is a skills-based, Cognitive-Behavioral approach that requires Members and their Providers to identify situations that place the Member at greater risk for relapse – both internal experiences (e.g., positive thoughts related to substance use or negative thoughts related to sobriety that arise without effort, called "automatic thoughts") and external cues (e.g., people that the Member associates with substance use). These internal experiences and external cues are known as "triggers" and the Providers works with the Member to identify, develop, and expand their coping skills to address risk situations for relapse. See Relapse Prevention (RP) (MBRP) – Recovery Research Institute for more information.

Harm Reduction

Harm reduction treats individuals with substance use disorders (SUD) with dignity and respect using social justice and health equity lens. Harm Reduction International describes it as "policies, programs, and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies, and drug laws." More simply, harm reduction is an approach to services to meet people where they are at while also supporting them in moving towards health and wellness. Harm reduction incorporates a spectrum of behaviors from abstinence, reduction in use, to overdose risk reduction. Harm reduction respects that all individuals seek health and should have access to treatment and services regardless of if they are seeking to stop using substances. See Harm Reduction Principles | National Harm Reduction Coalition.

Trauma-Informed Therapy and Trauma-Focused Therapy

Trauma-Informed Therapy is not a particular technique or method but rather a trauma sensitive lens to approach and engage Members throughout the course of treatment. Trauma-Informed Therapy treat Members within the context of their trauma in a safe environment that is conducive to their healing and recovery process. Every part of the therapy, from how the sessions are structured to the words used, is done with sensitivity to trauma. General principles of Trauma-Informed Therapy include safety, choice, collaboration, trust and transparency, peer support, empowerment, and cultural, historical, and gender awareness.

In contrast, Trauma-Focused Therapy is more specific. Trauma-Focused Therapy not only creates a safe space, but it also directly addresses trauma symptoms. In Trauma-Focused Therapy, the Provider uses targeted methods such as Trauma-Focused Cognitive Behavior Therapy (TF-CBT), Eye Movement Desensitization and Reprocessing (EMDR), and Prolonged Exposure Therapy to help people process painful memories and reduce symptoms like flashbacks, anxiety, or panic. It is essential a Provider has the skills, training, knowledge, and support through clinical supervision before they provide specific therapeutic modalities to the Members.

For more information, see Trauma-informed Care - PTSD: National Center for PTSD, TIP 57 Trauma-Informed Care in Behavioral Health Services, Resource Library | Center for Child Trauma, Assessment, Services & Systems Integration, Trauma-Informed Therapy - StatPearls - NCBI Bookshelf.

Psychopharmacology and Medication for Addiction Treatment

Under the direction of the BHS Chief Medical Officer(s), the Medication Use Improvement Committee (MUIC) serves as the oversight body for BHS medication services and is a subcommittee of the BHS Quality Improvement Committee. MUIC is responsible for:

- Developing and the surveillance of medication services policies and practices for the behavioral health system Advising the BHS Chief Medical Officer(s) regarding issues related to medication services policy.
- Assisting the BHS Chief Medical Officer(s) in the formation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, disposal, and all other matters relating to pharmaceuticals for the behavioral health system.
- Monitoring the safety and effectiveness of medication practices at least annually. Monitor psychotropic medication use, including monitoring of psychotropic medication use for children/youth.
- Responding to medication-related issues identified by the BHS Risk Management Committee. The liaison for the BHS Risk Management Committee is the BHS Director of Pharmacy.
- Reviewing requests for new technologies (or new use of existing technologies) for medications, medical supplies and medical devices/equipment, and making recommendations for acceptance or denial of the use of new technology.

For more information about MUIC, see Behavioral Health Services Medication Use Improvement Committee (MUIC) Policy 3.02-26, Medication guidelines | SF.gov, and other medication related guidelines on the BHS Policies and Procedure website.

Adult/Older Adult (AOA) and Transitional Age Youth (TAY) EBP

Assertive Community Treatment (ACT)/Forensic Community Treatment (FACT)

General Information	Assertive Community Treatment (ACT) is a community-based, team- based service to support Members living with complex and significant behavioral health needs and a treatment history that may include psychiatric hospitalization and emergency room visits, residential treatment, involvement with the criminal justice system, homelessness, and/or lack of engagement with traditional outpatient services. ACT is delivered by a multidisciplinary ACT team and includes a full range of clinical treatment, psychosocial rehabilitation, care coordination, and community support services designed to support recovery. Forensic Assertive Community Treatment (FACT) adapts the ACT model to address the complex needs of members with significant behavioral health needs who are also involved with the criminal justice system. By addressing criminogenic risks and needs, FACT has been shown to improve functioning and reduce hospitalizations, homelessness, incarceration, and violations of probation and parole among enrolled members. FACT complements other DHCS initiatives designed to better meet the needs of members who are justice-involved, such as the CalAIM Justice-Involved Reentry Initiative.

Adoption/Revision Date	Service will be available to BHS Members starting Summer 2026.
Trend in SF	In Summer 2026, SFDPH Behavioral Health Services will operationalize ACT and FACT teams. Two civil service programs: South of Market Mental Health (SOMMH) SF FIRST (Fully Integrated Services Recovery Team)– Full Service Partnership (FSP); and Mission Mental Health (MMH) Intensive Case Management (ICM)—will be converted into two large ACT/FACT teams to serve individuals with the highest levels of clinical treatment, community support services, and justice-system involvement.
BHS Medication Guidelines	Safer Prescribing of Antidepressant Medication Guideline Safer Prescribing of Antipsychotic Medication Guideline Safer Prescribing of Mood Stabilizer Guideline Safer Prescribing of Sedative-Hypnotics and Related Medications Guideline Medications for Alcohol Use Disorder Guideline Medications for Cannabis Use Disorder Guideline Medications for Nicotine Use Disorders Guideline Medications for Opioid Use Disorder Guideline
Outcomes Measured	Monitor the utilization of ACT. Monitor the rate of Members receiving ACT services who: • visit an emergency department • are admitted to a hospital • are experiencing homelessness • encounter the justice system
References and Resources	SMHS FY2025-26 Billing Manual, BH-CONNECT Evidence-Based Practice Policy Guide 2025, DHCS Adult Evidence-Based Practices, PACT-ComprehensiveAssessmentTemplate.pdf

Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)

General Information	Coordinated Specialty Care (CSC) supports Members experiencing an initial episode of psychosis. CSC promotes recovery by providing timely and integrated support during the critical initial stages of psychosis to help Members cope with the symptoms of their mental health condition and to function and remain integrated in the community. CSC includes a wide range of individualized supports that are provided by a multidisciplinary team of licensed and non-licensed Providers. Participating in CSC has been shown to reduce the likelihood of psychiatric hospitalization, emergency room visits, residential treatment placements, criminal justice system involvement, substance use, and homelessness, and result in improved psychopathology and overall quality of life.
Adoption/Revision Date	Service available to BHS Members since February 2023.

Trend in SF	Since 2006, Felton Institute operates the program to fidelity, addressing the early signs of psychosis and bipolar disorder through the re(MIND) program.
BHS Medication Guidelines	Safer Prescribing of Antipsychotic Medication Guideline Safer Use of Psychotropic Medications in Children and Adolescents Guideline American Academy of Child and Adol Psychiatry Practice Parameters
Outcomes Measured	Monitor the utilization of CSC. Monitor the rate of Members receiving CSC services who: • visit an emergency department • are admitted to a hospital • are experiencing homelessness • involved in school or work
References and Resources	SMHS FY2025-26 Billing Manual, BH-CONNECT Evidence-Based Practice Policy Guide 2025, DHCS Adult Evidence-Based Practices

Individual Placement and Support (IPS)/Supported Employment

General Information	Individual Placement and Support (IPS) supports individuals living with behavioral health needs in obtaining and sustaining competitive employment to support their recovery. Members work with a team of employment specialists in their initial job search and have access to ongoing follow-along supports once employment is secured. IPS has been tied to improved self-esteem, community inclusion, reductions in homelessness and criminal justice system involvement, and improvements in overall quality of life among individuals living with behavioral health conditions.
Adoption/Revision Date	Supported Employment service will be available to BHS Members starting Summer 2026.
Trend in SF	SF Vocational Coop Services is a collaboration between Department of Rehabilitation (DOR) and BHS along with Richmond Area Multi Services Inc. Hire-Ability, Citywide Employment Program, Caminar Jobs Plus, Occupational Therapy Training Program, and PRC Employment Services for individualized support and job training.
BHS Medication Guidelines	General BHS Medication Guidelines, no specific guidelines indicated for this population.
Outcomes Measured	Monitor the utilization of IPS. Monitor the rate of Members receiving IPS services who: • visit an emergency department • are admitted to a hospital • are experiencing homelessness • involved in school or work

References and Resources	SMHS FY2025-26 Billing Manual, BH-CONNECT Evidence-Based Practice Policy Guide 2025, DHCS Adult Evidence-Based Practices,https://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters.aspx The IPS Employment Center – Research, Dissemination, Training, and Consultation

Enhanced Community Health Worker (CHW) Services

General Information	Enhanced CHW are preventive services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and behavioral health. Enhanced CHW Services include all the same service activities and practitioner requirements as other Medi-Cal CHW Services but are tailored to Medi-Cal Members who meet the access criteria for SMHS, DMC and/or DMC-ODS services.
Adoption/Revision Date	Currently not offered to BHS Members.
Trend in SF	N/A
Screening Tool(s)	N/A
BHS Medication Guidelines	General BHS Medication Guidelines, no specific guidelines indicated for this population.
Outcomes Measured	N/A
References and Resources	SMHS FY2025-26 Billing Manual, BH-CONNECT Evidence-Based Practice Policy Guide 2025, DHCS Adult Evidence-Based Practices. Practice Parameters, American Academy of Child and Adol Psychiatry Practice Parameters

Community Transition In-Reach Services (CTIRS)

General Information	Community Transition In-Reach Services will support adults, age 21 and older, who meet the access criteria for specialty mental health services, and who are experiencing or at-risk of experiencing extended stays in institutional settings in returning to the community. The In-Reach Team will provide intensive pre- and post-discharge care planning and transitional care management services. Qualifying BHPs may provide Community Transition In-Reach Services in inpatient, residential, or subacute settings, including IMDs.
Adoption/Revision Date	Currently not offered to BHS Members.
Trend in SF	N/A
BHS Medication Guidelines	General BHS Medication Guidelines, no specific guidelines indicated for this population.
Outcomes Measured	N/A

References and Resources	SMHS FY2025-26 Billing Manual, BH-CONNECT Evidence-Based Practice Policy Guide 2025, DHCS Adult Evidence-Based Practices. Practice Parameters,

Clubhouse

General Information	Clubhouses are inclusive, community-based environments to help Members living with behavioral health needs build emotional, cognitive, and social skills. Clubhouses facilitate opportunities to build skills and relationships to support Members in autonomous employment, education, and housing. Members work alongside Clubhouse staff as equals to contribute to shared community needs. Clubhouses offer employment programs and provide structured opportunities for socialization and recreation on evenings, weekends, and holidays.
Adoption/Revision Date	Service available to BHS Members March 2025.
Trend in SF	Westside Community Services operates a Clubhouse, to alleviate isolation, foster self-assurance, and cultivate skills for more effective life management, for a limited number of days during the week.
BHS Medication Guidelines	General BHS Medication Guidelines, no specific guidelines indicated for this population.
Outcomes Measured	Monitor the utilization of Clubhouse.
References and Resources	SMHS FY2025-26 Billing Manual, BH-CONNECT Evidence-Based Practice Policy Guide 2025, DHCS Adult Evidence-Based Practices

Children, Youth, and Families (CYF)/Transitional Age Youth

Multi-Systemic Therapy (MST)

General Information	Mult-Systemic Therapy (MST) is a family and community-based treatment that uses therapy sessions to address emerging high-risk behaviors including criminogenic behavior, anti-social activities, substance use, and other behaviors that may lead to juvenile justice involvement or out-of-home placement. Through MST, caregivers learn skills to independently address difficulties in raising children and adolescents as well as skills to cope with other family, peers, and neighborhood problems. MST emphasizes cultural responsiveness and the centering of home and community settings, as well as partnership with law enforcement and the juvenile justice system.
Adoption/Revision Date	Service available to BHS Members since September 2024.
Trend in SF	Seneca has been providing MST to juvenile justice-involved youth and their families, with each Provider serving 5-6 families at a time. From the

	CYF Specialties, Therapies, and Evidence-Based Practices (STEP) survey administered in Fall 2025, 15 Providers across multiple programs indicated using MST in FY24-25.
BHS Medication Guidelines	Safer Prescribing of Antidepressant Medication Guideline Safer Prescribing of Antipsychotic Medication Guideline Safer Prescribing of Mood Stabilizer Guideline Safer Prescribing of Sedative-Hypnotics and Related Medications Guideline Medications for Alcohol Use Disorder Guideline Medications for Cannabis Use Disorder Guideline Medications for Nicotine Use Disorders Guideline Medications for Opioid Use Disorder Guideline Safer Use of Psychotropic Medications in Children and Adolescents Guideline American Academy of Child and Adol Psychiatry Practice Parameters
Outcomes Measured	Monitor the utilization of MST.
References and Resources	SMHS FY2025-26 Billing Manual, BH-CONNECT Evidence-Based Practice Policy Guide 2025,DHCS Children and Youth Evidence-Based Practices

Functional Family Therapy (FFT)

General Information	Functional Family Therapy (FFT) is a multisystemic intervention designed for at-risk youth who experience challenges with externalizing behaviors (e.g., physical aggression, oppositional behavior, substance use) that require the engagement of the youth or family members' support system. FFT focuses on reducing adolescent behavioral problems, conduct disorder, substance use and recidivism, and improving parenting behaviors. A critical component of FFT is involvement of the family, caregivers, foster family, or other key home-based influences.
Adoption/Revision Date	Service available to BHS Members since February 2024.
Trend in SF	FFT has been provided by several organizations including Occupational Therapy Training Program (OTTP), Southeast Child & Family Therapy Center (SEFTC), and Mission Family Center (MFC). From the CYF Specialties, Therapies, and Evidence-Based Practices (STEP) survey administered in Fall 2025, 34 Providers across multiple programs indicated using FFT in FY24-25. Collectively FFT has been provided to at least 70 families.
BHS Medication Guidelines	Safer Use of Psychotropic Medications in Children and Adolescents Guideline American Academy of Child and Adol Psychiatry Practice Parameters
Outcomes Measured	Monitor the utilization of FFT.
References and Resources	SMHS FY2025-26 Billing Manual, BH-CONNECT Evidence-Based Practice Policy Guide 2025,DHCS Children and Youth Evidence-Based Practices

Parent-Child Interaction Therapy (PCIT)

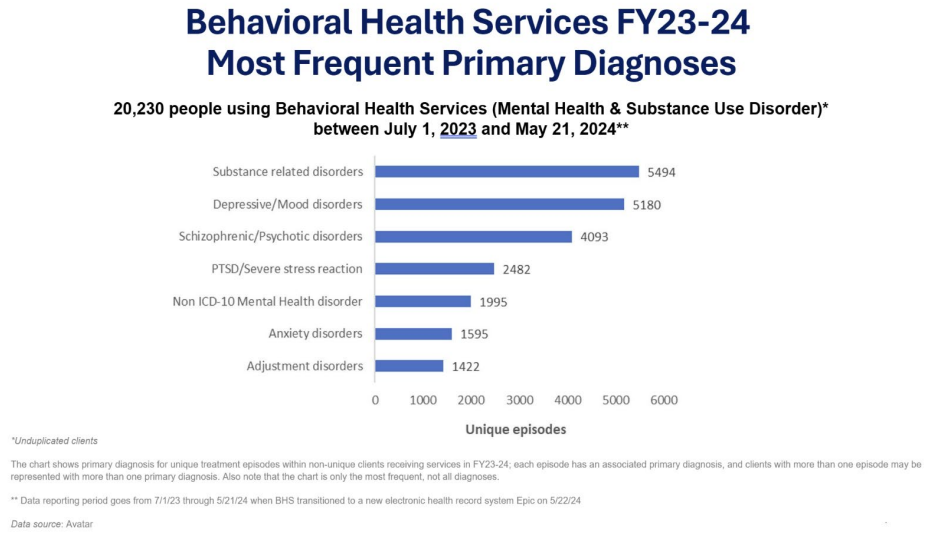
General Information	Parent-Child Interaction Therapy (PCIT) is a specialized behavior support intervention for young children, typically ages 2 to 8, and their parents/caregivers that strengthens the parent/caregiver-child relationship while reducing behavior challenges. Through PCIT, parents/caregivers are provided in-the-moment coaching, often using a wireless headset, while they engage in therapeutic play with their child. This helps parents/caregivers practice supportive and effective strategies in real time. PCIT focuses on decreasing child behavior challenges such as aggression, noncompliance, and tantrums, increasing positive parent/caregiver skills, and improving the parent/caregiver-child relationship through structured interactions.
Adoption/Revision Date	Service available to BHS Members since June 2025.
Trend in SF	Currently 13 CYF Providers are trained to provide PCIT, and 10 families are actively receiving PCIT services. From the CYF Specialties, Therapies, and Evidence-Based Practices (STEP) survey administered in Fall 2025, 30 Providers across multiple programs indicated using PCIT in FY24-25.
BHS Medication Guidelines	General BHS Medication Guidelines, no specific guidelines indicated for this population.
Outcomes Measured	Monitor the utilization of PCIT.
References and Resources	SMHS FY2025-26 Billing Manual, BH-CONNECT Evidence-Based Practice Policy Guide 2025,DHCS Children and Youth Evidence-Based Practices

High Fidelity Wraparound (HFW)

General Information	High-Fidelity Wraparound (HFW) is a team-based, family-centered approach for children and youth, typically birth to 21, with intensive behavioral health needs that builds an individualized plan of care and coordinates services around what the family needs to succeed. HFW is often an alternative to out-of-home placement by coordinating intensive supports in the family's home and community. The process is strengths-based and emphasizes family and youth voice and choice by bringing together natural supports and Providers to create, carry out, and adjust a single coordinated plan over time.
Adoption/Revision Date	Service will be available to BHS Members starting Summer 2026.
Trend in SF	Seneca, Edgewood, and Family Mosaic Project to deliver HFW FFPSA Aftercare Part IV services for approximately 160+ clients starting June 2026.

BHS Medication Guidelines	Safer Use of Psychotropic Medications in Children and Adolescents Guideline, American Academy of Child and Adol Psychiatry Practice Parameters
Outcomes Measured	Monitor the utilization of HFW.
References and Resources	SMHS FY2025-26 Billing Manual, BH-CONNECT Evidence-Based Practice Policy Guide 2025,DHCS Children and Youth Evidence-Based Practices, https://www.dhcs.ca.gov/Documents/Medi-Cal-HFW-Concept-Paper.pdf, FFPSA Part IV, FFPSA Part IV | Continuing and Professional Education | Human Services, BHIN 21-062

Diagnostic Specific Guidelines



Substance Use Disorders

General Information	DSM 5: The substance-related disorders encompass 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants; tobacco; and other (or unknown) substances. All drugs that are taken in excess have in common the ability to directly activate the brain reward systems, which are involved in the reinforcement of behaviors and establishment of memories. Instead of achieving reward system activation through adaptive behaviors, these substances produce such an intense activation of the reward system that normal activities may be neglected.
Related DSM Diagnoses (Partial List)	F10.20 Alcohol Use Disorder, Moderate F10.239 Alcohol Withdrawal, without perceptual disturbances 304.30 Cannabis-Use Disorder, Moderate F15.20 Stimulant Use Disorder, Moderate, Amphetamine-type substance F14.20 Stimulant Use Disorder, Moderate, Cocaine

Adoption/Revision Date	Reviewed and updated as needed February 2026.
Trend in SF	FY23-24 Data: Out of 20,230 Members using BHS, Substance Related Diagnosis was the Primary Dx for 5,494 Members.
Screening Tool(s)	Alcohol, Smoking, and Substance Involvement Screening Test, WHO (ASSIST) Addiction Severity Index (ASI) CAGE or CAGE-AID: Drug Abuse Screening Test (DAST, DAST-10, DAST-28) NIAAA Alcohol Screening for Youth Penn Alcohol Craving Scale (PACS) Screening to Brief Intervention (S2BI)
BH Evidenced Based Practices	Treatment considerations for Youth and Young Adults with Serious Emotional Disturbances and Serious Mental Illness and Co-occurring Substance Use
BHS Medication Guidelines SUD Medication Prescribing Resources	Medications for Alcohol Use Disorder Guideline Medications for Cannabis Use Disorder Guideline Medications for Nicotine Use Disorders Guideline Medications for Opioid Use Disorder Guideline
Outcomes Measured See Appendix C: Behavioral Health Accountability Set (BHSA) Measurement Year.	The Initiation and Engagement of Substance Use Disorder (IET) measure is a two-part performance tool that tracks how effectively health systems connect patients with a new Substance Use Disorder (SUD) diagnosis to timely, ongoing treatment, including psychosocial care and medication treatment. The IET measure applies to adolescents and adults (13+ years) and consists of two distinct rates based on a new episode of SUD; if treatment was initiated within 14 days, and if follow-up engagement treatment occurs within 34 days of the initial treatment. IET is recognized as a vital intermediate indicator of recovery, as early, consistent engagement reduces mortality, relapse, and healthcare costs.
Considerations for Youth and Minors	Safer Use of Psychotropic Meds in Child and Adolescents 2025 .pdf American Academy of Child and Adol Psychiatry Practice Parameters Clinical Practice Guidelines for CYF
References and Resources	Diagnostic and Statistical Manual of Mental Disorders (DSM) | Psychiatry Online

Opioid Use Disorder

General Information and DSM	An opioid is a synthetic or natural agent that stimulates opioid receptors and produces opium-like effects. Opiates are a type of opioid that are naturally derived from the opium poppy (e.g., codeine, morphine, opium). They are used to treat pain but may also be misused because of their euphoric effects. DSM defines opioid use disorder as a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least 2 out of 11 criteria within a 12-month period

Related DSM Diagnoses (Partial List)	F304.00 Opioid Use Disorder, Moderate F11.229 Opioid Intoxication, without perceptual disturbances, with use disorder, moderate or severe F11.23 Opioid Withdrawal
Adoption/Revision Date	Reviewed and updated as needed February 2026.
Trend in SF	FY23-24 Data: Out of 20,230 Members using BHS, Substance Related Diagnosis was the Primary Dx for 5,494 Members.
Screening Tools:	Alcohol, Smoking, and Substance Involvement Screening Test, WHO (ASSIST) Addiction Severity Index (ASI) CAGE or CAGE-AID: Drug Abuse Screening Test (DAST, DAST-10, DAST-28) NIAAA Alcohol Screening for Youth Penn Alcohol Craving Scale (PACS) Screening to Brief Intervention (S2BI) Opioid Risk Tool (ORT)
BH Evidenced Based Practices	ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: Pocket Guide
BHS Medication Guidelines Opioid Use Disorder Medication Prescribing Resources	OUD_Background_and_Evaluation.pdf Medications_for_Opioid_Use_Disorder_h3UgrzE.pdf SFDPH_DTI_5.20.25.pdf OUD_Clinical_Considerations.pdf Naloxone_Guideline.pdf OUD_References_and_Further_Reading.pdf Methadone_for_Treatment_of_Opioid_Use_Disorder_in_an_Opioid_Treatment_Program__gC9xQi0.pdf
Outcomes Measured See Appendix C: Behavioral Health Accountability Set (BHSA) Measurement Year.	The Centers for Medicare & Medicaid Services (CMS) Use of Pharmacotherapy for Opioid Use Disorder (OUD) measure serves as an intermediate outcome measure to treatment retention. This core measure tracks the percentage of Medi-Cal beneficiaries (age 18-64) with an opioid use disorder who receive medication-assisted treatment (MAT/MOUD). The goal of OUD is to improve outcomes by reducing mortality risk and decreasing ED visits. The Healthcare Effectiveness Data and Information Set (HEDIS) Pharmacotherapy for Opioid Use Disorder (POD) measure is a quality metric that evaluates the percentage of Medi-Cal Members 16 years of age and older with a new Opioid Use Disorder (OUD) diagnosis who remain on FDA-approved medication-assisted treatment (MAT) for at least 180 days (approximately 6 months). As an SUD outcome measure, it acts as a crucial indicator of treatment retention and stability, aiming to reduce relapse, overdose, and mortality.

Considerations for Youth and Minors	Safer_Use_of_Psychotropic_Meds_in_Child_and_Adolescents_2025_.pdf American Academy of Child and Adol Psychiatry Practice Parameters Clinical Practice Guidelines for CYF
References and Resources	Diagnostic and Statistical Manual of Mental Disorders (DSM) | Psychiatry Online

Mood Disorders

General Information and DSM	DSM 5: Mood Disorders are excessive disturbances of a person's emotional state that are abnormal and persistent and affect ability to function. Mood disorders include Depressive disorders (see section Depression below for subtypes) and Bipolar and related disorders. Bipolar disorders include periods of mania (elevated, expansive, or irritable mood and increased activity or energy) or hypomania, typically alternating with periods of depression. Individuals with bipolar disorder are at high risk of suicide; Provider should screen Members for suicide risk and establish safety plan when clinically indicated.
Related DSM Diagnoses (Partial List)	F31.12 Bipolar I Disorder, Current or most recent episode manic, Moderate F31.0 Bipolar I Disorder, Current or most recent episode hypomanic F31.5 Bipolar I Disorder, Current or most recent episode depressed, with psychotic features F31.81 Bipolar II Disorder F39 Unspecified Mood Disorder
Adoption/Revision Date	Reviewed and updated as needed February 2026.
Trend in SF	FY23-24 Data: Out of 20,230 Members using BHS, Depressive/Mood Disorder Diagnosis was the Primary Dx for 5,180 Members.
Screening Tool(s) *Not available in EHR	Mood Disorder Questionnaire (MDQ)*
BH Evidenced Based Practices	World Health Organization| Evidence-based recommendations for management of psychosis and bipolar disorders in non-specialized health settings Department of Veterans Affairs Department of Defense| Clinical Practice Guideline for Management of Bipolar Disorder
BHS Medication Guidelines	MUIC_Safer_Use_of_Mood_Stabilizers_Guideline_2024-04-04.pdf, American Psychiatric Association: Practice Guideline for the Treatment of Patients With Bipolar Disorder. Second Edition. Published 2002.,
Outcomes Measured	N/A
Considerations for Youth and Minors	APA: Treating bipolar disorder in kids and teens

	Journal of the American Academy of Child & Adolescent Psychiatry| Practice Parameter for the Assessment and Treatment of Children and Adolescents with Bipolar Disorder Safer Use of Psychotropic Meds in Child and Adolescents 2025 .pdf American Academy of Child and Adol Psychiatry Practice Parameters Clinical Practice Guidelines for CYF
References and Resources	American Psychiatric Association: Practice Guideline for the Treatment of Patients with Bipolar Disorder. Second Edition. Published 2002.,

Depression

General Information and DSM	The general feature of depression is the presence of sad, empty, or irritable mood, accompanied by related changes that significantly affect the individual's capacity to function (e.g., somatic, and cognitive changes in major depressive disorder and persistent depressive disorder). Individuals with depression may present with other symptoms such as predominant complaints of body aches, pain, fatigue, and may be exacerbated by the use of substances. Suicide and self-harm are significant risks in depression, and it is important for a Provider to screen Member for suicide risk and establish safety plan when clinically indicated.
Related DSM Diagnoses (Partial List)	F32.0 Major Depressive Disorder, Single episode Mild F33.3 Major Depressive Disorder, Recurrent episode, With Psychotic Features F34.1 Persistent Depressive Disorder
Adoption/Revision Date	Reviewed and updated as needed February 2026.
Trend in SF	FY23-24 Data: Out of 20,230 Members using BHS, Depressive/Mood Disorder Diagnosis was the Primary Dx for 5,180 Members.
Screening Tool(s) *Not available in EHR	General: Patient Health Questionnaire-9 (PHQ-9) Children and Youth: The Center for Epidemiological Studies Depression Scale for Children (CES-DC) (aged 6 or above), Patient Heath Questionnaire –A (PHQ-A) (aged 11-17)* Pregnancy and postnatal: Edinburgh Postnatal Depression Scale Geriatric: Geriatric Depression Scale (GDS) (aged 60 or above) Suicide-risk: Columbia-Suicide Severity Rating Scale (C-SSRS)
BH Evidenced Based Practices	APA Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts, Depression Treatments for Adults
BHS Medication Guidelines	Safer Prescribing of Antidepressant Medications Guideline
Outcomes Measured	N/A

Considerations for Youth and Minors	American Academy of Child & Adolescent Psychiatry| Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Major and Persistent Depressive Disorders APA Clinical Practice Guideline for the Treatment of Depression in Children and Adolescents Safer Use of Psychotropic Meds in Child and Adolescents 2025 .pdf American Academy of Child and Adol Psychiatry Practice Parameters Clinical Practice Guidelines for CYF
References and Resources	Diagnostic and Statistical Manual of Mental Disorders (DSM) | Psychiatry Online Clinical Practice Guidelines for the Management of Depression Neurology (3rd Edition), pp.54-55

Post Traumatic Stress Disorder (PTSD)

General Information and DSM	PTSD is characterized by exposure to a potentially traumatic event or events, the development, and persistence of specific trauma-related mental health symptoms beyond initial reactions (defined as several weeks or one month), and functional impairment. Comorbid conditions are very common for individuals with PTSD, including comorbid major depressive Disorder, anxiety disorders, substance use disorders, as well as somatization disorder or other somatoform disorders; in children and adolescents, some externalizing disorders such as attention-deficit/hyperactivity disorder (ADHD) and opposition defiant disorder are common co-occurring disorders. Thus, identification and treatment of comorbid psychiatric and any other medical illness are important to an integrated treatment plan that addresses all of Member's needs.
Related DSM Diagnoses (Partial List)	F94.1 Reactive Attachment Disorder F43.10 Post Traumatic Stress Disorder F43.0 Acute Stress Disorder F43.81 Prolonged Grief Disorder
Adoption/Revision Date	Reviewed and updated as needed February 2026.
Trend in SF	FY23-24 Data: Out of 20,230 Members using BHS, PTSD/Severe Stress Reaction Diagnosis was the Primary Dx for 2,482 Members.
Screening Tool(s)	General: PTSD Checklist for DSM-5 (PCL 5) Children and Youth: Children and Adolescents Trauma Screen (CATS)
BH Evidenced Based Practices	APA Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults, Treatments for PTSD
BHS Medication Guidelines	PRACTICE GUIDELINE FOR THE Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder Safer Prescribing of Antidepressant Medication Guideline Safer Prescribing of Sedative-Hypnotics and Related Medications Guideline

Outcomes Measured	N/A
Considerations for Youth and Minors	Posttraumatic Stress Disorder in Children Safer_Use_of_Psychotropic_Meds_in_Child_and_Adolescents_2025_.pdf American Academy of Child and Adol Psychiatry Practice Parameters Clinical Practice Guidelines for CYF
References and Resources	APA Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder US Department of Veterans Affairs| PTSD in Children and Adolescents Pediatric Trauma Society| Mental Health Guideline

Anxiety

General Information and DSM	DSM 5: Anxiety disorders include disorders that share features of excessive fear and anxiety and related behavioral disturbances. Fear is the emotional response to real or perceived imminent threat, whereas anxiety is anticipation of future threat. Obviously, these two states overlap, but they also differ, with fear more often associated with surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger, and escape behaviors, and anxiety more often associated with muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviors. The anxiety disorders differ from one another in the types of objects or situations that induce fear, anxiety, or avoidance behavior, and the associated cognition.
Related DSM Diagnoses (Partial List)	F93.0 Separation Anxiety Disorder F40.10 Social Anxiety Disorder F41.0 Panic Disorder F41.1 Generalized Anxiety Disorder
Adoption/Revision Date	Reviewed and updated as needed February 2026.
Trend in SF	FY23-24 Data: Out of 20,230 Members using BHS, Anxiety Disorder Diagnosis was the Primary Dx for 1,595 Members.
Screening Tool(s)	General: Generalized Anxiety Disorder 7-item (GAD7) Children and Youth Specific: Screen for Child Anxiety Related Disorders (SCARED)
BH Evidenced Based Practices	National Institute for Health and Care Excellence (NICE) Generalized anxiety disorder and panic disorder in adults: management
BHS Medication Guidelines	Safer Prescribing of Antidepressant Medication Guideline Safer Prescribing of Sedative-Hypnotics and Related Medications Guideline
Outcomes Measured	N/A

Considerations for Youth and Minors	Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders Safer_Use_of_Psychotropic_Meds_in_Child_and_Adolescents_2025_.pdf American Academy of Child and Adol Psychiatry Practice Parameters Clinical Practice Guidelines for CYF
References and Resources	Treatment Guidelines: Anxiety and Related Disorders

Schizophrenia and Other Psychotic Disorders

General Information and DSM	DSM 5: Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms. Providers should include suicide risk and aggressive behaviors in their assessment.
Related DSM Diagnoses (Partial List)	F21 Schizotypal (Personality) Disorder F22 Delusion Disorder F23 Brief Psychotic Disorder F20.96 Schizophrenia F25.1 Schizoaffective Disorder, Depressive type
Adoption/Revision Date	Reviewed and updated as needed February 2026.
Trend in SF	FY23-24 Data: Out of 20,230 Members using BHS, Schizophrenic/Psychotic Disorder Diagnosis was the Primary Dx for 4,093 Members.
Screening Tool(s)	Abnormal Involuntary Movement Scale (AIMS scale), Positive and Negative Syndrome Scale (PANSS), Prodromal Questionnaire – Brief, Prime Screening for Psychosis
BH Evidenced Based Practices	Treatment for Adults with Schizophrenia: A Systematic Review | SAMHSA The American Psychiatric Association Practice Guideline for the Treatment of Patients with Schizophrenia, Third Edition
BHS Medication Guidelines	Safer_Antipsychotic_Prescribing_Guideline_May_2024_IhUgVyH.pdf, MetabolicMonitorAtypicalAntipsychoticHandout_J6d7L1B.pdf, Anticholinergics-English_YCvRP7N.pdf., The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia, Third Edition
Outcomes Measured See Appendix C: Behavioral Health Accountability Set	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) The percentage of persons 18 years of age and older during the measurement period, with schizophrenia or schizoaffective disorder, who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

(BHSA) Measurement Year.	
Considerations for Youth and Minors	National Institute for Health and Care Excellence| Psychosis and schizophrenia in children and young people: recognition and management Clinical Practice Guidelines for the Management of Schizophrenia in Children and Adolescents Safer_Use_of_Psychotropic_Meds_in_Child_and_Adolescents_2025_.pdf American Academy of Child and Adol Psychiatry Practice Parameters Guidance on Strategies to Promote Best Practice in Antipsychotic Prescribing for Children and Adolescents | SAMHSA, The California Evidence-Based Clearinghouse for Child Welfare, ChoosingTheRightTreatment.qxd Clinical Practice Guidelines for CYF
Youth Outcomes Measured See Appendix C: Behavioral Health Accountability Set (BHSA) Measurement Year.	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) The percentage of persons 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
References and Resources	APA Practice Guideline for the Treatment of Patients with Schizophrenia, 3rd Edition

BHS Clinical Workflow

Access, Referrals, and Screening

Transparent Access to Care

An important aspect of CalAIM is the focus on timely and coordinated access to care regardless of where a Member first seeks services. This notion of "No Wrong Door," timely access, and equitable access is consistent with San Francisco Behavioral Health Services (BHS) vision for "all San Franciscans to experience mental and emotional well-being and participate meaningfully in the community across life spans and generations." The benefits of centralized and standardized processes for access to care include:

- Reduced Wait Time: Centralized processes promote timely access with streamlined workflows, faster eligibility processes, and an opportunity to identify the best fit services in real time for those in need.

- Improved Member Access and Experience: BHS aims to improve Member access and experience, foster positive Provider experience, and develop streamlined and efficient operations. These shifts aim to address the increased demand for accessible services and reduce the need for Members and families to navigate a complex and confusing service delivery system. Additionally, a coordinated entry to services aims to reduce an individual's need to tell their story multiple times as they journey to access the most appropriate care to meet their needs.

- Person/Family Centered Access: Consistent use of screening tools honor and promote the individual and unique needs of those we serve AND help tell stories about regional public health needs and inequities. These tools ensure that we ask all individuals critical questions related to who they are and how we can support them. OCC staff and Representatives of OCC assess for immediate needs, level of care, location, language, culture, and preferences for Provider and specialization. OCC staff and Representatives of OCC are familiar and knowledgeable about the community resources, clinics, and programs located throughout the system of care.

- Flexible Systems: Maintain the referral streams and community relationships that remove barriers to care for and meet the needs of Members.

- Strong Connections between Access Points and Care: The vision is to further deepen the connections between access points and Programs to ensure a warm and timely welcome and an appointment at the Program that can best meet the needs of the Member. Strengthening the collaboration between access points and Programs can increase awareness of available services as well as improving communication feedback loops. By utilizing a team approach to patient care, our network of Providers can have a better understanding of Member's history and needs and avoidance of service duplication. For many, the appointment offers hope and some relief that services are around the corner.

- Improved Provider Experience: Centralized access points are also intended to reduce administrative burden on clinics and Providers, allowing for more time to focus on service delivery and Member care. Given the complexity and frequent changes, centralized workflows related to assessing appropriateness for specialty services, eligibility, and other insurance requirements allow BHS to stay up to date and ensure that all Members receive the coverage they deserve. These shifts reduce the need for Programs and clinics to grapple with evolving changes and develop complex policies and procedures related to front end administrative requirements.

- Improved Data Reporting & Opportunities to Address Gaps: Centralized access points help us coordinate our systems, manage referral pathways consistently and equitably, and allow for system wide data reporting on Member needs, capacity and gaps in available services Effective data sharing is also a key priority as it serves as the engine of good care for BHS. There is also an emphasis on seeing patterns and responding globally to gaps, access, equity, social determinants of health, and population health issues to improve health outcomes proactively.

See No Wrong Door for Mental Health Services 3.04-11 at Behavioral Health Services Policies and Procedures | SF.gov. for more information.

Centralized Access through Office of Coordinated Care (OCC)

The Office of Coordinated Care (OCC) was called for by the 2019 Mental Health SF legislation to be SF BHS' central access point charged with 1) ensuring seamless access to care and 2) engaging and connecting people most vulnerable to disengaging from care. OCC is situated within the BHS Managed Care section and has two sections, Care Coordination Services and Central Access & Eligibility Services. Central Access & Eligibility

Services provides information, central access and eligibility, screening, and direct connection to behavioral health care for Members.

Access Criteria and Medical Necessity

The access criteria are different for Members 21 years of age and older and Members under the age of 21 years of age. It is important to note early on that Members can start receiving clinically appropriate services as long as they would benefit from SMHS and/or DMC-ODS services, even if a final diagnosis eligibility determination has not yet been made. See Behavioral Health Information Notice (BHIN) No: 26-002., BHIN 22-003, and California Code, WIC 14184.402 for more information.

SMHS Members under Age 21

SMHS shall be provided to Members under Age 21 who meet either of the following criteria, (1) or (2) below:

The Member has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following:
(1) Scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.
OR
(2) The Member meets both of the following requirements in a) and b), below:

a. The Member has at least one of the following:

i. A significant impairment.
ii. A reasonable probability of significant deterioration in an important area of life functioning.
iii. A reasonable probability of not progressing developmentally as appropriate.
iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal Managed Care Plan (MCP) is required to provide.

AND

b. The Member's condition as described in subparagraph (2) above is due to one of the following:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the ICD.
ii. A suspected mental health disorder that has not yet been diagnosed.
iii. Significant trauma placing the Member at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

If a Member under age 21 meets the criteria as described in (1) above, the Member meets criteria to access the SMHS delivery system; it is not necessary to establish that the Member also meets the criteria in (2) above.

For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as incorporated in subdivision (b)(1) of W&I Code section 14059.5. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan and, in the case of optional benefits by county or plan, irrespective of whether the BHP has opted to offer the benefit in question. Furthermore, federal guidance

from the Centers for Medicare & Medicaid Services (CMS) makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

SMHS Members 21 Years of Age or Older

For Members 21 years of age or older, a county BHP shall provide covered SMHS for Members who meet both of the following criteria, (1) and (2) below:

(1) The Member has one or both of the following:

a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

b. A reasonable probability of significant deterioration in an important area of life functioning.

AND

(2) The Member's condition as described in paragraph (1) is due to either of the following:

a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD).

b. A suspected mental disorder that has not yet been diagnosed.

Pursuant to W&I Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in subdivision (a) of W&I Code section 14059.5.

DMC-ODS Members under Age 21

Members under age 21 qualify to receive all medically necessary DMC-ODS services as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require states to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services. DMC-ODS plans are obligated to provide early intervention services under the outpatient modality to members under the age of 21 at risk of developing an SUD, regardless of whether they meet diagnostic criteria for SUD, and even if the member is not participating in the full array of outpatient treatment services. For additional information regarding EPSDT requirements, please refer to BHIN 22-003.

DMC-ODS Members 21 Years of Age or Older

To qualify for DMC-ODS services after the initial assessment process, members 21 years of age and older must meet one of the following criteria:

(1) Have at least one diagnosis from the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders,
OR
(2) Have had at least one diagnosis from the DSM for Substance Related and Addictive Disorders, with the exception of Tobacco Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

BHS Access Points

The Table below highlights the points within BHS that have been identified as access points, both those within OCC as well as those access points within the larger system that have been designated as "Representatives of OCC."

Access Type	Access Point	Description
Office of Coordinated Care	Behavioral Health Access Line (BHAL)	*24/7 state mandated phone line serving as a central and well-publicized access point for connecting individuals to behavioral health services. *Takes self-referrals from individuals seeking services and provides general information about behavioral health services. Also receives and manages referrals from Medi-Cal Managed Care plans for individuals needing specialty behavioral health services. *BHAL Toll Free Number: 888-246-3333
	Behavioral Health Access Center (BHAC)	*Central walk-in access point for connecting beneficiaries to behavioral health services. *Takes self-referrals from individuals seeking services and provides general information about behavioral health services. *Location: 1380 Howard Street, 1st floor *Open Mon-Fri 8am-7pm, Sat-Sun 9am-4pm
	Triage & Transition Support Team	*Central referrals point for OCC's care coordination services with focus on individuals post-involuntary hold, post-crisis, unhoused/experiencing homelessness. *Takes referrals from hospitals for individuals on involuntary holds, psychiatric emergency services, Comprehensive Crisis Services, Street Crisis Response Team, San Francisco Coordinated Street Response, and shelters and navigation centers.
	Human Services Agency (HSA)	*Children, Youth & Family (CYF) hub for connecting Human Service Agency (HSA) child welfare involved youth to behavioral health services; ages 0-21 yrs. *Takes referrals from Multi-Agency Service Team (MAST) and BHS Access Points (OCC & Representatives of OCC)
	Juvenile Justice	*Children, Youth & Family (CYF) hub for connecting juvenile justice-involved youth to behavioral health services; ages 0-18 yrs old.

Representative of Office of Coordinated Care (OCC)		*Takes referrals from Multi-Agency Service Team (MAST) and BHS Access Points (OCC & Representatives of OCC)
	Educationally Related Mental Health Services (ERMHS)	*Children, Youth & Family (CYF) hub for connecting *eligible* youth to educationally related mental health services; ages 3-22 yrs old. *Takes referrals from specific SFUSD Schools.
	Children, Youth & Family (CYF) Outpatient Program	*Children, Youth & Family (CYF) access point to support timely access for new Members. *Takes referrals from BHS Access Points (OCC & Representatives of OCC)
	Comprehensive Child Crisis	* Children, Youth & Family (CYF) access point for immediate crisis services. Ongoing services will be coordinated via the CYF Outpatient Hub *Crisis Number: 628-217-7000
	Transitional Age Youth (TAY) Linkage	* Transitional Age Youth (TAY) hub receiving referrals from key community partners for TAY who need connection to specialty and non-specialty behavioral health services; ages 18-25 yrs old.

Other BHS Access Points: Utilization Management

BHS Utilization Management (UM) also receives and authorizes referrals from Providers for individuals who are not currently connected to care in BHS and are directly seeking residential mental and substance use services.

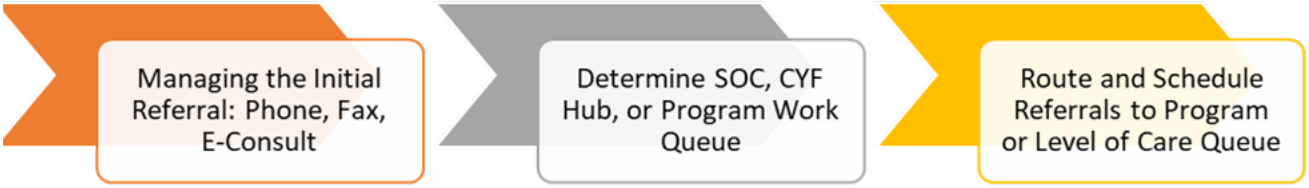
Consistent access procedures include the use of standardized screening tools to support determination of specialty behavioral health needs, level of care where they would be best served, and consistent referral and tracking processes. This standardization will allow BHS access points to:

- Quickly and efficiently connect individuals with the care they need.
- Have clear and consistent methods to determine level of care needs.
- Obtain greater visibility into referral status and system capacity.
- Enhance data tracking to better understand timely access and system needs.

Providers may contact **BHSCentralUM@sfdph.org** to determine the most appropriate level of care for referral, if needed. Providers are asked to request only one level of care at a time and to collaborate with other treatment Providers to identify the correct referral for each situation and minimize duplicate requests.

For additional information please reference BHS 3.03-22 Authorization of Outpatient Specialty Mental Health Services at Behavioral Health Services Policies and Procedures | SF.gov.

BHS Referrals



There are many steps from the initial referral request to the scheduling of the intake appointment including screening, level of care assessments, transcribe order, referral entry, eligibility, scheduling intake, and closing the referral. For referrals that go through the Office of Coordinated Care (OCC), OCC will complete most of the referral workflow, complete the eligibility check, and schedule the intake appointment. For referrals that go directly to the system of care, the Program will need to complete all the necessary steps to ensure that the referral workflow is followed and completed. At the first intake appointment, the Program will obtain the signed consent for services, complete the registration process, and start the assessment process. Within 60 days of the intake appointment, the Member will receive a comprehensive assessment to confirm that they meet medical necessity for services and have a qualifying mental health diagnosis for services as defined by Department of Health Care Services (DHCS).

OCC Workflow for New Referrals to System of Care

Most referrals for BHS services requests will be managed by the Office of Coordinated Care. OCC receives referral requests from multiple sources including calls from the Behavioral Health Access Line (BHAL) at 888-246-3333, walk ins from Behavioral Health Access Center (BHAC) at 1380 Howard St, Hospitals/Psychiatric Emergency Services (PES), Jail, TAY Linkage, Specialty Care, and Non-Specialty Care such as from Manage Care Plans. OCC follows a standardized process for triaging all new referrals into the BHS system after they receive the referral. They will first check and see if the Member is already in the EHR and if not, add the Member into the EHR. There are several screening tools used by OCC and by Programs that accept direct Member referrals. See BHS Screening Tools section for more information.

Walks-Ins and Direct Calls for Services

For non-urgent walk-ins or phone calls from individuals or a referral from community Provider/other referral source, Programs that are not approved to accept direct referrals must support a warm connection to OCC as the next step in the referral process.

When a referral received directly by a Program needs to be sent to OCC to manage, steps will vary depending on referral method:

Referral Method	Warm Connection to OCC
Phone call direct to the Program.	*The Program will initiate a 3-way call to BHAL (628)217-7799 and facilitate a warm hand-off to the BHAL staff answering the phone.

	*BHAL staff will then follow standard referral management procedures. *If there are language needs that that the Program is able to provide, BHAL may request for the Provider to stay on the line and assist when the use of the interpreter line is not clinically indicated.
Member walks into the Program.	*Program staff will identify a confidential room with a telephone and initiate a call to BHAL with the client. *BHAL staff will follow standard referral management procedures and should prioritize the call to ensure there is no need for callback. *If there are language needs that the Program can provide, BHAL may request the Provider to stay on the line and assist when the use of the interpreter line is not clinically indicated. *If BHAL determines that the client is in crisis and in need of immediate crisis intervention, the on-site Program staff will step in to support with resolving the crisis (see Crisis Walk-Ins section below).
Fax or Email referral sent to the Program.	*The Program will submit an E-Consult to BHS OCC Referral Order. *This will be routed to BHAL, and BHAL staff will then follow standard referral management procedures.

Crisis Walk-Ins

Most referrals will be managed through the OCC. However, there may be times when a Program receives a direct call or walk-in to the clinic, and the Member is presented in a crisis with an immediate need for services. In these situations, the Provider may begin immediate services using the *No Wrong Door Visit Type*, which bypasses some of the steps required for ongoing services. As soon as the Member is stabilized, there are standardized steps that must be taken to meet the timely access requirements and to open the client through a direct referral. Providers may always consult with OCC or a Representative of OCC regarding service needs and if it is determined after the assessment is completed, the Provider may follow the steps for a level of care change request.

Consents and Intake Paperwork

See Appendix D: Adult/Older Adult/Transitional Age Youth (AOA/TAY) Requirements at Intake, First 60 Days, Updates, and Discharge and Appendix E: Children, Youth and Families/Transitional Age Youth (CYF/TAY) Requirements at Intake, First 60 Days, Updates, and Discharge for more information regarding the episode opening paperwork including signed consents for services.

Informed Consent

Informed consent is a legal and ethical requirement that ensures that Members understand the therapy treatment process, risks, and benefits, as well as their rights as Members. This typically includes the potential risks and benefits of therapy, confidentiality and its limitations, course and goals of therapy, termination, emergency procedures, and the Provider's qualifications and limitations. The informed consent is in addition to the consents and paperwork that a Member will complete and sign at intake. Providers should consult with their supervisor or System of Care Leadership to determine what to review with Members under informed consent for the agency.

Telehealth Consent

BHS supports the delivery of behavioral health services through telehealth. California law defines telehealth as "a mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at the originating site and health care Provider is at the distant site." Telehealth is not a distinct service, but an allowable mechanism to provide clinical services. The standard of care is the same whether the Member is seen in-person, by telephone, or through telehealth with either video or audio-only. Members may receive services via telehealth in their home or other chosen location. In the event of technology failure, Providers should have an alternative way to provide the service.

BHS Providers must first inform the Member about the use of telehealth and assess whether the use of telehealth services would be appropriate for the Member. Members for whom telehealth sessions are not appropriate can include:

- Members with unstable phone or internet connections.
- Members who prefer in-person services.
- Members with more severe or complex conditions.
- Members at higher risk of needing urgent, immediate intervention.
- Members who have difficulty accessing private and/or safe spaces.
- Members who require monitoring of side effects related to medication(s).
- Members whose age or developmental stage makes telehealth suboptimal.
- Members engage in therapeutic modalities that make telehealth suboptimal, such as family therapy.

Prior to starting telehealth services, the Provider must review with the Member their rights, potential limitations, and risks with telehealth services, and obtain the consent for telehealth services with the Member.

<u>Examples of Potential Risks of Telehealth Services</u>

- The internet/phone connection may not be stable, or it may stop working during the session.
- A telephone session does not allow the Provider to assess the Member's expression or other important visual data (e.g., bruises or medication side effects like a rash).
- A Provider will not be able to intervene immediately in a crisis.
- Some Members will feel that telehealth negatively impacts the therapeutic alliance.

<u>Examples of Potential Benefits of Telehealth Services</u>

- Convenience: Members will not have to travel to a Program for treatment.
- Telehealth improves accessibility, which may result in improved show-rates.

For more information, see BHS Telehealth Services Policy via SF BHS Policy and Procedures website and DHCS Telehealth webpage.

Documenting Telehealth Consent

SB-184 Health (2021-2022) and DHCS BHIN 23-018 set forth specific requirements regarding telehealth services and guidelines for the telehealth consent. In the EHR, the Provider must use the *Telehealth Consent Smartphrase* form and complete the required sections in pink. The telehealth consent is required once per *Episode,* but it is recommended that the impact of telehealth services with the Member are evaluated throughout the course of treatment. For more information, see BHS Telehealth Policy 3.02-07.

Minor Consent

Under Family Code §6924 and Health & Safety Code §124260, a minor has the right to consent to their own treatment when specific requirements are met. Consent to treatment must be obtained to provide mental health services. California laws for minor consent are as follows:

Family Code §6924	Health & Safety Code §124260
*The minor is 12 years of age or older. *In the opinion of the Provider, the minor is mature enough to participate in outpatient services, and *Without the treatment, the minor either presents a danger of serious physical or mental harm to themselves or others OR the minor is a victim of incest or child abuse. *The practitioner must involve the minor's parent/guardian unless, in the opinion of the Provider, the involvement would be inappropriate.	*The minor is 12 years of age or older. *In the opinion of the Provider, the minor is mature enough to participate in outpatient services. *Treatment authorized by this section must include involvement of the minor's parent/guardian, unless after consulting with the minor, the Provider determines that involvement of the minor's parent(s)/guardian(s) would be inappropriate.

For more information regarding minor consents, see Bill Text - AB-665 Minors: consent to mental health, services. Bill Text - AB-665 Minors: consent to mental health services. California Code, Welfare and Institutions Code - WIC § 5328.03 | FindLaw , California Code, Civil Code - CIV § 56.106 | FindLaw , FAQs_Minor_Consent_Services_for_Youth_12_and_Older__FINAL_8.15.25.pdf.

SUS Minor Consent

In California, minors have defined rights to consent to substance use disorder (SUD) treatment depending on their age and the type of service. Under California Family Code § 6929, a minor who is 12 years of age or older may consent to "medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem." This provision generally applies to outpatient services such as screening, assessment, and counseling, including non-narcotic treatment modalities. The treating Provider must determine that the youth

is sufficiently mature to participate intelligently in the treatment. The statute also requires that the treatment plan includes the parent or guardian when appropriate, but the clinician may determine that parental involvement would be inappropriate under the circumstances. Importantly, nothing in the minor-consent law removes a parent's independent right to seek treatment for their child.

Confidentiality protections apply when a minor lawfully consents to their own SUD treatment. Disclosure of related records is governed by California Family Code § 6929, applicable state medical privacy provisions such as Health and Safety Code § 123110, and federal substance use confidentiality regulations under 42 CFR Part 2. In general, parents do not automatically have access to records when the minor independently consented to care, unless disclosure is otherwise permitted or required by law.

There are limits to what minors may consent to independently. Family Code § 6929 does not authorize minors ages 12 to 15 to consent on their own to certain opioid replacement therapies, such as methadone provided in a licensed opioid treatment program. Opioid treatment programs are regulated under California Health and Safety Code § 11839.2 and federal opioid treatment program regulations at 42 CFR § 8, and parental consent is generally required for younger adolescents receiving methadone in those settings.

A separate statute, California Family Code § 6929.1, establishes that a minor who is 16 years of age or older may consent to medical care for opioid use disorder that includes medications such as buprenorphine provided by a physician, clinic, or health facility, without parental consent. However, when treatment involves replacement opioid therapy delivered through a licensed opioid treatment program, federal regulations under 42 CFR § 8 may still impose additional requirements, and parental consent may be necessary unless federal law expressly allows otherwise.

SUS Minor Consent Summary

Age	What Minor May Consent To	Parental Consent Required?
12–15 yrs old	Outpatient SUD diagnosis and counseling (non-narcotic)	No
12–15 yrs old	Methadone/OTP narcotic replacement therapy	Yes (generally required)
16–17 yrs old	Buprenorphine or physician-based OUD treatment	No
16–17yrs old	OTP-based narcotic replacement therapy	Depending on federal law; often yes

SB 1024- License Display and Member Notice Requirements

A new law, SB 1024, sponsored by the Board of Behavioral Sciences (Board), implements a change to the legal requirement that mandates licensees and registrants display their license or registration in a conspicuous location at their primary place of practice. To account for the increasing use of telehealth, and the difficulty of physically displaying a license or registration when providing telehealth services, effective January 1, 2025, licensees and registrants are only required to display their license or registration in a conspicuous place in their primary place of practice when rendering professional clinical services in person. The license or registration does not need to physically be on display when services are provided via telehealth. However, to ensure that all clients maintain access to essential information confirming their therapist's licensure, the law now requires

additional information to be included in the required "Notice to Clients" that a Board licensee or registrant must provide each of their clients upon initiating psychotherapy services. For all new clients on and after July 1, 2025, the "Notice to Clients" must contain the following additional information:

- The licensee or registrant's full name as filed with the Board.
- Their license or registration number.
- The type of license or registration (for example, licensed marriage and family therapist, associate clinical social worker, etc.).
- The expiration date of their license or registration number.

To account for this change, Providers must complete the form "Requirement to Provide Notice to Clients (BHS 315)" as part of intake. See Appendix D: Adult/Older Adult/Transitional Age Youth (AOA/TAY) Requirements at Intake, First 60 Days, Updates, and Discharge and Appendix E: Children, Youth and Families/Transitional Age Youth (CYF/TAY) Requirements at Intake, First 60 Days, Updates, and Discharge for intake paperwork.

Intake Forms and Advisements

For the most update to date forms for BHS, go to BHS Forms Department SharePoint site or email cbhsforms@sfdph.org.

Document Title	Member Signs?	Process	Frequency-Timeline
SFDPH/SFHN Consent for Treatment Terms and Conditions	Yes	Available in EHR, EHR Welcome, or Paper Copy. If Paper copy, must be scanned into the EHR under Media Tab.	At intake during consent process and annually.
Patient Request for OPT-OUT of Electronic Health Exchange	Yes	Paper form must be faxed or emailed to the HIM Department when a Member opts out of Care Everywhere.	At intake, during consent process; client may opt out at any time
SFDPH Summary Notice of HIPAA Privacy Practices & Acknowledgement of Receipt	Yes	Available in EHR, EHR Welcome, or Paper Copy (paper copy Form # is 5795021). If Paper copy must be scanned into the EHR under Media Tab.	At intake and annually
BHRD84 Acknowledgement of Receipt of Materials	Yes	Paper Copy and signature must be obtained on the hard copy of the form at the time of intake and initials obtained for each relevant section listed. Signed form must be scanned into the EHR under Media Tab.	At intake.
BHS 315- Appeals and Grievance Process Handout	No	Hard copy provided to Members. This can be physical handbook of info sheet with URL Grievance and appeal	At intake and upon request

		information for Members of Behavioral Health Services | SF.gov	
Behavioral Health (Integrated) Member Handbook	No	Hard copy provided to Members. This can be physical handbook of info sheet with URL Mental health and substance use disorder Member handbook | SF.gov	At intake, upon request, and when updated
MHP Provider Directory	No	Hard copy provided to Members. This can be physical handbook of info sheet with URL Mental Health and Substance Use Disorder Provider Directories | SF.gov	At intake, upon request, and when updated
BHS 317- Requirement to Provide Notice to Clients	No	Hard copy provided to Members. Must document in the encounter that form was given to Member.	At intake and when the Provider changes.
ROI- Authorization for Use or Disclosure of Protected Health Information or Verbal Care Coordination	Yes	Hard copy given to Member. Signed ROI must be scanned into the EHR under Media Tab.	When disclosure is clinically indicated and updated annually as long as disclosure remains clinically necessary.
MyChart Proxy Access Form	Yes	Paper form must be faxed or emailed to the HIM Department when a Member grants proxy access to their chart.	May take up to 3 days for access to be granted.
MyChart Revoke Access Form	Yes	Paper form must be faxed or emailed to the HIM Department when a Member revoke access to their chart.	May take up to 3 days for access to be revoked.

See Appendix D: Adult/Older Adult/Transitional Age Youth (AOA/TAY) Requirements at Intake, First 60 Days, Updates, and Discharge and Appendix E: Children, Youth and Families/Transitional Age Youth (CYF/TAY) Requirements at Intake, First 60 Days, Updates, and Discharge for more information.

Member/Patient Coverage Verification

It is crucial for Providers to verify Member's insurance coverage before providing service to prevent denied claims, avoid surprise bills, and improve Member's satisfaction by setting clear financial expectations. The verification and monitoring of Medi-Cal and other eligibility for new referrals and current Members will be centralized with the BHS Eligibility Team.

Contacting BHS Eligibility

Members and Providers can contact BHS Eligibility team if they have questions about the Member's eligibility and/or coverage. BHS Eligibility team can be reached at:

- Provider or Member hotline: (628) 217-7750
- Provider email: BHS-Eligibility@sfdph.org

- Member hotline: (628) 217-7799 *(ask for Member Services or Eligibility)*
- Member email: BHSMemberServices@sfdph.org
- In EHR, via In-Basket, messages, Patient FYI flags, or secure chat. *Make sure that **BHS Eligibility** is selected or it will be routed to another Eligibility team.*

Members Without Coverage

Members without coverage or without an approved work order/alternate funding source should be referred to the BHS Eligibility team or directly to Medi-Cal to begin enrollment process. Providers must advise Members that they may receive billing statements while they remain uninsured or without a work order.

The BHS Eligibility team can assist Members with completing Medi-Cal applications, resolving Medi-Cal eligibility issues, or enrolling in Healthy SF benefits or other available Programs.

Members Actively Applying for Coverage

When a Member is in the process of obtaining coverage, Providers should document services as normal and ensure the relevant charges are selected during each Encounter. Medi-Cal can approve coverage retroactively for up to three months prior to the first of the month of application, and BHS can claim services for that retroactive period if the Member is ultimately approved.

While an application is pending:
*Eligibility will work with the Member to assess liability and provide guidance during the enrollment process. If Medi-Cal is approved, the BHS Eligibility Team will retroactively add coverage in the EHR to applicable encounters, removing any self-pay balance for services within the eligible period.
*If Medi-Cal is denied, BHS Eligibility will contact the Member to:
Establish sliding scale arrangements for any previous visits,
**Provide guidance on available coverage options, and
**Determine financial eligibility for future care.

Members Without Residency

In accordance with BHS Policy 3.03-06, Members must be SF residents to obtain both planned and unplanned behavioral health services. Unplanned services, which are distinguished as crisis or emergency services, can be provided to a Member whose place of residence is outside of San Francisco, however once the immediate crisis has been resolved, ongoing behavioral health services will need to be obtained in Member's own county-of-residence outside of San Francisco.

Prospective Members with Out of County Medi-Cal who can verify San Francisco residency will be considered on a case-by-case basis which will be screened and reviewed by OCC BHS Access points at the time of request for services or BHS Providers when receiving direct referrals. BHS Providers have a responsibility to update their Member's addresses and if there is a change, Providers should encourage Members to contact HSA/Medi-Cal with their new address and start transitioning care to the appropriate county of residence. Providers can provide up to 90 days of service while they complete the intercounty transfer (ICT) of Medi-Cal benefits to SF County. BHS Eligibility team will track and monitor ICT progress of BHS Members receiving

services. If the ICT is not completed within 90 days, the Eligibility team will reach out to the Member and provide advocacy with the Medi-Cal office if necessary. If over 90 days, Programs will need to secure approval from the relevant SOC Program Manager.

Providers working with Members who have requested an ICT should document services and select the relevant charges on the Charge Capture screen for each encounter. Services for Members who have requested an ICT can be claimed per BHIN 24-008.

BHS Screening Tools

Specialty Mental Health Services (SMHS) Screening Tools

Medi-Cal provides two types of mental health services: specialty mental health services and non-specialty mental health services. A Member's level of mental health need is determined by using the DHCS Screening tool for Mental Health Services, which *screens for* symptom severity and functional impairment. Members with moderate to severe mental health needs who meet medical necessity criteria are eligible for specialty mental health services (SMHS) and are served in BHS. Members with mild to moderate mental health needs who do not meet SMHS medical necessity criteria are eligible for non-specialty mental health services (NSMHS) and OCC will support connection between those Members with their Managed Care Plan (MCP).

The use of the DHCS Adult Screening Tool (over 21 years old) and DHCS Youth Screening Tool (under 21 years old) is required by DHCS for Members who are not currently receiving mental health services and are requesting services directly from OCC. The DHCS screening tool is not required when Members request services directly from clinics that are able to accept direct referrals. See Screening and Transition of Care Tools 3.03-23 at Behavioral Health Services Policies and Procedures | SF.gov..

Tool	Purpose	Age Group	Where Used
DHCS Mental Health Screening Tool Youth/Caregiver Screening Tool: 0-20 years Adult Screening Tool: 21+	Used at BHS Access Points with people who are not currently connected to behavioral health care. Determines whether an individual needs specialty mental health services vs non- specialty mental health service.	Youth 0-20 Adult: 21+	BHAL BHAC TAY SOC Linkage
CYF Level of Care Tool and CYF System Navigation Guide	Used at BHS Access Points to determine CYF level of care needs – mental health and substance use. Completed for all new Members and requests for higher level of care.	Youth: 0-21	BHAL CYF hubs TAY SOC Linkage Triage (as needed/applicable)
AOA/TAY Level of Care Determination Tool-	Used to determine level of outpatient specialty mental health care for TAY and AOA programs including PPN, Outpatient Clinic, ICM/FSP, and Stabilization. Completed for all new Members and requests for transfer in care. Also used to determine step down/step up needs.	18+	BHAL BHAC Triage TAY SOC Linkage

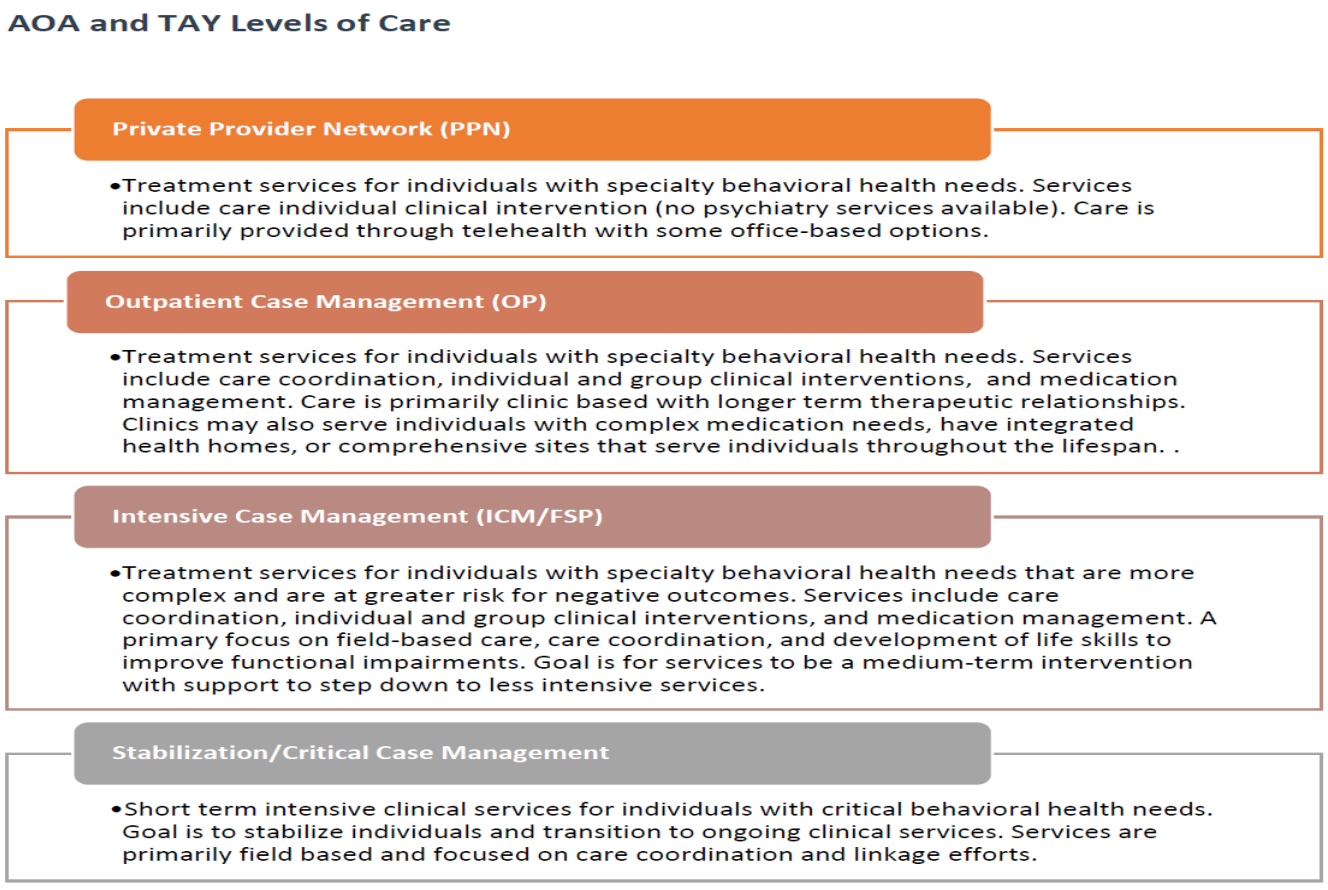
Standard SUD Screening Tool (In Development)	Used at BHS Access Points and elsewhere in the system as a standard way to help quickly screen and help direct people to the most appropriate level of care.	18+	BHAL BHAC Triage TAY SOC Linkage
Transition of Care Tool	Received by OCC's access point when a transition from non- specialty mental health services provided by Medi-Cal Managed Care Plans (MCP).	All ages	BHAL – all incoming Transition of Care Tools from MCP

There are also other screening tools available in the Electronic Health Record System for Provider to utilized, see Appendix J: Screening Tools in the Electronic Health Record (EHR).

SMHS Level of Care (LOC) Tool

For Members who qualify for SMHS, OCC will complete either the Adult and Older Adult (AOA) LOC Tool or Children, Youth & Families (CYF) LOC Tool . The LOC tools are designed to screen for additional clinical information, service utilization, risk, and acuity to ensure that each Member is scheduled at the most appropriate level of care.

For Adult Members that qualify for SMHS, OCC will refer them to the appropriate level care such as Private Provider Network (PPN), SMHS Outpatient Clinic, Intensive Case Management/Full-Service Partnership (ICM/FSP) services, or Stabilization.



For Youth/Child Members that qualify for SMHS, OCC will determine if the Youth/Child should be referred directly to a CYF Specialty Hub (e.g., Foster Care Mental Health, SFUSD, Juvenile PD, SUD), Intensive Services Review Committee, MRT/Child Crisis, or to a SMHS CYF Outpatient Clinic. Transitional Age Youth (TAY) Members may be placed at an AOA or CYF program depending on the Member's age, service needs, and other clinical factors that impact placement for TAY.

CYF Levels of Care

Health Promotion, Prevention, Early Intervention

- SFUSD High School Wellness Centers, MHSA Funded School Based Prevention. LEGACY. Parent Training Institute. Fuerte Prevention Program for Latine and other newcomer youth. Kuumba Healing Project for Black/AA Communities. Ma'at & DKI for Black/AA Communities
- Seek & Serve Outreach/Engagement for AAPI Families, SUD Prevention

Mental Health & SUD Outpatient

- Network of Civil Service & Contracted SMHS Providers, ERMHS Services, Comprehensive Psychological Assessment Services Drug Medical Organized Delivery System Outpatient, Contracted Provide

Intensive Services

- WRAP Providers, Intensive Care Coordination & In Home Behavioral Support (ICC/IHBS) Providers Intensive Supervision and Clinical Services (ISCS) for Justice Involved Youth, Multi-Systemic Therapy (MST) for Justice Involved Youth, Therapeutic Visitation Services (TVS) for Child Welfare Youth, Dialectical Behavioral Therapy (DBT), Family Based Treatment for Eating Disorders (FBT), Therapeutic Behavioral Services (TBS), SOAR Classrooms, CEEP Educational Placement

Crisis Services/Hospitalization

- Seneca 24/7 Mobile Response Team (MRT). Edgewood 23 Hour Crisis Stabilization Unit (CSU), Edgewood Hospital Diversion (HD), DPH Child Crisis – conducts 5585 evaluations and supports inpatient psychiatric hospitalization placements

Residential/Home-Based Placements & In Custody Services

- Intensive Services Foster Care (ISFC) Homes placements for Child Welfare & Juvenile Probation, Short Term Residential Treatment Programs (STRTP), Transitional Housing Program for TAY aging out of foster care system, Special Programs for Youth (SPY) - BH/Nursing/Medical services within Juvenile Hall

The use of the DHCS Screening Tool and the AOA or CYF LOC tool will indicate whether a Member should be directed to BHS vs to the MCP for assessment, and if referred to BHS, what level of care program is appropriate to complete the intake assessment. Ultimately, it is the Provider assessment that will determine whether the Member meets medical necessity to be served ongoing for SMHS. Based on Provider assessment, if the Member does not meet medical necessity, the Provider would use the Transition of Care Tool to transition care to the MCP.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Screening Tool

Members seeking SUS under the DMC-ODS may either self-present directly to a DMC-ODS Provider or contact the OCC for assistance with determining the appropriate level of care.

When OCC is involved, staff complete the SUD Screening Tool to support placement within the SUS continuum. The Screening Tool is a structured process used to collect and evaluate key clinical information, including substance use history, risk of withdrawal, biomedical and psychiatric conditions, functional impairment, safety risks, prior treatment history, and current service utilization. The purpose of the Screening Tool is to identify the least intensive, clinically appropriate level of care consistent with medical necessity. Based on the screening results, OCC refers Adult Members to the appropriate DMC-ODS service setting, which may include Outpatient Services (OP), Intensive Outpatient Services (IOP), Opioid Treatment Program (OTP/NTP), Residential Treatment, Withdrawal Management (WM), or Recovery Services. For Youth Members, OCC determines whether referral should be made to youth-specific outpatient or intensive outpatient services, residential treatment, withdrawal management, or other youth-focused SUD programming, considering age, developmental considerations, and clinical presentation. Transitional Age Youth (TAY) may be placed in either adult or youth programs depending on age, service needs, and other relevant clinical factors.

The SUD Screening Tool informs whether the Member should proceed to a DMC-ODS Provider for intake and identifies the recommended level of care. However, the final determination of medical necessity and authorization for ongoing services is made by the treating Provider after completion of a comprehensive SUD Level of Care (LOC) assessment consistent with ASAM criteria. If the Provider determines that the Member does not meet medical necessity for the referred level of care, the Provider will adjust placement as clinically indicated and coordinate transition to a more appropriate service within the SUS continuum.

SMHS Assessment Tools

BHS utilizes the AOA 7 Domain Assessment and ANSA for Members over the age of 18 years old and CYF 7 Domain Assessment and CANS for Members typically under the age of 18 years. When a Member is between the ages of 18 years to 24 years old, there are some situations where the use of the CYF 7 Domain Assessment and CANS Ratings may be clinically indicated to use. For CYF Members, PSC-35 is also required for the Member and/or their legal guardian to complete and incorporate into the assessment. See CANS and PSC-35 Implementation 3.10-13 policy at Behavioral Health Services Policies and Procedures | SF.gov.

To be a CANS/ANSA certified Provider, Provider would need to complete and pass the CANS and/or ANSA certification course on Praed Foundation Collaborative Training Website (TCOM) to administer the 7 Domain Assessment and Rating for CANS or ANSA. New staff can register to take the course at TCOM website. The Provider will need to take the exam every year and remain certified to use CANS/ANSA. See CANS and ANSA quality improvement and measurement documents | SF.gov for more information regarding CANS-ANSA Certification Instructions as well as CANS, ANSA manuals, rating sheets and reports.

7 Domain Assessment

Each of the seven domains represents a required category of information that must be addressed as part of the SMHS assessment. To the extent that information is available, all components identified within each

domain must be documented to ensure a comprehensive and clinically sound evaluation. Each domain must be organized and documented in a manner that ensures logical flow, minimizes redundancy, and clearly distinguishes between historical and current needs.

7 Domains Assessment
Domain 1: Presenting Problem, Current Mental Status
Domain 2: Trauma
Domain 3: Behavioral Health History, Substance Use
Domain 4: Medical History, Current Medications, Co-occurring conditions
Domain 5: Psychosocial Factors, Social and Life Circumstances, Cultural/Religion/Spirituality
Domain 6: Strengths, Risk Behaviors, Protective Factors
Domain 7: Clinical Summary and Recommendations, Diagnostic Impression, Medical Necessity Determination, LOC/ Access Criteria

SOC	Initial Assessment	Subsequent Assessment
CYF	*If there is no existing clinical assessment in EHR, Providers should complete the assessment within 60 Days of Episode Opening. If a Provider cannot complete the assessment within 60 days, the clinical justification should be documented in a progress note at least weekly. *If there is an existing assessment, the Provider will still need 1) to review the existing assessment and determine whether or not the assessment is still valid based on Member's current presentation and service needs and 2) determine whether or not to operate under the existing assessment and document the rationale for the clinical decision.	*The lead Provider should ensure that the assessment is updated at least once a year (within 30 days of anniversary of Episode Opening) or sooner if there is a clinically significant change. *Please note, while an assessment is considered valid if it occurred in the last year, it is the Provider's responsibility to review the assessment, update when clinically indicated (e.g. change in diagnosis, LOC needs, info that would impact course of treatment), and document these activities in the Member record.
AOA and TAY	*If there is not an existing Member assessment in EHR (one within the last three years), Providers should complete the assessment within 60 days of Episode Opening. If a Provider cannot complete the assessment within 60 days, the clinical justification should be	*The lead Provider should complete the Triennial assessment at least once every three years (within 30 days of anniversary of Episode Opening) or sooner if there is a clinically significant change (e.g., significant changes in presentation). *Please note, while an assessment is considered valid if it occurred in the last year, it is the

	documented in a progress note at least weekly. *If there is an existing assessment, the Provider will still need 1) to review the existing assessment and determine whether or not the assessment is still valid based on Member's current presentation and service needs and 2) determine whether or not to operate under the existing assessment and document the rationale for the clinical decision.	Provider's responsibility to review the assessment, update when clinically indicated (e.g. change in diagnosis, LOC needs, info that would impact course of treatment), and document these activities in the Member record.

Scope of Practice

Both Licensed Practitioners of the Healing Arts (LPHA) and Non-LPHAs must follow their scope of practice as outlined in the California State Plan SPA 24-0041 and what is designated by their licensing and/or credentialing party as well as what is designated by SF BHS and their agency. Non-LPHAs such as MHRS, OQP, and Certified Peers can provide valuable input into a Member's assessment and can contribute significantly to the Member's care plan while working under the discretion of an LPHA. Non-LPHAs would not be able to conduct the MSE, diagnose, approve/determine course of treatment, and operate independently on their own. For more information see Appendix I: Scope of Practice Spreadsheet.

Assessment	Contribute*	Finalize with Co-signature and attestation	Finalize without co-signature requirement**
	MHRS/ OQP	Social Work Student/ MFT Trainee/ PsyD Clinical Trainee/ PCC Trainee	ASW/ LCSW AMFT/ LMFT PsyD, PhD/ PhD/PsyD-Waiver APCC/ LPCC
AOA/ CYF 7-Domain	x	x	x
MSE		x	x
Substance Use	x	x	x
SDOH	x	x	x
History	x	x	x
Allergies	x	x	x
ANSA/ CANS	x (if certified)	x (if certified)	x (if certified)
PSC-35	x	x	x

In the EHR, only Clinical Trainees are required to have their supervisor co-sign their progress notes, assessments (co-sign and attestation) as well as co-sign any clinical activity/service that the Clinical Trainee provides. A MHRS or OQP can provide services within their scope of practice and bill for allowable services within their taxonomy code without needing a Supervisor to co-sign on their note in the EHR. This does not

mean that Supervisor cannot co-sign those notes, just that not having a co-sign would not create an error in the EHR. It is strongly recommended, especially for a new hire, that the supervisor closely assesses and reviews their staff's understanding of accurate documentation, billing and EHR navigation before they are able to finalize notes and submit those notes for billing to prevent errors that needs to be amended later on. Having a new staff send their notes to a supervisor for co-sign and review can be one way to check for those notes before they are finalized. A Provider should always check with their supervisor, Program Director and/or System of Care Leadership should they have any questions about requirements and workflows that best fit the needs of their agency.

Adult Needs and Strengths Assessment (ANSA)

The Adult Needs and Strengths Assessment is a multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The ANSA was developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The ANSA gathers information on the Member and their parents/caregivers' needs and strengths (if relevant). Strengths are the Member's assets: areas in life where they are doing well or have an interest or ability. Needs are areas where a Member requires help or serious intervention. Providers use an assessment process to get to know the Member and families with whom they work and to understand their strengths and needs.

The ANSA helps Providers decide which of a Member's needs are the most important to address in a treatment or service plan. The ANSA also helps identify strengths, which can be the basis of a treatment or service plan. By working with the Member and family (if relevant) during the assessment process and talking together about the ANSA, Providers can develop a treatment or service plan that addresses a Member's strengths and needs while building strong engagement. See CANS and ANSA quality improvement and measurement documents | SF.gov.

Child and Adolescent Needs and Strengths (CANS)

The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for monitoring of outcomes of services. The CANS was developed from a communication perspective to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The CANS gathers information on children/youth and parents/caregivers' strengths and needs. Strengths are the child/youth's assets: areas of life where they are doing well or have an interest or ability. Needs are areas where a child/youth requires help or intervention. Providers use an assessment process to get to know the child/youth and the families with whom they work and to understand their strengths and needs.

The CANS helps care Providers decide which of a child/youth's needs are the most important to address in treatment or service planning. The CANS also helps identify strengths, which can be the basis of a treatment or service plan. By working with the child/youth and family during the assessment process and talking together about the CANS, Providers can develop a treatment or service plan that addresses a child/youth's strengths and needs while building strong engagement. See CANS and ANSA quality improvement and measurement documents | SF.gov.

Pediatric Symptom Checklist 35 (PSC-35)

The Pediatric Symptom Checklist (PSC) is a 35-item parent/caregiver-report psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. It provides a 'snapshot' of difficulties or impairment and is NOT a diagnostic tool.

DMC ODS Assessment Tool American Society of Addiction Medicine (ASAM)

SFDPH BHS continues to utilize the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition, as the clinical decision making in alignment with DHC requirements for the DMC-ODS. To operationalize this requirement, SFDPH BHS uses a county-developed Substance Use Disorder Level of Care (SUD LOC) assessment tool, which is structured around the six ASAM dimensions and incorporates DHCS medical necessity standards. The county SUD LOC tool standardizes clinical documentation, supports consistent placement decisions across Providers, and ensures alignment with Medi-Cal reimbursement and audit requirements. This tool is required within 60 days of admission to OP and IOP programs, within 14 days for OTP, and within 7 days for 3.1, 3.3, and 3.5 residential program. It must also be completed when there is a significant change in the client's clinical condition, when transferring between levels of care, and at reauthorization intervals. Providers are expected to document clinical justification within the SUD LOC to support the selected ASAM level and ensure compliance with state oversight standards.

Although the ASAM Criteria, 4th Edition has been released nationally, including expanded guidance addressing youth-specific considerations, co-occurring behavioral and medical conditions, and health equity, DHCS has not yet authorized its implementation within DMC-ODS. Until statewide guidance is issued, SFDPH BHS will continue to require use of the ASAM 3rd Edition for all SUD LOC determinations to ensure compliance with Medi-Cal medical necessity criteria, audit standards, and regulatory requirements. SFDPH BHS will transition to the 4th Edition once formal DHCS direction is released, and implementation guidance is provided to counties and Providers.

The ASAM Criteria, 3rd Edition provides a nationally recognized, multidimensional framework for determining placement, continued stay, transfer, and discharge for individuals with substance use disorders (SUD). Rather than focusing solely on substance use patterns, ASAM applies a comprehensive biopsychosocial approach through six dimensions that collectively assess the full clinical presentation of the Member. These dimensions evaluate:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapses, continued use, or continued problem potential
6. Recovery and living environment

Each dimension is assigned a severity rating, typically on a scale from 0 to 4**,** reflecting the level of risk and service intensity required:

Rating	Level of Risk and Service Intensity
0	No issue or stable: No current risk; services not indicated for this dimension.
1	Mild: Minimal difficulty; can be addressed in outpatient settings with routine monitoring.
2	Moderate: Noticeable functional impairment or risk; requires structured outpatient or intensive services.
3	Significant: Serious risk or instability; requires highly structured services such as residential treatment or intensive support.
4	Severe/Imminent danger: Acute or life-threatening risk requiring immediate intervention, such as withdrawal management or medically monitored care.

Clinicians synthesize the severity ratings across all six dimensions to determine the most appropriate LOC. A higher rating in any single dimension may drive placement into a more intensive service setting, even if other dimensions are lower. This ensures that Members are placed in a setting capable of safely addressing their highest areas of need.

Within the DMC-ODS continuum, the ASAM Criteria serves as the foundation for LOC determinations. In San Francisco County, all contracted SUD Providers are required to complete the county's SUD LOC Assessment Tool, which operationalizes the six ASAM dimensions and corresponding severity ratings. This standardized approach promotes consistency in assessment, documentation, and placement decisions across the SUS SOC.

Other Assessment and Screening Tools

There are a lot of screening tools under the Electronic Health Record (EHR). These screening tools are utilized across different Systems in the EHR and are not all specific to BHS. As with use of any screening and/or assessment tools, a Provider must have the appropriate training and skills that is needed to administer those tools correctly, and be able to accurately interpret the results, if applicable. The results of the screening or assessment should be documented along with the clinical justification of why the use of the tool was clinically indicated (e.g., help establish diagnosis, use to determine appropriate course of treatment). Assessments tools are meant to be informative of a client's symptoms and not solely used as a diagnostic tool. See Appendix J: Assessment Tools in the Electronic Health Record (EHR).

Treatment Planning

Problem List

The Problem List serves as a combination of symptoms, conditions, diagnoses, and/or risk factors that are identified through assessments, psychiatric diagnostic evaluations, crisis situations, or other treatment factors. Problems identified during treatment should promptly be addressed by the Provider and subsequently added to the Problem List at the encounter when then the problem was identified, refined, or resolved. The problem list should be updated by an LPHA as clinically indicated but should be reviewed at least annually. Once a concern has been addressed, Providers should resolve the item in the problem list to indicate that progress has been made. In the EHR, Providers can view the Problem List of Members whose Care Team the Provider is a part of. This may include medical diagnosis, mental health diagnosis, Social Determinant of Health (SDOH), and other areas of concern. The Problem List should be reviewed with the Member at intake, updated as clinically

indicated throughout the course, or at minimal, annually, and updated when services are terminated with the Member.

Diagnostic and Statistical Manual of Mental Disorders (DSM)

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the primary reference for LPHAs for diagnosing mental health conditions. The most recent version of the DSM edition includes the most updated definitions, codes, and clarifications for mental health disorders. The DSM diagnostic criteria include specific symptoms, number of required symptoms, duration, functional impact, and exclusion criteria for each MH diagnosis and Providers must use this framework to make diagnostic decisions. Clinical supervision and consultations should be utilized for challenging and complex cases where the diagnostic impression may be unclear. Providers must utilize their clinical training, judgment, awareness of cultural implications, and careful review that the Member meets full DSM diagnostic criteria before diagnosing a Member.

International Classification of Diseases (ICD) & Current Procedural Terminology Codes

The International Classification of Diseases (ICD) is a World Health Organization (WHO) system used globally to classify diagnoses, symptoms, and procedures. The Current Procedural Terminology (CPT) code sets and classification summary are maintained and updated by several agencies including Centers for Medicare & Medicaid Services (CMS), National Drug Code (NDC), Centers for Disease Control & Prevention (CDC), American Medical Association (AMA), and American Dental Association (ADA).

Social Determinants of Health (SDOH)

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. See Social Determinants of Health - Healthy People 2030 | odphp.health.gov. Please click here for the complete list of ICD-10-CM Z Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z55.4	Educational maladjustment and discord with teachers and classmates*
Z55.5	Less than a high school diploma*
Z56.0	Unemployment*
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity

Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness, or behavior)
Z62.21	Child in welfare custody*
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family Member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z64.0	Problems related to unwanted pregnancy*
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.4	Victim of crime and terrorism*
Z65.5	Exposure to disaster, war, and other hostilities*

*Indicates codes that are not listed on the DHCS Priority SDOH Codes list.

Treatment and Care Plans

As part of CalAIM reform, a comprehensive treatment plan of care (TPOC) is no longer needed for most services under outpatient SMHS. This does not mean that Providers no longer work towards treatment goals with the Member, but SMHS can be delivered without a formal TPOC.

SMHS Care Plan

Although a comprehensive treatment plan of care for outpatient SMHS is no longer required, a *BH Care Plan* is still required for certain services and must be reviewed annually. Care Plans are stand-alone documents that must be completed in collaboration with the Member and must be completed under the direction of an LPHA. If the Care Plan was not completed and signed by an LPHA, it is recommended that the LPHA who is directing the services for the Member co-sign the Care Plan. This would document that the LPHA reviewed and approved of the Care Plan completed by the non-LPHA in collaboration with the Member.

Care Plans can be shared across Programs if the goals and objectives align. However, the Programs should be working with the Member on different tasks and goals to prevent duplication of services. Providers must ensure there is a valid and current care plan in place for specific services that require a care plan. Programs that require care plans include Targeted Case Management (TCM), Intensive Care Coordination (ICC), Peer Support Service, Therapeutic Behavioral Service (TBS), and Short-Term Residential Therapeutic Program (STRTP) Treatment Plan.

DMC-ODS Care Plan

San Francisco BHS currently uses Avatar NX as its electronic health record (EHR) system for Substance Use Services. At this time, Avatar NX does not support a system-wide, integrated Problem List. Until BHS implements this functionality, providers must document member problems clearly and consistently within treatment plans, progress notes, and assessments to maintain continuity of care. Agencies that use their own EHR systems with Problem List capability are strongly encouraged to apply this feature in alignment with DHCS requirements and best practices. BHS leadership is actively working to incorporate Problem List functionality into future EHR platforms, including Epic, to improve compliance, care coordination, and documentation. Providers must also be able to share the Care Plan with the member, other treating providers, and Medi-Cal systems, in compliance with HIPAA and 42 CFR Part 2.
In alignment with BHIN 23-068, San Francisco BHS recognizes the Care Plan as an active, ongoing process reflected throughout the member's record. However, BHS still requires a formal Care Plan in the following settings:

- Providers using the BHS EHR, where an integrated problem list is not yet available
- All ASAM 3.1, 3.3, and 3.5 residential programs
- Targeted Case Management (TCM)
- Peer Supportive Services

In these settings, Substance Use Services (SUS) providers must document care planning elements using one of the following methods:

1. A standalone Treatment Plan uploaded or entered into the EHR
2. A Care Plan progress note that outlines:
    a. The member's treatment goals
    b. Measurable objectives
    c. Planned interventions

Both approaches meet DHCS requirements if documentation:

- Reflects ongoing, clinically relevant care planning
- Links to assessed needs
- Aligns with ASAM dimensions and medical necessity
- Is updated regularly to reflect changes in the member's condition

In alignment with BHIN 23-068, providers do not need to complete a separate Care Plan for clients receiving ASAM 1.0 Outpatient or ASAM 2.1 Intensive Outpatient services if they actively maintain an integrated Problem List.
However, when a provider does not maintain a Problem List, they must complete a Care Plan or standalone Treatment Plan within 60 days of admission or by the finalization of the Level of Care (LOC) assessment, whichever occurs first.

For Residential levels of care ASAM 3.1, 3.3, and 3.5 providers must complete a Care Plan within 10 calendar days of admission, in accordance with BHIN 21-001, Exhibit A documentation standards.
For ASAM 3.2 Clinically Managed Residential Withdrawal Management, providers do not need to complete a Care Plan. BHIN 21-001, Exhibit A clarifies that this level of care focuses on stabilization and transition planning, rather than ongoing treatment planning.

Progress Notes and Completion Requirements

Encounter Progress Note

Clinical records are accessible to the Member, agency, other stakeholders, and can be subpoenaed. Documentation should be person-centered, encounter-specific, and written in a clear, concise manner. Documentation should contain only the information necessary to describe the service and interventions provided, including how the service addressed the Member's needs (e.g., symptoms, conditions, diagnosis, and/or risk factors). The content should also:

- Indicate how the Member responded to the clinical interventions provided as opposed to documenting answers to Provider's questions.
- Identify next steps planned for the Provider and/or Member, and
- Update the problem list as appropriate.

A Provider should only document information that is essential to the Member's care and treatment, as well as information necessary for legal reasons or service payment. For example, documenting the name of an external Provider who made a diagnosis or provided test results is essential but putting down the name of Member's teacher and exactly what they stated about the Member would not be considered essential. In the latter case, it is appropriate to just use the role of the individual and document general concerns that they shared e.g., peer interaction.

Examples of things that belong in EHR progress note	Examples of things that do NOT belong in EHR progress note	Example of things that may be appropriate to documented in another section in EHR
*Treatment decisions among the Member's care team. *Clinically relevant information pertaining to the Members' treatment, response to treatment, changes in service, etc. *Important information that another Provider on the care team would need to know.	*Provider's travel time/ mileage. *Time spent on documentation by Provider. *Non-Member PHI. *Non-Clinically relevant Information that the Provider would like to remember about the Member. *Information for purposes of clinical supervision with the Provider or Supervisee.	*No-shows. *Outreach attempts. *CPS/ APS report. *Member FYI Flags.

*Facts and objective clinical judgement. *Documentation about diagnosis, treatment options, informed consents and relevant clinical discussions and agreements.	*Subjective opinions or comments about Members, Other Providers, and/or Significant People in Member's Life. *Internal Incident reports. *Information that is speculative or hearsay.	

Although Smart Phrases and some templates may be used for guidance on formulating progress notes, generic or repeated notes may not accurately reflect the individual Member encounter, their current progress and response in services and/or the Providers interventions and services provided.

Progress Note Template (Mental Health PN)

Per DHCS, Providers must complete progress notes within three (3) business days of providing a service, except for notes for crisis services, which must be completed within one (1) calendar day. The day of the service is considered day zero (0). The three (3) business day requirement is still applicable even when the note is written by a Clinical Trainee and requires a co-sign by their LPHA Supervisor. The progress note is not completed until the LPHA Supervisor co-signs the note. LPHA Supervisor should incorporate progress note review and feedback into their weekly supervision with their Clinical Trainee as part of their professional development and growth. If an LPHA Supervisor is not receiving progress notes for their co-signature, they need to make sure that their Clinical Trainee are selecting the co-sign box and selecting the LPHA Supervisor as the Provider to send the note to for co-sign.

The focus on the progress note is on what clinical interventions the Provider utilized in response to the problem(s) identified in this visit, what was the impact of the intervention(s) on the Member, and how this impacted Member's treatment outcome. It is best to utilize active voice and use active change verbs, such as fostered, enhanced, improved, and supported. The progress note needs to make sense as a standalone note in terms of why the service(s) provided was needed for the Member for the challenge(s) that they are experiencing. This does not mean that the session cannot be a continuation of a topic or intervention reviewed at a previous session.

Providers are strongly encouraged to use the Mental Health PN template to ensure that the required elements of the progress note are met for purposes of continuity and quality of care, billing, and other documentation standards. The required elements as defined by Behavioral Health Information Notice (BHIN) No: 23-068 that BHS adopted on the Mental Health PN2 template include:

> What services did I provide? Describe the service provided to the Member. What specific service activities/interventions did I provide?
> -The service and interventions provided must match the items identified on the problem list.

How did the service address the Member's needs? What symptoms, diagnosis(es), risk factors, and/or social determinants of health were focused on? Include how the service addresses the Member's behavioral health of impairments, social determinants of health needs (e.g., symptoms, condition, diagnosis, and/or risk factors)
-What interventions did the Provider use?
-This section is not what the Member shared in session in response to the questions that were asked by the Provider, but rather how they responded to the Provider's clinical interventions.

What is the plan? What actions will be taken by me/and or the Member? Is care coordination needed? Do I need to make any updates to the problem list?
-The response cannot just be to meet with the Member the next session as scheduled.

Problem List Items Addressed This Visit
-The EHR automatically pulls this information in from what the Provider selected under Charge Capture.
-Make sure that the problem list items match the content of the session. If the problem list does not match the contend of the session, the Provide will need to update the problem list.

For group service, there is a group progress note template available in the EHR for Providers to utilize when they schedule the appointment as a group visit. The group visit and group documentation set up in the EHR meets the group documentation requirements at designated in Behavioral Health Information Notice (BHIN) No: 23-068.

In the EHR, SUS will also have their own Progress Note template that contains the same elements as the Mental Health PN as required by Behavioral Health Information Notice (BHIN) No: 23-068.

For services that are billed per service day (e.g. bundled services), Providers must complete a daily progress note for those services. These bundled services include those provided at Crisis Residential Treatment, Adult Residential Treatment, DMC/DMC-ODS Residential Treatment, and day treatment services (including Therapeutic Foster Care, Day Treatment Intensive, and Day Rehabilitation). If a bundled service is delivered on the same day as a second service that is not included in the bundled rate, there must also be a progress note to support the second, unbundled service. The elements of the daily progress note must still meet the requirements of the progress note outlined in Behavioral Health Information Notice (BHIN) No: 23-068.

Documentation and Travel Time

Providers must not include documentation time or travel time in progress notes, as these activities are considered non-reimbursable under Medi-Cal billing guidelines. This includes time spent typing, editing, or entering information into the electronic health record (EHR). These administrative tasks, while essential to clinical operations, do not qualify for reimbursement and should not be reflected in the member's chart. All BHS providers are expected to follow applicable County, State, Federal, and professional standards for clinical documentation and recordkeeping, ensuring that progress notes accurately reflect the services delivered and support medical necessity.

SMHS Discharge Planning and Transition of Care Tool

Members may be closed out of services for a variety of reasons, including Member request, transferring to other services and being lost to follow up. If a Member is being closed due to being lost to follow up, the following conditions must be met:
*Program must have conducted outreach to Member within the last seven days to attempt to reengage in services.
*Last date of encounter should be at least 90 days (cases should be closed after 90 days to ensure capacity for new cases), or four or more no shows (whichever comes first), and
*Provider must review chart to determine if the individual has had a recent crisis visit within the last 30 days (e.g., 5150/5585 WIC, DUCC, CCS, Child Crisis, SCRT, CSU, ADU, ED visit, withdrawal management, jail). In the case of a recent crisis contact the individual should remain open and attempts should be made to coordinate with systems and reengage Member in care.

Steps to Close an Episode

i. Complete all documentation for any services delivered
ii. Update the problem list as clinically indicated
iii. Close out any open Encounters
iv. Complete the AMB BHS Discharge form for the relevant Episode Type only
v. *For AOA/TAY* Complete the closing ANSA, *for CYF* Complete the CANS and PSC-35 *only* if all episodes are closing (see more details below)
vi. Verify whether client is open to other programs to determine whether the Episode is Resolved
    a. If client is exiting services or moving to a different level of care, resolve the Episode in the Behavioral Health Episode Section of the Screen in Rooming tab (or go to the Episodes of Care tab).
    b. If it is a lateral transfer to the same level of care (e.g., outpatient to outpatient), then the episode should *NOT* be resolved.

CYF/TAY Providers: The CANS and PSC-35 assessments are completed at the client level. The Closing CANS and PSC-35 are only completed when a client is leaving all BHS episodes in EHR. That is, CYF Providers should only complete the Closing CANS and PSC-35 if the client will no longer receive any other services in another BHS program.

AOA/TAY Providers: The ANSA assessment items are integrated throughout several tools in EHR. To account for this, AOA and TAY Providers will need to complete the Discharge ANSA and the AMB Discharge form when a client is closed from an episode.

See Appendix D: Adult/Older Adult/Transitional Age Youth (AOA/TAY) Requirements at Intake, First 60 Days, Updates, and Discharge and Appendix E: Children, Youth and Families/Transitional Age Youth (CYF/TAY) Requirements at Intake, First 60 Days, Updates, and Discharge for more information.

DMC ODS Discharge Planning and Discharge Summary

All Substance Use Services (SUS) programs under Drug Medi-Cal (DMC) must complete discharge documentation in accordance with Title 22, Section 51341.1 and BHIN 24-023. This process ensures continuity of care, regulatory compliance, and an accurate reflection of each member's treatment journey and recovery plan. Clinicians must determine the discharge type voluntary, involuntary, or loss of contact (unplanned) and complete the appropriate documentation, including a Discharge Plan and/or Discharge Summary. Providers must follow their agency's internal procedures to ensure timely and thorough documentation that meets state standards and supports ongoing care coordination.

San Francisco County Exceptions to 30-Day Discharge Planning Requirement

San Francisco County allows exceptions to the 30-day discharge planning requirement when specific conditions prevent the member from engaging in treatment, as long as the clinical record clearly documents the circumstances. Providers are not required to complete a Discharge Plan within 30 calendar days prior to the last treatment date if the member is traveling outside the treatment area for more than 30 days, is incarcerated or detained, is hospitalized or admitted to a higher level of care, has a clinically appropriate follow-up scheduled beyond 30 days, or has active medication coverage that extends beyond 30 days without requiring in-person follow-up.

Note: These exceptions apply only to the timing of the Discharge Plan and do not remove the requirement to complete a Discharge Summary when the member is discharged due to loss of contact or an unplanned discharge.

Discharge Types:

1. Voluntary Discharge: A voluntary discharge occurs when a member chooses to end services by mutual agreement with the provider or after achieving treatment goals. Examples include successful completion of treatment or voluntary withdrawal for personal reasons. In these cases, the provider must complete a Discharge Plan within 30 calendar days prior to the member's last treatment date. The plan must describe the member's relapse triggers and outline strategies to help the member avoid relapse. It must also include a support plan listing individuals and organizations that can assist the member in maintaining recovery. A LPHA, Clinical Trainee, or Certified Counselor must sign and date the Discharge Plan, and the provider must give a copy to the member.

2. Involuntary Discharge: An involuntary discharge occurs when a provider terminates services due to rule violations, safety concerns, continued substance use on premises, or other program-related issues. Providers must follow the procedures outlined in Title 22 §51341.1(p), including preparing a Discharge Plan within 30 calendar days prior to the member's last treatment date. The plan must describe the member's relapse triggers and outline strategies to prevent relapse, along with a support plan listing individuals and organizations available to assist the member post-discharge. Providers must also issue a written notice at least 10 calendar days before terminating or reducing services. This notice must specify the intended action, the reason, the supporting regulation, the member's right to a fair hearing under Section 50951, instructions for submitting a hearing request, and a statement confirming that

services will continue during the appeal process if the member requests a hearing within 10 calendar days. Providers must retain a copy of this notice in the member's record to ensure compliance and protect the member's rights.

3. Loss of Contact / Unplanned Discharge: A loss-of-contact or unplanned discharge occurs when a member stops attending treatment, cannot be located, or fails to respond to outreach efforts. Providers must document all re-engagement attempts and complete a Discharge Summary that clearly identifies "loss of contact" as the reason for discharge. Even if the provider loses contact with the member, they must complete the Discharge Summary within 30 calendar days of the last contact. The summary must include the duration of treatment based on admission and discharge dates, a narrative of services provided and progress prior to the loss of contact, and a prognosis reflecting the member's clinical and recovery outlook. Providers must also document all outreach efforts, such as phone calls, letters, and care coordination attempts. A Discharge Plan is not required in these cases.

San Francisco BHS requires providers to complete and document a 3.2 Clinically Managed Residential Withdrawal Management Discharge Plan within 72 hours of a member's admission, regardless of whether the discharge is voluntary or involuntary. This early planning ensures a safe transition, facilitates timely coordination with next-level care providers, and aligns with state expectations for continuity of care. The discharge plan must detail the member's withdrawal stabilization progress, identified needs, the referral level of care where a full SUD level of care assessment will occur, referrals made, and any follow-up arrangements to support ongoing recovery.

SUS Discharge Plan- Documentation and Billing instructions

Providers must document the Substance Use Services (SUS) Discharge Plan to reflect clinical discharge-planning activities that support the member's care. These services may be billable under HCPCS code T1007 (Comprehensive Community Support / Treatment Planning Service) when the provider spends time developing or updating the discharge plan either with the member or on the member's behalf. Billable activities include reviewing the member's progress and recovery supports, identifying relapse-prevention strategies, coordinating follow-up care or aftercare referrals, consulting with other providers, and synthesizing clinical information to finalize discharge recommendations. Providers may bill for clinically necessary services that directly benefit the member, even if the member is not present during the activity. Documentation must clearly reflect the time spent and the clinical relevance of the service provided.

Documentation Requirements

Clinicians must:

1. Indicate whether the session is Initial Discharge Planning or an Update.
2. Provide a brief narrative describing the interventions performed. Examples include:
   - Reviewing relapse triggers and prevention strategies
   - Coordinating follow-up or aftercare appointments
   - Confirming recovery supports or community resources
   - Reinforcing coping strategies for relapse prevention.

3. Record the reason for discharge (e.g., treatment goals met, voluntary withdrawal, involuntary discharge, referral to another level of care).
4. Identify relapse triggers and include a plan to avoid or manage each trigger.
5. Develop a Support Plan listing family members, peers/sponsors, outpatient programs, and community resources with names, contact information, and roles.
6. Explain how the service addressed the member's needs, including behavioral-health symptoms, social determinants of health, and care coordination needs (e.g., relapse prevention, housing, transportation).
7. Specify next steps or provider actions, such as follow-up referrals, coordination with outpatient programs, or updates to the problem list.

All discharge documentation must be signed and dated by the responsible LPHA, Clinical Trainee, or Counselor and completed within the required timelines. Supervisors should verify completeness and accuracy, ensuring that copies of Discharge Plans are given to members and that discharge summaries accurately reflect clinical outcomes. Programs must maintain auditable records and ensure that all discharge documentation complies with Medi-Cal and DMC-ODS standards for medical necessity, continuity of care, and quality assurance.

Notice of Adverse Benefit Determination (NOABD) to Medi-Cal Members

San Francisco Behavioral Health Services (BHS) is required to issue a Notice of Adverse Benefit Determination to eligible San Francisco Medi-Cal members when BHS, or a provider on behalf of BHS, takes any action defined as an adverse benefit determination in regard to a Medi-Cal member's SMHS or DMC-ODS services. Adverse benefit determination means any of the following actions taken by BHS:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure of BHS to act within the required timeframes for standard resolution of grievances and appeals; or
- The denial of a Medi-Cal member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other financial liabilities.

A Medi-Cal member who receives a Notice of Adverse Benefit Determination (NOABD) has a right to appeal this decision within 60 calendar days from the date on the NOABD. For more information, see Issuing Notices of Adverse Benefit Determination to Medi-Cal Members Receiving Specialized Mental Health or Drug Medi-Cal Organized Delivery System Services Policy 311.04 Behavioral Health Services Policies and Procedures | SF.gov and Notice of adverse benefit determination documents | SF.gov.

BHS Reviews and Audits

Performance, compliance, quality reviews of programs, and Member care are performed across different departments across SFDPH, BHS, and internally within a Program Agency.

Business Office of Contract Compliance (BOCC)

The mission of the Business Office of Contract Compliance (BOCC) are:

- Program Compliance: To ensure that (individual) programs are accountably serving priority populations, as indicated by their contracts or civil service clinic requirements.
- Fiscal Accountability: To ensure that public dollars are spent in accordance with funding requirements as well as local, state, and federal laws/policies and regulations

BOCC completes the Annual Program Monitoring, which assess an agency's individual program compliance with performance objectives, deliverables, and other requirements on the annual Program Declaration of Compliance. In addition, BOCC completes the Fiscal and Compliance Monitoring, which assess the overall agency's financial stability, proper invoicing to the City, and compliance with tax filings through Audited Financial analysis and participation in the Citywide Fiscal and Compliance Non-profit Monitoring and Capacity Building program. BOCC completed these monitoring for both Civil Service Program and Contracted Programs, Community Based Organizations. For more information about BOCC, see RFI Orientation.

Office of Compliance and Privacy Affairs (OCPA)

The Office of Compliance and Privacy Affairs (OCPA) is responsible for implementing a comprehensive health care Program Integrity, including preventing and remediating improper payments, fraud, waste and abuse. The BHS Compliance Unit implements a Program Integrity system that includes overpayments related to claims (chart documentation does not meet the payment standards) as well as overpayments related to Provider eligibility (Provider qualifications do not meet the payment standards). Providers must successfully complete the screening/credentialing process (as well as the DPH Compliance and Privacy Training) before providing any care and/or treatment to BHS Members. Services cannot be claimed or reimbursed if they have been rendered by a Provider who has not correctly completed the screening/credentialing process.

Program Utilization Review Quality Committee (PURQC)

The Program Utilization Review Quality Committee (PURQC) process ensures that clinical services are appropriately utilized, that care is right for each Member, and that BHS SOC are meeting the state's minimum requirements for service levels and utilization. It evaluates the level of care provided, the effectiveness of services, and tracks potential over- or under-utilization. See Appendix A: Program Utilization Review Quality Committee (PURQC) Form and Appendix B: PURQC Memo for more information. The PURQC Form must be signed by the Provider and the Provider's Supervisor before it the form is submitted to PURQC.

The Program Utilization Review and Quality Control (PURQC) process ensures that clinical services are appropriately utilized, aligned with each client's needs, and meet state requirements for service delivery. The review considers the level and effectiveness of care, the client's current utilization of services, and whether the services remain an appropriate fit. To maximize clinical time and reduce documentation burden, programs are required to review a minimum of 5% of total active cases, excluding cases with imminent termination and medication-mostly services. Cases should be selected based on acuity and engagement, with an approximate distribution of 35% high-acuity clients, 35% non-engaging clients, and 30% routine outpatient cases. For each selected chart, reviewers should examine 5 to 7 progress notes to confirm that services match the procedure codes billed and time claimed,, reflect delivery of Specialty Mental Health Services, and align with the client's

treatment goals and problem list. While BHS continues exploring ways to streamline compliance review, Providers should ensure that required documentation is present and meets clinical and regulatory standards.

Supervision

SF BHS promotes the provision of quality clinical supervision using a competency framework to enhance the development of Clinical Staff in their professional skill development, navigate complex cases/situations, and uphold ethical, professional, and quality standards of practice and documentation of those services as set forth by SF BHS, DHCS, Federal Guidelines, and the licensing board/entity of the Supervisee, if applicable.

BHS Policy Use of Interns for Clinical Services 2.06-16 defines supervision as "an activity that is provided by a senior member of a profession to a junior member of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior, monitoring the quality of professional services offered to the clients they serve, and serving as a gatekeeper for those who are to enter the profession." The supervision role for most supervisors involves both clinical and administrative supervision.

Clinical Supervision

Supervisors must have the competence, skills, and knowledge necessary in order to provide guidance and direct the course of treatment for their supervisees. They are expected to stay current in clinical, legal, and ethical knowledge and follow to all Board of Behavioral Sciences (BBS), California Board of Psychology (BOP), or AOD Counselor certification boards' regulations for clinical supervisors, whichever applies to the supervisory relationship. Supervisors are expected to have knowledge of various theoretical orientations, evidence-based practices, cultural considerations, clinical specialty areas specific to the population the supervisee is serving. A Supervisor cannot provide supervision to a technique, intervention, specialty that they do not have expertise in.

Supervision can take place in different forms, including individual supervision, group supervision and peer supervision/review and utilize various supervision models, developmental, integrated, competency-based, and reflective. Adapting to the needs, experience level, and learning style of the supervisee is essential to fostering growth and ensuring that the Members are receiving quality care from the Supervisee. In addition, the supervisor must establish a set supervision time as well as flexibility to address urgent issues that may come up before the next scheduled supervision. Although Supervisors may have more regulations to follow when supervising a Provider for clinical hours, it is also important to provide quality and consistent supervision to Providers who are not be receiving clinical hours but still require guidance and the attention towards their professional development and growth.

Administrative Supervision

Another important component to the supervision process is the administrative aspect of the supervision which includes reviews and discussion surrounding charting, documentation, accurate billing of services, organizational accountability, caseloads, and performance reviews. Current changes in CalAIM documentation reform and BHS changes to a new EHR has made it even more essential for Supervisors to have strong knowledge of clinical documentation, CPT coding and charge review for services provided, accurate billing and timely corrections of errors in the EHR, and follow through with timely completion of progress notes, which is 3 business days from date of service. Supervisors will need to work with their supervisees, especially those

that are Clinical Trainees that require LPHA Supervisor to cosign all documentation on how to meet timely documentation requirements. Progress notes in the EHR that Clinical Trainees did not route to their LPHA Supervisor for Cosign or progress notes that the LPHA Supervisor did not Cosign are incomplete notes and not reimbursable for payment.

See below for resources about supervision from various regulatory boards, certification programs, that BHS supervisors with the relevant license, experience, and skills set can provide supervision for. This list is not meant to be exhaustive.
BBS Statutes and Regulations, APA Guidelines for Clinical Supervision in Health Service Psychology, TIP 52: Clinical Supervision and Professional Development of the Substance Abuse Counselor | SAMHSA., California Board of Psychology, NASW Home. CAMFT | California Association of Marriage and Family Therapists, CAADE – California Association for Alcohol/Drug Educators, Home • Certification For Alcohol And Drug Treatment Professionals, California Consortium of Addiction Programs and Professionals, and Training for Supervisors - California Peer Certification.

References/Resources

SFDPH Emails/Contacts

Behavioral Health Access Center: BHACgeneral@sfdph.org
BHS Billing: sfbhs_billingquestions@sfdph.org
BHS Compliance & Privacy Affairs: Compliance.Privacy@sfdph.org
BHS Provider Credentialing: Credentialing@sfdph.org
BHS Eligibility: BHS-Eligibility@sfdph.org
BHS Service Desk: dph.helpdesk@sfdph.org
BHS Grievance & Appeal: bhs.grievanceappeal@sfdph.org
BHS QA: QA.BHS@sfdph.org
BHS Private Provider Network (PPN): BHS.PPN@sfdph.org
BHS Revenue Integrity: bhsrevenueintegrity@sfdph.org
Health Information Management: DPH-Himforms@sfdph.org
SFDPH Onboarding: Dph.Onboarding@sfdph.org
BHS Quality of Care (QOC) Report: BHSQualityofCareREport@sfdph.org

SFDPH References/Resources

Department of Public Health | SF.gov
SF BHS Policy and Procedures website
CANS and ANSA quality improvement and measurement documents | SF.gov
Compliance at DPH | SF.gov
DPH Compliance Policies | SF.gov
Performance Objectives | SF.gov
BHS Cultural and Linguistic Competency Resources | SF.gov
Grievance and appeal information for Members of Behavioral Health Services | SF.gov
Mental health and substance use disorder Member handbook | SF.gov
Mental Health and Substance Use Disorder Provider Directories | SF.gov
Getting started at the Department of Public Health (DPH) | SF.gov

Behavioral Health Services Provider Portal | SF.gov
Provider Screening, Enrollment & Credentialing | SF.gov
Adult and Older Adult QOC Form
CANS and ANSA quality improvement and measurement documents | SF.gov
Clinical Practice Guidelines for CYF
Culturally Responsive Clinical Tools
DBT Informed Training
Tools to Improve Practice
Transdiagnostic CBT Training

External References/Resources

MedCCC - Library
Behavioral Health Information Notice
BHIN 26-002 Access Criteria
BHIN 23-068 Documentation Requirements for SMH DMC and DMC-ODS Services.pdf
Home - California Mental Health Services Authority California Mental Health Services Authority
Clinical Practice - California Mental Health Services Authority
Documentation Trainings - California Mental Health Services Authority
Medicare NCCI Policy Manual | CMS
ARTICLE 5.51. California Advancing and Innovating Medi-Cal Act [14184.100 - 14184.800]
eCFR:: 42 CFR 455.2 -- Definitions.
CFR-2011-title42-vol4-sec455-2.pdf

Appendix A: Program Utilization Review Quality Committee (PURQC) Form

Behavioral Health Services
System of Care

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Program Utilization Review Quality Committee Form			
REVIEW DATE:	**CLINICIAN:**	**SUPERVISOR:**	**PROGRAM NAME:**
EPISODE OPENING DATE:	**CLIENT NAME:**	**BIS/MRN#**	**DEP/EPISODE:**
Case Type: ☐ High Acuity ☐ Low or Non-Engaging ☐ Routine Outpatient ☐ Other			
System of Care: ☐ Children Youth & Families ☐ Adult/Older Adult ☐ Transitional Age Youth ☐ Outpatient Services at Residential (via Residential System of Care)			

Section I: Documentation Compliance & Quality-Check List **General Documents:** *Instructions: It is required that charts are reviewed for compliance. Clinician fills out this section with relevant data and dates. PURQC member confirms each category (Yes/No, Comments).*	**YES**	**NO**	**Comments/Feedback**
1. Consent to Treatment: signed & dated by client and staff			
2. Telehealth Consent: is there a telehealth consent progress note, on the same day or prior, to the first telehealth service (verify in the Encounters list for the first telehealth service)			
3. HIPAA Form			
4. Acknowledgment of Receipt of Materials, including Grievance Procedure			
5. Relevant Authorization to Release/Exchange Information			
6. Authorization for Billing			
7. Copy of Insurance Card			
8. Accounting of Disclosure Log (for DPH Civil Service Clinics Only)			
9. Psychiatric Medication Consent, if applicable			
II. ASSESSMENT	**YES**	**NO**	**Comments/Feedback**
1. Date of most recent Assessment: ____/____/____ *MM/DD/YYYY*			
2.a. Has there been a 7 Domain Assessment completed by a BHS provider in the last year for CYF; last 3 years for AOA; or last year/3 years for TAY?			
2.b. If your program did not issue the Assessment, was a progress note available indicating the provider has reviewed and agreed with the Assessment?			
3. Are diagnoses and problem list consistent with information noted in the assessment?			
4. AOA: is there a Level of Care completed annually?			
5. CYF: CANS: is there a current and complete CANS? If initial, 60 days of E.O. If update, no more than 6 months from the previous CANS.			
6. CYF: Is there a current and complete PSC-35? If initial, 60 days of E.O. If update, no more than 6 months from the previous PSC-35.			
7.a. For CYF: Does assessment documentation support access criteria for SMHS? Check all that apply below: ***Access Criteria 1***: ☐ Unhoused ☐ High-Risk Range Trauma* ☐ HSA Involved ☐ JPD Involved ***Access Criteria 2***: Meets a and b: ☐ Yes ☐ No (see Access Criteria at end of document)			
7.b. For AOA & TAY: Does assessment documentation support access criteria for SMHS (including detailing symptoms and functional impairments that meet SMH criteria below? ***Access Criteria 1***: ☐ Significant Impairment and/or ☐ Reasonable probability for deterioration ***Access Criteria 2***: Meets a or b: ☐ Yes ☐ No (see Access Criteria at end of document) • The beneficiary's condition (Criteria 1) is due to either of the following: (a) A suspected mental disorder that has not yet been diagnosed (b) A diagnosed mental health disorder, according to the criteria of the current editions of the DSM and the ICD.			

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III. Care Plans (for specific services)	**YES**	**NO**	**Comments/Feedback (or indicate Not Applicable here)**
1. If client received TCM, ICC, IHBS, TBS, or Peer Services is there a completed care plan documented within the client record?			
2. If the client is receiving ICC/IHBS, does the client record contain documentation that a Child and Family Team meeting has occurred every 90 days? If timelines are not met, does chart include documentation for reasons of postponement and regular contact with the CFT?			
IV. Problem List	**YES**	**NO**	**Comments/Feedback**
1. Does the problem list reflect the current client needs, including at least one identified mental health diagnoses, substance use, social determinants of health and/or Z codes and has the problem list been updated any time there is a relevant change to the beneficiary's condition?			
V. PROGRESS NOTES (Spot check 5-7 notes)	**YES**	**NO**	**Comments/Feedback**
1. Do progress notes have Direct Service Time for each service?			
2. Did the service that was claimed (procedure code) match the service documented in the progress note? If no, identify the claims in the comments.			
3. Do all units of time for services match the amount of time documented in the progress note? If no, identify the date of service in the comments.			
4. Do progress notes include a sufficient description of specialty mental health intervention(s) provided?			
5. Do progress notes reflect an item(s) from the Problem List?			
6. Does the chart as a whole include evidence of care coordination across providers, agencies, county systems (e.g. child welfare and Behavioral Health (BH), significant support person(s) and/or between delivery systems (Managed Care Plan (MCP) and Mental Health Plan (MHP))?			
7. Have all risk and safety issues in the client record been addressed?			
8. Gaps in services are supported by non-billable notes (longer than 90 days)			

This chart has been reviewed by Staff/Supervisor to ensure that all documents are in place & current *Signature of Supervisor:*_____ *Date:* _____	*Staff Signature:*_____ *Staff Title:*_____ *Date:* _____

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Section II: Clinical Quality Review

The Following Sections are Completed by PURQC Reviewers only

Clinical Quality Review ***PURQC committee member*** *to review care plan, assessment, and 5 to 7 progress notes to answer the following:*
a. Does the Level of Care match the Client's needs (*see note below)? ☐ Yes ☐ Needs Attention Provide an explanation if Needs Attention was selected:
b. Are the family and caregivers engaged? ☐ Yes ☐ No ☐ Needs Attention
c. How does race and other aspects of the client's diversity affect and impact the therapeutic relationship, care coordination, intervention, and response to treatment?
d. Risks/Barriers: Are all safety issues or risk factors well documented and addressed? What are the potential barriers in this case?
e. Is this client making progress toward their goals? (Data to help support the review may include, ANSA or CANS actionable items, PSC-35 Reports) ☐ Yes ☐ No ☐ Needs Attention
f. Is there a clear discharge plan? ☐ Yes ☐ No ☐ Needs Attention Additional supports or interventions needed for stepdown/discharge?

***Note on Level of Care (LOC):**

AOA's LOC tool (reminder: same tool to be used by AOA & TAY programs): Providers are reminded to review LOC tool annually.

CYF's LOC tool: General guidelines are as follows:

- Outpatient services: Clients are seen a minimum of 1 x per week (unless in the discharge phase)
- Intensive Services: Clients are seen at a minimum 3+times per week and in the field with collateral support.

Section III: Clinical Assessment Review

Clinical Assessment: Required to be reviewed by PURQC Committee member
a. Is this formulation well thought out and supported based on assessment data (may use the CANS Priorities for Treatment section to support your review), theory, and the culture and context within which the child/youth, and family are embedded? ☐ Yes ☐ No: (if no, please explain)
b. Does the clinical formulation inform the best course of treatment (e.g., needs to focus on; interventions to deliver)? Does the formulation match the ANSA or CANS actionable items Priorities for Treatment? ☐ Yes ☐ No: (if no, please explain)

Section IV: Clinical Recommendations/Feedback to Clinician & Supervisor

This section is intended to facilitate feedback & interaction between PURQC & the treatment team regarding Clinical Care. For each check boxes below, please explain in comments box below.

Recommended clinical services	Recommended duration/intensity of services
☐Need for additional case management/supportive services	☐Work towards termination
☐Need for medication evaluation, primary care, and/or psychological testing	☐Adjust level of service intensity and/or dosage (please specify)
☐Need for new/additional intervention	☐Adjustment/creation of treatment goals or interventions, etc.
☐Need for building of natural/community support system	☐Need for a case conference with other providers
☐Need for updated problem list	
COMMENTS / RECOMMENDED ACTION STEPS:	

Section V:

Behavioral Health Services
System of Care

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

PURQC Review Action	
☐	No additional follow up needed.
☐	Need for supervisor attention (see recommendations above).
☐	Conditional Review: See PURQC Recommendations & Resubmit to PURQC on _____ (date)
☐	Denied: See PURQC Recommendations above
Next PURQC/Review Date *(if applicable)*:	
PURQC Reviewer Signature _____ PURQC Reviewer's Signature & Discipline _____ Date	
PURQC Second Reviewer Signature (Post-Revision) _____ PURQC Reviewer's Signature & Discipline _____ Date	

Behavioral Health Services
System of Care

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Medical Necessity and Access Criteria Reference*

Definition of Medical Necessity
Medi-Cal services provided to persons in care need to meet the standard of being "Medically necessary". For individuals under age 21, a service is medically necessary when needed to correct or ameliorate a mental health condition. Services do not need to be curative or restorative to ameliorate a mental health condition per CMS. The service may sustain, support, improve or make more tolerable the client's condition. (Federal EPSDT Law – Title 42 USC 1396d(r)(5))

Criteria for Beneficiaries Under 21 to Access SMHS (Either Criteria 1 OR Criteria 2)
Criteria 1:
1. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: • Scoring in the high-risk range on a trauma screening tool approved by DHCS • Involvement in the Child Welfare System • Juvenile Justice involvement • Experiencing homelessness
OR
Criteria 2:
1. The beneficiary meets both of the following requirements in **a and b** below: a. The beneficiary has **at least one** of the following: • A significant impairment • A reasonable probability of significant deterioration in an important area of life functioning • A reasonable probability of not progressing as developmentally appropriate • A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide
AND
b. The beneficiary's condition as described above is due to **one of the following**: • A diagnosed mental health disorder, according to criteria of the current editions of the DSM and ICD • A suspected mental health disorder that has not yet been diagnosed • Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional

***While a mental health diagnosis is not a prerequisite to access SMHS, this does not eliminate the requirement that all Medi-Cal claims include a CMS valid ICD-10 diagnosis code. In cases where services are provided due to a suspected mental health disorder that has not yet been diagnosed or due to significant trauma, options are available in the CMS approved ICD-10 diagnosis code list. These include codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services" (Z codes). These codes will meet ICD-10 claiming requirements and allow for needed mental health care to be provided even while the clinician is determining a diagnosis.*

*See SF Policy Manual Number: 3.04-10
And https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf

Appendix B: PURQC Memo

Docusign Envelope ID: C7E183E2-2B88-44BB-96A8-D29B1CB68166

City and County of San Francisco
Daniel Lurie
Mayor

San Francisco Department of Public Health
San Francisco Health Network
Behavioral Health Services

Maximilian Rocha, LCSW
Director of Systems of Care
Behavioral Health Services
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MEMORANDUM

DATE: March 31, 2025

TO: BHS Providers

FROM: Maximilian Rocha, LCSW, Director of Systems of Care DS MR

RE: Updates to PURQC Process

This memo provides an overview of the **PURQC (Program Utilization Review and Quality Control)** process and highlights the changes that have been made to improve efficiency, reduce documentation burden, and ensure compliance with state requirements. This revised process will take place on April 1st, 2025.

I. What is the PURQC Process

The PURQC process ensures that clinical services are appropriately utilized, that care is right for each individual, and that we are meeting the state's minimum requirements for service levels and utilization. It evaluates the level of care provided, the effectiveness of services, and tracks potential over- or under-utilization.

II. Key Changes to the PURQC Process

a. Maximizing Clinical Time & Reducing Documentation Burden

- The updated process reduces the number of cases reviewed, allowing clinicians to focus more on providing care.

b. Maintaining Accountability

- The contract performance measures are simplified, making expectations clearer for providers.
- While BHS is seeking Epic solutions to streamline the compliance review process, we are asking providers to continue to review necessary documentations are in place, and documentation meets standards.

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III. Highlight of Key Changes

a. Sample Size: Review a minimum of 5% of the total active case (rather than 100% of all cases with episodes anniversary due).

b. Exclude: medication-mostly cases.

c. The 5% sample is to be determined by providers based on acuity and engagement level. Programs are recommended to ensure sample size of providers are evenly distributed over time.

d. Distribution of cases:
   - **Highly acuity patients (35%):** Recent hospitalizations and/or multiple contacts with Crisis
   - **Non-engaging clients (35%)**: frequent no-shows and/or low participation.
   - **Routine outpatient cases (30%)** - general outpatient care.

   *Example: For a program with 125 clients. Since the sample size is 5% of the total 125 clients, we need to select **6-7 client** charts for PURQC. The distribution of cases in the program is:*

   - ***2–3 High Acuity clients** (e.g., recent hospitalization, frequent crisis intervention)*
   - ***2–3 Non-Engaging clients** (e.g., frequent no-shows, minimal participation)*
   - ***1–2 Routine Outpatient clients** (consistent care, stable symptoms)*

e. **Progress Notes**: Review 5 to 7 progress notes, along with guidance on reviewing documentation to ensure services:
   - match procedure codes, time claimed,
   - describe delivery of specialty mental health services, and
   - meet of treatment goals (problem list)

IV. When will this take place?

The revised PURQC process will take effect on April 1, 2025. We are not asking providers to retrospectively review cases from 07/01/2024 – 03/31/2025. Our expectations are:

- April: programs will form group and develop implementation process
- May: PURQC process commences

V. How to keep track of cases reviewed?

Programs are asked to keep track of cases by using the attached PURQC Minutes tracker, and file these tracking systems securely.

Attached are the revised form reflecting these changes, and PURQC Minutes. For questions or further clarification, please reach out to your System of Care Program Managers.

Appendix C: Behavioral Health Accountability Set (BHAS) Measurement Year

See Medi-Cal Managed Care Accountability Sets for most up to date measurement year.

County MHP Priorities Measures for Year 2023 and 2024

County Mental Health Plan (MHP) Priority Measures[i]

#	MEASURE REQUIRED OF MHP	MEASURE ACRONYM	MEASURE STEWARD	Methodology	Target (MPL)[ii]
County MHP Priority Measures					
1	Follow-Up After Emergency Department Visit for Mental Illness—30 days*	FUM	NCQA	Administrative	>50th percentile **OR** 5%-point increase over prior year rate if <50th percentile
2	Follow-Up After Hospitalization for Mental Illness—30 days	FUH	NCQA	Administrative	>50th percentile **OR** 5%-point increase over prior year rate if <50th percentile
3	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	APP	NCQA	Administrative	>50th percentile **OR** 5%-point increase over prior year rate if <50th percentile
4	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	NCQA	Administrative	>50th percentile **OR** 5%-point increase over prior year rate if <50th percentile

County MHP Priorities Measures for Year 2025

Measure Name	Abbreviation	Measure Description
Antidepressant Medication Management	AMM	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported. 1. Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). 2. Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	APP	The percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
Follow-Up After Hospitalization for Mental Illness	FUH	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 30 days after discharge. 2. The percentage of discharges for which the member received follow-up within 7 days after discharge.
Follow-Up After Emergency Department Visit for Mental Illness	FUM	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	SAA	The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an anti psychotic medication for at least 80% of their treatment period.

County DMC ODS Priorities Measures for Year 2023 and 2024

Drug Medi-Cal Organized Delivery System (DMC-ODS) Priority Measures[i]

#	MEASURE REQUIRED OF DMC-ODS	MEASURE ACRONYM	MEASURE STEWARD	Methodology	Target (MPL)[ii]
	DMC-ODS Priority Measures				
1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30 days*	FUA	NCQA	Administrative	>50th percentile **OR** 5%-point increase over prior year rate if <50th percentile
2	Pharmacotherapy of Opioid Use Disorder*	POD	NCQA	Administrative	>50th percentile **OR** 5%-point increase over prior year rate if <50th percentile
3	Use of Pharmacotherapy for Opioid Use Disorder	OUD	CMS	Administrative	>50th percentile **OR** 5%-point increase over prior year rate if <50th percentile
4	Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment	IET-I	NCQA	Administrative	>50th percentile **OR** 5%-point increase over prior year rate if <50th percentile
5	Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment	IET-E	NCQA	Administrative	>50th percentile **OR** 5%-point increase over prior year rate if <50th percentile

i. For Behavioral Health Plans that are integrated or will be during MY 2025, both MHP and DMC-ODS measure sets are required.

ii. MCPs held to the 50th percentile as established by the National Committee for Quality Assurance (NCQA) Quality Compass© Medicaid HMO or Centers for Medicare & Medicaid Services (CMS) calculated national medians. If a county plan's rate is

* Measures must be stratified by race/ethnicity per NCQA categorizations.t increase from the MY's baseline rate.

County DMC ODS Priorities Measures for Year 2025

Measure Name	Abbreviation	Measure Description
Follow-Up After Emergency Department Visit for Substance Use	FUA	The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Initiation and Engagement of Substance Use Disorder Treatment	IET	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: • Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. • Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
Pharmacotherapy for Opioid Use Disorder	POD	The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.
Use of Pharmacotherapy for Opioid Use Disorder	OUD	Percentage of adults aged 18 years and older with pharmacotherapy for opioid use disorder (OUD) during the measurement year. • Adults aged 18 years and older who had a qualifying encounter during the performance year, *and* a diagnosis of OUD • Pharmacotherapy for OUD (2 or more claims) during the denominator identification period. • Pharmacotherapy for OUD: ○ Buprenorphine ○ Buprenorphine (extended-release injectable) ○ Naltrexone (oral) ○ Buprenorphine/naloxone ○ Methadone ○ Naltrexone (extended-release injectable)

Appendix D: Adult/Older Adult/Transitional Age Youth (AOA/TAY) Requirements at Intake, First 60 Days, Updates, and Discharge

Adult/Older Adult/Transitional Age Youth (TAY) Requirements at Intake, First 60 Days, Updates, and Discharge

Due at Day of Intake/Episode Opening (EO)	Due within first 60 Days of EO	Due Annually on Date of Last Completed	Due Triennially on Date of Last Completed	Due at Discharge
Obtain Signature *SFHN Consent for Treatment Terms and Conditions. * SFDPH Summary Notice of HIPPA Privacy Practices & Acknowledgement of Receipt. * BHRD84 Acknowledgement of Receipt of Materials. **Obtain Information/Consent** *CSI Information. * Missing Registration Information. *Telehealth Consent at first Telehealth Session, if applicable. **Info to Give** * Appeal and Grievance Process Handout (BHS 315). * Behavioral Health (Integrated) Member Handbook. * MHP Provider Directory. * Requirement to Provide Notice to Clients (BHS 315).	**Complete** *ANSA. *Diagnosis. *Problem List. *7 Domain Assessment. *If there is an active assessment that was completed within the last year and the Provider wants to operate under that assessment, a new assessment does not need to be update. However, Provider will still need to document rationale for using that assessment.*	**Signature Required** *SFHN Consent for Treatment Terms and Conditions. * SFDPH Summary Notice of HIPPA Privacy Practices & Acknowledgement of Receipt of Materials. *ROI Authorization, if applicable. **Recheck** *CSI Information. *Registration Info. **Review & Update** *Diagnosis. *Problem List. *Care Plan. **Complete** *Level of Care Tool.	**Complete Update** *7 Domain Assessment.	**Complete if there isn't another Program Using the Current Episode** *ANSA. *Resolve Episode. *CSI. *Resolve Problem on Problem List. *AMB BHS Discharge. *Level of Care Tool.

* DHCS' Informational Notice to Medi-Cal beneficiaries if Telehealth Consent was obtained. **Need to Create/Enter** *New Episode if one is not open. *Enter Timely Access Data.				

At Anytime During Course of Treatment When Applicable
*ROI Authorization for Use or Disclosure of Protected Health Information. *Patient Request for OPT-OUT of Electronic Health Exchange. *Care Plan on the day of or prior to providing certain services such as Targeted Case Management, Peer Support, etc. *When there is significant clinical change, updates to the 7 Domain Assessment, ANSA, Care Plan, Problem Lists, etc. *Telehealth Consent prior to or at first Telehealth Session and Member to receive a copy or the link to DHCS' Informational Notice to Medi-Cal beneficiaries regarding telehealth services for Members.

Appendix E: Children, Youth and Families/Transitional Age Youth (CYF/TAY) Requirements at Intake, First 60 Days, Updates, and Discharge

Children, Youth, and Families/Transitional Age Youth Requirements at Intake, First 60 Days, Updates, and Discharge

Due at Day of Intake/Episode Opening	Due within first 60 Days of Episode Opening	Due at 6 Months on Date of Last Completed	Due Annually on Date of Last Completed	Due at Discharge
Obtain Signature *SFHN Consent for Treatment Terms and Conditions. * SFDPH Summary Notice of HIPPA Privacy Practices & Acknowledgement of Receipt. * BHRD84 Acknowledgement of Receipt of Materials. **Obtain Information/Consent** *CSI Information. *Missing Registration Information. *Telehealth Consent at first Telehealth Session, if applicable. **Info to Give** * Appeal and Grievance Process Handout (BHS 315). * Behavioral Health (Integrated) Member Handbook. * MHP Provider Directory. * Requirement to Provide Notice to Clients (BHS 315).	**Complete** *CANS & Priorities for Treatment. *PSC-35. *Diagnosis. *Problem List. *7 Domain Assessment. *If there is an active assessment that was completed within the last year and the Provider wants to operate under that assessment, a new assessment does not need to be update. However, Provider will still need to document rationale for using that assessment.*	**Complete** *CANS & Priorities for Treatment. *PSC-35.	**Signature Required** *SFHN Consent for Treatment Terms and Conditions. * SFDPH Summary Notice of HIPPA Privacy Practices & Acknowledgement of Receipt of Materials. *ROI Authorization, if applicable. **Recheck** *CSI Information. *Registration Info. **Complete Update** *7 Domain Assessment. *CANS & Priorities for Treatment. *PSC-35. **Review & Update** *Diagnosis. *Problem List.	**Complete if there isn't another Program Using the Current Episode** *CANS. *PSC-35. *Resolve Episode. *CSI. *Resolve Problem on Problem List. *AMB BHS Discharge. **Complete if Transitioning to another SOC** *Level of Care Tool.

* DHCS' Informational Notice to Medi-Cal beneficiaries if Telehealth Consent was obtained. **Need to Create** *New Episode if one is not open. *Enter Timely Access Data.			*Care Plan.	

At Anytime During Course of Treatment When Applicable
*ROI Authorization for Use or Disclosure of Protected Health Information. *Patient Request for OPT-OUT of Electronic Health Exchange. *Care Plan on the day of or prior to providing certain services such as Targeted Case Management, Peer Support, etc. *When there is significant clinical change, updates to the 7 Domain Assessment, CANS, Care Plan, Problem Lisa, and Level of Care Tool. *Telehealth Consent prior to or at first Telehealth Session and Member to receive a copy or the link to DHCS' Informational Notice to Medi-Cal beneficiaries regarding telehealth services for Members.

Appendix F: Adult/Older Adult (AOA)/Transitional Aged Youth (TAY) Level of Care (LOC) Tool

AOA Level of Care Tool

MENTAL HEALTH NEEDS

Psychosis

0	1	2	3

0 = No Evidence
1 = Mild History, Sub Threshold Watch
2 = Moderate – Need for Action
3 = Severe – Need for immediate/Intensive action

Impulse Control

0	1	2	3

0 = No Evidence
1 = Mild History, Sub Threshold Watch
2 = Moderate – Need for Action
3 = Severe – Need for immediate/Intensive action

Depression

0	1	2	3

0 = No Evidence
1 = Mild History, Sub Threshold Watch
2 = Moderate – Need for Action
3 = Severe – Need for immediate/Intensive action

Anxiety

0	1	2	3

0 = No Evidence
1 = Mild History, Sub Threshold Watch
2 = Moderate – Need for Action
3 = Severe – Need for immediate/Intensive action

Adjustment to Trauma

0	1	2	3

Substance Use

0	1	2	3

0 = No Problem
1= Mild Problem
3 = Severe Problem

RISK

Danger to Self

	0		1		2		3

0 = None
1 = History but no recent intent, ideation, or feasible plan
2 = Recent ideation, intention, plan that is feasible and/or history of a potential lethal attempt
3 = Current ideation or command hallucinations re: self-harm, current intent, plan that is feasible and/or history

Self-Injurious behavior

	0		1		2		3

0 = No Evidence
1 = Mild History
2 = Moderate – Need for action
3 = Severe – Need for immediate/intensive action

Danger to Others

	0		1		2		3

0 = None
1 = History but no recent intent, ideation, or feasible plan
2 = Recent ideation, intention, plan that is feasible and/or history of a potential lethal attempt
3 = Current ideation or command hallucinations re: self-harm, current intent, plan that is feasible and/or history

Grave Disability

	0		1		2		3

0 = None
1 = History but no recent intent, ideation, or feasible plan
2 = Recent ideation, intention, plan that is feasible and/or history of a potential lethal attempt
3 = Current ideation or command hallucinations re: self-harm, current intent, plan that is feasible and/or history

Exploitation

	0		1		2		3

0 = No Evidence
1 = Mild History
2 = Moderate – Need for action
3 = Severe – Need for immediate/intensive action

SERVICE UTILIZATION

Psychiatric Hospitalizations in last 6 months

☐ 0 = 0	☐ 1=1	☐ 2=2	☐ 3= >3

Crisis Contacts in last 60 days (PES, DUCC, CCS, ADU, SCRT, 5150's)

☐ 0 = 0	☐ 1= 1-2	☐ 2= 3-5	☐ 3= >5

OTHER FACTORS

Recent Contacts

☐ Emergency Department ☐ Withdrawal Management ☐ Residential Treatment

Jail Contacts in last 6 months

☐ 0	☐ 1	☐ 2	☐ 3

Housing Stability

☐ Stable Housing (e.g., Independent, PSH) ☐ Unstable Housing (e.g. with friends)

☐ Shelter/Temporary Placement (e.g., residential placement) ☐ No Housing

Current System Involvement

☐ Criminal Court/Collaborative Court ☐ Assisted Outpatient Treatment

☐ Care Court ☐ Conservatorship ☐ Regional Center/Intellectual Disability

☐ CPS/APS

RECOMMENDATIONS

Level of Care based on Scores

☐ PPN	☐ Outpatient	☐ ICM	☐ Stabilization

Level of Care Client is being placed in/continuing in

☐ PPN	☐ Outpatient	☐ ICM	☐ Stabilization

Justification if level of care client is placed in is different than level of care recommended

Other factors listed above shift need ☐	Being referred to level of care while waiting for specialty services (e.g., ICM) ☐	Client preference ☐	Other, Specify ☐

Appendix G: Children, Youth, and Families (CYF)/Transitional Aged Youth (TAY) Level of Care (LOC) Screening Tool

CYF LOC Screening Tool Complete to determine referral to CYF Outpatient Program	**Date of Referral:** **Client's Insurance: Full-Scope Medi-Cal Yes/No** **Medi-Cal #:** **Referred by:** **Referring party name and phone number:**

I. DEMOGRAPHICS	
Client Name:	**Date of Birth:**
Client Race/Ethnicity:	**Preferred Language of Client:**
Client Gender:	**Caregiver/Parent/Legal Guardian Name:**
Caregiver/Parent/Legal Guardian Phone:	**Preferred Language of Caregiver/Parent/Legal Guardian:**
Address:	
Current Grade:	**School/Childcare Site:**

II. SYSTEMS INVOLVEMENT (check all apply) May obtain via DHCS Screening Tool

	Juvenile Probation – ward of the court (602)		HSA – Child Welfare
	SFUSD – IEP with learning disability only		Mental Health
	SFUSD – IEP in ERMHS		Child Crisis
	SFUSD – IEP in special day class (SOAR class)		Other (Specify):

Note: Referral should be sent to CYF HUB if JPD, SFUSD, or HSA is selected.

Current Services

- ☐ Regional Center Services
- ☐ Speech Therapist, OT, PT, SST/504/IEP
- ☐ Therapy (list program and name):
- ☐ Psychiatrist (list program and name):
- ☐ Developmental Behavioral Pediatrician:

III. CURRENT PRESENTATION: Presenting problem and concerns (What is going on? How often is it happening? How long has it been happening? Where is it happening? And how is it impacting the child/youth's functioning? Also include cultural context, noteworthy life events, caregiver capacity/family stressors affecting care, additional information we need to be concerned about). ***Please indicate the severity/intensity for each identified concern/need below.***

IV. Risk Factors (check all that apply)

- ☐ Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- ☐ Thoughts about harming or killing yourself
- ☐ Thoughts about harming or killing someone else
- ☐ Psychiatric hospitalization in the past year
- ☐ Sexual Abuse/Assault
- ☐ History of neglect/Abuse
- ☐ Separation/loss of primary caregiver

If in imminent threat of harm, call Child Crisis; *If not imminent threat of harm but elevated concern*, call Seneca MRT

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V. OTHER CONCERNS/NEEDS (check all apply)

Mood Concerns:	Behavioral Concerns:	Social/Family Concerns
☐ Depression/Sadness. ☐ Feelings of Worthlessness ☐ Feelings of Hopelessness ☐ Withdrawn/Isolative ☐ Sleep Issues or Concerns ☐ Rapid Mood Changes Anxiety Concerns: ☐ Anxious/Severe Worries ☐ Obsessive/Compulsive Behaviors ☐ Panic Attacks Trauma-Related Concerns: ☐ Trauma/Grief/Loss ☐ Racial or Ethnic-Based Trauma/Discrimination ☐ Feeling Numb ☐ Avoiding people, places, activities, or specific things	☐ Violent/Aggressive Behavior ☐ Impulsivity in at least two areas that are potentially self-damaging ☐ Difficulty following directions or paying attention ☐ Can't sit still / too active/impulsive ☐ Intense Anger/Difficulty Controlling Anger Eating-Related Concerns: ☐ Eating disorder with medical complications ☐ Disordered Eating Behaviors without medical complications (restrictive food intake, excessive exercise, binge eating) Psychosis-Related Concerns: ☐ Seeing or hearing things others don't ☐ Delusions	☐ Not making friends / Poor social skills ☐ Not doing well in school / Poor attendance ☐ Parent/Caregiver-Child relationship interaction problems ☐ Significant parent/caregiver-child attachment concerns (0-5 years old) ☐ Difficult to soothe / Excessive crying (0-5 years) Other Concerns: ☐ Substance Use ☐ Age-inappropriate sexualized behaviors

VI. ELIGIBILITY CRITERIA for Intensive Services (check all apply)

	Involved in multiple child/youth serving systems
	Has been discharged within 90 days from a psychiatric hospitalization or a 24-hour mental health treatment facility.
	Is being considered for a psychiatric hospitalization.
	Has experienced 2 or more mental health hospitalizations in the last 12 months.
	Has experienced 2 or more placement changes within 24 months due to behavioral needs.
	Currently on probation and/or detained and not complying with court orders due to mental health needs.
	Receiving SMHS and is/was homeless in the past 6 months

VII. Service Request

What specific services are being requested?

☐ Outpatient Services (e.g., individual/family therapy, case management)
☐ Psychiatry
☐ Psychological Evaluation
☐ Other: _____

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Appendix H: Substance Use Disorder (SUD) Adult Screening Tool

SUD Adult Screening Tool

Prior to completing tool, please ensure confidentiality has been reviewed

1. Are you currently experiencing severe life-threatening withdrawal symptoms or a life-threatening emergency?	☐Yes ☐ No
2. Are you thinking about hurting yourself or someone else right now? **NOTE: If yes, do not finish the screening and handle according to existing emergency or crisis protocols.**	☐Yes ☐ No

What service are you seeking today?

☐ I am looking for medication to treat my addiction (aka. MAT or MOUD). *Staff completes Medication for Addiction Treatment section only.*

☐ I am looking for "detox" (Withdrawal Management) service. *Staff completes dimension 1, 2, and 3 in this screening tool with the client.*

☐ I am looking for substance use treatment services. *Staff completes all 6 dimensions in this screening tool with the client.*

☐ I am not sure, or I don't know. *Staff completes all 6 dimensions in this screening tool with the client.*

ASAM Screening Tool

Dimension 1: Substance Use, Acute Intoxication, Withdrawal Potential

1. In the past 30 days, have you used:

NOTE: Substances in "red" require access to MAT Medications.

Substance Name	Date of last use	Frequency (Daily, Weekly, etc.)	Amount	Duration (Length of use)	Route (Injection, smoke, snorting, etc.)
Alcohol (beer, wine, hard liquor etc.)					
Benzodiazepine (Xanax, valium, Ativan, etc.)					
Opioid (Oxy, fentanyl, heroin etc.)					
Cocaine					
Methamphetamine/ Amphetamine					
Marijuana					
Other (Ketamine, GHB, etc.):					
Other:					
Other:					

Question	Yes	No
2. Have you used in the last 72 hours?	☐1	☐0
3. Does your substance use significantly impact your life?	☐1	☐0
4. Have you ever experienced intentional or unintentional overdose in your life?	☐2	☐0
5. Are you currently in withdrawal or feel physically sick because you stopped using alcohol and/or other substances? **NOTE: If yes, seek consultation.**	☐2	☐0
6. Have you ever experienced alcohol-related seizures or needed to be hospitalized for alcohol or benzodiazepine withdrawal? **NOTE: If yes, seek consultation.**	☐0	☐1

7. Are you currently prescribed or taking one of the following medications for addiction treatment? (Buprenorphine (Subutex or Suboxone), Methadone, Vivitrol (Naltrexone))	☐0	☐1

Scoring Guide:

Severity Rating	Total Score
4	7-8
3	6
2	4-5
1	2-3
0	0-1

Severity Rating- Dimension 1: Substance Use, Acute Intoxication, Withdrawal Potential

☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
• No signs of withdrawal present • No signs of intoxication present	• Mild/moderate intoxication • Interferes with daily functioning. • Minimal risk of severe withdrawal • No danger to self/others	• May have severe intoxication but responds to support. • Moderate risk of severe withdrawal • No danger to self/others	• Severe intoxication with imminent risk of danger to self/others • Difficulty coping • Significant risk of severe withdrawal	• **Incapacitated** • **Severe signs and symptoms.** • **Life threatening withdrawal i.e., seizures.** • **Continued substance use poses an imminent threat to life**

Comments:

Medication for Addiction Treatment

Staff: "You are interested in medication treatment. Let's get you connected to a clinic to support this."

IF MAT required: "To help you be more successful in WM/Residential services, let's get you connected to a clinic to support you."

1. What medication are you interested in?
   - ☐Buprenorphine (Subutex or Suboxone) for opioid use disorder. *Refer to Bup Workflow.*
   - ☐Methadone for opioid use disorder. *Refer to methadone workflow.*
   - ☐Naltrexone (Vivitrol) for alcohol or opioid use disorder. *Refer to Naltrexone Workflow*
   - ☐Other medications for addiction treatment. *Ask questions in D1 and follow MAT workflow.*
   - ☐"I am not sure" or "I want to talk to a prescriber to know my options". *Ask questions in D1 and follow MAT workflow*

2. Do you want to talk to someone within the next 24 hours?	☐Yes ☐No
3. Referred to:	4. MAT Appt Date and Time:
5. Member declined MAT Service: ☐	

Dimension 2: Biomedical Conditions and Complications		
Question	**Yes**	**No**
8. In the past 30 days, have you experienced serious medical problems or been to the emergency room for any medical problems?	☐1	☐0
9. Do you currently have any physical health concerns such as open sores or abscesses that require medical treatment?	☐1	☐0
10. Do you have any medical conditions, like COPD, heart disease, kidney disease, cirrhosis, diabetes, and/or a history of seizures?	☐1	☐0
11. Are you currently taking medications for any medical conditions?	☐0	☐0
12. Do you currently have a primary care provider?	☐0	☐0
13. Are you able to go to the bathroom, move around, etc. on your own?	☐0	☐2
14. *If the person has childbearing potential*: Are you currently pregnant? (*Optional*) *If yes, please see Pregnancy Workflow.*	☐2	☐0

Scoring Guide:

Severity Rating	Total Score
4	6-8
3	4-5
2	2-3
1	1
0	0

Severity Rating- Dimension 2: Biomedical Conditions and Complications

☒ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe*	☐ 4 Very Severe*
• Fully functional/no significant pain or discomfort	• Mild symptoms interfere minimally with daily functioning.	• Acute, non-life-threatening medical needs. • Chronic medical conditions not currently being treated. • Health issues impact ADLs and independent living • Sufficient support to manage medical problems at home with medical intervention	• Medical conditions not currently at goal and in need of evaluation. • Insufficient support to manage medical problems independently. • Difficulty with ADLs and/or independent living	• **Unstable condition with severe medical problems, including but not limited to:** • **Emergent chest pain or shortness of breath** • **Confusion or Delirium tremens (DTs)** • **Unstable pregnancy** • **Vomiting bright red blood** • **Withdrawal seizure in the past 24 hours** • **Recurrent seizures**

Comments:

*Please address medical conditions first and seek consultation. Refer to medical workflow.

4

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications		
Question	**Yes**	**No**
15. Do you ever hear or see things that others do not? **NOTE: If yes, consult with a LPHA**	☐2	☐0
16. Has your substance use caused you to behave in a way that was dangerous to yourself or others (e.g., history of violence, aggression, impaired driving, being arrested, behaving in ways you normally don't, etc.)	☐1	☐0
17. Have you even been diagnosed with and/or received treatment for a mental health condition?	☐1	☐0
18. Are you currently taking any medications for your mental or emotional health?	☐1	☐0

Scoring Guide:

Severity Rating	Total Score
4	5
3	3-4
2	2
1	1
0	0

Severity Rating- Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications

0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe*
• No emotional, behavioral, or cognitive conditions.	• Possible diagnosis of emotional, behavioral, cognitive condition • Requires monitoring for stable mental health condition. • Symptoms do not interfere with recovery goals.	• Requires treatment and management of mental health condition. • No immediate risk of harm to self/others • Symptoms do not prevent independent functioning	• Difficulty to care for self independently. • Severe, active symptoms • Does require 24 hour support. • At risk of becoming a 4/Very Severe without treatment	• **Life-threatening symptoms including active suicidal ideation.** • **Psychosis** • **Imminent danger to self/others**

Comments:

*Seek consultation immediately.

Dimension 4: Readiness to Change	
Question	**Score**
19. How important it is for you to receive treatment for alcohol or drug problems currently? 0 - Not Important; 1 - Slightly Important; 2 - Important; 3 - Fairly Important; 4 - Very Important	
20. How ready are you to change your alcohol or drug use? 0 - Not Ready; 1 - Slightly Ready; 2 - Ready; 3 - Fairly Ready; 4 - Very Ready	

Scoring Guide: NOT WEIGHTED

Severity Rating- Dimension 4: Readiness to Change

☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
• Proactive responsible participant in treatment	• Willing to enter treatment. • Ambivalent to the need to change	• Hesitant about treatment. • Low commitment to change AOD use.	• Only partially able to follow through with treatment.	• **Not interest or believe change is NOT needed**

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• Committed to changing alcohol or other drug (AOD) use		• Variable adherence to treatment	• Passively compliant, goes through the motions in treatment	• Engaging in potentially dangerous behavior • Follow through with treatment recommendations can be challenging
Comments:				

Dimension 5: Relapse, Continued Use, or Continued Problem Potential	
Question	**Score**
21. How strong are your urges to use alcohol or drugs currently? 0 - Not Strong 1 - Slightly Strong 2 - Strong 3 - Fairly Strong 4 - Very Strong	
22. How likely do you think it is you might return or continue using substances because of cravings for alcohol and/or other drugs? 0 - Not Likely 1 - Slightly Likely 2 - Likely 3 - Fairly Likely 4 - Very Likely	
23. Without immediate treatment, how likely will you return to continue or return to using alcohol and/or drugs? 0 - Not Likely 1 - Slightly Likely 2 - Likely 3 - Fairly Likely 4 - Very Likely	

Scoring Guide:

Severity Rating	Total Score
4	10-12
3	7-9
2	4-6
1	1-3
0	0

Severity Rating- Dimension 5: Relapse, Continued Use, or Continued Problem Potential				
0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
• Low/no potential for relapse	• Some minimal risk for continue use or return to use. • Fair coping and return to use prevention skills	• Coping skills may be use inconsistently. • Able to self-manage with prompting	• Little recognition of risk for use • At risk to return to use or continue use	• No coping skills for relapse/addiction problems • Substance use/behavior places self/others in imminent danger
Comments:				

Dimension 6: Recovery/Living Environment		
Question	**Yes**	**No**
24. Do you currently have someone who you would consider as a social support, or someone you can rely on for support when needed?	☐0	☐1
25. Do you currently live in an environment where others are using alcohol and/or other drugs?	☐2	☐0
26. Would you consider your current living situation stable?	☐0	☐2
27. Are you currently involved with the legal system (e.g., probation or parole)?	☐0	☐0

Scoring Guide:

Severity Rating	Total Score
4	5
3	3-4
2	2
1	1
0	0

Severity Rating- Dimension 6: Recovery/Living Environment

☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3 Severe	☐ 4 Very Severe
• Able to cope in environment/ supportive	• Passive/Disinterested social support, but still able to cope. • No serious environmental risks	• Unsupportive environment, but able to cope in the community with clinical structure most of the time	• Unsupportive environment, difficulty coping even with clinical structure	• Environment toxic/hostile to recovery • Unable to cope and the environment may pose a threat to safety

Comments:

Levels of Care Referral Tool

SUD Level of Care- Adult Scoring

Ambulatory WM level 1.0 = total score on D1 0-1 with D2 and D3 0-1

3.2 Clinically Managed Residential WM = Total score on D1 = 2-6 with D2 and D3 1-2

Medically managed Intensive Inpatient Service (aka Hospital, ASAM level 4.0) = total score on D1 = 7-8 regardless of scoring on D2 and D3

0.5 Early Intervention = Total score D2, D3, D5, D6 = 0

1.0 Outpatient (ASAM Level 1.0) = Total score D2, D3, D5, D6 = 4-7

2.0 Intensive outpatient (ASAM level 2.0) = Total score D2, D3, D5, D6 = 10-13 moderate

3.0 Short-Term Residential (ASAM Level 3.0) = Total score D2, D3, D5, D6 = 17-22 Severe

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Hospital (ASAM Level 4.0) = total score 26=30 very severe

Overall Comments:

SUD Level of Care Recommendation	
Screening Result Indicated LOC: ☐ Outpatient Services (ASAM Level 1.0) ☐ Intensive Outpatient Services (ASAM Level 2.0) ☐ Short-Term Residential (ASAM Level 3.0) ☐ Ambulatory Withdrawal Management (ASAM Level 1.0, or MAT) ☐ Clinically Managed Residential Withdrawal Management (ASAM Level 3.2)	
Actual LOC referral Decision: ☐ Outpatient Services (ASAM Level 1.0) ☐ Intensive Outpatient Services (ASAM Level 2.0) ☐ Short-Term Residential (ASAM Level 3.0) ☐ Ambulatory Withdrawal Management (ASAM Level 1.0, or MAT) ☐ Clinically Managed Residential Withdrawal Management (ASAM Level 3.2)	
Primary Reason for Difference (if Different): ☐ Service Not Available ☐ Client Preference ☐ Service Available but no payment source ☐ On Waitlist for Appropriate Level ☐ Waiting for Appropriate Language ☐ Geographic Access ☐ Family Responsibilities ☐ Language	☐ Provider Judgement Provider Judgement detail: ☐ Not Listed/Other Not listed/Other Detail:
Secondary Reason for Difference (if Different):	

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☐ Service Not Available ☐ Client Preference ☐ Service Available but no payment source ☐ On Waitlist for Appropriate Level ☐ Waiting for Appropriate Language ☐ Geographic Access ☐ Family Responsibilities ☐ Language	☐ Provider Judgement Provider Judgement detail: ☐ Not Listed/Other Not listed/Other Detail:		
If the indicated and actual LOC referral decision differ, has it been reviewed and approved by appropriate LHPA or designated personnel?		YES ☐	NO ☐
If yes, name of LPHA or Designated Personnel consulted:			

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Appendix I: Scope of Practice Spreadsheet

	Licensed or Waivered Psychologist: Post doctorate	Licensed or Associate BH Clinician: Must be registered or licensed with the Board of Behavioral Sciences.	Clinical Trainee (CT): Graduate Student of Social Work or Psychology currently in practicum/ internship.	Mental Health Rehabilitation Specialist (MHRS)	Other Qualified Provider (OQP)
Minimal Degree	Doctorate in Psychology	Master of Social Work (MSW) **or** Master of Psychology (MA/MS Psychology)	Bachelor of Art (BA) or Bachelor Science (BS)	Associate of Arts (AA)	High School (HS) Diploma **or** Equivalent
License, Associate, Registrant or Certificate	Psy.D. Ph.D.	ASW, LCSW, AMFT, LMFT, APCC, LPCC	CTs cannot register with BBS as an Associate until after they graduate from the Masters program. MFT trainees are the only CTs that can count hours while in practicum.	No formal certificate but must have either AA w/6 yrs exp **or** BA w/4 yrs exp **or** MA w/2 yrs exp.	No formal certificate but must have HS Diploma or equivalent w/2 yrs experience or HS Diploma or equivalent w/2 yrs of Secondary Education.
Scope of Practice	Can act independently within their scope of practice as defined by Board of Psychology.	Can act independently within their scope of practice as defined by Board of Behavioral Sciences (BBS).	CT has the same scope of practice/privileges as their LPHA Supervisor except when the LPHA has more privileges than what the CTs graduate program allows. For example, a CT who is in a MSW program supervised by a Psy.D. in their internship would not be able to do psychological testing.	Must work under the direction of a LPHA who is responsible for the course of treatment and determines that MHRS services are needed.	Must work under the direction of a LPHA who is responsible for the course of treatment and determines that OQP services are needed.
Can bill as both service Provider and billing Provider in the EHR?	Yes, can bill for services under their scope of practice as both service and billing Provider.	Yes, can bill for services under their scope of practice as both service and billing Provider.	No, CTs are the service Provider but the billing Provider is the LPHA Supervisor since the CT is providing services under the LPHA.	Yes, MHRS can be both the service and billing Provider for services provided under the direction of a LPHA and within their scope of practice.	Yes, OQP can be both the service and billing Provider for services provided under the direction of a LPHA and within their scope of practice.

	Licensed or Waivered Psychologist: Post doctorate	Licensed or Associate BH Clinician: Must be registered or licensed with the Board of Behavioral Sciences.	Clinical Trainee (CT): Graduate Student of Social Work or Psychology currently in practicum/ internship.	Mental Health Rehabilitation Specialist (MHRS)	Other Qualified Provider (OQP)
Can authorize BH services as LPHA and determine course of treatment?	Yes	Yes	Yes	No, must work under direction of a LPHA and the LPHA determines the course of treatment.	No, must work under direction of a LPHA and the LPHA determines the course of treatment.
Can independently create and finalized Assessment?	Yes, can create and finalize w/o restrictions.	Yes, can create and finalize w/o restrictions.	Yes and LPHA Supervisor must co-sign and attest to the finalized assessment.	No, but can contribute info to parts of the assessment and there must be documentation that the assessment was reviewed and approved by LPHA.	No, but can contribute info to parts of the assessment and there must be documentation that the assessment was reviewed and approved by LPHA.
Can independently create and finalize care plan.	Yes	Yes	Yes and LPHA Supervisor must co-sign the finalized care plan.	No, but can contribute and work with the Member on developing the care plan. There must be documentation that the care plan was reviewed and approved by LPHA.	No, but can contribute and work with the Member on developing the care plan. There must be documentation that the care plan was reviewed and approved by LPHA.

	Licensed or Waivered Psychologist: Post doctorate	Licensed or Associate BH Clinician: Must be registered or licensed with the Board of Behavioral Sciences.	Clinical Trainee (CT): Graduate Student of Social Work or Psychology currently in practicum/ internship.	Mental Health Rehabilitation Specialist (MHRS)	Other Qualified Provider (OQP)
ANSA/CANS: Domain 1 Presenting Problem (Presenting problem, Impairment in functioning, Current MSE)	Yes	Yes	Yes	No, this section must be completed and documented as completed by LPHA.	No, this section must be completed and documented as completed by LPHA.
ANSA/CANS: Domain 2 Trauma	Yes	Yes	Yes	Yes, can gather info and contribute to info in this section.	Yes, can gather info and contribute to info in this section.
ANSA/CANS: Domain 3 Behavioral Health History	Yes	Yes	Yes	Yes, can gather info and contribute to info in this section.	Yes, can gather info and contribute to info in this section.
ANSA/CANS: Domain 4 Medical History & Medications	Yes	Yes	Yes	Yes, can gather info and contribute to info in this section.	Yes, can gather info and contribute to info in this section.
ANSA/CANS: Domain 5 Psychosocial Factors	Yes	Yes	Yes	Yes, can gather info and contribute to info in this section.	Yes, can gather info and contribute to info in this section.
ANSA/CANS: Domain 6 Strengths, Risks & Protective Factors	Yes	Yes	Yes	Yes, can gather info and contribute to info in this section.	Yes, can gather info and contribute to info in this section.

	Licensed or Waivered Psychologist: Post doctorate	Licensed or Associate BH Clinician: Must be registered or licensed with the Board of Behavioral Sciences.	Clinical Trainee (CT): Graduate Student of Social Work or Psychology currently in practicum/ internship.	Mental Health Rehabilitation Specialist (MHRS)	Other Qualified Provider (OQP)
ANSA/CANS: Domain 7 Clinical Summary & Treatment Recommendations	Yes	Yes	Yes	No, this section must be completed and documented as being completed by LPHA.	No, this section must be completed and documented as being completed by LPHA.
ANSA/CANS: Mental Status Exam (MSE)	Yes	Yes	Yes	No	No
ANSA/CANS: Substance Use	Yes	Yes	Yes	Yes, can gather info and contribute.	Yes, can gather info and contribute.
ANSA/CANS: Social Determinants of Health (SDOH)	Yes	Yes	Yes	Yes, can gather info and contribute.	Yes, can gather info and contribute.
ANSA/CANS: History (Medical, Family, Legal, Allergies)	Yes	Yes	Yes	Yes, can gather info and contribute.	Yes, can gather info and contribute.
ANSA Ratings: Client Strengths and Danger to Self/Others/Grave Disability	Yes	Yes	Yes	Yes, and assessment of high-risk factors should be completed by LPHA.	Yes, and assessment of high-risk factors should be completed by LPHA.
CANS Ratings: Behavioral/Emotional, Substance Use, Trauma, Cultural, Risk, Life Domain Functioning, Strengths, Caregiver	Yes	Yes	Yes	Yes, and assessment of high-risk factors should be completed by LPHA.	Yes, and assessment of high-risk factors should be completed by LPHA.

	Licensed or Waivered Psychologist: Post doctorate	Licensed or Associate BH Clinician: Must be registered or licensed with the Board of Behavioral Sciences.	Clinical Trainee (CT): Graduate Student of Social Work or Psychology currently in practicum/ internship.	Mental Health Rehabilitation Specialist (MHRS)	Other Qualified Provider (OQP)
PSC-35 (Child/Youth Member or Legal Guardian Gives Ratings)	Yes, can assist with filling out the questions with Member's responses.	Yes, can assist with filling out the questions with Member's responses.	Yes, can assist with filling out the questions with Member's responses.	Yes, can assist with filling out the questions with Member's responses.	Yes, can assist with filling out the questions with Member's responses.
Diagnosis	Yes	Yes	Yes	No	No
Determine Medical Necessity for SMHS	Yes	Yes	Yes	No, medical necessity must be determined and documented as being determined by LPHA.	No, medical necessity must be determined and documented as being determined by LPHA.
Therapy	Yes	Yes	Yes w/supervisor co-sign note.	No	No
Psychosocial Rehabilitation	Yes	Yes	Yes w/supervisor co-sign note.	Yes	Yes
Referral/ Targeted Case Management	Yes	Yes	Yes w/supervisor co-sign note.	Yes	Yes
Crisis Intervention	Yes	Yes	Yes w/supervisor co-sign note.	Yes	Yes
Plan Development	Yes	Yes	Yes w/supervisor co-sign note.	Yes	Yes
Peer Support Services	No	No	No	No	No

Appendix J: Screening Tools in the Electronic Health Record (EHR)

The Screening Tools in the Electronic Health Record (EHR) include tools that are also used by other systems of care outside of BHS such as primary care. For more information, see Screening and Transition Tools at Behavioral Health Services Policies and Procedures | SF.gov.

Screening Tools	Description
Adverse Childhood Experiences (ACE) *In EHR: ACE*	10-item self-report measure designed to retrospectively assess exposure to potentially traumatic experiences from birth to age 18 years.
Abnormal Involuntary Movement Scale (AIMS) Scale *In EHR: AIMS Scale*	12-item, clinician-administered tool designed to measure the severity of tardive dyskinesia (TD) in patients taking neuroleptic (antipsychotic) medications
AOA Level of Care Assessment (LOC) *In EHR: AOA LOC*	BHS internal LOC assessment form.
Autism Quotient (AQ) 4-11 *In EHR: AQ 4-11*	50-item parent-report questionnaire designed to measure autistic traits in children aged 4–11.
Autism Quotient (AQ) Adolescent *In EHR: AQ Adolescent*	50 item parent-report measure that assesses autistic traits in adolescents between the ages of 12 and 15 years
Autism Quotient (AQ) 16+ *In EHR: AQ 16+*	50-question self-report screening tool designed for adolescents and adults (16+) with normal intelligence (IQ > 80) to measure the presence of autistic traits
Cultural Assessment for Risk of Suicide Measure-Adolescents (CARS-A) *In EHR: CARS-A*	Self-report instrument for detecting cultural suicide risk factors. The CARS has 8 subscales including: Family Conflict, Social Support, Idioms of Distress (Suicidal Actions), Idioms of Distress (Emotional/Somatic), Sexual Minority Stress, Acculturative Stress, Non-specific Minority Stress, Cultural Sanctions.
Child and Adolescent Trauma Screen (CATS) - Caregiver Report (Ages 3-6) *In EHR: CATS 3-6*	The CATS questionnaire is a screening instrument for children and adolescents based on the DSM criteria for PTSD. Symptoms are to be rated on a 4-point scale according to frequency and severity. Scores are calculated differently for preschoolers and children 7 years and older or adolescents.
Child and Adolescent and Adolescent Trauma Screen (CATS) - Caregiver Report (Ages 7-17 years) *In EHR: CATS 7-17 Caregiver*	
Child and Adolescent Trauma Screen (CATS) - Youth Report (Ages 7-17) *In EHR: CATS 7-17 Youth*	
Center for Epidemiological Studies Depression Scale for Children (CES-DC) *In EHR: CES-DC*	20-item self-report depression inventory with possible scores ranging from 0 to 60.
CRAFFT+N Questionnaire	Health screening tool designed to identify substance

In EHR: CRAFFT+N	use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21.
CSI *In EHR: CSI*	CSI screening data is required data submission to DHCS.
COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS) *In EHR: C-SSRA Lifetime/Recent*	Screening separates ideation and behavior by using 4 constructs (severity of ideation, intensity of ideation, behavior, and lethality), based on factors predictive of suicide attempts and completed suicide.
CYF Level of Care (LOC) Screening *In EHR: CYF LOC*	BHS internal LOC assessment form.
DAST 10 Screening *In EHR: DAST 10 Screening*	10 standardized items designed to evaluate the extent of individuals' drug use and related problems, excluding alcohol. Each question addresses specific behaviors and consequences linked to drug consumption over the past 12 months.
Discharge ANSA *In EHR: Discharge ANSA*	BHS internal discharge ANSA form.
DSM-5 Level 1 Cross-Cutting Symptom Measure- Adult *In EHR: DSM-5 Symptom Measure*	23-item self-report that covers 13 mental health domains in adults over the past two weeks. It covers areas like anxiety, depression, mania, and substance use
Eating Disorder-15 for Youth (ED-15-Y) *In EHR: ED-15*	15-item scale to measure session-by-session change for eating disorder attitudes and behaviors. The scale measures the frequency of eating-disordered behaviors and has two factors, Weight & Shape Concerns and Eating Concerns.
Generalized Anxiety Disorder-7 (GAD-7) *In EHR: GAD-7*	7-item self-report questionnaire used by clinicians to measure the severity of generalized anxiety disorder.
Geriatric Depression Scale (GDS) *In EHR: GDS*	30-item yes or no self-report questionnaire designed to screen for depression in older adults.
Hamilton Rating Scale for Depression (HAM-D) *In EHR: HAM-D*	17 item clinician-administered tool designed to assess the severity of depression in patients by measuring symptoms like mood, insomnia, agitation, and anxiety.
Min-Cog *In EHR: Mini-Cog (Enter results only)*	3-minute, two-part screening tool used by clinicians to quickly assess cognitive impairment (dementia) in older adults. It combines a three-word recall test (memory) with a clock-drawing test.
Folstein Mini Mental Status Exam (MMSE) *In EHR: MMSE (Enter results only)*	30-point questionnaire used by clinicians to screen for cognitive impairment, particularly in older adults. It assesses orientation, memory, attention, language, and, visual-spatial skills.
Montreal Cognitive Assessment (MOCA) *In EHR: MOCA (Enter results only)*	30-point screening tool designed to detect mild cognitive impairment (MCI) and early dementia. It evaluates executive functions, memory, language,

	attention, and orientation.
NICHQ Vanderbilt Assessment Scales *In EHR: NICHQ*	55-item tool for parents and 43-item tool for teachers that helps diagnose and monitor ADHD in children aged 6–12. It assesses core symptoms (inattention, hyperactivity, impulsivity) and screens for comorbidities like ODD, conduct disorder, and anxiety/depression
Positive and Negative Symptoms Scale for Schizophrenia (PANSS) *In EHR: PANSS*	30-item, 45-minute clinician-administered interview used to measure the severity of schizophrenia symptoms. It assesses positive symptoms (e.g., hallucinations), negative symptoms (e.g., blunted affect), and general psychopathology (e.g., anxiety) on a 7-point scale
Patient Health Questionnaire-9 (PHQ-9) *In EHR: PHQ-9*	9-question, self-report tool to screen for, diagnose, and monitor the severity of depression in adults and adolescents. It assesses symptoms over the past two weeks, with scores ranging from 0 to 27, where higher scores indicate greater severity.
Prodromal Questionnaire – Brief *In EHR: PQ Brief*	21-item self-report screening tool designed to identify adolescents and young adults at risk for psychosis. It screens for "prodromal" (early) symptoms like attenuated positive symptoms, unusual thoughts, or social/academic withdrawal. A score of 6 or more in distress is typically used to prompt further clinical assessment.
Prime Screen for Psychosis *In EHR: PRIME*	12-item self-report questionnaire designed to identify individuals at high risk for developing psychotic disorders. It screens for "prodromal" (early) symptoms—such as unusual thoughts, perceptual changes, or social withdrawal—over the past year to determine if a full clinical evaluation is needed
Post Traumatic Stress Disorder (PTSD) Checklist for DSM-5 (PCL-5) *In EHR: PTSD PCL5*	20-item self-report measure of the twenty DSM-5 symptoms of PTSD in adult populations (ages 18+). It is designed for use with people who have experienced traumatic events.
Post Traumatic Stress Disorder (PTSD) Checklist-Civilian Version (PCL-C) *In EHR: PTSD PCL-C*	17-item self-report questionnaire used to screen for and monitor symptoms of Post-Traumatic Stress Disorder (PTSD) in civilian populations. It measures symptoms based on the DSM-IV criteria, assessing how much an individual has been bothered by them in the past month.
PTSD Short Screening Scale *In EHR: PTSD Short Screening*	A brief, 7-to-8-item self-report tool used to quickly identify potential PTSD cases. It assesses core symptoms like avoidance, emotional numbing, and

	hyperarousal, with high sensitivity (80–85%) for identifying individuals needing further, in-depth evaluation
PTSD SPAN Scale *In EHR: PTSD SPAN Scale*	Brief, four-item self-report screening tool designed to quickly identify potential cases PTSD. Derived from the Davidson Trauma Scale (DTS), it focuses on key symptoms: Startle, Physically upset by reminders, Anger, and Numbness.
Short Post-Traumatic Stress Disorder Rating Interview (SPRINT) *In EHR: PTSD Sprint Scale*	an 8-item self-report or interview-based tool designed to rapidly assess the severity of PTSD symptoms, global improvement, and functional impairment. It measures key areas like intrusion, avoidance, numbing, hyperarousal, and somatic distress.
Trauma Screening Questionnaire (TSQ) *In EHR: PTSD Trauma*	10-item symptom screen that was designed for use with survivors of all types of traumatic stress. The TSQ is based on items from the PTSD Symptom Scale - Self Report (PSS-SR) and has five re-experiencing items and five arousal items.
Scale for the Assessment of Negative Symptoms (SANS) *In EHR: SANS*	25-item, clinician-rated tool to measure negative symptoms in schizophrenia. It assesses five key domains—alogia, affective blunting, avolition-apathy, anhedonia-asociality, and attentional impairment
Scale for the Assessment of Positive Symptoms (SAPS) *In EHR: SAPS*	34-item clinician-administered tool to measure the severity of positive symptoms in schizophrenia and other psychotic disorders. It evaluates four main domains—hallucinations, delusions, bizarre behavior, and positive formal thought disorder
The Brief Non-Suicidal Self-Injury Assessment Tool (BNSSI-AT) *In EHR: Self Injury Brief*	12-module questionnaire to assess the frequency, severity, function, and characteristics of self-injury. It is used for research and clinical assessment to identify behavioral patterns and motivations in individuals
The Non-Suicidal Self-Injury Assessment Tool (NSSI-AT) *In EHR: Self Injury Long*	12-module, comprehensive, self-report instrument used to measure the characteristics of non-suicidal self-injury, including frequency, function, severity, and habituation.
Screen for Child Anxiety Related Disorders (SCARED) - Child *In EHR: SCARED Child*	41-item self-report questionnaire designed to measure anxiety symptoms in children and adolescents aged 8 to 18. It assesses five domains—panic/somatic, generalized anxiety, separation anxiety, social anxiety, and school avoidance—to help identify potential anxiety disorders.
Screen for Child Anxiety Related Disorders (SCARED) - Parent *In EHR: SCARED Parent*	41-item questionnaire used by caregivers to assess symptoms of anxiety disorders in children aged 8–18. It measures five key areas—generalized, separation, and social anxiety, panic/somatic symptoms, and school

	avoidance—to help identify potential anxiety issues.
Saint Louis University MSE (SLUMS) *In EHR: SLUMS*	11-question screening tool designed to detect mild cognitive impairment (MCI) and dementia in older adults to assess areas like orientation, memory, attention, and executive function.
TADT First Follow-up *In EHR: TAD First Follow-up*	BHS internal TADT form for first follow up appointment.
Transition of Care *In EHR: Transition of Care*	BHS internal transitional of care form.