alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Quality Assurance Office
2000 Embarcadero Cove, Ste 400
Oakland, CA 94606
510-567-8105/TTY 510-533-5018
Karyn L. Tribble, PsyD, LCSW, Agency Director

CSI Assessment Record Data FAQ

General Questions

Q1 When do we collect timeliness data?

A. Timeliness data should be collected for all new and returning new Medi-Cal clients (see list of definitions) that are requesting outpatient mental health services.

Q2 When a client enters the system through one program and then gets referred out (either directly to another program or through ACCESS) how does data get collected across programs?

A. The initial demographic data, type of service, and date of first contact to request services will be collected by the original agency and the remaining data points will be collected by the agency receiving the referral. Every provider needs a process for passing on the information to the agency which the client was referred for services (i.e.: fax, letter, encrypted email, etc.).

Q3 Do we need to request a PSP number at the beginning for all new clients in order to input data into the e-form and INSYST?

A. Yes. Do the registration form in InSyst and/or create an internal tracking system until such time that you have enough information to complete the registration form.

Q4 Providers have walk-ins at their clinics. For those that do not have openings, they refer them to ACCESS and ACCESS then refers those clients to other providers. Is the date of request the date the client went to the walk-in clinic or the date that ACCESS passes the referral to the other provider?

A. In this case, the date of request is the date the client went to the walk-in clinic.

Q5 What happens if it is found that this part of our system is consistently out of compliance with this standard? What are the consequences and who will be held accountable?

A. It is possible that we will be held fiscally accountable by the state for up to $500 per incident of non-compliance. However, the intent of gathering this information is simply to identify the areas of our system that are not meeting these requirements and make adjustments to come into compliance.

Q6 For programs that offer both psychiatric medication services as well as other specialty mental health services, what is the Type of Service code used (1, 2 or 3)?

A. The Type of Service depends on the type of service that the client is requesting at the "Date of First Contact to Request Services." Typically this will be psychiatry services and then the other mental health services are added on as needed after the assessment is completed or as the need arises.

Q7 If my program is structured in a way that the Offer Date, Assessment Date, and Treatment Date will be the same. Is that a problem?

A. This is not a problem if this is what is occurring. It is important that you are utilizing the definitions provided by ACBH for each of these data points. Also, make sure that a treatment plan is in place before providing any planned services (there are exceptions -see doc manual) and remember that the Treatment Start Date is most often the date that the first planned service is provided.

Q8 Do we need to collect timeliness data for a walk-in consumer? Some of the walk-ins have private insurance or Medi/Medi and we do not serve them. What should we do in this case?

A. If it is determined that a consumer who has requested services from your agency will be served within the ACBH System of Care, then the timeliness data should be collected.

B. If there is any possibility that the client will get Medi-Cal, you need to collect all the information needed to report timeliness data and pass on to accepting agency/provider who will render services. If the client leaves the walk-in clinic prior to reporting information and before client is given a referral it would be impossible to pass on the information, then you would not need to.

C. For those situations where not enough information was gathered or the person is not eligible: there is a field on the CSI Timeliness eForm "type of request" (Req-Sevc_Referred/ Not Eligible/ No Contact) there is an option here where minimal information is required. This does not require a client number in order to complete the form.

Q9 Please define 'Prior Authorization' on Page 2 of the Policy Letter.

A. Prior Authorization refers to services that require an authorization prior to services being rendered. DHCS MHSUDS Information Notice 19-026 Authorization of Specialty Mental Health Services indicate the prior authorization requirement for the following outpatient services: Day Rehabilitation, Day Treatment Intensive Therapeutic Behavioral Services, Therapeutic Foster Care, and Intensive Home-Based Services.

Q10 Does the Assessment Appointment ACCEPTED DATE change if client accepts a date, then misses that appoint, then accepts another appointment?

A. No. The date would remain the same even if they do not show up for the accepted appointment.

Q11 For clients in Residential programs only, are they considered new clients?

A. According to the CSI Data Dictionary, Residential is not listed under Outpatient Services (CSI Data Dictionary S-06.0 Service Function).

B. They are considered new clients if they have not received outpatient services in 12 months or are new to the MHP.

Q12 For clients that do not have Medi-Cal initially, but later end up obtaining Medi-Cal, do providers have to do the timeliness form once they have Medi-Cal?

A. Fill out the form as soon as someone is requesting mental health services if they are a new or returning new client, regardless of their Medi-Cal status.

Q13 For clients that do not have Medi-Cal initially, but then obtain Medi-Cal later, what would be the date of request for those clients?

A. The date of request for services would be the date of first contact, regardless of their Medi-Cal status.

Q14 Providers are asked to select psychiatry, outpatient services, or outpatient services-prior authorization, but what about FSP or other providers where they are a bundled service (psychiatry and other specialty mental health services), what do they select since the timeline is different for psychiatry and outpatient?

A. Typically, clients don't request FSPs for themselves. Usually a client needs all the services offered (psychiatry, case management and MH services).

B. choose "outpatient services" for this one.

Q15 Are there confidentiality concerns in reporting this information to the State for Non-Medi-Cal, private pay clients?

A. Under HIPAA, a covered entity is permitted to use and disclose protected health information, without an individual's authorization, for the purposes of "health care operations" which includes quality assessment and improvement activities and "competency assurance activities" which includes provider or health plan performance evaluation.

Q16 How will this timeliness data be audited?
Alameda County Behavioral Health Care Services is monitoring CSI Assessment Record Data collection via reports for use by providers and ACBHCS staff.

Adult System of Care Questions

Q17 When does the clock start ticking for the 10/15 day window to offer the first appointment? When someone is P-Coded to us? Or when we are first able to contact them? Or when they are open to a Team (intake)?

A. when the beneficiary agrees to the service when they sign the consent/Informing Materials (which is almost always the day the T code is opened). ACCESS assigns the P code often times prior to the client agreeing to the service. The program does assertive outreach and engagement once the P code is assigned and then usually the client agrees to treatment and the T code is opened the day they sign consent.

Q18 What if the client is at a psychiatric inpatient setting or in jail at the time of referral? Does engagement at a lockout setting count as a first appointment?

A. Date of request of services would be the date that the first stepdown service is requested

B. Assessment start and end date and treatment start date could all happen on one day.

Q19 Do services through AFBH (Adult Forensic Behavioral Health), BHC (Behavioral Health Court) or CAP (Court Advocacy Project) count as receiving services in the past twelve months?

A. No because they are not using their Medi-Cal insurance for these programs.

Q20 How do lockouts apply? If services are started in jail, for example, how does this affect these dates?

A. First, determine if the client is a new client/new returning client.

B. When a beneficiary enters the system via a crisis stabilization or in-patient service, this is not the Date of First Contact to Request Services. The Date of First Contact to Request Services is initiated on the date that the first stepdown service is requested

i.e., the beneficiary is discharged and a follow-up appointment/stepdown service is requested by the provider, client, or other referral source - that date is considered the Date of First Contact to Request Services.

Q21 For clients that received services from IHOT or other engagement only programs, are they considered new clients?

A. Yes. IHOT does not provide treatment services, but rather outreach and engagement services.

Q22 If a new client came through Mobile Crisis and then referred out, are they still considered a new client?

A. Yes. When the "new" beneficiary interacts with Mobile Crisis and willingly agrees to participate this would be date of request of services. If they agree to an assessment by mobile crisis that would be the assessment start date. If they receive crisis therapy by mobile crisis that would be treatment start date. If they are then referred to another agency Mobile crisis would forward those dates to ensure an assessment end date is completed.

Q23 What if the client is homeless and cannot be located right away?

A. If a program gets referred a client they cannot locate than that client would only be opened to their P code. Then when the client is located and able to engage and agrees to services and signs consent the T code would be opened and the day the client signs consent would be the day the clock would start.

Children System of Care Questions

Q24 School based programs receive their referrals through the school district. Often during an IEP meeting with the client legal guardian, the school district discusses resources and mental health services and legal guardian agreement is obtained then. Is that date considered the date of request?

A. In this situation, if there is a therapist/clinician present from a contracted mental health agency, the date of the IEP meeting is the date of request (assuming the legal guardian agreed). If there are only school district employees present for the IEP meeting, the date of request would not be until the legal guardian expresses agreement to have their child receive mental health services to the person from the contracted mental health agency once they reach out to the family to engage them in services. In other words, the date of request is the date that the system becomes aware that the legal guardian of the child wants mental health services to be provided.

Q25 How does presumptive transfer fit in with Timeliness reporting?

- **A.** Presumptive transfer (PT) - If a child/youth beneficiary is presumptively transferred to an MHP, that MHP is responsible for providing, or arranging for, SMHS.
- **B.** If a child has not received outpatient mental health services in Alameda County and there is a presumptive transfer from another county. When that child is referred to the program and a legal guardian/or parent agrees to services that is the date of requested services.
- **C.** These beneficiaries should be included in geo-mapping based on placement. If Presumptive Transfer is waived and the MHP contracts with providers out-of-county (not within time & distance standards), these providers should NOT be included in the NACT.

Q26 For ERMHS clients who are referred to a provider for services from county's Children Specialized Services (CSS) unit, are they considered new if they were assessed by CSS to determine ERMHS eligibility?

- **A.** When a child is new/new returning and the legal guardian or parent agrees to ERMHS assessment, that would be the date of requested services. The ERMHS assessor should keep track of the date of request and pass that along to the next agency. It may be some time since the school district is in control of who and when gets referred out to the agencies. It is requested that the agency reaches out to ERMHS assessment team to get the date of request information.
- **B.** The person completing the ERMHS assessment can inform the caregiver of the length of time it takes to get through the school district system, and offer the caregiver services outside of the school through ACCESS. The date of request services would then be passed on to ACCESS.

ACCESS/Language Specific ACCESS Program Questions

Q27 If a referral came through ACCESS, how do we know if it's urgent? Will ACCESS indicate "urgent" on their referral form?

- **A.** Yes, ACCESS will indicate if a request is "urgent" on the Referral Letter sent to the provider.

Q28 Could the Contact Tracking Database be aligned with the timeliness requirements for ACCESS programs?

- **A.** We will take this under advisement and, if it is a possibility, it will not happen for some time.

Q29 If a referral came through ACCESS, will ACCESS indicate the type of service requested on their referral form?

A. It can usually be determined what type of service ACCESS is requesting based on who the referral is sent to (e.g. if a person needs a forensic FSP we would send to one of the forensic FSP programs). In situations where there may not be clarity, such as if ACCESS refers a consumer to an individual provider who does therapy and psych testing, the type of service being requested for that consumer is always indicated on the referral letter.

Q30 Providers receive referrals through ACCESS, Help Me Grow, etc. and sometimes there is a lag from ACCESS to providers, which greatly impacts the timeliness requirement. What is the ACCESS referral process and what is the timeline from request from client/legal guardian to ACCESS and to providers?

A. ACCESS sends out Referral letters (by fax or email) the same day or within 2 days of the request; if there are insurance issues or more information is needed to determine level of care, it may take longer (those are the exceptions).

Q31 What is the Referral Source code for ACCESS?

A. The referral source code for ACCESS is 14 = Other County / Community Agency