ATTACHMENT A

MENTAL HEALTH SERVICES CATEGORIES AND PROGRAM INFORMATION

Instructions

The Sonoma County Department of Health Services (DHS), Behavioral Health Division (BHD) is accepting applications to provide treatment services to adult clients with serious and persistent mental illness. Please review the following adult continuum level of care information and requirements in preparation for your application.

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BACKGROUND AND PURPOSE OF RFA

The County seeks to award a contract or multiple contracts to Mental Health Adult Services programs that enable the MHP to accomplish the following:

- Provide appropriate coverage and capacity across all regions of the county; applications that support the County's efforts to provide services in West County (Monte Rio, Guerneville, Sebastopol), North County (Cloverdale, Windsor, Healdsburg), Central County (Santa Rosa), South County (Cotati, Petaluma, Rohnert Park), and East County (Sonoma Valley) are of particular importance.
- Provide bi-lingual, bi-cultural, and culturally sensitive/competent services where appropriate.
- Promote continuity of care; CBOs or collaborations of CBOs that provide the most complete range of services will be better positioned to provide continuity of care for clients whose needs change over time.
- Support program and service delivery models that are proven to be effective; proposers that utilize Evidence Based Practices (EBP) and can demonstrate their ability to implement those practices with fidelity are desired

ADULT SYSTEM CONTINUUM OF CARE

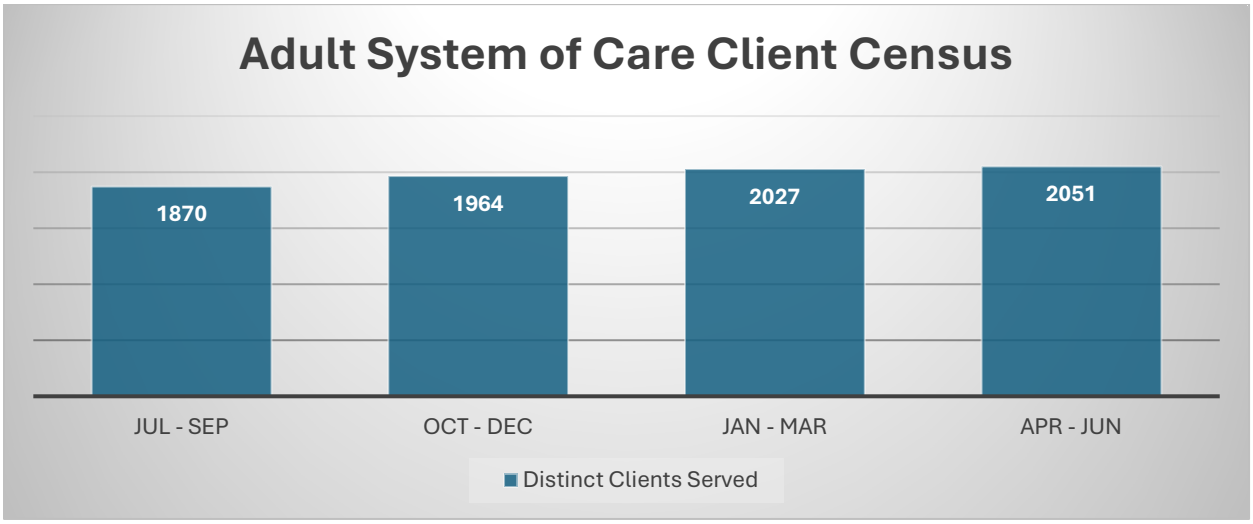
DHS-BHD seeks to maintain a robust continuum of support for adult consumers of Specialty Mental Health Services. This continuum includes the following:

- Outpatient Services: including clinic-based specialty services, Full-Service Partnership (FSP) ancillary services, Assertive Community Treatment (ACT) services, and field or embedded supported housing services
- Day Treatment Services: including Day Treatment Rehabilitative (DTR) and Day Treatment Intensive (DTI) services
- Residential Services: including Social Rehabilitation Programs
- High-Intensity Wraparound Services: including embedded services within long-term placement
- Other Specialty Services: including Eating Disorder Treatment programs, Transcranial Magnetic Stimulation (TMS) programs, and Supported Employment programs

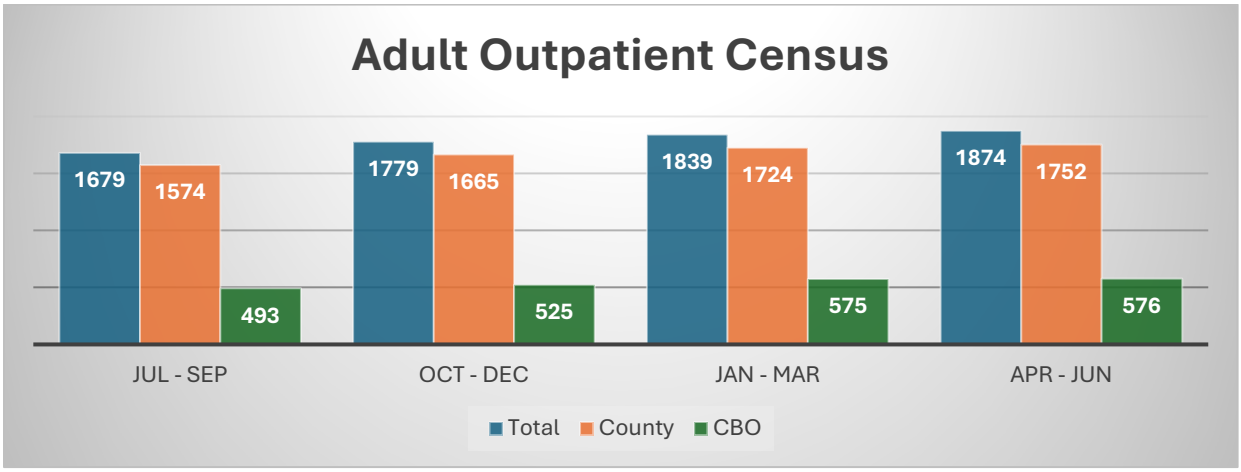
ADULT SYSTEM METRICS

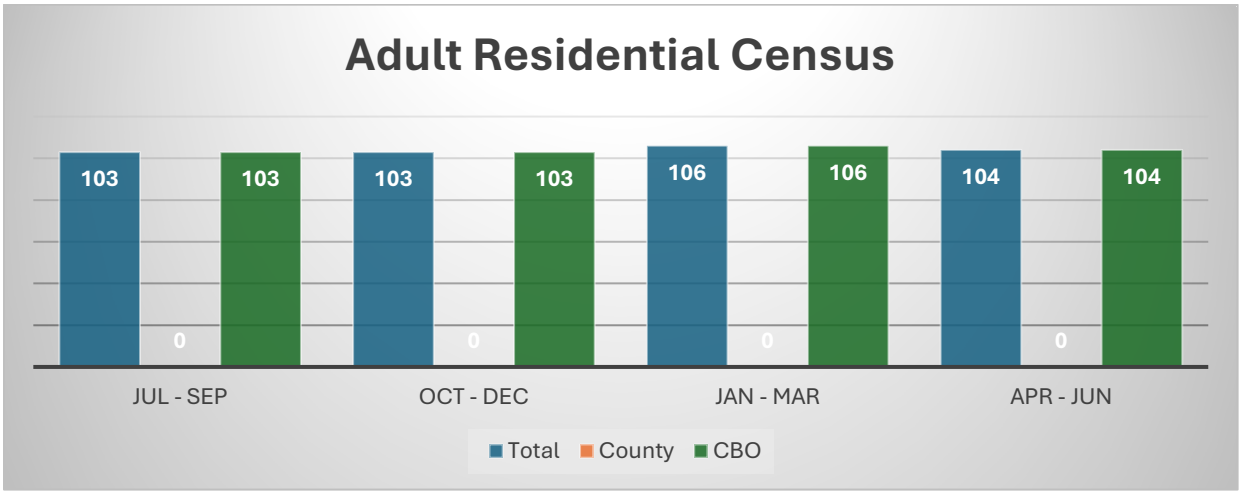
In fiscal year 24-25, 2758 unduplicated adult clients, age 18+, were served by Sonoma County Behavioral Health Division Adult Outpatient, Residential, and High-Intensity Wraparound Programs. Additionally, the Adult Access Team received an average of 211 inquiries per month, resulting in an average of 159 requests for service per month.

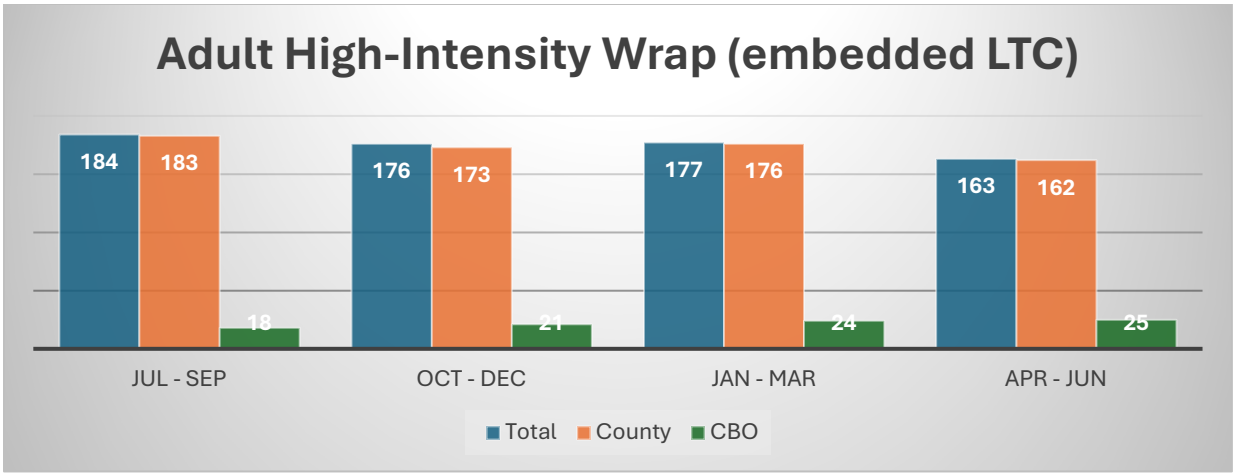
Quarterly Adult System census is as follows:



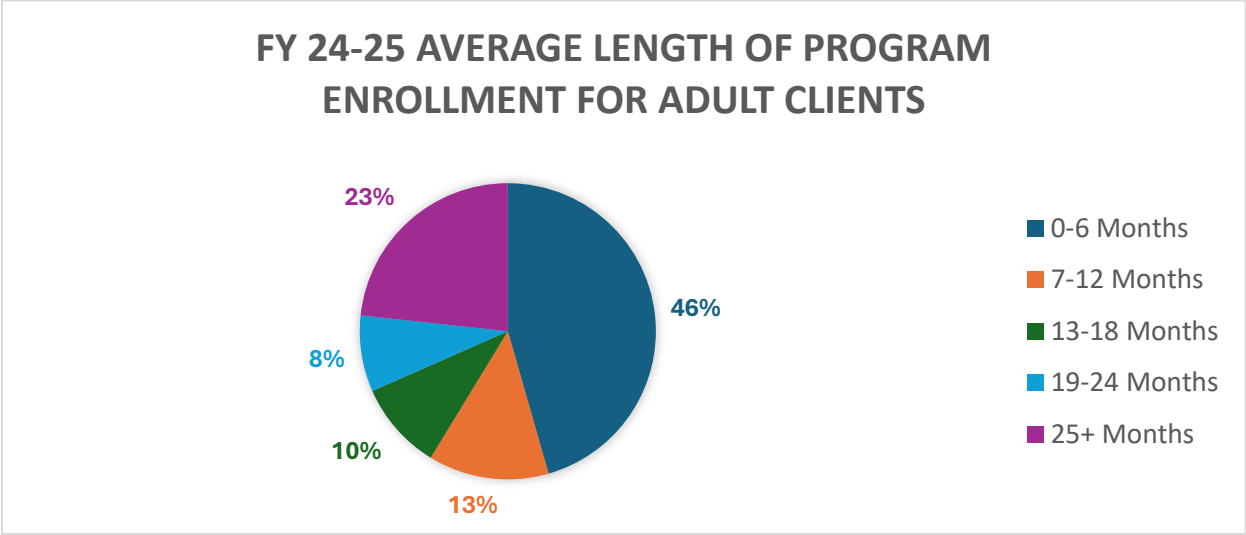
Service provision is rendered by both County run and community contracted programs. Census by level of care is as follows:







The average length of program enrollment per adult client open to services in FY 24-25 was 19 months.



1.0 OUTPATIENT SERVICES

OUTPATIENT SERVICES OVERVIEW

Outpatient specialty mental health services are mental health treatments delivered outside of a hospital setting, designed for individuals who don't require 24/7 care. These services are typically provided in settings like doctor's officers, community clinics, or field-based community programs. They encompass a range of treatments, including individual and group therapy, medication management, and other rehabilitative services aimed at improving mental health and functional abilities.

Key aspects of outpatient specialty mental health services include:

LOCATION

Services are delivered in non-hospital settings like clinics, community programs, or supported housing programs.

TREATMENT TYPES

This may include therapy (individual, group, family), medication management, case management, rehabilitative, and crisis support. Examples of services include assessment, treatment planning, therapy, medication support, crisis intervention, psychosocial rehabilitation, and targeted case management.

TARGET POPULATION

These services are for adults with diagnosed mental health conditions, including but not limited to, depression, anxiety, bipolar disorder, and psychotic disorders.

GOAL

The aim is to reduce symptoms, improve functioning, and support individuals in managing their mental health conditions, often to avoid hospitalization.

REHABILITATIVE FOCUS

Services are designed to restore, improve, or maintain a person's functional level, including social, academic/employment, and independent living skills.

COLLABORATION

Outpatient services typically involve collaboration with other professionals, such as primary care physicians, housing services providers, eligibility specialists, and legal advocates.

1.1 OUTPATIENT HIGH-MODERATE INTENSITY (NON-FSP)

Programs at the high-moderate, non-FSP level of care provide an array of services to adults identified as needing a service constellation that is less than that provided by an FSP.

TARGET POPULATION

Adults with at least one behavioral health need and three functional needs (or 2 functional needs and 1 risk factor).

Behavioral Health Needs	Functional Needs	Risk Factors
• Psychosis • Impulse Control • Depression • Anxiety • Interpersonal Problems • Adjustment to Trauma • Eating Disturbance	• Physical/Medical • Employment • Social Functioning • Independent Living Skills • Residential Stability • Basic Activities of Daily Living • Decision Making	• Danger to Self/Others • Self-Injurious Behavior • Other Self-Harm • Exploitation • Sexual Aggression • Criminal Behavior

SERVICE LIST

- Rehabilitative Mental Health Services (community and/or home-based)
- Outpatient Therapy and Mental Health Services (assessment and plan development)
- Targeted Case Management Services to assist clients with connecting to:
    - Financial support services
    - Housing programs and resources
    - Medical/Physical Health services
    - Transportation supports

SERVICE DOSAGE

Service frequency expectations per client include a minimum of 1 hour of service every two weeks, and a maximum of up to 3 hours per week. Typically, clients would receive therapy or other rehabilitative services 2x per month and case-management 1x per month.

The anticipated caseload size per provider at this program level is 35 clients, with a maximum program census of 250-270 total clients.

1.2 OUTPATIENT HIGH INTENSITY (FSP LEVEL SUPPORT)

Full Service Partnership (FSP) programs deliver recovery-oriented, comprehensive services targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe mental illness often with a history of criminal justice involvement and repeat hospitalizations. FSP programs were designed to serve people in the community rather than in locked state hospitals. By engaging mental health consumers in their own care and providing services tailored to individual needs, FSPs can reduce costs, improve the quality and consistency of care, enhance outcomes, and, most importantly, save lives. The name – Full Service Partnership – reflects the goal of developing a partnership between the person being served and the service provider, and offering a full array of services, through a “whatever it takes” approach to meeting needs – or Full Service. FSPs are core investments of the Mental Health Services Act and the Behavioral Health Services Act and a key element of California’s continuum of care, intended to be the bulwark against the most devastating impacts of untreated mental illness.

Programs at the high-intensity FSP level of care provide an array of ancillary services to adults participating in County FSP programs.

TARGET POPULATION

Adults with at least one behavioral health need and four functional needs (or 3 functional needs and 1 risk factor).

Behavioral Health Needs	Functional Needs	Risk Factors
• Psychosis • Impulse Control • Depression • Anxiety • Interpersonal Problems • Adjustment to Trauma • Eating Disturbance	• Physical/Medical • Employment • Social Functioning • Independent Living Skills • Residential Stability • Basic Activities of Daily Living • Decision Making	• Danger to Self/Others • Self-Injurious Behavior • Other Self-Harm • Exploitation • Sexual Aggression • Criminal Behavior

SERVICE LIST

- Rehabilitative Mental Health Services (community and/or home-based)
- Outpatient Therapy and Mental Health Services (assessment and plan development)
- Targeted Case Management Services to assist clients with connecting to:
    - Financial support services
    - Housing programs and resources
    - Medical/Physical Health services
    - Transportation supports

SERVICE DOSAGE

Service frequency expectations per client include a minimum of 1 hour of service per week, and a maximum of up to 4 hours per week. Typically, clients would receive therapy or other rehabilitative services 1x per week and case-management 2x per month.

The anticipated caseload size per provider at this program level is 20 clients, with a maximum program census of 80-100 total clients.

1.3 ACT LEVEL

Assertive Community Treatment (ACT) supports 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 promotes recovery by helping members cope with the symptoms of their behavioral health conditions and acquire the skills they need to function and remain integrated in the community. ACT is provided by a multidisciplinary team that typically consists of a psychiatrist, nurse, peer support specialists, and other behavioral health practitioners. When delivered to fidelity, ACT leads to improved health and social outcomes, including improved psychiatric symptoms, fewer inpatient and emergency department admissions, and increased integration with and participation in the community.

TARGET POPULATION

Adults with at least one behavioral health need and four functional needs (or 3 functional needs and 1 risk factor), plus significant struggles with Involvement in Recovery.

Behavioral Health Needs	Functional Needs	Risk Factors
• Psychosis • Depression	• Physical/Medical • Employment • Social Functioning • Independent Living Skills • Residential Stability • Basic Activities of Daily Living • Decision Making	• Danger to Self/Others • Self-Injurious Behavior • Other Self-Harm • Exploitation • Sexual Aggression • Criminal Behavior

SERVICE LIST

- Medication Management and Support Services
- Rehabilitative Mental Health Services (community and/or home-based)
- Outpatient Therapy and Mental Health Services (assessment and plan development)
- Targeted Case Management Services to assist clients with connecting to:
    - Financial support services
    - Housing programs and resources
    - Medical/Physical Health services
    - Transportation supports

SERVICE DOSAGE

Service frequency expectations per client include a minimum of 2 hour of service per week, and a maximum of up to 6 hours per week. Typically, clients would receive therapy or other rehabilitative services 2-3x per week and case-management 1x per week.

The anticipated caseload size per provider at this program level is 15 clients, with a maximum program census of 70-80 total clients.

1.4 SUPPORTED HOUSING PROGRAM LEVEL (FIELD OR EMBEDDED)

Supported housing programs that offer specialty mental health services provide a combination of housing and intensive support for individuals with severe mental health needs who may also be experiencing or at risk of homelessness. These programs prioritize individuals with the most complex needs and aim to promote long-term housing stability and recovery.

Key aspects of supported housing programs with specialty services include:

HOUSING

The core of these programs is providing or supporting stable, affordable housing options. This can range from permanent supportive housing (with on-site services) to transitional housing (providing temporary housing while individuals work toward permanent solutions).

SPECIALTY SUPPORTIVE SERVICES

These programs offer a range of services tailored to the specific needs of individuals with severe mental health conditions, to support their success in housing stability. These services may include:

- **Medication monitoring:** Assisting individuals in developing the skills to self-manage their medication routines, including setting reminders and performing medication check observations.
- **Individual and group psychosocial rehabilitation:** Providing skill-building and counseling support to address mental health symptoms which may disrupt housing stability, and promote coping skills for long-term success.
- **Case management:** Connecting individuals with necessary resources to support successful housing stability.
- **Crisis intervention:** Providing immediate support during mental health crises.
- **Supportive employment services:** Helping individuals find and maintain employment, which in turn supports long-term stability.

LOW-BARRIER ACCESS

Many supported housing programs prioritize individuals with complex needs and utilize low-barrier tenant selection practices, meaning they focus on support individuals regardless of their history or current circumstances.

TARGET POPULATION

Adults with at least one behavioral health need and four functional needs (or 3 functional needs and 1 risk factor).

Behavioral Health Needs	Functional Needs	Risk Factors
• Psychosis • Impulse Control • Depression • Anxiety • Interpersonal Problems • Adjustment to Trauma • Eating Disturbance	• Physical/Medical • Employment • Social Functioning • Independent Living Skills • Residential Stability • Basic Activities of Daily Living • Decision Making	• Danger to Self • Self-Injurious Behavior • Other Self-Harm • Exploitation

SERVICE DOSAGE

Service frequency expectations at this level of care involve daily checks on clients in housing. Typically, a minimum of 3 hours per client per week, and a maximum of up to 7-10 hours per week. Typically, clients would receive psychosocial rehabilitation services and medication monitoring 5-7x per week, and in some cases, twice daily checks. Group services offered on-site are also typical of this level of care.

The anticipated caseload size per provider at this program level is 10 clients, with a maximum program census of 20-30 total clients.

2.0 DAY TREATMENT SERVICES

DAY TREATMENT OVERVIEW

Specialty mental health day treatment, also known as partial hospitalization or intensive outpatient programs, provides intensive support and treatment for individuals with moderate to severe mental health conditions. These programs offer structured therapy and rehabilitation services for at least 3 hours a day, but less than 24 hours, as an alternative to inpatient hospitalization or more restrictive placements.

Key aspects of day treatment specialty mental health service include:

STRUCTURED ENVIRONMENT

Day treatment involves a structured schedule with therapeutic activities, individual and group therapy, and skills training, typically lasting several hours per day.

INTENSIVE TREATMENT

This level of care is suitable for individuals who need more intensive support than traditional outpatient services but do not require 24-hour inpatient care.

MULTI-DISCIPLINARY APPROACH

Day treatment programs often involve a team of mental health professionals, including therapists, psychiatrists, and other specialists, offering a range of services.

REHABILITATION AND THERAPY

Services focus on improving, maintaining, or restoring daily living and social skills, as well as reducing mental health symptoms.

ALTERNATIVE TO HOSPITALIZATION

Day treatment can be used as an alternative to hospitalization or to prevent the need for more restrictive care, or as a step-down from hospitalization to facilitate successful transition to the community.

COMMUNITY INTEGRATION

Day treatment programs are typically offered in community settings, allowing individuals to maintain connections with their families and communities. The aim is to help individuals maintain or regain their ability to live and function within the community.

2.1 DAY TREATMENT REHABILITATIVE PROGRAM LEVEL

Day Treatment Rehabilitation (DTR) is a structured program which provides services to a distinct group of individuals. Day rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Intensive Outpatient Programs (IOP) are considered to be equivalent to Day Treatment Rehabilitation level of care.

SERVICE COMPONENTS

DTR Programs contain the following required service components:

- Therapeutic Milieu
- Skill-Building Groups
- Adjunctive Therapies
- Collateral Contact
- Mental Health Crisis Protocol
- Written Weekly Schedule

THERAPEUTIC MILIEU

This component must include process groups and skill-building groups. Specific activities shall be performed by identified staff and take place during the scheduled hours of operation of the program. The goal of the therapeutic milieu is to teach, model, and reinforce constructive interactions by involving beneficiaries in the overall program. For example, beneficiaries are provided with opportunities to lead community meetings and to provide feedback to peers. The program includes behavior management interventions that focus on teaching self-management skills that adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention. Activities include, but are not limited to, staff feedback to beneficiaries on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.

PROCESS GROUPS

These groups, facilitated by staff, shall assist each beneficiary to develop necessary skills to deal with their problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.

SKILL-BUILDING GROUPS

In these groups, staff shall help beneficiaries identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, beneficiaries identify skills that address symptoms and increase adaptive behaviors.

ADJUNCTIVE THERAPIES

These are therapies in which both staff and beneficiaries participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able utilize the modality to develop or enhance skills directed toward achieving beneficiary plan goals. Adjunctive therapies assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of day rehabilitation are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the beneficiary's needs.

MENTAL HEALTH CRISIS PROTOCOL

There shall be an established protocol for responding to beneficiaries experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the beneficiary's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the day rehabilitation program staff shall have the capacity to handle the crisis until the beneficiary is linked to an outside crisis service.

WRITTEN WEEKLY SCHEDULE

A weekly detailed schedule shall be available to beneficiaries and as appropriate to their families, caregivers or significant support persons. The schedule will identify when and where the service components of the program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their services.

STAFFING REQUIREMENTS

The allowable staffing credentials for DTR include:

- Physicians
- Psychologists or related waivered/registered professionals.
- Licensed Clinical Social Workers or related waivered/registered professionals.
- Marriage, Family and Child Counselors or related waivered/registered professionals.
- Registered Nurses

- Licensed Vocational Nurses
- Psychiatric Technicians
- Occupational Therapists
- Mental Health Rehabilitation Specialists

The required staffing ratio is 1:10. Persons who are not solely used to provide Day Treatment services may be utilized according to program need but shall not be included as part of the above ratio.

STAFF ACTIVITIES

Staff may be required to spend time on day treatment activities outside the hours of operation and therapeutic program (e.g., time for travel, documentation, caregiver contacts). At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation

STAFF IN MULTIPLE PROGRAMS

The program may use day treatment staff who are also staff with other responsibilities (e.g., staff of a group home, staff of a residential program, staff of another mental health treatment program). The program shall document the scope of responsibilities for these staff and the specific times in which day rehabilitation activities are being performed exclusive of other activities.

STAFFING IN PROGRAMS SERVING MORE THAN 12 CLIENTS

For DTR programs serving more than 12 clients, two of the staff must have a non-OT (Occupational Therapist) credential.

DOCUMENTATION REQUIREMENTS

Providers shall complete a daily progress note for services that are billed on a daily basis, and a separate progress note for collateral contact.

DAILY NOTE

The daily progress note shall include:

- Type of service rendered
- Sufficient detail to support the service code(s) selected for the service type(s) as indicated by the service code description(s)
- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
- The date that the service was provided
- Duration of the service, including travel and documentation time

- Location of the beneficiary at the time of service
- Printed name, signature or the service provider, and date of signature
- Next steps, including planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other providers and any update to the problem list

COLLATERAL CONTACT

Providers shall document at least one contact per month with a family member, caregiver or other significant support person identified by an adult beneficiary. This contact occurs outside hours of operation and outside the therapeutic program for day treatment.

- This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.)
- Adult beneficiaries may decline this service component
- The contacts should focus on the role of the support person in supporting the beneficiary's community reintegration

PROBLEM LIST

The provider(s) responsible for the member's care shall create and maintain a problem list. The problem list may include symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters

The problem list shall include the following:

- Diagnosis/es identified by a provider acting within their scope of practice, if any
- Current International Classification of Diseases (ICD) Clinical Modification (CM) codes
- Problems identified by a provider acting within their scope of practice, if any
- Problems identified by the member and/or significant support person, if any
- The name and title (or credentials) of the provider that identified, added, or resolved the problem, and the date the problem was identified, added, or resolved

BILLING REQUIREMENTS

A half-day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

A full day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available more than four hours per day.

Although the beneficiary must receive face-to-face services on any full day or half-day claimed, all service activities during that day are not required to be face-to-face with the beneficiary.

CONTINUOUS HOURS OF OPERATION

The requirement for continuous hours of operation does not preclude short breaks between activities. A lunch or dinner break may also be appropriate depending on the program's schedule. These breaks do not count toward the total hours of operation of the day program for purposes of determining minimum hours of service.

2.2 DAY TREATMENT INTENSIVE PROGRAM LEVEL

Day Treatment Intensive (DTI) is a structured, multi-disciplinary program which provides services to a distinct group of individuals. Day treatment intensive is intended to provide an alternative to hospitalization, avoid placement in a more restrictive setting, or assist the beneficiary in living within a community setting. Partial Hospital Programs (PHP) are considered to be equivalent to Day Treatment Intensive level of care.

SERVICE COMPONENTS

DTI Programs contain the following required service components:

- Therapeutic Milieu
- Skill-Building Groups
- Adjunctive Therapies
- Collateral Contact
- Mental Health Crisis Protocol
- Written Weekly Schedule

THERAPEUTIC MILIEU

This component must include process groups and skill-building groups. Specific activities shall be performed by identified staff and take place during the scheduled hours of operation of the program. The goal of the therapeutic milieu is to teach, model, and reinforce constructive interactions by involving beneficiaries in the overall program. For example, beneficiaries are provided with opportunities to lead community meetings and to provide feedback to peers. The program includes behavior management interventions that focus on teaching self-management skills that adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention. Activities include, but are not limited to, staff feedback to beneficiaries on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.

PROCESS GROUPS

These groups, facilitated by staff, shall assist each beneficiary to develop necessary skills to deal with their problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies to resolve behavioral and emotional problems.

SKILL-BUILDING GROUPS

In these groups, staff shall help beneficiaries identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, beneficiaries identify skills that address symptoms and increase adaptive behaviors.

ADJUNCTIVE THERAPIES

These are therapies in which both staff and beneficiaries participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able utilize the modality to develop or enhance skills directed toward achieving beneficiary plan goals. Adjunctive therapies assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of day treatment intensive are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the beneficiary's needs.

PSYCHOTHERAPY

Day Treatment Intensive shall additionally include Psychotherapy.

MENTAL HEALTH CRISIS PROTOCOL

There shall be an established protocol for responding to beneficiaries experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the beneficiary's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the day treatment intensive program staff shall have the capacity to handle the crisis until the beneficiary is linked to an outside crisis service.

WRITTEN WEEKLY SCHEDULE

A weekly detailed schedule shall be available to beneficiaries and as appropriate to their families, caregivers or significant support persons. The schedule will identify when and where the service components of the program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their services.

STAFFING REQUIREMENTS

The allowable staffing credentials for DTI include:

- Physicians
- Psychologists or related waivered/registered professionals.
- Licensed Clinical Social Workers or related waivered/registered professionals.
- Marriage, Family and Child Counselors or related waivered/registered professionals.

- Registered Nurses
- Licensed Vocational Nurses
- Psychiatric Technicians
- Occupational Therapists
- Mental Health Rehabilitation Specialists

The required staffing ratio is 1:8 and must include at least one staff person whose scope of practice includes psychotherapy. Persons who are not solely used to provide Day Treatment services may be utilized according to program need, but shall not be included as part of the above ratio.

STAFF ACTIVITIES

Staff may be required to spend time on day treatment activities outside the hours of operation and therapeutic program (e.g., time for travel, documentation, caregiver contacts). At least one staff person must be present and available to the group in the therapeutic milieu for all scheduled hours of operation

STAFF IN MULTIPLE PROGRAMS

The program may use day treatment staff who are also staff with other responsibilities (e.g., staff of a group home, staff of a residential program, staff of another mental health treatment program). The program shall document the scope of responsibilities for these staff and the specific times in which day treatment intensive activities are being performed exclusive of other activities.

STAFFING IN PROGRAMS SERVING MORE THAN 12 CLIENTS

For DTI programs serving more than 12 clients, two of the staff must have a non-MHRS (Mental Health Rehabilitation Specialist) credential.

DOCUMENTATION REQUIREMENTS

Providers shall complete a daily progress note for services that are billed on a daily basis, and a separate progress note for collateral contact.

DAILY NOTE

The daily progress note shall include:

- Type of service rendered
- Sufficient detail to support the service code(s) selected for the service type(s) as indicated by the service code description(s)
- A narrative describing the service, including how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
- The date that the service was provided

- Duration of the service, including travel and documentation time
- Location of the beneficiary at the time of service
- Printed name, signature or the service provider, and date of signature
- Next steps, including planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other providers and any update to the problem list

COLLATERAL CONTACT

Providers shall document at least one contact per month with a family member, caregiver or other significant support person identified by an adult beneficiary. This contact occurs outside hours of operation and outside the therapeutic program for day treatment.

- This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.)
- Adult beneficiaries may decline this service component
- The contacts should focus on the role of the support person in supporting the beneficiary's community reintegration

PROBLEM LIST

The provider(s) responsible for the member's care shall create and maintain a problem list. The problem list may include symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters

The problem list shall include the following:

- Diagnosis/es identified by a provider acting within their scope of practice, if any
- Current International Classification of Diseases (ICD) Clinical Modification (CM) codes
- Problems identified by a provider acting within their scope of practice, if any
- Problems identified by the member and/or significant support person, if any
- The name and title (or credentials) of the provider that identified, added, or resolved the problem, and the date the problem was identified, added, or resolved

BILLING REQUIREMENTS

A half-day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

A full day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available more than four hours per day.

Although the beneficiary must receive face-to-face services on any full day or half-day claimed, all service activities during that day are not required to be face-to-face with the beneficiary.

CONTINUOUS HOURS OF OPERATION

The requirement for continuous hours of operation does not preclude short breaks between activities. A lunch or dinner break may also be appropriate depending on the program's schedule. These breaks do not count toward the total hours of operation of the day program for purposes of determining minimum hours of service.

3.0 RESIDENTIAL SERVICES

RESIDENTIAL SERVICES OVERVIEW

Residential specialty mental health services provide 24/7 care in a community-based setting, offering intensive support for individuals with mental health conditions. These services aim to help residents manage their symptoms, develop independent living skills, and ultimately, improve their overall well-being. They are typically provided in facilities with 16 beds or less and can be a crucial step for individuals who need more support than outpatient services can offer, but who do not require the intensity of a hospital setting.

Key aspects of residential specialty mental health services include:

24/7 CARE AND SUPPORT

Residents receive continuous care and supervision from trained professionals, ensuring their needs are met around the clock.

INTENSIVE TREATMENT

These services involve a range of therapies, including individual and group counseling, medication monitoring, and rehabilitative activities, all designed to address specific mental health challenges.

FOCUS ON SKILL DEVELOPMENT

Residential programs help residents build and improve crucial life skills, such as communication, problem-solving, and self-care, to facilitate a successful transition back into the community.

TRANSITION TO COMMUNITY LIVING

The ultimate goal is to empower residents to live independently and integrate successfully into the community, often with ongoing support through outpatient services.

LEVELS OF CARE

Residential treatment can vary in intensity and duration, with some programs focusing on short-term stabilization and others offering longer-term support.

3.1 TRANSITIONAL RESIDENTIAL PROGRAM LEVEL

Transitional Residential Programs are licensed Social Rehabilitation Facilities who serve ambulatory adults with serious and persistent mental health disorders associated with multiple life domain functional impairments, identified risk factors, and demonstrate some involvement in their recovery.

SERVICE DESCRIPTION

Services are designed to increase independent living skills and reduce or eliminate barriers to successful community living. Methods include in vivo learning, individual and group learning and practice activities, task analysis, motivational interviewing, peer support and modeling, case management, individualized plan development, and monitoring and regular re-assessment of client functioning.

Residential programs provide education on trauma and substance abuse, development of effective self-management skills, development of skills in social and interpersonal communication, as well as substance use disorder counseling individually and in groups. Residents are connected with community supports and resources during their stay, working collaboratively with County and other community programs to transition to community living.

Services are individualized and provided in a way that teachers and enhances movement toward increased self-sufficiency. Clients work toward strengthening skills in organization of household tasks, nutritional needs and menu planning, meal preparation, food shopping, housekeeping, personal care, money management, ordering and picking up medication and medication management, problem-solving and conflict resolution, goal setting, access to community resources such as employment and pre-vocational service, co-occurring disorders services, health management and access to healthcare, and recreational and social activities.

LICENSING AND CERTIFICATION REQUIREMENTS

This program must be certified by the State Department of Health Care Services as a Transitional Residential Treatment Program (TRTP) and licensed by the State Department of Social Services as a Social Rehabilitation Facility.

TREATMENT DURATION

Transitional Residential Program treatment duration is between 9-12 months. These programs operate 24 hours/day, seven days/week, 365 days/year.

TARGET POPULATION

Transitional Residential Programs serve individuals diverted from going to Long Term Care Facilities, and also adult LPS conservatees stepping down from Long Term Care Facilities.

Adults presenting with at least one behavioral health need in the area of Psychosis or Depression and at least 3 additional Behavioral Health needs, 4 functional needs, and 1 risk factor.

Behavioral Health Needs	Functional Needs	Risk Factors
• **Psychosis** • Impulse Control • **Depression** • Anxiety • Interpersonal Problems • Adjustment to Trauma • Eating Disturbance	• Family • Physical/Medical • Employment • Social Functioning • Independent Living Skills • Residential Stability • Basic Activities of Daily Living • Decision Making	• Danger to Self • Self-Injurious Behavior • Other Self-Harm • Exploitation

4.0 HIGH-INTENSITY WRAPAROUND SERVICES

HIGH-INTENSITY WRAPAROUND SERVICES OVERVIEW

High-intensity adult wraparound specialty mental health services involve intensive, individualized support for adults with significant behavioral health needs, aiming to improve their functioning and integration into the community. This level of service is provided as an embedded component within locked residential care or enhanced residential care facilities serving LPS conservatees. The goal is to provide a more person-centered, comprehensive model of care designed to promote reintegration back into the community.

Key aspects of these services include:

WRAPAROUND APPROACH

These services are designed to meet the unique needs of each individual. This involves a team-based, collaborative process that focuses on the individual's strengths and natural supports to develop a personalized plan of care.

MULTI-DISCIPLINARY TEAM

The wraparound team can include facility staff (clinicians, nurses), but also community members, family, peers, and mentors whenever possible within the constraints of the setting.

EMPHASIS ON RECOVERY AND COMMUNITY REINTEGRATION

The aim is to help individuals manage their symptoms, acquire skills, and participate more fully in their communities. This involves coordination with community-based services and supports to ensure continuity of care after leaving the residential/locked setting.

4.1 HIGH-INTENSITY WRAPAROUND: EMBEDDED SERVICES LEVEL

High-Intensity Wraparound treatment programs provided embedded specialty mental health services for adults with serious mental illness whose behavioral characteristics may exceed the capacity of most traditional adult residential facilities and related services. These programs ensure that individuals living in adult residential facilities or other locked settings successfully maintain their placement by avoiding inpatient and high utilization of psychiatric hospitalizations. The goal of treatment is to support and encourage successful transition back to the client's county of origin, to a board and care home, independent living situation, or back to family's home when appropriate.

Typically, this level of program provides Integrated Recovery treatment, where mental health, substance use, and physical health treatments are integrated within one comprehensive program that is designed to enable individuals to actively participate in their recovery process by developing the skills and capabilities necessary to maintain a healthy lifestyle. Each participant is encouraged to engage in meaningful work, education, recreation and leisure activities and to develop a capacity for independent living.

SERVICE DESCRIPTION

These programs provide intensive outpatient mental health services, including:

- Medication support
- Individual therapy
- Group therapy
- Family therapy
- Rehabilitation services (individual and group)
- Targeted case management
- Peer support services

Services are provided within a modified therapeutic community which includes living accommodations and clinical services/supports.

Living Accommodations include:

- Shared Living Unit
- Meals and Snacks
- Utilities
- Weekly Housekeeping
- Laundry Facility
- Housing Sustaining Services and Supports

Clinical Services and Supports include:

- Recreational Activities
- Psychosocial Rehabilitation Classes
- Independent Living Skills Group Training
- Psychiatric and Medication Services

TARGET POPULATION

High-Intensity Embedded Services Programs serve LPS conservatees in long-term care settings as they transition back to community settings.

Adults presenting with at least one behavioral health need in the area of Psychosis or Depression and at least 3 additional Behavioral Health needs, 4 functional needs, and 1 risk factor.

Behavioral Health Needs	Functional Needs	Risk Factors
• **Psychosis** • Impulse Control • **Depression** • Anxiety • Interpersonal Problems • Adjustment to Trauma • Eating Disturbance	• Family • Physical/Medical • Employment • Social Functioning • Independent Living Skills • Residential Stability • Basic Activities of Daily Living • Decision Making	• Danger to Self • Self-Injurious Behavior • Other Self-Harm • Exploitation

5.0 SPECIALTY PROGRAMS

In an effort to augment the current service continuum, DHS-BHD seeks programs within the following specialties:

- Transcranial Magnetic Stimulation
- Eating Disorder Treatment
- Supported Employment: Individual Placement and Support (IPS) Model

5.1 TRANSCRANIAL MAGNETIC STIMULATION (TMS) PROGRAMS

Transcranial Magnetic Stimulation (TMS) is an FDA-approved, non-invasive treatment for Major Depressive Disorder and Obsessive-Compulsive Disorder (OCD). It uses magnetic pulses to stimulate specific regions of the brain associated with mood regulation and behavior, particularly the prefrontal cortex. TMS is a safe and well-tolerated option for individuals who have not responded to traditional treatments such as medication or psychotherapy. The therapy involves a series of sessions, typically lasting 20-40 minutes each, over several weeks, with no need for anesthesia or recovery time, allowing patients to resume daily activities immediately after treatment. Its proven efficacy and minimal side effects make TMS a valuable addition to mental health care.

SERVICE DESCRIPTION

Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment includes:

- Initial cortical mapping and motor threshold determination

- Initial delivery and management of TMS
- Subsequent motor threshold re-determination
- Subsequent delivery and management of TMS

TARGET POPULATION

Transcranial magnetic stimulation (TMS) is a non-invasive neuromodulation therapy used for treatment-resistant major depressive disorder (MDD) and obsessive-compulsive disorder (OCD).

REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION (RTMS) FOR DEPRESSION

The National Network of Depression Centers and the American Psychiatric Association recommend rTMS for patients with MDD who have not responded to at least two antidepressant medications. rTMS typically involves daily sessions over 4-6 weeks, with each session lasting approximately 30-40 minutes. The standard protocol involves high-frequency (10 Hz) stimulation of the left dorsolateral prefrontal cortex (DLPFC).

DEEP TRANSCRANIAL MAGNETIC STIMULATION (DTMS) FOR OCD

dTMS targets deeper brain regions, such as the medial prefrontal cortex and anterior cingulate cortex, which are implicated in OCD.

ELIGIBILITY CRITERIA

Clients must meet the following criteria for referral to TMS Programs:

- A confirmed diagnosis of severe Major Depressive Disorder (MDD) or recurrent episode, or Obsessive Compulsive Disorder (OCD), as defined by the current DSM.
- One or more of the following:
    - Resistance to treatment with psychopharmacologic agents as evidenced by a lack of clinically significant response to 2 trials of psychopharmacologic agents in the current depressive episode from at least 2 different agent classes.
    - Inability to tolerate psychopharmacologic agents as evidenced by 2 trials of psychopharmacologic agents from at least 2 different agent classes, with distinct side effects.
    - History of response to TMS in a previous depressive episode.
    - If client is currently receiving ECT, TMS may be considered reasonable and necessary as a less invasive treatment option.
- A trial of an evidence-based psychotherapy known to be effective in the treatment of MDD or OCD of an adequate frequency and duration without significant improvement in depressive or OCD symptoms as documented by standardized rating scales that reliably measure depressive/OCD symptoms.

Clients with any of the following contraindications would not be eligible for referral to TMS Programs:

- Metal in, near, or around the head (30 centimeters from top of head), such as:
    - Metal plates/pins/screws
    - Aneurysm clip/coil/stent
    - Carotid or cerebral stents
    - Bullet or metal fragments
- Have the following devices:
    - Pacemaker
    - Implanted cardioverter defibrillator (ICD)
    - Vagus nerve stimulator (VNS)
    - Deep brain stimulator
- Diagnosis of Schizophrenia
- Client is pregnant
- History of:
    - Seizure or stroke (active seizure or stroke within the past six months)
    - Recent head trauma (within the last six months)
    - Aneurysm (lifetime history)
- Current substance or alcohol use

5.2 EATING DISORDER TREATMENT – INTENSIVE OUTPATIENT LEVEL (EDO IOP)

EDO IOP is considered equivalent to the Day Treatment Rehabilitative Program level, with an Eating Disorder Treatment Specialty. Please review the DTR section above for an overview of requirements.

IOP (Intensive Outpatient Programs) are structured mental health treatment programs that offer more intensive care than regular outpatient therapy but differs in intensity and time commitment from residential programs. IOP typically involves 3-5 days of programming for around 3-4 hours per day while working with outpatient providers. This allows clients to maintain their daily routines such as work or school. It focuses on providing support and strategies for managing symptoms while clients live at home.

IOP is typically provided by a team of licensed psychologists, therapists, clinicians, dietitians and psychiatrists. IOP may be provided in-person, or through telehealth modalities.

PROGRAM ELEMENTS

EDO IOP Programs provide daily group therapy sessions (both process and skills-based groups), weekly individual therapy, and weekly individual sessions with a dietician. Each individual is assigned to a multi-disciplinary team who creates an individualized eating disorder treatment plan and provides medical and psychiatric oversight. Typically, one supported meal and snack is provided during each IOP session.

EDO IOP Programs include adjunctive therapies to promote recovery, such as weekly experiential therapies including restaurant outings, grocery shopping, and cooking groups. They may also provide individual sessions with exercise physiologists, if cleared by the treatment team.

GROUP COMPONENT (PROCESS AND SKILLS-BASED GROUPS)

EDO IOP group schedules and curriculum are grounded in evidence-based practices, including Cognitive Behavioral Therapy and Dialectical Behavior Therapy.

The following are examples of groups provided in EDO IOP programs:

- Movement in moderation psycho-education group
- Joyful movement and exercise groups
- Art therapy groups
- Body Image groups
- Relationship Skills groups
- Stress Management skills groups
- Life Skills groups
- Medical Integrated Care psychoeducation groups
- Peer Support groups

COLLATERAL CONTACT

Included in many programs are family sessions and a family group without clients to provide psychoeducation and build effective support strategies.

TELEMEDICINE EDO IOP

EDO IOP can be adapted for telehealth modalities. In this format, individuals typically participate in group sessions 3 times per week (for a minimum of 9 hours of group work), plus individual therapy and dietitian sessions. Telehealth allows for flexible time options for IOP programming, which may provide options for those who work or attend school during the day.

With video conferencing, staff are able to work with clients as they engage in daily activities. For example, a therapist may work with a client while they are grocery shopping or clothing shopping to address anxiety issues, or a dietitian may join a client at a restaurant or on a trip when food choices are limited. The nutrition program can be adapted to provide weekly meal support where clients eat a meal online once a week.

BEST PRACTICES

Effective EDO IOP Programs consider the following best practices:

- Utilizing a non-diet approach with individualized nutritional programming
- Providing personalized treatment within real life settings

- Providing medical oversight
- Retaining staff who are specialists in Anorexia Nervosa, Bulimia Nervosa, Binge Eating and other eating disorders treatment; staff are typically masters-level, with 5 years experience treating eating disorders
- Offering support groups for continuing aftercare
- Utilizing adjunctive therapies, such as meditation, experiential therapies, body image support & wellness activities
- Integrating trauma treatment to address co-occurring PTSD in eating disorders
- Involving family and support persons
- Providing comprehensive discharge planning to support long-term recovery

TARGET POPULATION

A client could be appropriate for IOP if:

- They are medically and psychiatrically stable
- They need less structured meal support
- They are able to function in some aspects of their daily life
- They need minimal accountability regarding their urges and behaviors
- They could benefit from more individual sessions and groups than provided in outpatient therapy

TREATMENT DURATION

The length of the program is based on several factors, including the client's specific recovery needs, the severity of the eating disorder, the clients progress in treatment, and the program's structure. For some individuals, treatment might be shorter in duration, while others could extend to several months, depending on their progress and treatment goals.

5.3 EATING DISORDER TREATMENT – PARTIAL HOSPITALIZATION PROGRAM LEVEL (EDO PHP)

EDO PHP is considered equivalent to the Day Treatment Intensive Program level, with an Eating Disorder Treatment Specialty. Please review the DTI section above for an overview of requirements.

PHP (Partial Hospitalization Programs) are structured mental health treatment programs that offer more intensive care than regular outpatient therapy but differ in intensity and time commitment from Residential Treatment. PHP is more intensive than IOP, running from 5-6 days per week for 6 or more hours per day. It provides a higher level of care, but clients return home at the end of the day. PHP is designed for individuals who need significant support but do not require 24-hour supervision.

PROGRAM ELEMENTS

EDO PHP Programs provide multiple daily group sessions, two individual therapy sessions per week, as well as weekly sessions with a dietitian and medical team. Each individual is assigned to a multi-disciplinary team who creates an individualized eating disorder treatment plan and provides medical and psychiatric oversight. Typically, one supervised meal and two snacks are provided during each PHP session.

EDO PHP Programs include adjunctive therapies to promote recovery, such as weekly experiential therapies including restaurant outings, grocery shopping, and cooking groups. They may also provide individual sessions with exercise physiologists, if cleared by the treatment team.

GROUP COMPONENT (PROCESS AND SKILLS-BASED GROUPS)

EDO PHP group schedules and curriculum are grounded in evidence-based practices, including Cognitive Behavioral Therapy and Dialectical Behavior Therapy.

The following are examples of groups provided in EDO PHP programs:

- Movement in moderation psycho-education group
- Joyful movement and exercise groups
- Art therapy groups
- Body Image groups
- Relationship Skills groups
- Stress Management skills groups
- Life Skills groups
- Medical Integrated Care psychoeducation groups
- Peer Support groups

COLLATERAL CONTACT

Included in many programs are family sessions and a family group without clients to provide psychoeducation and build effective support strategies.

BEST PRACTICES

Effective EDO PHP Programs consider the following best practices:

- Utilizing a non-diet approach with individualized nutritional programming
- Providing personalized treatment within real life settings
- Providing medical and psychiatric oversight
- Retaining staff who are specialists in Anorexia Nervosa, Bulimia Nervosa, Binge Eating and other eating disorders treatment; staff are typically masters-level, with 5 years experience treating eating disorders

- Offering family support groups
- Utilizing adjunctive therapies, such as meditation, experiential therapies, body image support & wellness activities
- Integrating trauma treatment to address co-occurring PTSD in eating disorders
- Providing comprehensive discharge planning to support long-term recovery

TARGET POPULATION

A client could be appropriate for PHP if:

- They are medically and psychiatrically stable
- They need structured meal support for the majority of their meals
- They have some insight that their eating disorder is adversely affecting their daily life
- They need accountability regarding their urges and behaviors
- They could benefit from daily group therapy and multiple individual sessions throughout the week

TREATMENT DURATION

The length of the program is based on several factors, including the client's specific recovery needs, the severity of the eating disorder, the clients progress in treatment, and the program's structure. For some individuals, treatment might be shorter in duration, while others could extend to several months, depending on their progress and treatment goals.

5.4 EATING DISORDER TREATMENT – RESIDENTIAL LEVEL (EDO RES)

Please review the Residential Treatment program requirements in the Residential Treatment Level section above.

EDO Residential Treatment provides 24/7 care in a home-like environment, integrating therapy-based treatment interventions with those that are experiential, allowing clients to have exposure to real life issues and challenges, while still receiving the care and support of their treatment team.

EDO Residential treatment is provided by a team of care professionals, including doctors, psychiatrists, nurses, dietitians, therapists, and mental health counselors. Together, they create a comprehensive treatment plan to guide clients on their path to recovery while staying in a home-like treatment setting.

PROGRAM ELEMENTS

EDO Residential Treatment includes group interventions, individual sessions, medical support, nutritional support, and adjunctive therapies.

MEDICAL SUPPORT

Clients are seen at least once a week by a physician or nurse practitioner for standard assessments to track and support treatment outcomes. Many eating disorders can cause health complications that require specialized treatment, like anemia, heart failure, or malnutrition, which the program medical team can evaluate and monitor during treatment. Additionally, clients are seen at least weekly by a Psychiatrist. 24/7 nursing staff are also typical of this level of care.

INDIVIDUAL AND GROUP COUNSELING

Master's-level or higher therapists provide individual therapy 3 times per week and small group therapy 7 days a week.

The following are types of groups and treatment activities that may be offered residential settings:

- Individual therapy (three sessions a week)
- Family therapy
- Detoxification Services
- Medication management
- Medical care
- Expressive arts group
- Solution-focused group
- Connected recovery group
- Attachment repair group
- Acceptance and commitment therapy group (ACT)
- Self-empowerment group
- Rational somatic therapy group
- Self-empowered body image group
- Dialectical behavior therapy group (DBT)
- Cognitive behavioral therapy group (CBT)
- Yoga
- Guided meditation/soothing stretch
- Exposure therapy
- Community meetings

COLLATERAL CONTACT

Family and support persons are integrated into care. Programs provide coaching, therapeutic support, and educational resources for loved ones as they assist in recovery.

NUTRITIONAL SUPPORT

Clients meet with registered dieticians one-on-one for nutritional education and meal support. Supervised meals and snacks are provided in program. Nutritional support typically includes:

- Nutritional counseling session (one session a week)
- Nutrition education
- Restaurant outings with dietitian
- Challenge food outings with dietitian
- Group dinner planning

TARGET POPULATION

EDO Residential Treatment is appropriate for individuals who require 24-hour supervision and care, but not inpatient medical care.

TREATMENT DURATION

The length of stay in residential programs varies based on several factors, but a typical stay is around 6 weeks.

5.5 SUPPORTED EMPLOYMENT: INDIVIDUAL PLACEMENT AND SUPPORT (IPS)

Individual Placement and Support (IPS) is a model of supported employment for people living with significant behavioral health needs who need assistance to find and maintain competitive employment in the community. Employment is a social determinant of health and working provides many benefits, such as income, structured daily activity, social connection, etc. Although variations of supported employment exist, IPS refers to a specific evidence-based practice of supported employment. Mainstream education and technical training are included as ways to advance career paths.

8 PRACTICE PRINCIPLES OF IPS

IPS is based on eight principles as follows:

- Zero Exclusion
- Competitive Employment
- Integrated Services
- Worker Preferences: Attention to consume preferences
- Benefits Planning: Personalized benefits planning
- Rapid Job Search: Job search starts after consumer expresses interest in working
- Systematic Job Development: IPS specialists build relationships with employers
- Time-Unlimited Supports: Individualized long-term job support

ZERO EXCLUSION

Eligibility for this service is based on consumer choice. People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement. All people who want to work are eligible for IPS.

COMPETITIVE EMPLOYMENT

The focus is on competitive jobs in the open labor market. These are jobs anyone can apply for, pay at least minimum wage/same pay as coworkers with similar duties, and have no artificial time limits imposed by the social service agency.

INTEGRATED SERVICES

IPS programs are integrated with mental health treatment teams. IPS specialists are active members of mental health treatment teams with other practitioners (e.g., care managers, therapists, psychiatrists, etc.) to provide coordinated, recovery-oriented services.

WORKER PREFERENCES

IPS program services are based on each job seeker's preferences and choices rather than the employment specialist's and supervisor's judgments. IPS specialists listen to the person's desired job types, work hours, and job supports.

BENEFITS PLANNING

Employment specialists help people obtain personalized, understandable, and accurate information about their Social Security, Medi-Cal, and other government entitlements.

RAPID JOB SEARCH

IPS programs use a rapid job search approach to help job seekers obtain jobs rather than assessments, training, & counseling. The first face to face contact with the employer occurs within 30 days.

SYSTEMATIC JOB DEVELOPMENT

Employment specialists systematically visit employers, who are selected based on the job seeker's preferences, to learn about their business needs and hiring preferences.

TIME-UNLIMITED SUPPORTS

Job supports are individualized and continue for as long as each worker wants and needs the support. Employment Specialist have face to face contact at least monthly.

IPS SERVICE TYPES

IPS supported employment both pre-employment services and employment sustaining services as follows:

Pre-Employment Services	Employment Sustaining Services
Job-related discovery or assessment	Career advancement services
Person-centered employment planning	Negotiation with employers
Job development and placement	Job analysis
Job carving	Job coaching
Benefits education and planning	Benefits education and planning
	Asset development
	Follow-along supports

TEAM STRUCTURE/STAFFING MODEL

IPS teams are typically composed of two employment specialists and an employment supervisor who supports up to five IPS teams. A typical IPS team will support a caseload of 35-40 members. Any behavioral health practitioner may serve as an employment specialist if they are trained in the IPS model. A bachelor's degree is preferred for IPS specialists, and a bachelor's degree is strongly preferred for IPS supervisors.

BILLING AND DOCUMENTATION

IPS services are billed on a monthly bundled rate (per member per month). The full rate is billable when the IPS team makes at least 4 contacts on 4 different days of the month, of which at least 3 are face-to-face (in-person) with the member. The partial rate is billable when the IPS team makes at least 2 contacts on 2 different days of the month, of which at least one is face-to-face (in-person) with the member.

IPS supported employment teams must abide by all Medi-Cal documentation requirements for Specialty Mental Health Services. All teams must complete at minimum a daily progress note for each service rendered.

SYSTEM MONITORING METRICS

DHS-BHD utilizes metrics across several domains to assess quality and patient outcomes. System metrics are grouped into measures of efficiency and measures of effectiveness. Specifically:

- Effort Quantity (How much did we do?)
- Effort Quality (How well did we do it?)
- Effect (Are clients better off?)

EXPECTED PROCESS METRICS FOR ALL SERVICE CATEGORIES

The Department is committed to tracking meaningful outcomes and working with CBOs to ensure that high quality services are delivered effectively and efficiently. The primary system outcomes of interest for this RFA include:

- Access to Services: The County is committed providing services in such a way as to reflect and honor the social and cultural characteristics of the community and focuses on organizational efforts to reduce barriers to service utilization. No client should be turned away from services due to lack of system capacity.
- Timeliness: Adults identified as eligible for a potential service should be offered a service appointment with an appropriate provider within 10 business days.
- Clinical Outcome Improvements: Clients should show improvements on the Adult Strengths and Needs Assessment (ANSA) and/or other outcome measurement tools CBOs may utilize.
- Functional Improvements: The County aims to provide clients with the services, skills, and supports necessary to obtain and maintain stable housing, engage community connections, and avoid hospital or other facility placements unless absolutely necessary.

The County is eager to work with service providers to identify additional outcomes and metrics to measure over the duration of these contracts that could help ensure that clients are receiving the services and supports they need.

TYPICAL PROGRAM OUTCOME METRICS

The following chart outline expected program monitoring metrics by level of care.

Level of Care	Effort Quantity	Effort Quality	Effect
Outpatient Non-FSP	Total client volume Average program census Average service volume per member per month Program utilization rate	Documentation timeliness percentage Client to staff ratio Timeliness to services Language capacity Program retention	Average actionable items on ANSA Functional improvement rates Hospital admission rates
Outpatient FSP	Total client volume Average program census Average service volume per member per month Program utilization rate	Documentation timeliness percentage Client to staff ratio Timeliness to services Language capacity Program retention	Average actionable items on ANSA Functional improvement rates Hospital admission rates Housing stability Utilization of crisis services

Level of Care	Effort Quantity	Effort Quality	Effect
Outpatient ACT	Total client volume Average program census Average service volume per member per month Program utilization rate	Documentation timeliness percentage Client to staff ratio Timeliness to services Language capacity Program retention ACT model fidelity	Average actionable items on ANSA Functional improvement rates Hospital admission rates Housing stability Utilization of crisis services Justice-involvement rates
Outpatient Housing Support	Total client volume Average program census Average service volume per member per month Program utilization rate	Documentation timeliness percentage Client to staff ratio Timeliness to services Language capacity Program retention	Functional improvement rates Housing stability
Day Treatment	Total client volume Average program census Average length of stay Program utilization rate	Client to staff ratio Language capacity Program retention	Functional improvement rates Hospital admission rates Utilization of crisis services
Residential Treatment	Total client volume Average program census Average length of stay Program utilization rate	Client to staff ratio Language capacity Program retention	Disposition to lower level of care Hospital admission rates Hospital re-admission rates post-discharge
High-Intensity Wraparound (Embedded)	Total client volume Average program census Average service volume per member per month Program utilization rate	Documentation timeliness percentage Client to staff ratio Language capacity Program retention	Functional improvement rates Hospital admission rates Disposition to lower level of care

REIMBURSEMENT RATES

Contract rates are set as a percentage of the County rates. Historically DHS has paid between 65-80% of the DHCS published rates, depending on several factors outlined below. DHS rate range methodology is comprised of the following steps. Annually an analysis of the most recent fiscal year of Medi-Cal approved claim data is conducted to determine the Reimbursement

Percentage of Federal Financial Participation (FFP) and State Grant Funds (SGF) the County receives relative to the amount claimed in order to establish a Sustainable Percentage of the County rates which can be passed through to Contracted providers.

Rates will be negotiated individually with each contracted agency

- Negotiated rates must be approved by the Director and Chief Finance Officer

During rate setting negotiations, special consideration is given for:

- Level of care
- The impact of travel/field-based services
- Specialty focus within a program (e.g., dual-diagnosis or eating disorders)
- The programs impact on continuity of care

For a full listing of County rates, utilize the Fee Schedule link in the Reference section below.

LICENSING AND CERTIFICATION REQUIREMENTS

All programs awarded contract will need to complete a Medi-Cal site certification through DHS-BHD. Additionally, residential programs must be licensed through the California Department of Social Services. Current licensure and certification preferred at time of application.

REFERENCES

STATE OF CALIFORNIA SERVICE ACTIVITY DEFINITIONS AND REFERENCES

1. 2025-2026 Specialty Mental Health Services Table - https://www.dhcs.ca.gov/services/MH/Documents/Specialty-Mental-Health-Service-Table-25-26.xlsx
2. Mental Health Plan Agreement - https://www.dhcs.ca.gov/Documents/Sonoma-4260-2220139.pdf
3. BHIN 23-068: Documentation Requirements for all Specialty Mental Health Services - https://www.dhcs.ca.gov/Documents/BHIN-23-068-Documentation-Requirements-for-SMH-DMC-and-DMC-ODS-Services.pdf

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (DHCS) SPECIALTY MENTAL HEALTH SERVICES REIMBURSEMENT RATES

1. Fee Schedules by Fiscal Year - https://www.dhcs.ca.gov/services/MH/Pages/Fiscal-Year-2025-26-Medi-Cal-Behavioral-Health-Fee-Schedules-FY25-26.aspx