



Client and Service Information (CSI) Database

CSI TRAINING II:

Managing Changes to CSI with the
Mental Health Services Act (MHSA) and the
Data Infrastructure Grant (DIG)

Presenters

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Department of Mental Health

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CSI System Staff Assignments

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Department of Mental Health

Statistics and Data Analysis

CSI System Staff Assignments (cont'd)

To locate your specific county:

1. Go to DMH Website: www.dmh.ca.gov
2. Click on Information Technology Web Services (ITWS) weblink (right side of the DMH homepage)

NOTE: It is not necessary to login (information is located in a public area)

3. Under “Systems” tab below the heading “DMH- Department of Mental Health,” click “Client and Service Information” – This will bring you to the “CSI-Client and Service Information Overview” page
 4. Under the “CSI Information” tab- click “Contact Us”
 5. This will bring you to the “CSI-Contact Us” page
 6. Click “DMH Staff Responsible”
 7. You are then able to open a word document with county names and the corresponding responsible CSI contacts.
- **Full URL-** <https://mhhitws.cahwnet.gov/systems/csi/docs/public/contacts.asp>

Covered in this presentation

- I. Overview of Mental Health Services Act (MHSA) & Data Infrastructure Grant (DIG) Changes to CSI
- II. Changes to CSI with MHSA & DIG
- III. Integrating the changes into CSI

What this presentation does not cover

The Data Collection Reporting (DCR) System for Full-Service Partners (FSPs) enrolled in MHSA FSP programs is not covered in this presentation.

The DCR captures the important life-events of FSP consumers, except for service data. CSI captures the service data for all county mental health consumers, including FSP consumers.



I. Overview: MHSA & DIG Changes

CSI Data Reporting Goals

I. Overview: MHSA & DIG Changes

CSI Data Reporting Goals

1. To further the Mental Health Services Act (MHSA) vision of transformation by collecting relevant data on all services.
2. To revise and update the existing Client Services Information (CSI) System.
3. To develop the capacity to report data to the federal Uniform Reporting System (URS).

I. Overview: MHSA & DIG Changes

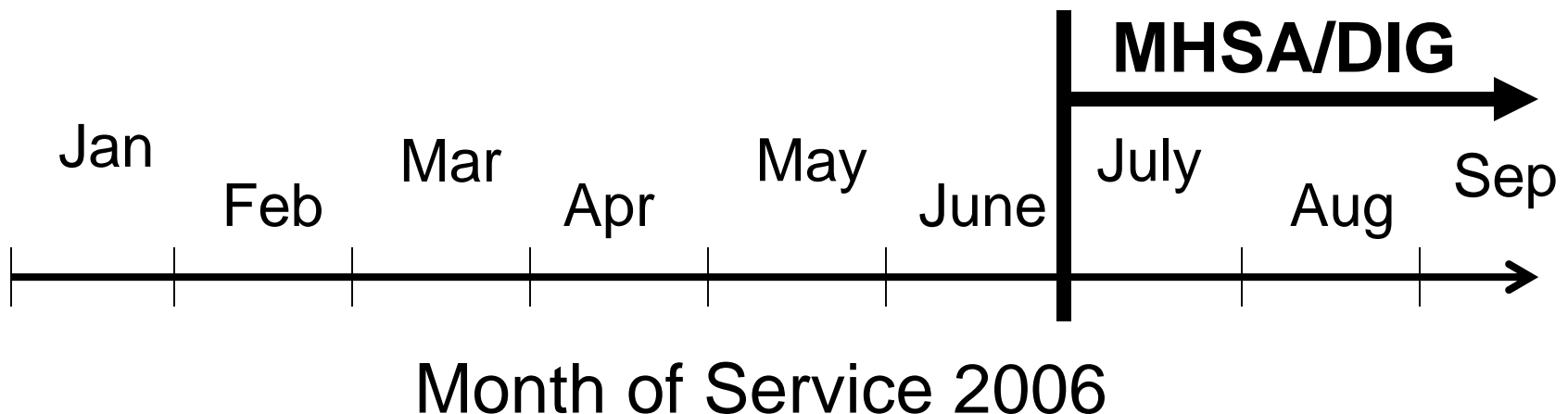
CSI Data Reporting Goals

1. County data submission to CSI must be current to June 2006
2. MHSA-required CSI data collected for all services (MHSA or not MHSA services), and for all consumers (MHSA FSPs and all other county mental health consumers).
3. County must pass the DMH CSI submission testing process.

I. Overview: MHSA & DIG Changes

CSI Data Reporting Goals

- Services delivered before July 1st, 2006 must be in the pre-MHSA/DIG format.
- Services delivered on or after July 1st, 2006 must be in the new MHSA/DIG format.





II. Changes to CSI with MHSA & DIG

Affected Fields within the Client, Service
and Periodic Records

II. Changes to CSI with MHSA & DIG

- A. CSI System Documentation
- B. Client Record – Ethnicity/Race
- C. Client Record – Remaining Fields
- D. Service Record – Diagnosis Fields
- E. Service Record – Evidence-Based Practices and Service Strategies
- F. Service Record – Remaining Fields
- G. Periodic Record – Caregiver

II. Changes to CSI with MHSA & DIG

A. CSI System Documentation

The authority on the data reporting requirements for CSI

Changes to the CSI System Documentation are available for download:

1. Go to ITWS
2. Logon with Username: mhsaworkgroup / Password: meeting
3. Go to Systems menu, select Mental Health Services Act (MHSA)
4. Go to MHSA Information menu, select CSI Information
5. Documentation available under section header "MHSA/DIG Documents"

II. Changes to CSI with MHSA & DIG

B. Client Record – Ethnicity/Race

- Now two distinct fields.
 - Ethnicity (C-09.0)
 - Race (C-10.0)

II. Changes to CSI with MHSA & DIG

B. Client Record – Ethnicity (C-09.0)

- Purpose: Identifies whether or not the client is of Hispanic/Latino ethnicity.
- Use: Allows analysis of ethnicity data to ensure provision of culturally competent mental health services. Allows state and county data to be compared to federal census data.

II. Changes to CSI with MHSA & DIG

B. Client Record – Race (C-10.0)

- Purpose: Identifies the race of the client.
- Use: Allows analysis of race data to ensure provision of culturally competent mental health services. Allows state and county data to be compared to federal census data.

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

What we'll cover:

- Background (basis for changes)
- Summary of Changes
- Data Collection/Management
- Q&A

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

Data Collection &
Management

Q&A

- Separation of Ethnicity & Race
 - Establishes consistency with and allows capacity to report to the Federal Uniform Reporting System
 - Improves accuracy of data & reduces underreporting of Hispanic/Latino demographic data
 - Satisfies Public Law 94-311
- Descriptive race data
 - Establishes consistency with Federal Standards
 - CA's diverse population

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

**Summary of
Changes**

Data Collection &
Management

Q&A

- General Overview:
 - Ethnicity & Race now separate
 - Ethnicity covers Hispanic/Latino origin
 - Race field allows up to five races

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

Data Collection &
Management

Q&A

- **Amendments (Race):**

OLD VALUES (before 7/1/06)

NEW VALUES (7/1/06 →)

Other Asian or Pacific Islander

Other Asian

Other Pacific Islander

Black

Black or African American

Hawaiian Native

Native Hawaiian

American Native

American Indian or
Alaska Native

White

White or Caucasian

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

**Summary of
Changes**

Data Collection &
Management

Q&A

- **Additions:**

- **Ethnicity (new field):**

- Ethnic Background

- **Race:**

- Hmong

- Mien

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

**Summary of
Changes**

Data Collection &
Management

Q&A

- **Deletions (Race):**
 - Hispanic
 - Amerasian
 - Multiple
 - Other Asian or Pacific Islander

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

**Data Collection
& Management**

Q&A

VALID CODES (ETHNICITY):

Y = Yes
N = No
U = Unknown/Not Reported

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

**Data Collection
& Management**

Q&A

VALID CODES (RACE):

1 = White or Caucasian	M = Samoan
3 = Black or African American	N = Asian Indian
5 = American Indian or Alaska Native	O = Other Asian
7 = Filipino	P = Native Hawaiian
C = Chinese	R = Guamanian
H = Cambodian	S = Mien
I = Hmong	T = Laotian
J = Japanese	V = Vietnamese
K = Korean	8 = Other
L = Other Pacific Islander	9 = Unknown/Not Reported

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

**Data Collection
& Management**

Q&A

- **Data Collection Overview**

- Collecting Ethnicity BEFORE Race has been found to improve response accuracy
 - “Yes” to Hispanic/Latino more likely
- Response should be obtained for BOTH questions
- New collection method for:
 - New clients (after 7/1/06)
 - Existing client record updates

- **Data Management**

- No need to convert existing data

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

Data Collection
& Management

Q&A

- **Federally recommended methods**
(for collecting R/E data)

1. Ensure that **BOTH** questions are answered (Hispanic or Latino *and* Race).

For example: *“Please answer **BOTH** questions (Hispanic or Latino **AND** Race).”*

FAQ: What if someone identifies ONLY with Hispanic/Latino?

Answer: Race = “Other”

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

Data Collection
& Management

Q&A

2. Indicate that **multiple responses are accepted** when collecting race data.

For example: *“Please select one or more of the following categories (up to five) to describe your race.”*

3. Follow ethnicity question with possible Hispanic/Latino regions of origin.

For Example: *“Are you Spanish, Hispanic or Latino? **For example,** Mexican, Central American, South American, Cuban, Puerto Rican, or another Hispanic group?”*

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

**Data Collection
& Management**

Q&A

Examples (valid entries):

Question (clinician/intake staff)		Answer (client)	Valid Code(s)
1.	Are you Spanish, Hispanic or Latino?	Yes	Y
	Please select <u>one or more</u> of the following categories to best describe your race.	Black; Guamanian	3 (Black or African American); R (Guamanian)
2.	Are you Spanish, Hispanic or Latino?	Yes	Y
	Please select <u>one or more</u> of the following categories to best describe your race.	I'm only Hispanic	8 (Other)

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

**Data Collection
& Management**

Q&A

Examples (valid entries) (cont'd):

Question (clinician/intake staff)	Answer (client)	Valid Code(s)
3. Are you Spanish, Hispanic or Latino?	Not sure	
→ For example, Mexican, Puerto Rican, Cuban, or another Hispanic Group.	Yes	Y
Please select <u>one or more</u> of the following categories to best describe your race.	White	1 (White or Caucasian)

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

**Data Collection
& Management**

Q&A

Examples (valid entries) (cont'd):

	Question (clinician/intake staff)	Answer (client)	Valid Code(s)
4.	Are you Spanish, Hispanic or Latino?	No	N
	Please select <u>one or more</u> of the following categories to best describe your race.	Chinese, Japanese, Korean	C (Chinese); J (Japanese); K (Korean)

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

Data Collection
& Management

Q&A

Examples (errors):

Question (clinician/intake staff)		Answer (client)	Invalid Code(s) entered	Valid Code(s)
1.	Are you Spanish, Hispanic or Latino?	Lost Data	(BLANK)	(U) Unknown
	Please select <u>one or more</u> of the following categories to best describe your race.	Chinese, Japanese, Korean	C (Chinese); D (Japanese); K (Korean)	(J) Japanese

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

**Data Collection
& Management**

Q&A

Examples (errors):

Question (clinician/intake staff)	Answer (client)	Invalid Code(s) entered	Valid Code(s)
2. Are you Spanish, Hispanic or Latino?	Lost Data	(U) Unknown	(U) Unknown
Please select <u>one or more</u> of the following categories to best describe your race.	White; Vietnamese	A (Amerasian)	(1) White or Caucasian (V) Vietnamese

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

Data Collection
& Management

Q&A

Examples (errors):

Question (clinician/intake staff)		Answer (client)	Invalid Code(s) entered	Valid Code(s)
3.	Are you Spanish, Hispanic or Latino?	Unknown	(BLANK)	(U) Unknown
	Please select <u>one or more</u> of the following categories to best describe your race.	Mien; Hmong	S (Mien) I (Hmong) S (Mien)	(S) Mien (I) Hmong

II. Changes to CSI with MHSA & DIG

B. Ethnicity (C-09.0) / Race (C-10.0)

Background

Summary of
Changes

Data Collection &
Management

Q&A

**ANY
QUESTIONS?**

II. Changes to CSI with MHSA & DIG

C. Client Record – Remaining Fields

- **CLIENT RECORD**

- Primary Language (C-07.0)**

- Preferred Language (C-08.0)**

- ✓ **Ethnicity (C-09.0)**

- ✓ **Race (C-10.0)**

- Data Infrastructure Grant Indicator (C-11.0)**

II. Changes to CSI with MHSA & DIG

C. Client Record – Remaining Fields

- Primary Language (C-07.0)

Purpose: Identifies the primary language utilized by the client

Approach: Amend data element.

Outcome: Language values were corrected for accuracy.

Field Changes:

Values amended:

Ilacano to Ilocano

Other Chinese Languages to Other Chinese Dialects

For more details, see the revised CSI data dictionary.

II. Changes to CSI with MHSA & DIG

C. Client Record – Remaining Fields

C-07.0 PRIMARY LANGUAGE – VALID CODES:

0 = American Sign Language (ASL)	H = Hmong
1 = Spanish	I = Lao
2 = Cantonese	J = Turkish
3 = Japanese	K = Hebrew
4 = Korean	L = French
5 = Tagalog	M = Polish
6 = Other Non-English	N = Russian
7 = English	P = Portuguese
A = Other Sign Language	Q = Italian
B = Mandarin	R = Arabic
C = Other Chinese Dialects	S = Samoan
D = Cambodian	T = Thai
E = Armenian	U = Farsi
F = Ilocano	V = Vietnamese
G = Mien	9 = Unknown / Not Reported

II. Changes to CSI with MHSA & DIG

C. Client Record – Remaining Fields

- Preferred Language (C-08.0)

Purpose: Identifies the language in which the client prefers to receive mental health services.

Approach: Add data element.

Outcome: Implement a methodology for collecting information on the client's preferred language.

Example: *“In what language would the client prefer to receive mental health services?”*

For more details, see the revised CSI data dictionary.

II. Changes to CSI with MHSA & DIG

C. Client Record – Remaining Fields

C-08.0 PREFERRED LANGUAGE – VALID CODES:

0 = American Sign Language (ASL)	H = Hmong
1 = Spanish	I = Lao
2 = Cantonese	J = Turkish
3 = Japanese	K = Hebrew
4 = Korean	L = French
5 = Tagalog	M = Polish
6 = Other Non-English	N = Russian
7 = English	P = Portuguese
A = Other Sign Language	Q = Italian
B = Mandarin	R = Arabic
C = Other Chinese Dialects	S = Samoan
D = Cambodian	T = Thai
E = Armenian	U = Farsi
F = Ilocano	V = Vietnamese
G = Mien	9 = Unknown / Not Reported

II. Changes to CSI with MHSA & DIG

C. Client Record – Remaining Fields

- DIG Indicator (C-11.0)

Purpose: Identifies whether or not the client record being submitted contains DIG data.

Approach: Add data element.

Outcome: Determines whether the Client record will be edited using the old or new format.

For more details, see the revised CSI data dictionary.

II. Changes to CSI with MHSA & DIG

C. Client Record – Remaining Fields

- DIG Indicator (C-11.0)

0 = Client record does not contain DIG data
1 = Client record does contain DIG data

II. Changes to CSI with MHSA & DIG

C. Client Record – Remaining Fields

- DIG Indicator (C-11.0)

Examples:

1. Adding a **new client** (enrolled on or after 07/01/06) - report client information with **new** elements - therefore fill indicator field with 1.
2. Updating an **existing client** (enrolled before 07/01/06) - report client information with **new** elements - therefore fill indicator field with 1.
3. Updating an **existing client** (enrolled before 07/01/06) - report client information with **old** elements - therefore fill indicator field with 0.

Note: Counties are encouraged to collect and report DIG data for each Client record until all of the county's CSI Client records, both new and existing clients, contain valid data in the DIG data fields.

II. Changes to CSI with MHSA & DIG

C. Client Record – Remaining Fields

- DIG Indicator (C-11.0)

Examples:

Client	Type	Date Enrolled/ Date of Service	Client Data Collected	DIG Indicator
A	New Enrollee	6/15/06	Old Format (w/o DIG) (C-01.0 – C-07.0)	0
B	New Enrollee	10/20/06	New Format (w/DIG) (C-01.0 – C-11.0)	1
A	Existing	12/5/06	New Format (w/DIG) (C-01.0 – C-11.0)	1



II. Changes to CSI with MHSA & DIG

D. Diagnosis

II. Changes to CSI with MHSA & DIG

D. Diagnosis

Covered in this Section

- a. Overall Objective
- b. S-28.0 Axis I Diagnosis
- c. S-29.0 Axis I Primary
- d. S-30.0 Additional Axis I Diagnosis
- e. S-31.0 Axis II Diagnosis
- f. S-32.0 Axis II Primary
- g. S-33.0 Additional Axis II Diagnosis
- h. S-34.0 General Medical Condition Summary Code
- i. S-35.0 General Medical Condition Diagnosis
- j. S-36.0 Axis-V /GAF Rating
- k. S-37.0 Substance Abuse/ Dependence
- l. S-38.0 Substance Abuse/Dependence Diagnosis
- m. Diagnosis Reporting Examples

II. Changes to CSI with MHSA & DIG

D. Diagnosis

a. Overall Objective

Current Diagnosis Reporting- Services Prior 07/01/06

1. One Principal Mental Health Diagnosis
2. One Secondary Mental Health Diagnosis
3. Up to Three Additional Mental or Physical Health Diagnoses
4. Axis-V / GAF (Periodic Record)
5. Other Factors Affecting Mental Health- Substance Abuse (Periodic Record)

Review of CSI Diagnosis data versus anecdotal experience show that CSI data have not been accurately or completely reported. The CSI System's current diagnosis reporting is limited and is being changed to collect the most comprehensive data pertaining to mental health clients and the services they receive at the county level.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

a. Overall Objective

New Diagnosis Reporting- Service On or After 07/01/06

b & e. Axis I and Axis II

c & f. Primary Axis I and Axis II

d & g. Additional Axis I and Axis II

Eliminating the current diagnosis reporting of one primary and one secondary mental health diagnosis and adding the new diagnosis reporting elements will allow for more comprehensive data. The new diagnosis reporting is similar to clinical reporting of diagnosis therefore reducing the chance for inaccurate reporting.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

a. Overall Objective

New Diagnosis Reporting- Services On or After 07/01/06

h. General Medical Condition Summary Code

i. General Medical Condition Diagnosis

Eliminating the current diagnosis reporting of optional information in the Additional Mental or Physical Health Diagnosis field and adding the new diagnosis reporting Elements will allow for the collection of more comprehensive data. These data may be potentially relevant to the understanding or management of the client's mental disorder.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

a. Overall Objective

New Diagnosis Reporting- Services On or After 01/07/06

j. Axis-V / GAF (Service Record)

Eliminating the Axis-V / GAF from the Periodic Record and adding it to the Service Record will allow for more comprehensive data reporting. The current diagnosis reporting on the Periodic Record is reported only at admission, annually, and at formal discharge. The new diagnosis reporting will enable Axis-V / GAF to be reported for each service.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

a. Overall Objective

New Diagnosis Reporting- Services On or After 07/01/06

k. Substance Abuse / Dependence

l. Substance Abuse / Dependence Diagnosis

Eliminating the Other Factors Affecting Mental Health- Substance Abuse and adding the new diagnosis reporting will allow for more comprehensive data. The current diagnosis reporting on the Periodic Record is reported only at admission, annually, and at formal discharge. The new diagnosis reporting will enable Substance Abuse / Dependence to be reported for each service. An additional Substance Abuse / Dependence element has been added to reinforce the importance and encourage efforts to report these data.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

a. Overall Objective

Goal: To make DIG recommended changes to the CSI system regarding the collection of diagnosis.

Approach: Amend or Add data elements

Outcome: Improve reporting and completeness in all fields related to diagnosis.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

b. S-28.0 Axis I Diagnosis

Services Prior 07/01/06: S-09.0 Principal Mental Health
Diagnosis
S-10.0 Secondary Mental Health
Diagnosis

Services On or After 07/01/06: S-28.0 Axis I Diagnosis

S-28.0 Axis I Diagnosis

Purpose

Identifies the Axis I diagnosis, which may be the primary focus of attention or treatment for mental health services.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

b. S-28.0 Axis I Diagnosis

Reporting Requirements

- Preferred - DSM-IV-TR Axis I code
- Acceptable - ICD-9-CM code
- Acceptable - Substance use or developmental disorder
- Acceptable - V7109 and 7999, IF there is not a valid DSM-IV-TR Axis I or ICD-9-CM code
- Enter all letters and/or numbers
- Do not enter decimal points
- Do not enter blanks
- Do not zero fill

II. Changes to CSI with MHSA & DIG

D. Diagnosis

c. S-29.0 Axis I Primary

Services Prior 07/01/06: Not Applicable

Services On or After 07/01/06: S-29.0 Axis I Primary

S-29.0 Axis I Primary

Purpose

Identifies whether or not the Axis I diagnosis is the primary mental health diagnosis, which should reflect the primary focus of attention for mental health services.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

c. S-29.0 Axis I Primary

Reporting Requirements

- Acceptable- Y = Yes, the Axis I is the primary mental health diagnosis
- Acceptable- N = No, the Axis I diagnosis is not the primary mental health diagnosis
- Acceptable- U = Unknown/Not Reported
- Do not report N if N is reported in the Axis II Primary field, unless Axis I Diagnosis and Axis II Diagnosis are both coded V7109.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

d. S-30.0 Additional Axis I Diagnosis

Services Prior 07/01/06: Not Applicable

Services On or After 07/01/06: S-30.0 Additional Axis I
Diagnosis

S-30.0 Additional Axis I Diagnosis

Purpose

Identifies an additional Axis I diagnosis.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

d. S-30.0 Additional Axis I Diagnosis

Reporting Requirements

- Preferred - DSM-IV-TR Axis I code
- Acceptable - ICD-9-CM code
- Acceptable - Substance use or developmental disorder
- Acceptable - 0000000 = No additional Diagnosis or Condition on Axis I
- Acceptable - 7999, IF there is not a valid DSM-IV-TR Axis I or ICD-9-CM code
- Not Acceptable - V7109
- Enter all letters and/or numbers
- Do not enter decimal points
- Do not enter blanks

II. Changes to CSI with MHSA & DIG

D. Diagnosis

e. S-31.0 Axis II Diagnosis

Services Prior 07/01/06: S-09.0 Principal Mental Health
Diagnosis
S-10.0 Secondary Mental Health
Diagnosis

Services On or After 07/01/06: S-31.0 Axis II Diagnosis

S-31.0 Axis II Diagnosis Purpose

Identifies the Axis II diagnosis, which may be the primary focus of attention or treatment for mental health services.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

e. S-31.0 Axis II Diagnosis

Reporting Requirements

- Preferred - DSM-IV-TR Axis II code
- Acceptable - ICD-9-CM code
- Acceptable - V7109 and 7999, IF there is not a valid DSM-IV-TR Axis II or ICD-9-CM code
- Enter all letters and/or numbers
- Do not enter decimal points
- Do not enter blanks
- Do not zero fill

II. Changes to CSI with MHSA & DIG

D. Diagnosis

f. S-32.0 Axis II Primary

Services Prior 07/01/06: Not Applicable

Services On or After 07/01/06: S-32.0 Axis II Primary

S-32.0 Axis II Primary

Purpose

Identifies whether or not the Axis II diagnosis is the primary mental health diagnosis, which should reflect the primary focus of attention for mental health services.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

f. S-32.0 Axis II Primary

Reporting Requirements

- Acceptable- Y = Yes, the Axis II is the primary mental health diagnosis
- Acceptable- N = No, the Axis II diagnosis is not the primary mental health diagnosis
- Acceptable- U = Unknown/Not Reported
- Do not report N if N is reported in the Axis I Primary field, unless Axis I Diagnosis and Axis II Diagnosis are both coded V7109.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

g. S-33.0 Additional Axis II Diagnosis

Services Prior 07/01/06: Not Applicable

Services On or After 07/01/06: S-33.0 Additional Axis II
Diagnosis

S-33.0 Additional Axis II Diagnosis

Purpose

Identifies an additional Axis II diagnosis.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

g. S-33.0 Additional Axis II Diagnosis

Reporting Requirements

- Preferred - DSM-IV-TR Axis II code
- Acceptable - ICD-9-CM code
- Acceptable - 0000000 = No additional Diagnosis or Condition on Axis II
- Acceptable - 7999, IF there is not a valid DSM-IV-TR Axis II or ICD-9-CM code
- Not Acceptable - V7109
- Enter all letters and/or numbers
- Do not enter decimal points
- Do not enter blanks

II. Changes to CSI with MHSA & DIG

D. Diagnosis

h. S-34.0 General Medical Condition Summary Code

Services Prior 07/01/06: Not Applicable

Services On or After 07/01/06: S-34.0 General Medical
Condition Summary Code

S-34.0 General Medical Condition Summary Code

Purpose

Identifies up to three General Medical Condition
Summary Codes from a set list that
most closely identify the
client's general medical condition(s), if any.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

h. S-34.0 General Medical Condition Summary Code

Reporting Requirements

- Do not report General Medical Condition Diagnosis (S- 35.0)
IF reporting General Medical Condition Summary Code(s)
- Acceptable - Report up to three General Medical Condition
Summary Code(s)

II. Changes to CSI with MHSA & DIG

D. Diagnosis

h. S-34.0 General Medical Condition Summary Code

VALID CODES:

Select up to three codes from the list of general medical conditions below:

01	=	Arterial Sclerotic Disease	21	=	Osteoporosis
02	=	Heart Disease	22	=	Cancer
03	=	Hypercholesterolemia	23	=	Blind / Visually Impaired
04	=	Hyperlipidemia	24	=	Chronic Pain
05	=	Hypertension	25	=	Deaf / Hearing Impaired
06	=	Birth Defects	26	=	Epilepsy / Seizures
07	=	Cystic Fibrosis	27	=	Migraines
08	=	Psoriasis	28	=	Multiple Sclerosis
09	=	Digestive Disorders (Reflux, Irritable Bowel Syndrome)	29	=	Muscular Dystrophy
10	=	Ulcers	30	=	Parkinson's Disease
11	=	Cirrhosis	31	=	Physical Disability
12	=	Diabetes	32	=	Stroke
13	=	Infertility	33	=	Tinnitus
14	=	Hyperthyroid	34	=	Ear Infections
15	=	Obesity	35	=	Asthma
16	=	Anemia	36	=	Sexually Transmitted Disease (STD)
17	=	Allergies	37	=	Other
18	=	Hepatitis			
19	=	Arthritis	99	=	Unknown / Not Reported General Medical Condition
20	=	Carpal Tunnel Syndrome	00	=	No General Medical Condition

II. Changes to CSI with MHSA & DIG

D. Diagnosis

i. S-35.0 General Medical Diagnosis

Services Prior 07/01/06: S-11.0 Additional Mental or
Physical Health Diagnosis

Services On or After 07/01/06: S-35.0 General Medical
Condition Diagnosis

S-35.0 General Medical Condition Diagnosis

Purpose

Identifies up to three general medical condition diagnoses
that most closely identify the
client's general medical condition(s), if any.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

i. S-35.0 General Medical Diagnosis

Reporting Requirements

- Do not report General Medical Condition Summary Code (S-34.0) IF reporting General Medical Condition Diagnosis
- Acceptable - DSM-IV-TR Axis III code(s)
- Acceptable - ICD-9-CM code(s)
- Acceptable - 0000000 = No General Medical Condition Diagnosis
- Acceptable - 7999
- Not Acceptable - V7109
- Enter all letters and/or numbers
- Do not enter decimal points

II. Changes to CSI with MHSA & DIG

D. Diagnosis

j. S-36.0 Axis-V / GAF

Services Prior 07/01/06: Periodic Record P-04.0 Axis-V/GAF

Services On or After 07/01/06: S-36.0 Axis-V / GAF Rating

S-36.0 Axis-V/GAF Rating

Purpose

Identifies the Global Assessment of Functioning (Axis-V / GAF) Rating.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

j. S-36.0 Axis-V / GAF

Reporting Requirements

- Acceptable - 001 through 100 = Valid Axis-V / GAF Rating
- Acceptable - 000 = Unknown/Inadequate Information for Axis-V / GAF Rating
- Acceptable - 000 IF Axis-V / GAF rating cannot be determined

II. Changes to CSI with MHSA & DIG

D. Diagnosis

k. S-37.0 Substance Abuse / Dependence

Services Prior 07/01/06: Periodic Record P-05.0

Other Factors Affecting Mental Health- Substance Abuse

Services On or After 07/01/06: S-37.0 Substance Abuse /
Dependence

S-37.0 Substance Abuse / Dependence

Purpose

Identifies whether or not the client has a
substance / dependence issue.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

k. S-37.0 Substance Abuse / Dependence

Reporting Requirements

- Acceptable - Y = Yes, the client has a substance abuse / dependence issue
- Acceptable - N = No, the client does not have a substance abuse / dependence issue
- Acceptable - U = Unknown / Not Reported

II. Changes to CSI with MHSA & DIG

D. Diagnosis

I. S-38.0 Substance Abuse / Dependence Diagnosis

Services Prior 07/01/06: Not Applicable

Services On or After 07/01/06: S-38.0 Substance Abuse /
Dependence Diagnosis

S-38.0 Substance Abuse / Dependence Diagnosis
Purpose

Identifies the client's substance abuse /
dependence diagnosis, if any.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

I. S-38.0 Substance Abuse / Dependence Diagnosis

Reporting Requirements

- Preferred - DSM-IV-TR Axis I code
- Acceptable - ICD-9-CM code
- Acceptable - V7109 and 7999, IF there is not a valid DSM-IV-TR Axis I or ICD-9-CM code
- Acceptable - 0000000 = No substance Abuse / Dependence Diagnosis
- Enter all letters and/or numbers
- Do not enter decimal points
- Do not enter blanks

II. Changes to CSI with MHSA & DIG

D. Diagnosis

m. Diagnosis Reporting Examples

Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code			GMC Diagnosis			Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
3004	Y	0000000	V7109	N	0000000	00						057	N	0000000

VALID: The Axis I Diagnosis is reported and identified as the Primary Diagnosis.
No other diagnosis information, except the Axis-V / GAF Rating, is reported.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

m. Diagnosis Reporting Examples

Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code			GMC Diagnosis			Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
2973	Y	29012	7999	N	0000000	27						059	N	0000000

VALID: The Axis I Diagnosis is reported and identified as the Primary Diagnosis. The record also contains an Additional Axis I Diagnosis, a 7999 (Diagnosis Deferred on Axis II) code in the Axis II Diagnosis, a GMC Summary Code, and an Axis-V / GAF Rating.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

m. Diagnosis Reporting Examples

Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code			GMC Diagnosis			Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
29622	N	7999	V7109	Y	0000000				0000000			059	Y	0000000

INVALID: The Axis II Primary is coded 'Y' and the Axis II Diagnosis is coded V7109 (NO Diagnosis on Axis II). If the Axis II Primary is coded 'Y', then the Axis II Diagnosis must not be coded V7109.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

m. Diagnosis Reporting Examples

Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code			GMC Diagnosis			Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
3010	N	3007	7999	U	0000000	36	02					000	U	7999

INVALID: The diagnosis in the Axis I Diagnosis is not valid. The Axis I Diagnosis must be a valid DSM-IV-TR Axis I or ICD-9-CM code within the DSM-IV-TR Axis I Clinical Disorders/Other Conditions That May Be of Focus of Clinical Attention classification. 3010 is a DSM-IV-TR Axis II Diagnosis Code.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

m. Diagnosis Reporting Examples

Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code			GMC Diagnosis			Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
7999	N	7999	3019	Y	0000000				1701	7063	7865	068	Y	30480

VALID: The Axis I Diagnosis and Axis II Diagnosis are reported, with the Axis II Diagnosis identified as the Primary Diagnosis. The record also contains 7999 (Diagnosis or Condition Deferred on Axis I) code in the Additional Axis I Diagnosis, multiple GMC Diagnoses, and Axis-V / GAF Rating, a Substance Abuse / Dependence issue, and a Substance Abuse / Dependence Diagnosis.

II. Changes to CSI with MHSA & DIG

D. Diagnosis

m. Diagnosis Reporting Examples

Axis I DX	Axis I Primary	Add'l Axis I DX	Axis II DX	Axis II Primary	Add'l Axis II DX	GMC Summary Code	GMC Diagnosis	Axis-V / GAF Rating	Substance Abuse / Dependence	Substance Abuse / Dependence DX
29532	Y	0000000	V7109	N	0000000	00	0000000	062	N	0000000

INVALID: The GMC Summary Code field must be blank if the GMC Diagnosis field contains data. For each Service record, utilize either the GMC Summary Code field or GMC Diagnosis field to report general medical condition information to CSI, but not both fields within the same Service record.



E. Reporting Evidence-Based Practices and Service Strategies to CSI

Managing Changes to CSI (CSI Training II)

Covered in this section of today's presentation

1. Overall objectives of reporting these data
2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting
3. Federal resources defining these EBPs and their implementation
4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting
5. Examples of how reporting may be implemented

Covered in this section of today's presentation

1. Overall objectives of reporting these data
2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting
3. Federal resources defining these EBPs and their implementation
4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting
5. Examples of how reporting may be implemented

Not covered in this presentation

There is no state-defined method to implement or identify an Evidence-Based Practice.

We will discuss the material published by SAMHSA on these EBPs. Counties are required to use federal resources on EBPs as available. For those EBPs that do not have federal resources, research literature and other sources of expertise may be used.

There will be opportunities at the Regional Conferences in the next few months to share with other counties implementation strategies for EBPs including those EBPs identified for reporting to CSI.

Not covered in this presentation

There is no State-defined method to determine if a county program or service reflects a specific service strategy.

Each county has the responsibility of determining how service strategies will be identified for reporting to CSI. We will discuss some examples of how counties may do this.

1. Overall objectives of reporting these data

- a. Objective of reporting federally-identified EBPs
- b. Objective of reporting Service Strategies

1. Overall objectives of reporting these data

a. Objective of reporting federally-identified EBPs

The Uniform Reporting System (URS) of the SAMHSA Block Grant includes two tables focused on EBPs. For the reporting year 2003 and 2004, nine EBPs focused on care for adults and children were identified for reporting.

California has not yet fulfilled the reporting requirements for EBPs in the Block Grant.

1. Overall objectives of reporting these data

a. Objective of reporting federally-identified EBPs

The five adult care EBPs already identified for reporting in the URS tables are:

- Assertive Community Treatment
- Supported Housing
- Supported Employment
- Illness Management and Recovery
- Integrated Dual Diagnosis Treatment

1. Overall objectives of reporting these data

a. Objective of reporting federally-identified EBPs

The four EBPs focused on care for children already identified for reporting in the URS tables are:

- Therapeutic Foster Care
- Multisystemic Therapy
- Functional Family Therapy
- Family Psychoeducation

1. Overall objectives of reporting these data

a. Objective of reporting federally-identified EBPs

The following two EBPs are to be added for reporting year 2005 or 2006:

- Medication Management Approaches in Psychiatry
- New Generation Medications

1. Overall objectives of reporting these data

b. Objective of reporting Service Strategies

The service strategies identified for reporting to CSI were selected based on the MHSA process and the CSS plans submitted by the counties.

This provides the counties with the opportunity to describe the progressive strategies reflected in their programs/services, responding to the transformational vision of MHSA and the needs expressed by their consumers.

1. Overall objectives of reporting these data

b. Objective of reporting Service Strategies

Service strategies are intended as modifiers of the service mode and service function data fields. However, we recognize that the definitions given for service strategies are general. We anticipate that there may be variability in how reporting on this data field will be implemented, both within and between counties.

1. Overall objectives of reporting these data

b. Objective of reporting Service Strategies

Question: Why not wait until the definitions for service strategies have been refined before introducing the field as a CSI reporting requirement?

Answer: Data are needed to help inform the process of refining these definitions. We need more information about the kind of services being provided. In the end, this process of implementing the reporting of service strategies in this way should result in a more valid and more useful field.

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

EBP (*code*)

Assertive Community Treatment (01)

Supportive Employment (02)

Supportive Housing (03)

Family Psychoeducation (04)

Integrated Dual Diagnosis Treatment (05)

Illness Management and Recovery (06)

Medication Management (07)

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

EBP (*code*) cont'd

New Generation Medications (08)

Therapeutic Foster Care (09)

Multisystemic Therapy (10)

Functional Family Therapy (11)

Unknown EBP value (99)

NB. There is no separate 'Other EBP' value.

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

Question: Why is there no way to report an EBP that is not on the list of those EBPs that are federally identified for reporting?

Answer: We have not offered an 'Other EBP' value, because there is currently no way to pass those data on in the Uniform Reporting System. For services from EBPs not on the list, counties may use the service strategies to characterize the core components of the program.

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

Assertive Community Treatment

A team-based approach to the provision of treatment, rehabilitation, and support services.

Core components include:

- Small caseloads
- Team approach
- Full responsibility for treatment services
- Community-based services
- Assertive engagement mechanisms
- Role of consumers and/or family members on treatment team

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

Supportive Employment

Services that promote rehabilitation and a return to productive employment for persons with serious mental illness.

Core components include:

- Vocational services staff
- Integration of rehabilitation with mental health treatment
- No exclusion criteria
- Rapid search for competitive jobs
- Jobs as transition
- Follow-along supports

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

Supportive Housing

Services to assist individuals in finding and maintaining appropriate housing arrangements and independent living situations.

Criteria include:

- Housing choice
- Functional separation of housing from service provision
- Affordability
- Integration (with persons who do not have mental illness)
- The right to tenure
- Service choice
- Service individualization

- Service availability

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

Family Psychoeducation

Offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through active involvement of family members in treatment and management.

Core components include:

- Family Intervention Coordinator
- Quality of clinician-family alliance
- Education curriculum
- Structured problem-solving technique

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

Integrated Dual Diagnosis

Treatments that combine or integrate mental health and substance abuse interventions at the level of the clinical encounter.

Core components include:

- Multidisciplinary team
- Stage-wise interventions
- Substance abuse counseling
- Outreach and secondary interventions

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

Illness Management and Recovery

A practice that includes a broad range of health, lifestyle, self-assessment and management behaviors by the client, with the assistance and support of others.

Core components include:

- Comprehensiveness of the curriculum
- Illness Management Recovery goal setting
- Cognitive-behavioral techniques
- Relapse prevention training

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

Medication Management

A systematic approach to medication management for severe mental illnesses that includes the involvement of consumers, families, supporters, and practitioners in the decision-making process. Includes monitoring and recording of information about medication results.

Critical elements include:

- Utilization of a systemic plan for medication management
- Objective measures of outcome are produced
- Documentation is thorough and clear
- Consumers/family and practitioners share in the decision-making

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

New Generation Medications

A practice that tracks adults with a primary diagnosis of schizophrenia who received atypical second generation medications (including Clozapine) during the reporting year.

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

Therapeutic Foster Care

Services for children within private homes of trained families. The approach combines the normalizing influence of family-based care with specialized treatment interventions, thereby creating a therapeutic environment in the context of a nurturant family home.

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

Multisystemic Therapy

A practice that views the individual as nestled within a complex network of interconnected systems (family, school, peers). The goal is to facilitate and promote individual change in this natural environment. The caregiver(s) is viewed as the key to long-term outcomes.

2. Evidence-Based Practices (EBPs) identified by CMHS for federal reporting

Functional Family Therapy

A program designed to enhance protective factors and reduce risk by working with both the youth and their family. Phases of the program are engagement, motivation, assessment, behavior change, and generalization.

3. Federal resources defining these EBPs and their implementation

Federally published material available on these EBPs:

Assertive Community Treatment

[SAMHSA Toolkit](#)

(to open this hyperlink, highlight “SAMHSA Toolkit” and right-click, then select Open Hyperlink on the menu)

Supportive Employment also called Supported Employment

[SAMHSA Toolkit](#)

Family Psychoeducation

[SAMHSA Toolkit](#)

3. Federal resources defining these EBPs and their implementation

Federally published material available on these EBPs (cont'd):

Integrated Dual Diagnosis Treatment

[SAMHSA Toolkit](#)

Illness Management and Recovery

[SAMHSA Toolkit](#)

Medication Management Approaches in Psychiatry

[Incomplete SAMHSA Toolkit](#)

[NRI Fidelity Scale](#)

[Draft SAMHSA Fidelity Scale](#)

3. Federal resources defining these EBPs and their implementation

Research literature characterizes these EBPs:

Supported Housing

New Generation Medications

Therapeutic Foster Care

Multisystemic Therapy

Functional Family Therapy

3. Federal resources defining these EBPs and their implementation

Example of SAMHSA Toolkit:

Assertive Community Treatment

- Implementation Resource Kit User's Guide
- Assertive Community Treatment Literature Review
- Implementation Tips for
 - Consumers
 - Family members
 - Clinicians
 - Mental Health Program Leaders and Authorities
- Use of Fidelity Scales in EBPs
- **Assertive Community Treatment Fidelity Scale**
- Statement on Cultural Competence
- Implementing Assertive Community Treatment Workbook

3. Federal resources defining these EBPs and their implementation

Example of SAMHSA Toolkit:

Assertive Community Treatment

A team-based approach to the provision of treatment, rehabilitation, and support services.

Core components include:

- **Small caseloads**
- **Team approach**
- **Full responsibility for treatment services**
- **Community-based services**
- **Assertive engagement mechanisms**
- **Role of consumers and/or family members on treatment team**

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

Contents:

- ACT Overview
- Overview of the Scale
- What is Rated
- Unit of Analysis
- How the Rating is Done
- How to Rate a Newly-Established Team
- How to Rate Programs Using Other Program Models
- Who Does the Ratings
- Missing Data

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

ACT Overview

As an evidence-based psychiatric rehabilitation practice, ACT provides a comprehensive approach to service delivery to consumers with severe mental illness (SMI). ACT uses a multidisciplinary team, which typically includes a psychiatrist, a nurse, and at least two case managers. (p.3, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

ACT Overview (cont'd)

ACT is characterized by (1) low client to staff ratios; (2) providing services in the community rather than in the office; (3) shared caseloads among team members; (4) 24-hour staff availability; (5) direct provision of all services by the team (rather than referring consumers to other agencies); and (6) time-unlimited services. (p.3, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

ACT Overview of the Scale

The ACT Fidelity Scale contains 28 program-specific items.

The scale has been developed to measure the adequacy of implementation of ACT programs. Each item on the scale is rated on a 5-point scale ranging from 1 (“Not implemented”) to 5 (“Fully implemented”).

(p.3, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

ACT Overview of the Scale (cont'd)

The standards used for establishing the anchors for the “fully-implemented” ratings were determined through a variety of expert sources as well as empirical research. The scale items fall into three categories: human resources (structure and composition); organizational boundaries; and nature of services. (p.3, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

What is Rated

The scale ratings are based on current behavior and activities, not planned or intended behavior. For example, in order to get full credit for Item O4 (“responsibility for crisis services”), it is not enough that the program is currently developing an on-call program. (p.3, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

Unit of Analysis

The scale is appropriate for organizations that are serving clients with SMI and for assessing adherence to evidence-based practices, specifically for an ACT team. If the scale is to be used at an agency that does not have an ACT team, a comparable service unit should be measured (e.g., a team of intensive case managers in a community support program). The DACTS measures fidelity at the team level rather than at the individual or agency level (p.3, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

- Fidelity Assessor Checklist
- Item-Level Protocol
 - Human Resources (11 items)
 - Organization Boundaries (7 items)
 - Nature of Services (10 items)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

Human Resources

Item H2. Team Approach

Definition: Provider group functions as a team; clinicians know and work with all clients.

Rationale: The entire team shares responsibility for each client; each clinician contributes expertise as appropriate. The team approach ensures continuity of care for clients, and creates a supportive organizational environment for practitioners. (p.11, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

Human Resources

Item O1. Explicit admission criteria

Definition: The program has a clearly identified mission to serve a particular population; it uses measurable and operationally defined criteria to screen out inappropriate referrals. Admission criteria should be pointedly targeted toward the individuals who typically do not benefit from usual services. (p.20, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

Human Resources

Item O1. Explicit admission criteria

Definition: Examples of more specific admission criteria that might be suitable include:

- Pattern of frequent hospital admissions
- Frequent use of emergency services
- Individuals discharged from long-term hospitalizations
- Co-occurring substance use disorders

(p.20, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

Human Resources

Item O1. Explicit admission criteria

Definition: Examples of more specific admission criteria that might be suitable include: (*cont'd...*)

- Homeless
- Involvement with the criminal justice system
- Not adhering to medications as prescribed
- Not benefiting from usual mental health services (e.g., day treatment.)

(p.20, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

Human Resources

Item O1. Explicit admission criteria

Rationale: ACT is best suited to clients who do not effectively use less intensive mental health services.

Sources of Information: (includes specific questions)

Team leader interview

Clinician interview

Internal records

(p.20-21, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

Human Resources

Item S1. Community-based services

Definition: Program works to monitor status, develop skills in the community, rather than in office.

Rationale: Contacts in natural settings (i.e. where clients live, work, and interact with other people) are thought to be more effective than when they occur in hospital or office settings, as skills may not transfer well to natural settings.

(p.26, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

Human Resources

Item S1. Community-based services

Rationale: (cont'd...) Furthermore, more accurate assessment of the client can occur in his or her community setting because the clinician can make direct observations rather than relying on self-report. Medication delivery, crisis intervention, and networking are more easily accomplished through home visits.

(p.26, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit:

Assertive Community Treatment Fidelity Scale

Human Resources

Item S1. Community-based services

Sources of Information: (includes specific questions)

Chart review

Review of internal reports

Clinician interview

Client interview

Item Response Coding: If at least 80% of total service time occurs in the community, the item is coded as a '5'.

(p.26-27, ACT Fidelity Scale, SAMHSA, 2003)

3. Federal resources defining these EBPs and their implementation

SAMHSA Toolkit

These extracts are from the materials published by SAMHSA on the Assertive Community Treatment EBP.

This and the other SAMHSA EBP toolkits are available on the Internet.

It is the county's responsibility to decide how best to make use of these and other available resources and materials to report EBPs to CSI.

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Service Strategies (*code*):

Peer and/or Family Delivered Services (50)

Psychoeducation (51)

Family Support (52)

Supportive Education (53)

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Service Strategies (*code*):

Delivered in Partnership with Law Enforcement (54)

Delivered in Partnership with Health Care (55)

Delivered in Partnership with Social Services (56)

Delivered in Partnership with Substance Abuse Services
(57)

Integrated Services for Mental Health and Aging (58)

Integrated Services for Mental Health and Developmental
Disability (59)

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Service Strategies (*code*):

Ethnic-Specific Service Strategy (60)

Age-Specific Service Strategy (61)

Unknown Service Strategy (99)

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Peer and/or Family Delivered Services (50)

Services and supports provided by clients and family members who have been hired as treatment program staff, or who provide adjunct supportive or administrative services, such as training, information dissemination and referral, support groups and self-help support and empowerment. Please note that if the service/support is to be reimbursed by Medi-Cal, client and family member staff duties and credentials must meet Medi-Cal provider certification requirements.

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Psychoeducation (51)

Services that provide education about:

- Mental health diagnosis and assessment
- Medications
- Services and support planning
- Treatment modalities
- Other information related to mental health services and needs

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Family Support (52)

Services provided to a client's family member(s) in order to help support the client.

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Supportive Education (53)

Services that support the client toward achieving educational goals with the ultimate aim of productive work and self-support.

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Delivered in Partnership with Law Enforcement (54) (includes courts, probation etc.)

Services that are integrated, interdisciplinary and/or coordinated with law enforcement, probation or courts (e.g., mental health courts, jail diversion programs, etc.) for the purpose of providing alternatives to incarceration/detention for those with mental illness/emotional disturbance and criminal justice system involvement.

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Delivered in Partnership with Health Care (55)

Integrated, interdisciplinary and/or coordinated physical and mental health services, including co-location and/or collaboration between mental health and primary care providers, and/or other health care sites.

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Delivered in Partnership with Social Services (56)

Integrated, interdisciplinary and/or coordinated social services and mental health services, including co-location and/or collaboration between mental health and social services providers.

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Delivered in Partnership with Substance Abuse Services (57)

Integrated, interdisciplinary and/or coordinated substance use services and mental health services, including co-location and/or collaboration between mental health providers and agencies/providers of substance use services. This strategy is distinguished from the Federal evidence-based practice, “Integrated Dual Diagnosis Treatment”, in that for this strategy the integration does not need to occur at the level of the clinical encounter.

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Integrated Services for Mental Health and Aging (58)

Integrated, interdisciplinary and/or coordinated services for mental health and issues related to aging, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to the aging (e.g., health, social, community service providers, etc).

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Integrated Services for Mental Health and Developmental Disability (59)

Integrated, interdisciplinary and/or coordinated mental health services and services for developmental disabilities, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to developmental disabilities.

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Ethnic-specific service strategy (60)

Culturally appropriate services that reach and are tailored to persons of diverse cultures in order to eliminate disparities. Includes ethnic-specific strategies and community cultural practices such as traditional practitioners, natural healing practices, and ceremonies recognized by communities in place of, or in addition to, mainstream services.

4. Service Strategies defined by the State Department of Mental Health (DMH) for reporting

Age-specific service strategy (61)

Age-appropriate services that reach and are tailored to specific age groups in order to eliminate disparities. Age-specific strategies should promote a wellness philosophy including the concepts of both recovery and resiliency.

5. Examples of how EBP and service strategy reporting may be implemented

Evidence-Based Practices

Examples of Reporting Method

- When considering a given service, first consider whether the service is part of an Evidence-Based Practice (EBP); then consider if the service reflects any underlying Service Strategies.
- When considering whether a service is part of an EBP, look for a program-level effort to provide the core components of the specific EBP, and a generally accepted measure of fidelity to the EBP.
- It is unusual for a service to be part of more than one EBP.

5. Examples of how EBP and service strategy reporting may be implemented

Evidence-Based Practices

Examples of Reporting Method (cont'd)

- It may be helpful to consider assigning EBPs to entire county programs with the assistance of county program staff.

5. Examples of how EBP and service strategy reporting may be implemented

Evidence-Based Practices

Examples of Reporting Method (cont'd)

- Fidelity measures from the SAMHSA toolkits or the clinical literature may be used by the county to measure the degree to which a program has fidelity to the core components of that EBP

5. Examples of how EBP and service strategy reporting may be implemented

Evidence-Based Practices

Examples of Reporting Method (cont'd)

- It is entirely possible that no county programs will qualify as EBPs that have been identified by SAMHSA for reporting.

5. Examples of how EBP and service strategy reporting may be implemented

Evidence-Based Practices

Example of Reporting Method (cont'd)

- For example, a county has a program that may qualify as an Assertive Community Treatment (ACT) program.
- The county program staff examine the fidelity scale supplied in the SAMHSA toolkit. They decide that it is worth administering the fidelity scale. They determine a cut-off score, above which the program will qualify as an ACT EBP.
- The fidelity scale is administered. The results indicate that this program does qualify as an ACT EBP. All services provided by this program are now reported as ACT services to CSI

5. Examples of how EBP and service strategy reporting may be implemented

Evidence-Based Practices

Examples of Reporting Method (cont'd)

- A second county has a program that may qualify as an Assertive Community Treatment (ACT) program.
- The county program staff examine the fidelity scale supplied in the SAMHSA toolkit. They decide that given their knowledge of the county program, the program does not qualify as an ACT program because it is missing some key components.
- However, they make note of their research, indicating that should these other components be filled, it may be worth applying the fidelity scale.

5. Examples of how EBP and service strategy reporting may be implemented

Evidence-Based Practices

Examples of Reporting Method (cont'd)

- A third county has a program that has been designed to be an Assertive Community Treatment (ACT) program.
- The program is early in its implementation, so many core components are still missing. The county program staff are using the SAMHSA ACT fidelity scale for their program to track progress in implementation.
- The county program staff decide on a cut-off above which they consider the program to qualify as an ACT EBP. The program is not yet there, but may qualify in six months. Services for this program will not yet be reported as an EBP, but will be once the program qualifies using the county's fidelity measures.

5. Examples of how EBP and service strategy reporting may be implemented

Service Strategies

Examples of Reporting Method

- If the service in question has already been described as part of an EBP (see above), then there is no need to report the same components of the service as Service Strategies. However, Service Strategies may be used to describe strategies reflected in the service that are not captured by the EBP.
- Any given service may reflect none of the progressive service strategies described here, one service strategy, or more than one service strategy.

5. Examples of how EBP and service strategy reporting may be implemented

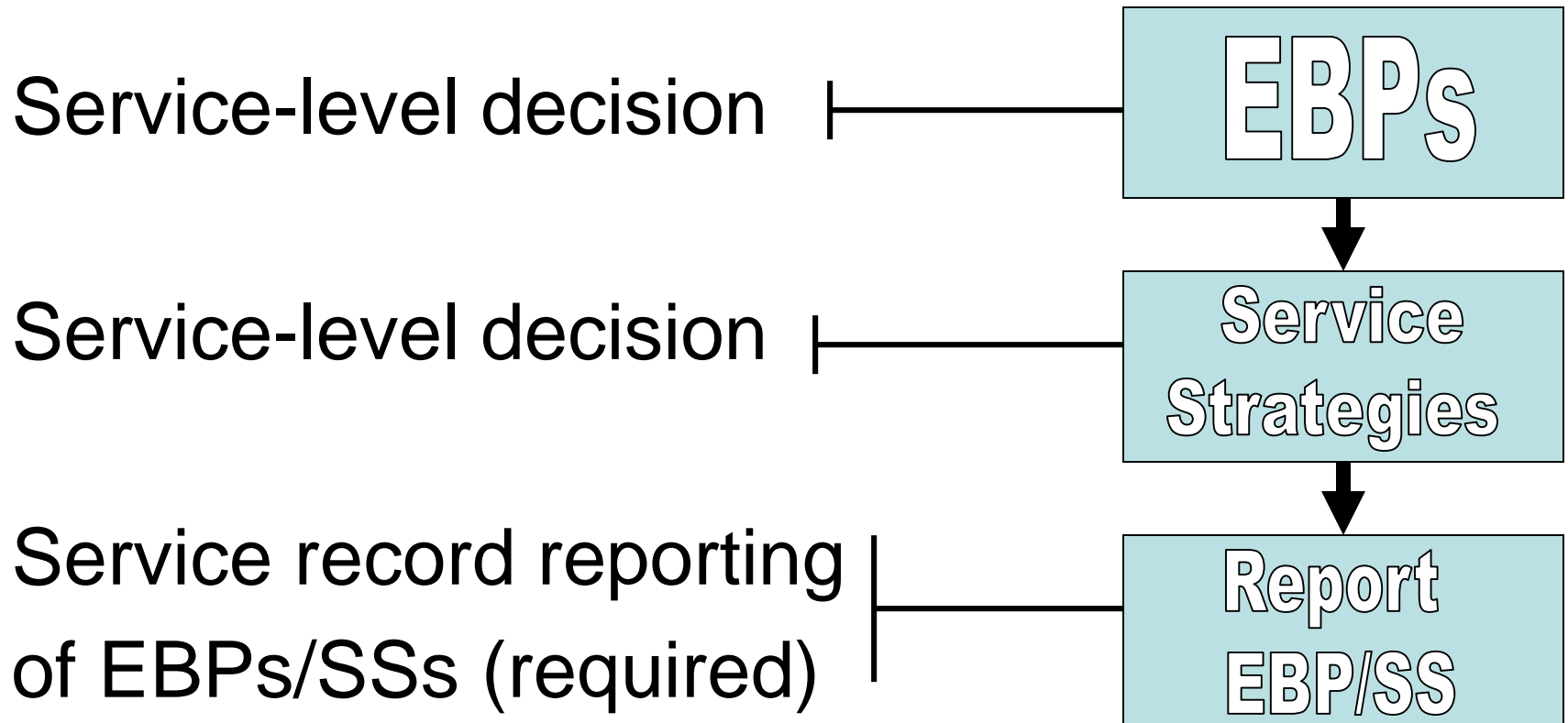
When considering the assignment of a service to EBPs and service strategies, EBPs should be considered first, and service strategies second.

Strategies captured in an EBP that is applicable to a service, do not also need to be reported in a service strategy.

However, there are no edits on the relationships between EBPs and Service Strategies.

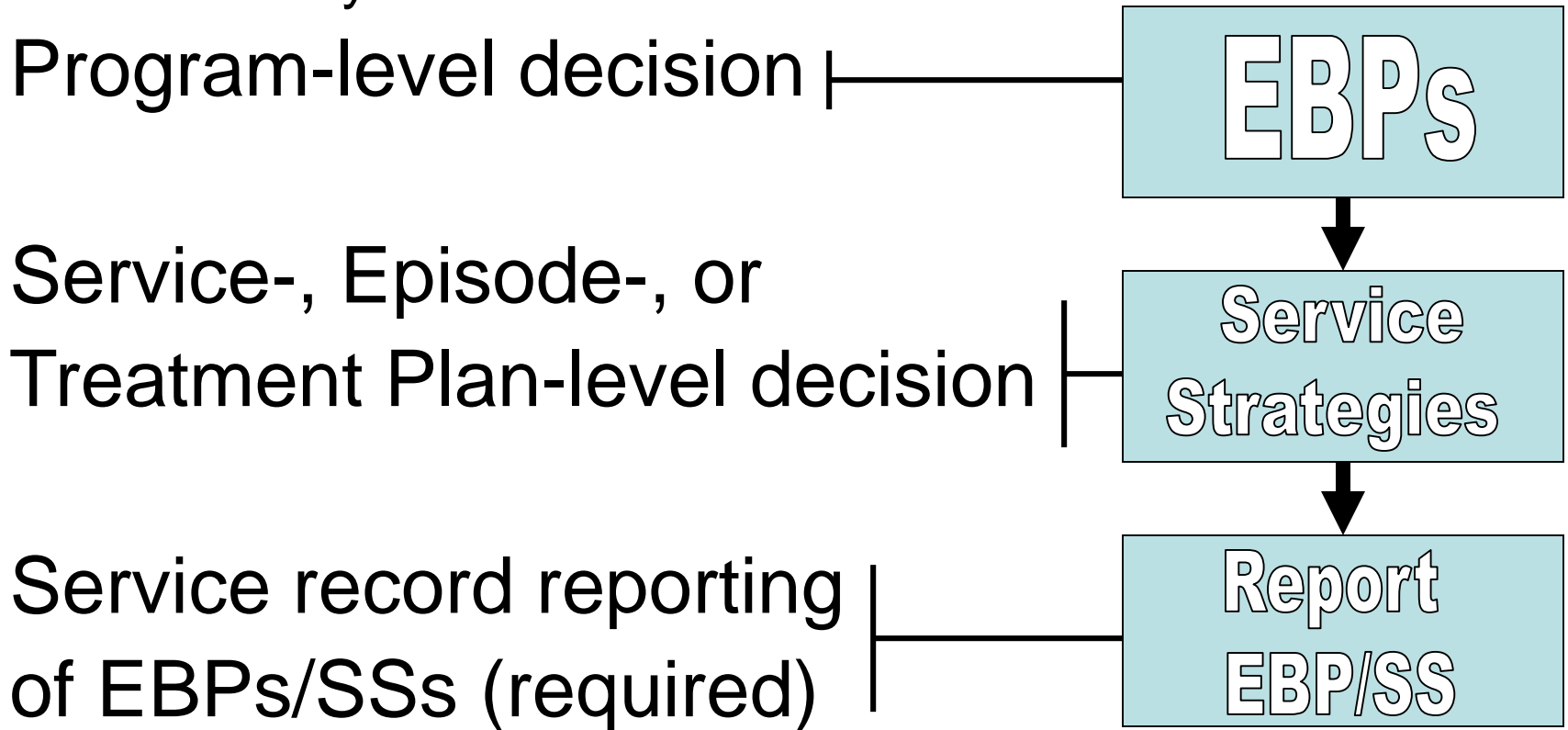
5. Examples of how EBP and service strategy reporting may be implemented

Example i. Possible design EBP/SS decision flow :



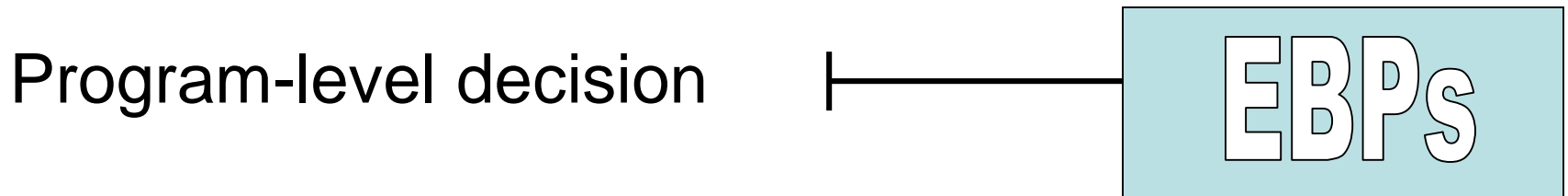
5. Examples of how EBP and service strategy reporting may be implemented

Example ii. Possible design EBP/SS decision flow for efficiency:



5. Examples of how EBP and service strategy reporting may be implemented

Example ii. Possible design EBP/SS decision flow for efficiency:



EBPs are well-suited for consideration at the program-level. EBP is a program that incorporates core components and that use fidelity measures to examine adherence to these components. All services within the EBP should be assigned to that EBP in reporting.

Counties may choose to introduce reporting of EBPs at whatever level(s) they consider to be best for accuracy and efficiency of reporting.

5. Examples of how EBP and service strategy reporting may be implemented

Example ii. Possible design EBP/SS decision flow for efficiency:

Service-, Episode-, or
Treatment Plan-level decision



Service Strategies will vary as to what level they are suited for assignment.

For example, a treatment plan entirely geared to care for a child could be have the Age-Specific service strategy (61) assigned at the treatment plan level.

On the other hand, treatment of a transition-age youth might involve some services that are geared toward his age-group (assigned the Age-Specific service strategy). Other services for the same client, such as meds support, may be generic adult services (not assigned the Age-Specific service strategy).

Counties may choose to introduce reporting of service strategies at whatever levels they consider to be best for accuracy and efficiency of reporting. 157

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example a: Description

The county provides a program serving transitional age youth (TAY) with involvement with law enforcement. There is no effort at the program level to adhere to the practices of a specific evidence-based strategy. The program as a whole reflects some service strategies, including Family Support (52), Supportive Education (53), and Age-Specific (61) service strategies. The treatment plan for this client was formed in conjunction with the approval and support of the client's probation officer. This specific service provides counseling to the client to prepare the client to re-enter an educational environment with the goal of obtaining a vocational certificate while on probation.

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example a: Example of Decision Flow

- As there is no program-level effort to adhere to a specific EBP, no EBP code is assigned.
- The age-specific nature of the service and program indicates that an Age-Specific service strategy (61) underlies this service.
- Although this program does include services that are designed to help the client's family support the client, this particular service is directed solely at the client, so the Family Support service strategy (52) is not appropriate.
- This service is provided with the support of the client's parole officer and with the knowledge of the court, so the Delivered in Partnership with Law Enforcement (54) strategy underlies this service.

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example a: Example of Coding

S-25.0 EBPs/Service Strategies: 6154 ____

- Note that the order that these codes are reported is not significant and will not be used to assign priority or importance.
- Note also that in the recommended decision flow, the EBPs are considered first, and service strategies are considered second.

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example b: Description

The county provides an AB2034 program serving individuals who have been recently discharged from psychiatric hospitals, state hospitals or prisons and are currently homeless or at high risk of homelessness. This program is best described as an Assertive Community Treatment (ACT) Program, including the core components of small caseloads, team approach, full responsibility for treatment services, community-based services, assertive engagement mechanisms, and a role for consumers on the treatment team. Substance abuse treatment and secure and independent housing for consumers are important objectives of the program. In addition, there is a program-wide effort to measure fidelity of the program practices to the evidence-based practices described in Assertive Community Treatment (using the fidelity scale from the SAMHSA toolkit) .

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example b: Example of Decision Flow

- The results from the SAMHSA ACT fidelity scale satisfy the county program staff that the treatment teams in this AB2034 program meet the criteria of an ACT evidence-based practice; therefore all services in this program are assigned the ACT EBP.
- Housing for consumers is an important objective of this program. Housing is a core component of ACT, therefore, the Assertive Community Treatment (01) is a more complete description of the program than the Supportive Housing EBP (03).

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example b: Example of Decision Flow

- Substance abuse treatment for consumers is an important objective of this program. Treatment for substance abuse is a core component of ACT; therefore, the Assertive Community Treatment (01) is a more complete description of the program than the Integrated Dual Diagnosis Treatment EBP (05).

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example b: Example of Coding

S-25.0 EBPs/Service Strategies: 01 ____ ____

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example c: Description

The county provides cognitive-behavioral group therapy sessions for consumers in the psychiatric ward of the local hospital. These sessions include some education of the consumers on mental health diagnosis and assessment.

There is no long-term follow-up treatment of the consumers after they are released from the inpatient setting. There is no effort at the program level to adhere to the practices of a specific evidence-based strategy, although the program contains some core components of the EBP Illness Management and Recovery (06) such as cognitive-behavioral techniques, and self-assessment of behaviors by client.

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example c: Example of Decision Flow

- This service contains some components of the Illness Management and Recovery (06) EBP; however, the service is part of a program that is much smaller in scope than an EBP.
- The service does reflect the service strategy of Psychoeducation (51) involving the education of the consumer on mental health diagnosis and assessment.

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example c: Example of Coding

S-25.0 EBPs/Service Strategies: 51 ____ ____

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example d: Description

The county provides cognitive-behavioral group therapy sessions for consumers in the psychiatric ward of the local hospital. These sessions include some education of the consumers on mental health diagnosis and assessment.

This service is part of an outpatient program in which an eligible consumer will receive extensive and comprehensive psychoeducation and training on illness management and relapse-prevention. In addition to the training and education, consumers form recovery goals and participate in cognitive-behavioral therapy to achieve those goals. There is a program-level effort to include the core components of the EBP, Illness Management and Recovery (06), and to measure the fidelity of the program to these core components using the SAMHSA fidelity scale.

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example d: Example of Decision Flow

- This service contains the components of the Illness Management and Recovery (06) EBP and includes a program-level effort to measure fidelity to these components.
- Although the service does reflect the service strategy of Psychoeducation (51), the EBP Illness Management and Recovery covers this strategy, so there is no need to report the strategy separately.

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example d: Example of Coding

S-25.0 EBPs/Service Strategies: 06 ____ ____

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example e: Description

The county provides crisis intervention services to consumers who call in to a mental health crisis hot-line. The mandate of the hot-line is to provide emotional support to callers and educate them as to sources of mental health treatment and support. The service is offered in English and in Spanish. The specific service is in Spanish.

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example e: Example of Decision Flow

- There is no program-level effort to adhere to any EBP, so no EBP is applicable.
- The service strategy Psychoeducation (51) is reflected in the educational objectives of the service.
- The service was provided in Spanish in response to the caller's language preference. This reflects an Ethnic-Specific (60) service strategy. Note that the same type of service from the same program supplied in English and without any other accommodation of the ethnicity of the consumer would not be considered to reflect an Ethnic-Specific service strategy.

5. Examples of how EBP and service strategy reporting may be implemented

EBPs and Service Strategies

Examples of Reporting Method

Example e: Example of Coding

S-25.0 EBPs/Service Strategies: 51 60 ____



F. Reporting Other New Service Record Fields to CSI

Managing Changes to CSI (CSI Training II)

Covered in this section of today's presentation

1. Special Population (S-12.0)
2. Place of Service (S-24.0)
3. Trauma (S-26.0)
4. Client Index Number (CIN) (S-27.0)

1. Special Population (S-12.0)

Purpose: Identifies any special population services for statistical purposes.

Values: **(new values in bold)**

Individualized education plan (IEP) required service(s) (AB 3632)
Value = C

Welfare-to-work plan specified service(s) Value = W

Governor's Homeless Initiative (GHI) service(s) Value = G

Assisted Outpatient Treatment service(s) (AB 1421) Value = A

No special population service(s) Value = N

1. Special Population (S-12.0)

Purpose: Identifies any special population services for statistical purposes.

Only those services funded by these programs to clients enrolled in the programs should be reported under that special population code.

For example, the services to a client enrolled in an Individualized Education Plan IEP that are provided under the IEP would be reported under the Special Population code 'C'.

The services to a client enrolled in IEP that are NOT provided under the IEP would NOT be reported under the Special Population code 'C'

2. Place of Service (S-24.0)

Purpose: Identifies the location where the service was rendered.

Old values:

Office (including phone)	A
Field	B
Correction Institutions	C
Inpatient	D

2. Place of Service (S-24.0)

Purpose: Identifies the location where the service was rendered.

New values: (slide 1 of 3)

Office	A
Field (unspecified)	B
Correction Facility	C
Inpatient	D
Homeless/Emergency Shelter	E
Faith-based (e.g., church, temple)	F
Health Care / Primary Care	G

2. Place of Service (S-24.0)

Purpose: Identifies the location where the service was rendered.

New values: (slide 2 of 3)

Home	H
Age-Specific Community Center	I
Client's Job Site	J
Residential Care – Adults	L
Mobile Service	M
Non-Traditional service location	N
Other Community location	O

2. Place of Service (S-24.0)

Purpose: Identifies the location where the service was rendered.

New values: (slide 3 of 3)

Phone	P
Residential Care – Children	R
School	S
Telehealth	T
Unknown / Not Reported	U

2. Place of Service (S-24.0)

Definitions of New Values (slide 1 of 20)

A = Office [formerly “Office (including phone)”]

Definition: Services are provided in a location, other than a hospital, skilled nursing facility (SNF), correctional facility, public health clinic or facility supplying residential care, where the mental health professional routinely provides assessments, diagnosis, and mental health treatment on an ambulatory basis.

2. Place of Service (S-24.0)

Definitions of New Values (slide 2 of 20)

B = Field (unspecified) [formerly “Field (when location is away from the clinician’s usual place of business, except for Correctional Institution and Inpatient)”].

Definition: Services are provided in an unspecified location away from the clinician’s usual place of business, except for Correctional Institution, Inpatient, or Residential Care for adults or children.

2. Place of Service (S-24.0)

Definitions of New Values (slide 3 of 20)

C = Correctional Facility (eg., Jail, Prison, camp/ranch, etc.) [Formerly “Correctional Institution”]

Definition: Services are provided in a correctional facility, including adult or juvenile detention facilities.

2. Place of Service (S-24.0)

Definitions of New Values (slide 4 of 20)

D = Inpatient (e.g., Hospital, Psychiatric Health Facility (PHF), Skilled Nursing Facility (SNF), Institute for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC)).

Definition: Services are provided in a facility which primarily provides diagnostic, therapeutic, and rehabilitative services. Includes hospitals, psychiatric health facilities (PHFs), skilled nursing facilities (SNFs), Institutes for Mental Disease (IMDs), Mental Health Rehabilitation Centers (MHRCs).

2. Place of Service (S-24.0)

Definitions of New Values (slide 5 of 20)

E = Homeless / Emergency Shelter

Definition: Services are provided in a facility specifically designed to provide shelter to the general homeless population.

2. Place of Service (S-24.0)

Definitions of New Values (slide 6 of 20)

F = Faith-based (e.g., church, temple, etc.)

Definition: Services are provided in a location owned or leased by a faith group, with partial or full involvement of the faith group.

2. Place of Service (S-24.0)

Definitions of New Values (slide 7 of 20)

G = Health Care / Primary Care

Definition: Services are provided by the consumer's primary care or general health care provider, or in the clinic or facility of the health care provider, including emergency room and public health clinics.

2. Place of Service (S-24.0)

Definitions of New Values (slide 8 of 20)

H = Home

Definition: Services are provided at a location, other than a hospital or other facility, where the client receives care in a private residence.

2. Place of Service (S-24.0)

Definitions of New Values (slide 9 of 20)

I = Age-Specific Community Center

Definition: Services are provided in a location owned or leased by an age-specific community center, such as a senior's center, a teen drop-in center, etc.

2. Place of Service (S-24.0)

Definitions of New Values (slide 10 of 20)

J = Client's Job Site

Definition: Services are provided at the client's site of employment.

2. Place of Service (S-24.0)

Definitions of New Values (slide 11 of 20)

L = Residential Care – Adults

Definition: Services are provided in a location supplying 24-hr non-medical care for adults, not including inpatient hospital, psychiatric health facilities (PHFs), skilled nursing facilities (SNFs), Institutes for Mental Disease (IMDs), Mental Health Rehabilitation Centers (MHRCs), or homeless/emergency shelters. Includes assisted living facilities for adults such as group homes.

2. Place of Service (S-24.0)

Definitions of New Values (slide 12 of 20)

M = Mobile Service

Definition: This definition is consistent with the concept of a Mobile Clinic. Mobile clinics provide services to individuals in rural or outlying areas where services are otherwise inaccessible. The concept of mobile services is in contrast to services provided at other community locations (see other listed service settings) that are reached by vehicle.

2. Place of Service (S-24.0)

Definitions of New Values (slide 13 of 20)

N = Non-Traditional service location (e.g., park bench, on street, under bridge, abandoned building)

Definition: Services are provided in the community, but not in a community center, school, faith-based location, homeless/emergency shelter, health-care center, or the client's job site. Examples include park bench, on the street under a bridge, in an abandoned building, etc.

2. Place of Service (S-24.0)

Definitions of New Values (slide 14 of 20)

O = Other Community location

Definition: Services are provided in the community, but not in a homeless/emergency shelter, a faith-based location, home, the client's job site, a non-traditional service location, an age-specific community center, or school. Includes community centers that are not age-specific, non-residential substance-abuse treatment centers etc.

2. Place of Service (S-24.0)

Definitions of New Values (slide 15 of 20)

P = Phone

Definition: Services are provided by telephone contact with the client, not involving video conferencing.

2. Place of Service (S-24.0)

Definitions of New Values (slide 16 of 20)

R = Residential Care – Children

Definition: Services are provided in a location supplying 24-hr non-medical care for children, other than inpatient hospital, or psychiatric health facilities (PHFs). Includes Community Treatment Facilities (CTFs) and family foster homes.

2. Place of Service (S-24.0)

Definitions of New Values (slide 17 of 20)

S = School

Definition: Services are provided in any facility that has the primary purpose of education.

2. Place of Service (S-24.0)

Definitions of New Values (slide 18 of 20)

T = Telehealth

Definition: Also known as “Telemedicine.” Services are provided so that the clinician and client are in two different locations but can see each other via visual equipment (e.g., video camera, web camera).

2. Place of Service (S-24.0)

Definitions of New Values (slide 19 of 20)

U = Unknown / Not Reported

2. Place of Service (S-24.0)

Definitions of New Values (slide 20 of 20)

Please use the most specific term possible to describe the place of service.

For example, Non-traditional service location (N) is preferred over Field (B).

2. Place of Service (S-24.0)

Other Glossary Terms:

Community Treatment Facility (CTF): Any residential facility that provides mental health treatment services to children in a group setting which has the capacity to provide secure containment.

Institute for Mental Disease (IMD): A term used by the Federal Government in California to distinguish skilled nursing facilities (SNF) that primarily care for people with psychiatric diagnoses, from those that provide care for people with primarily medical illnesses. Any SNF with greater than 16 beds and with 51% or more of its population with a psychiatric diagnosis is considered to be an IMD.

Mental Health Rehabilitation Center (MHRC): This is a 24-hour program, licensed by the State DMH, which provides intensive support and rehabilitation services designed to assist persons 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop skills to become self-sufficient and capable of increasing levels of independent functioning.

Psychiatric Health Facility (PHF): A non-hospital 24-hour acute care facility licensed by the DMH.

Skilled Nursing Facility (SNF): A health facility which provides the following basic medical services: skilled nursing care and supportive care to clients whose primary need is for availability of skilled nursing care on an extended basis.

State Hospital: A psychiatric facility owned and operated by the State of California.

3. Trauma (S-26.0)

Purpose: Identifies clients that have experienced traumatic events including experiences such as having witnessed violence, having been a victim of crime or violence, having lived through a natural disaster, having been a combatant or civilian in a war zone, having witnessed or having been a victim of a severe accident, or having been a victim of physical, emotional, or sexual abuse.

3. Trauma (S-26.0)

Values

Yes	Y
No	N
Unknown / Not reported	U

3. Trauma (S-26.0)

Question: Why is Trauma a field on the service record and not on the Client record? Doesn't Trauma refer to a client's history?

Answer: Trauma was placed on the service record in recognition of the fact that traumatic events can happen at any point in an individual's life. In addition, trauma is considered to be significant to diagnosis and is therefore reported with diagnosis.

3. Trauma (S-26.0)

Question: What if some service records for a given client report a 'yes' in Trauma and others a 'no'? How is that going to be interpreted?

Answer: It is possible that some mental health providers working with a client may be aware of traumatic events in the client's life and that others are not. If any provider in contact with the client is aware of trauma in the client's history, they are encouraged to report it. It's understood that some service records may reflect the client's contact with trauma, while other records may not.

3. Trauma (S-26.0)

Trauma is an area of growing significance in mental health.

4. Client Index Number (CIN) (S-27.0)

Purpose: Identifies Medi-Cal or Healthy Families Plan recipients. The Client Index Number (CIN) must be reported if the client is a Medi-Cal recipient or Healthy Families Plan recipient. If the client is neither a Medi-Cal recipient or a Healthy Families Plan recipient, then this 9-digit field must be zero filled.

4. Client Index Number (CIN) (S-27.0)

Question: Do we report the CIN if the service is not a Medi-Cal service?

Answer: The CIN is reported whenever it is available, whether or not the service is a Medi-Cal or Health Family service. Even if the client is not currently eligible for benefits, the CIN should still be reported.

4. Client Index Number (CIN) (S-27.0)

Question: How is the CIN going to be used?

Answer: Because the CIN is to be reported on every service record, Medi-Cal or not, as available, we are not going to use the reporting of the CIN to indicate that the service is a Medi-Cal or Health Family service, or even that the client is currently eligible for services. The CIN will be used in our system as a supplementary identifier to allow us to cross-walk to other systems.



G. Reporting the Caregiver field to CSI

Managing Changes to CSI (CSI Training II)

Periodic Record Changes

The following fields are being deleted from the Periodic Record:

Axis-V / GAF (P-04.0)

Other Factors Affecting Mental Health – Substance Abuse (P-05.0)

Other Factors Affecting Mental Health – Developmental Disabilities (P-06.0)

Other Factors Affecting Mental Health – Physical Disorders (P-07.0)

Caregiver (P-10.0)

Purpose: Identifies the number of persons the **client** cares for / is responsible for at least 50% of the time:

Subfield A: Number of children less than 18 years of age the client cares for / is responsible for at least 50% of the time.

Subfield B: Number of dependent adults 18 years of age and above the client cares for / is responsible for at least 50% of the time.

Caregiver (P-10.0)

Subfield A:

00 = None

01 through 98 = Number of children less than 18 years of age that the client cares for / is responsible for at least 50% of the time

99 = Unknown / Not Reported

Caregiver (P-10.0)

Subfield B:

00 = None

01 through 98 = Number of dependent adults 18 years of age and above that the client cares for / is responsible for at least 50% of the time

99 = Unknown / Not Reported

Caregiver (P-10.0)

This data element is needed to produce summary data on the number of clients who have dependent children under 18 years of age and/or dependent adults 18 years and older, how many dependents, and if the client is primary caregiver in order to identify patterns of need. This information will help reflect critical areas of the lives of California's mental health clients.



III. MHSA and DIG changes

Integrating MHSA and DIG changes
into CSI

III. Integrating the Changes to CSI

A. Requirements

B. Timeline

C. Impact of Data Collection Issues

D. Transition

III. Integrating the Changes to CSI

A. Requirements

Testing Requirements

In order to meet testing requirements, counties must pass the error thresholds submitting data in the old and new formats

III. Integrating the Changes to CSI

B. Timeline

In order to remain on schedule, the July 2006 submission file must be sent to DMH by September 30th, 2006.

The testing process must be complete before this file can be submitted in production.

If the county anticipates that there will be great difficulty in making this goal, the county should communicate the nature of the challenges to the county's CSI analyst as early as possible.

III. Integrating the Changes to CSI

C. Impact of Data Collection Issues

The collection of the data for the new and amended fields must be in place by July 1st, 2006 in order to remain on schedule.

Time to prepare for these changes is short. It would be very understandable if it was not possible for counties to complete all these changes.

III. Integrating the Changes to CSI

C. Impact of Data Collection Issues

Given these challenges, it will be very helpful if counties would report their status regarding the collection of the new data with their CSI analyst as we approach July 1st, 2006.

The CSI analysts anticipate working individually with each county to respond to that county's concerns about collecting the new data.

III. Integrating the Changes to CSI

D. Transition

To help customize the goals of each county in this transition, the DMH CSI analyst will work with each county through the transition.

III. Integrating the Changes to CSI

D. Transition

Together, the CSI analyst and county staff will track the necessary changes to data collection, management and reporting for that county.