



## **Appendix M – Business Process Decomposition Reference**



**San Luis Obispo County  
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- **Administrative** = processes and activities initiated and established in order for a client to access and receive services.



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- **Financial** = processes and activities conducted, completed, or established to request, draw upon, or receive monetary funds, payment or reimbursement for care, services, or treatment rendered by a provider.
- **Client Care** = processes and activities directly related to the delivery of care, services, or treatment to a client or managing a client's care, services, or treatments.

### 1.0 Application and Enrollment

The process of completing a group of initial administrative functions necessary to provide behavioral health services to an individual. Includes application for services, initial intake prior to prospective client completing an application to enroll in a covered program or service. May include assessment and placement (for DA/S).

| Sub-Function/Process                  | Function/Process Description   |
|---------------------------------------|--|
| 1.1 Completing enrollment application | Prospective client or other appropriate party completes enrollment application via paper forms or online (Internet, intranet) for the purpose of obtaining Health Agency behavioral health services. Includes gathering 3 <sup>rd</sup> party payer information. |
| 1.2 Submitting enrollment application | Prospective client or other appropriate party submits completed enrollment application in person, or via US mail, fax, e-mail, or online (Internet, intranet), for the Health Agency to decide the appropriate disposition of the application.                   |

### 2.0 Eligibility

The process of determining whether clients/beneficiaries meet medical necessity or clinical parameters for services that can be addressed through an existing Health Agency program or service. The process also includes financial eligibility, which involves determining if a client meets various payer sources' eligibility requirements.

| Sub-Function/Process                                       | Function/Process Description  |
|--|---|
| 2.1 Establishing eligibility criteria                      | Eligibility criteria for benefits may be based on a client's medical necessity, financial status, age, diagnosis, court referral, etc. A client may not qualify for one program, but may qualify for an alternative program, depending on payer-specified criteria. |
| 2.2 Obtaining client's eligibility information for payment | Client or other appropriate party provides eligibility information, which is available during the enrollment process. Eligibility data may include the client's total benefit package information.  |
| 2.3 Electronically verifying eligibility                   | Accessing the Medi-Cal Eligibility Data System (MEDS) to determine if a client is eligible to receive Medi-Cal services. Also includes providing online, real-time eligibility verification for non-Medi-Cal payers who support this capability.                    |
| 2.4 Downloading electronic eligibility data                | Periodically downloading electronic eligibility data from payers and plans, including Medi-Cal and Medicare Parts A & B.  |



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|---|--|
| 2.5 Verifying and updating Medi-Cal eligibility and share of cost information | Automatically verifying and updating each client's Medi-Cal eligibility and share of cost balances in the Medicaid Management Information System (MMIS) using the most recently downloaded state MEDS file.  |
| 2.6 Verifying benefits  | Collecting enrollee eligibility information and allowing staff to verify benefits through a variety of mechanisms for Medicaid, Medicare and Private Insurance clients.  |
| 2.7 Processing eligibility information  | Client's information is verified with established eligibility criteria to determine qualification. Also, client episode or encounter information is cross-referenced with eligibility information for appropriate authorization and payment. A client can belong to more than one reimbursement 'group' with respect to coordination of benefit process. Grouping can be based on criteria such as insurance, age, grant status, legislation, and so forth. If a client is determined to be eligible, then an assignment of eligibility period is determined with begin/end date. Other eligibility information may include, Medi-Cal mandated benefits, co-payment, deductible, co-insurance, coordination of benefit (COB), subrogation (workers compensation), exclusions, and other limits/restrictions. |
| 2.8 Notifying county staff  | Alerting counselors, therapists and other appropriate parties of Medi-Cal eligibility status changes, either prospective or retrospectively.   |
| 2.9 Notifying clients   | Eligibility result is communicated to client or other appropriate party in person, or via online, mail, telephone, fax, etc. Includes generating a notice to the client when the client's annual financial evaluation expires.   |
| 2.10 Maintaining eligibility information                                      | Eligibility information is maintained and updated to include client's qualification or disqualification status; includes updating client financial and employment status; and revising eligibility criteria.   |
| 2.11 Generating reports   | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc).   |

### 3.0 Wait List

The maintenance of a roster of clients who have been deemed eligible for covered services, but cannot yet receive services due to provider or program capacity constraints. As active clients complete or are removed from a program or service, individuals on the wait list are accepted into a program or service for treatment.

| Sub-Function/Process          | Function/Process Description  |
|-------------------------------|---|
| 3.1 Managing program capacity | Maintaining accurate and up-to-date information on the program's capacity to provide different types of treatment to different types of clients, and how much of the capacity was utilized during specific time frames. |
| 3.2 Managing wait list        | Supports manual and automatic placement and movement of individuals on a list awaiting program services. For inpatient or residential settings, this is related to 9.0 Bed Management.                                  |
| 3.3 Prioritizing wait list    | Identifies individuals, or categories of individuals, considered a higher priority for services based on acuity measures found in selected assessments  |



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| 3.4 Generating reports | Includes generating statistical reports to the State Department of Alcohol And Drug Programs identifying program census of clients treated and/or awaiting drug and alcohol treatment. Includes the Drug and Alcohol Treatment Access Report (DATAR). |
|------------------------|---|

## 4.0 Demographics Management

The collection and retention of current information that describes characteristics of individuals (e.g., clients and providers) for the purpose of accurately and properly identifying individuals who provide, request and/or receive treatment and services.

| Sub-Function/Process                                    | Function/Process Description  |
|---|---|
| 4.1 Capturing, updating, and maintaining client data    | Capturing data on client name, aliases, address, SSN, DOB, age, sex, race, primary language spoken, education, and other characteristics. Correcting, modifying or updating data to reflect changes or new information.   |
| 4.2 Capturing, updating, and maintaining clinician data | Capturing data on clinician name, address, SSN, DOB, age, sex, race, primary language spoken, education, licenses, credentials, and other characteristics. Correcting, modifying or updating data to reflect changes or new information. Accommodates HIPAA-compliant National Provider Identifier (NPI). |

## 5.0 Call Intake

Accepting clients' and other individuals' inquiries (both written and verbally), documenting client and call information, and responding appropriately to the inquiry on a timely basis. Incoming inquiries may be via telephone, fax, paper mail, or website. The types of inquiries can be related to County-provided services, referrals, emergency situations, directions, eligibility, benefits, change of address, complaints, claim filing, etc. Mental Health Services performs this function on a centralized basis through "Central Access." Drug and Alcohol Services performs this function on a de-centralized basis through reception desks at various clinic sites throughout the County.

| Sub-Function/Process      | Function/Process Description  |
|---------------------------|---|
| 5.1 Responding to inquiry | Policies and procedures are established in response to inquiry on a timely basis (via telephone, letters, e-mail, fax, Internet, intranet, etc.). Incoming calls or other notifications that involve emergency situations (e.g., medical crisis, fire, crime, terrorism) are to be coordinated by the County Crisis Center.   |
| 5.2 Intake screening      | A determination is made if a client should be seen by the Health Agency or by another clinic/24-hour facility or County department. Screening is facilitated by medical and financial eligibility information provided by the client and the system along with the business rules and other eligibility protocols to help direct a client to an appropriate provider. |
| 5.3 Call disposition      | Based on results from available information or from research or fact-finding process, inquiries or complaints are addressed and resolved. For example, client may receive an appointment with a County provider or may be referred to a community-based organization (CBO) or network provider.   |
| 5.4 Logging calls         | Recording information on all calls and contacts (e.g., name, phone number, primary language, reason for call, etc.)   |



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| 5.5 Performing tracking and follow-up           | For unresolved inquiries or complaints, call status is tracked and monitored for completion. Follow-up efforts are made to ensure inquiries or complaints are completed or closed.       |
| 5.6 Managing quality and performance of process | Quality and performance of the call center is monitored and evaluated. For example, call monitoring is considered a widely used method of quality and performance measurement.           |
| 5.7 Generating reports                          | Generating appropriate reports for internal and external reporting as needed and on a timely basis (e.g., volume and type of inquiries, turnaround time, and number of abandoned calls). |

## 6.0 Appointment Scheduling/Attendance

The purpose of appointment scheduling is to accept requests for, and to record, the date and time of a client’s future visit(s), reason for the visit(s), and with which service provider. Appointments can be based on a block schedule or a first come/first served basis. Appointments may be individual, group, or a combination of individual and group.

Appointment scheduling includes providing appointment schedules for all affected personnel and distributing hard copy of appointment schedules to clients. Whether the appointment schedule is based on a centralized or decentralized model, it is designed to accommodate the availability of clients and providers.

Attendance is documenting or recording whether a client was present at a scheduled appointment, group, or event. Includes noting absences and reasons for not being present, such as excused absences. Attendance also includes recording the presence of a client who dropped-in at a group or event for which there was no scheduled appointment.

| Sub-Function/Process                 | Function/Process Description  |
|--------------------------------------|---|
| 6.1 Requesting an appointment        | Request for an appointment can be made in person, via telephone, fax, or online.  |
| 6.2 Maintaining staff schedules      | Indicates dates and times individual clinicians are available to see clients.   |
| 6.3 Rostering                        | Setting up groups (e.g., counseling, therapy, etc) for various programs and assigning individuals to one or more group.   |
| 6.4 Scheduling the appointment       | The individual and/or group appointment(s) is scheduled based on program availability and preferences of the client(s) and provider(s). Information regarding appointment time, place, provider(s), and client is captured and/or updated. Requests for room, equipment, and supplies are also scheduled. |
| 6.5 Confirming the appointment       | Confirmation of the scheduling information is provided to client, providers, and other appropriate parties. DUI clients receive a paper copy of their appointment schedule (Title IX).  |
| 6.6 Reminding patient of appointment | In addition to hard copy patient reminders sent via US Mail, mechanisms can include e-mail, fax, and telephony approaches. Development of an automated information system to improve patient compliance is considered.  |
| 6.7 Maintaining appointment status   | Scheduling information is revised and updated; appropriate parties are promptly notified of changes.  |



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| 6.8 Capturing attendance | Documenting client attendance at individual or group counseling sessions. DA/S documents client attendance via group rosters. Rosters are automatically generated from appointments and completed at the point of service, noting clients who are present, absent, and reason(s) for absence. |
| 6.9 Generating report    | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, online screen, etc.).  |

## 7.0 Registration

The process of recording and tracking the presentation of a (DA/S) client to an outpatient setting for service. The registration process captures relevant information about a client, his/her assigned clinician, and service type.

| Sub-Function/Process                 | Function/Process Description   |
|--------------------------------------|--|
| 7.1 Entering/updating client profile | Upon a client's arrival or check-in based on a scheduled appointment or walk-in, client information is captured or updated.              |
| 7.2 Confirming the arrival           | Confirmation of the client's arrival is documented and all necessary parties are informed.   |
| 7.3 Maintaining visit status         | Client visit status is tracked and monitored during the visit or episode, and through discharge.   |
| 7.4 Generating report                | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc). |

## 8.0 Admission, Discharge, and Transfer (ADT) / Episode Management

ADT is the process of tracking a client's admission, discharge, and transfer (change in location), and often within an organization's health care system. ADT also keeps track of clients who are placed on leave of absence but who remain active clients. Includes transfers between settings, programs, or clinics; special population client status tracking.

Episode management is maintaining single or multiple, simultaneous episodes/statuses for clients who are receiving services on a concurrent or overlapping basis until the case is closed.

| Sub-Function/Process                                     | Function/Process Description  |
|--|---|
| 8.1 Scheduling/canceling/rescheduling an admission (PHF) | If known in advance, indicating in the system the anticipated date that a patient will present at the facility for inpatient services. Changing or removing a patient who has previously been noted in the system as scheduled to arrive for inpatient services   |
| 8.2 Admitting a patient/client                           | Upon a patient's arrival, client information is captured or updated and acceptance in to the facility for treatment is acknowledged.  |
| 8.3 Inventorying property                                | Documenting all property and effects that a patient has on their person or in their possession upon admission to the facility. Including noting location of each article (e.g., in the room, on the unit, in a locker). At discharge or transfer, property is again inventoried to ensure patient leaves with his/her |



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|                                  | own personal effects   |
| 8.4 Discharging a patient        | After the discharge order has been written and patient has been prepared to leave the facility, acknowledging in the system that the patient has been released from the facility.  |
| 8.5 Transferring a patient       | Acknowledges a change in patient status or location during an inpatient stay, e.g., transfers outside of the facility, but still within the same inpatient episode of care.  |
| 8.6 Maintaining admission status | Client admission status is tracked and monitored during the stay, and through discharge.   |
| 8.7 Episode tracking             | Defining and tracking episodes of care for clients based on State and local definitions of episodes. This includes tracking all of the care provided to an individual within a given service program during a given time period (e.g. a client could have mental health and drug and alcohol episodes open at the same time and services would be tracked separately). This also includes tracking outpatient services separately from inpatient facility admissions that may occur during the same time period. |
| 8.8 Crisis tracking              | Tracking crisis episode data including date and time of first contact, referral source, clinical notes about the crisis including user-defined checklists and text-based crisis notes that allow for the recording of diagnosis, level of functioning and other relevant clinical data.  |
| 8.9 Generating report            | Generate appropriate reports for internal and external reporting as needed and on a timely basis.  |

## 9.0 Bed Management

The bed management function allows the Health Agency to track the availability of beds in Agency-owned or -managed client accommodations by type of facility (e.g., 24 hour care facility, apartments) and to generate rosters by facility that may be used to support resource management and payer requirements.

| Sub-Function/Process  | Function/Process Description   |
|---|--|
| 9.1 Monitoring/managing bed availability  | Maintaining accurate and up-to-date status of occupied beds relative to total available bed capacity. Maintains information for inpatient PHF and all other Agency-owned or –managed beds in the community.  |
| 9.2 Assigning patient to an inpatient bed and/or room (PHF)/changing bed assignment | Noting which bed and/or room an individual patient will be placed for the duration of their inpatient stay. Takes into consideration availability of beds, the client’s behavior, and client’s age, and sex. Noting changes in bed and/or room placements that may occur during an inpatient stay. |
| 9.3 Managing placements   | Based on assessment, client’s level of care is determined. Client may be placed at a number of Agency-owned or –managed beds in facilities throughout the County representing various levels of care (e.g., Group Homes and IMD).  |
| 9.4 Completing referral packet  | Documenting and assembling all paper work or other information required for a non-Health Agency-owned or –managed facility to decide if a referred Client is appropriate.  |



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| 9.5 Generating report | Generates bed rosters by unit and occupancy reports for all Agency-owned or –managed beds. |
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## 10.0 Health Record Management

Health record management encompasses maintaining the organization’s legal health record in a way that is compliant with Federal, State, and local regulations and/or policies (e.g. HIPAA and 42CFR). Health record management involves recording, maintaining, retaining, and archiving client information to meet various functions, and ensuring the record is accurate, complete, and secure.

|  |   |
|--|---|
| 10.1 Maintaining Master Patient Index (MPI)              | Automatically assigning a unique client/patient identifier that will be used for all client encounters and for client look-ups. Checking for and managing duplicate identities/identifiers, and retaining only a single valid client identifier and record. |
| 10.2 Managing the record                                 | Retention, reproduction, storage, merging records including checking and merging records if a client has more than one record, and retaining only a single valid client identifier and record. Retains all historical information.                          |
| 10.3 Abstracting data                                    | Automatically extracting a subset of data already in the record for Medicare, Medicaid, vital records, etc. reporting.  |
| 10.4 Analyzing charts for deficiencies and delinquencies | Reviewing the completeness of a client’s chart and following up with service providers to ensure the timely and accurate entry of required data.  |
| 10.5 Record completion                                   | Monitoring unsigned/co-signed reports, results, etc.  |
| 10.6 Managing Release of Information                     | Ensuring clients, staff, and external sources have access to— or receive— needed personal health information (PHI) in a manner consistent with HIPAA and other pertinent business requirements.   |
| 10.7 Managing Consents and Authorizations                | Ensuring accurate, current, and necessary consents and authorizations are completed, stored, and accessible to providers; includes tracking disclosures, directives, etc.   |
| 10.8 Transcribing  | Includes editing information created by natural language processing (NLP).  |
| 10.9 Managing external documents                         | Document and image management, including receiving, scanning, storing, and indexing documents received from external sources (e.g., Court reports) in paper-based or electronic formats.  |
| 10.10 Generating report                                  | Generate appropriate reports for internal and external reporting as needed and on a timely basis.   |

## 11.0 Portal

Maintaining a website that offers a range of capabilities that support accessing Health Agency services or promoting a client’s well-being, such as e-mail, chat boards, search engines, and content (e.g., Network of Care, DA/S web site).



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| 11.1 Client application/enrollment               | Enabling the public to register or apply for services online.   |
| 11.2 Client appointments                         | Supports online requests by clients for an appointment with specific clinician(s).  |
| 11.3 Client account checking and bill payment    | Client checking status of their account; making payments for services received.   |
| 11.4 Communication                               | Active clients sending secure messages to their clinician.  |
| 11.5 Service provider data submission            | Health Agency, Community-Based Organizations, and Network Providers submitting State-mandated CSI, CalOMS and DATAR data.   |
| 11.6 Service provider treatment/service planning | Supports online completion of service plans.  |
| 11.7 Drug testing                                | Service provider and active clients accessing drug testing schedules and results, as appropriate.   |
| 11.8 Chart access                                | Service provider and client accessing a client's chart, as appropriate.   |
| 11.9 Information and education                   | Provides information— including downloadable documents— that may be of interest to the general public, active or prospective clients (e.g., what to expect during an inpatient PHF stay). |

## 12.0 Screenings/Assessments/Evaluations

Screenings, assessments, and evaluations are tools used by service providers to determine the current condition (e.g., psychological, psychiatric, medical, emotional, severity of abuse) of a client across a variety of parameters for the purpose of deciding appropriate intervention, treatment, and follow-up. Review eligibility for appropriate program(s) or service(s). Assessments and evaluations provide information on persons who likely or definitively have a behavioral health problem and/or substance abuse problem. Assessments and evaluations may be periodically re-administered to ensure that clinicians have up-to-date information on a client's current behavioral health status. Documentation of medical history, physical exams findings, and vital signs may be included (e.g. PHF, outpatient detox).

| Sub-Function/Process                | Function/Process Description   |
|-------------------------------------|--|
| 12.1 Intake Assessment (MHS & DA/S) | Gathering a comprehensive history about a client including current level of functioning (behaviors, symptoms, and ability to function in a community) and needs of client per report for client as well as outside systems and agencies. This is performed by a clinician in order to determine medical necessity (mental health, diagnosis) and/or eligibility for services. For MHS, this includes the Client and Service Information assessment (CSI); for DA/S, this includes CalOMS, ASI and SASSI. |
| 12.2 Risk Assessment/management     | Safety plan<br>Address high risk concerns (e.g., detox)<br>Referrals to immediate treatment  |



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|---|--|
| 12.3 History and Physical (PHF)                                 | Gathering a comprehensive health history and current health concerns in order to make medical treatment recommendations. May be completed by a MD or nurse practitioner.   |
| 12.4 Nursing Assessment (PHF)                                   | Gathering a health history and conducting a brief exam.  |
| 12.5 Interim Treatment Recommendations                          | Provides referral to outside resources/agencies<br>Outpatient therapy<br>Explain recommendations to client<br>Schedule initial appointments (w/ doctor, group, individual, etc.)<br>Develop interim treatment plan for first 60 days of services |
| 12.6 Site Approval Team (SAT) (MH) / Licensed Supervisor (DA/S) | Assessment is presented to SAT for approval for appropriate services (MH only).<br>NOTE: DA/S requires approval by licensed supervisor for non-licensed clinicians.  |
| 12.7 Assessment Disposition                                     | Assessment team can close, refer out, or pass to treatment.  |

## 13.0 Treatment Plans

Preparing and documenting a multi-disciplinary approach to addressing a client's problems, condition and needs for the purpose of restoring the individual to health. Treatment plans vary by program and are based on assessments and evaluations conducted by multiple disciplines, often with client and/or family input during treatment team meetings. Treatment plans provide documentation often required by payers to substantiate claims submitted for reimbursement of covered services. Treatment plans are re-evaluated per program guidelines.

| Sub-Function/Process                              | Function/Process Description  |
|---|---|
| 13.1 Interim Treatment Recommendations            | Client and assessing clinician come up with a plan which is presented at SAT for approval. Mental Health Services prepares an Interim plan for the initial 60 days.   |
| 13.2 Crisis Plan                                  | Client and Case Manager develop a Crisis Management Plan. Access to this plan must be secure yet easy to access by the care team and other providers who have contact with the client.  |
| 13.3 Care Plan                                    | Completed by treating clinician. Identifies symptoms, diagnosis, strengths, functional impairments, and recommended services. Health Agency policy states that the Care Plan must be completed within 30 days of Interim Treatment Recommendations being approved.                |
| 13.4 Master Service Plan (MH)/DA/S Treatment Plan | In collaboration with the client, the counselor/therapist develops goals, interventions, and desired, measureable outcomes for each identifiable service. Includes at least three objectives for each service type on the Care Plan that must have time frames and be measurable. |



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| 13.5 Service Plan                                    | As needs are identified in collaboration with the client, additional services with goals, interventions, and outcomes are added.   |
| 13.6 Therapeutic Behavioral Services (TBS)           | Therapeutic Behavioral Services (TBS) are short-term, one-to-one interventions for full-scope Medi-Cal eligible children and youth under 21 years of age who are at risk for group home placement. TBS clinician collaborates with client to identify target behaviors to be addressed by specific behavior interventions. |
| 13.7 Discharge Planning (PHF)                        | Treatment team meets daily to review medical necessity, available resources, patient readiness, discharge or aftercare plans.  |
| 13.8 Transfer/Closing Summary/DA/S Discharge Summary | Clinician completing a brief summary of client's progress and treatment and recommendations for future treatment.  |
| 13.9 Treatment Protocols and Care Guidelines         | Best practice clinical guidelines.   |

## 14.0 Education/Counseling/Therapy

Education, counseling, therapy, and medication are common approaches to treatment of behavioral health problems. The processes by which these services are provided are core components of a client's treatment and are provided in accordance with the treatment plan. Documentation of units of service is required by funding sources and payers.

| Sub-Function/Process    | Function/Process Description   |
|-------------------------|--|
| 14.1 Education          | Occurring in individual or group (including family) settings, providing rehabilitation interventions to assist client in gaining skills. Includes delivering didactic education classes (DA/S), disseminating client/patient education material, and providing prevention activities aimed at educating the community. |
| 14.2 Counseling/Therapy | Providing individual, group, family, or collateral therapy.  |
| 14.3 Medication         | Prescribing medication to reduce/address mental health symptoms or facilitate detoxification, using a Psycho-pharmaceutical approach to client change.   |

## 15.0 Individualized Education Plans (IEPs)

Each public school child who receives special education and related services must have an Individualized Education Program (IEP). Upon referral by a school, IEP Team, BHS provides assessment (See assessment) and generates 26.5 Report. Expanded IEP Team (School and BHS) meets to review,



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approve, and develop treatment goals and objectives.

The Individuals with Disabilities Education Act (IDEA) requires certain information to be included in each child's IEP. Local school districts include additional information in IEPs in order to document that they have met certain aspects of federal or state law which results in IEP forms looking different from school system to school system.

| Sub-Function/Process                          | Function/Process Description  |
|---|---|
| 15.1 Identifying clients who require an IEP   | Referrals to MHS are generated by the school IEP Team (the IEP team must meet to write an IEP for the child within 30 calendar days after a child is determined eligible).  |
| 15.2 Preparing individualized education plans | Mental health assessment completed and authorized by SAT and 26.5 Report provided to school.  |
| 15.3 Completing MH portion of IEP             | Expanded IEP team meeting scheduled by school to review 26.5 report, Develops treatment, goals, objectives, and delivered services specific to 26.5 definition criteria. NOTE: Need standardized form for report and documentation of goals/objectives. |
| 15.4 Providing services                       | BHS provides services, tracking due dates and referral dates. The IEP is reviewed by the IEP team at least once a year, and revised as necessary.   |
| 15.5 Generating reports                       | Generate appropriate reports for internal and external reporting as needed and on a timely basis.   |

## 16.0 Notes/Documentation

Notes and documentation refers to entering information into a client's record. Notes and documentation are required to record service, treatment, or care-related comments and findings that may be related to assessments, evaluations, history, physicals, lab results, reaction to medications, special diets, etc. In addition to individualized notes, notes and documentation for group sessions are also prepared.

| Sub-Function/Process                        | Function/Process Description   |
|---|--|
| 16.1 Determining format and content of note | Determining note and documentation format, content, and document workflow based on program and payer guidelines and requirements. Includes an interface with 26.0 Coding to ensure proper note completion. |
| 16.2 Completing Note/Documentation          | Ensuring that providers meet the requirements for providing services and document services provided according to program/payer requirements.   |
| 16.3 Tracking Note/Documentation Status     | Tracking applicable notes/documentation for clinical appropriateness, timelines, and overall system of care.   |



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## 17.0 Orders/Results

Orders include the issuing and documentation of a physician's request for lab tests, medications, diagnostic exams, special diets, various treatments, services etc. Results include receiving and retaining the outcome of tests that were ordered and performed.

| Sub-Function/Process             | Function/Process Description   |
|----------------------------------|--|
| 17.1 Ordering tests and services | After determining appropriate tests and services (e.g., medical, drug, and diagnostic) based on assessment, clinician orders tests and services. Tests are performed at facilities, in-house or other divisions within HA. Orders are currently stored in database and paper file. |
| 17.2 Receiving results           | Receiving test results for tests done in-house (e.g., dipstick), receiving results for tests done by outside lab facilities or other divisions within the Health Agency via fax or e-mail notifications. Results are stored in database and paper file.                            |
| 17.3 Generating report           | Generate appropriate reports for internal and external reporting as needed e.g., for courts and funding) and on a timely basis. Extracting data from database (DA/S) for statistical analysis.   |

## 18.0 Referrals

The process of sending and receiving a client from one provider to another for services. This includes the tracking of outgoing and incoming referrals made to/from the Health Agency, as well as to/from network providers, community based organizations (CBOs), and other institutions (e.g., state hospital, IMDs).

| Sub-Function/Process               | Function/Process Description  |
|------------------------------------|---|
| 18.1 Incoming referrals            | Capturing and maintaining information on incoming referrals (e.g., referral source, reason for referral, client demographics, release of information, etc.). Referrals may be from MHS Managed Care/Central Access, other County agencies or departments, community-based organizations, and independent fee-for-service network providers. |
| 18.2 Deciding referral disposition | Decision process based on established criteria, protocol, standard, etc.  |
| 18.3 Assigning referral            | For accepted client, deciding which clinician will serve as the lead therapist or counselor, and adding the client to the clinician's case load.  |
| 18.4 Determining service coverage  | The type, quantity, service period, authorized clinicians, and other essential information are used to determine or substantiate benefit/coverage in accordance with established business rules.  |



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|------------------------------|--|
| 18.5 Maintaining information | Referral information is revised or updated, along with established standards and protocols.  |
| 18.6 Outgoing Referrals      | Recording and maintaining information that client has been referred to another provider (e.g., housing, social services, and primary care). These referrals may be within or outside of the Health Agency. |
| 18.7 Generating report       | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc).   |

## 19.0 Laboratory Services

The key function of laboratory services is to furnish providers with accurate lab test results on a timely basis. The Agency performs limited testing in-house and outsources other lab services. Both MHS and DA/S use outside labs for these services (e.g., the PHF contracts with French Hospital and D/AS contracts with and external toxicology lab for drug test results).

|   |   |
|---|---|
| 19.1 Placing people in testing groups   | Randomly assigning individuals to testing groups that specify dates, times, frequency, and location of test(s) to be performed.   |
| 19.2 Generating labels                  | Entering client information onto labels that will be printed and affixed to sample container for the purpose of ensuring valid correlation of test result to client sample. Includes automatically assigning accession numbers.   |
| 19.3 Performing lab test                | Based on established protocols, certain tests are performed in-house (e.g., dip sticks) whereas other tests are outsourced.   |
| 19.4 Tracking test status               | Tracking and monitoring the status of lab tests that have been sent out.  |
| 19.5 Receiving results                  | Electronic downloading of test results (e.g., from toxicology lab).   |
| 19.6 Recording and storing test results | Recording and storing lab results in the system.  |
| 19.7 Capturing order request            | For inpatient PHF, laboratory order information is captured and documented via telephone, fax, or online (Internet, intranet). An interface between the pharmacy and laboratory functions is required to allow restricting issuing prescriptions until laboratory results are obtained. |
| 19.8 Transmitting order                 | Transmitting the order to the lab that will fulfill the order.  |



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|---|---|
| 19.9 Generating billing/payment   | Billing or payment information is processed.  |
| 19.10 Generating report   | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc).  |
| <b>20.0 Pharmaceutical/Medication Management Services</b>   |   |
| <p>Pharmacy services represents the process of accepting and fulfilling a prescription order, performing drug utilization reviews (DUR), billing for the pharmaceutical service, and maintaining a record of the transaction. The pharmacy process may include the acquisition, distribution, and control of all pharmaceutical products, including medications, injectables, and supplies. The process may also include educating clients and providers about drugs or advise providers on drug selection.</p> <p>Neither MHS nor DA/S operates a pharmacy; MHS and DA/S outsource the fulfillment of medication orders to Community Health Centers (CHC). CHC will continue filling PHF Pharmacy orders.</p> <p>The system should interface with the PHF's Med-Dispense unit.</p> |   |
| 20.1 Capturing order request  | <p>Pharmacy order or prescription information is captured verbally or via telephone, fax, or online (Internet, intranet) and documented. The system will have a GUI interface that will encourage the prescribing clinician to enter the prescription directly into the system.</p> <p>Physician orders medications by phone, fax, or script. Checks JV220 status and complete form(s) as needed.</p>   |
| 20.2 Dispensing and administration of orders  | <p>Based on formulary or special order protocols, pharmacy prepares or dispenses medications as ordered (internally or outsourced).</p> <p>MHS outpatient dispenses samples and both MHS inpatient and outpatient administer injectables and other medications. DA/S administers Detox kits that are dispensed by CHC.</p>  |
| 20.3 Documentation  | Documenting PHF pharmacy information, such as MD Note, transcribed to medication administration record (MAR), medical note, medical log, medical request slip.  |
| 20.4 Tracking order status  | Tracking and monitoring the status of the order.  |
| 20.5 Medication Management Services   | <ol style="list-style-type: none"> <li>a. Performing or obtaining necessary assessments of the client's/patient's health status</li> <li>b. Obtaining authorizations, including TAR</li> <li>c. Formulating a medication treatment plan</li> <li>d. Selecting, initiating, modifying, or administering medication therapy</li> <li>e. Dispensing samples and related documentation</li> <li>f. Administering injections and medications (including detox kits ordered through CHC) and related documentation</li> <li>g. Monitoring and evaluating the patient's response to therapy, including safety and effectiveness</li> <li>h. Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events</li> </ol> |



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|  | <ul style="list-style-type: none"> <li>i. Documenting the care delivered (including medication log, MAR, patient reaction to medications)</li> <li>j. and communicating essential information to the patient's other primary care providers</li> <li>k. Providing verbal education and training designed to enhance patient understanding and appropriate use of his/her medications</li> <li>h. Providing information, support services, and resources designed to enhance patient adherence with his/her therapeutic regimens (including providing patient education material)</li> <li>l. Coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient</li> </ul> |
| 20.6 Generating billing/payment  | Processing billing or payment information on a timely basis.   |
| 20.7 Maintaining formulary   | Maintaining the inpatient formulary for the Psychiatric Health Facility (PHF).   |
| 20.8 Managing inventory  | Maintaining and controlling the inventory of medications (drug supplies). Maintaining the PHF's MAR, drug samples, lot lists, and ensuring secured storage. Tracking and managing identification and destruction of expired medicines. Interfaces with the inpatient Psychiatric Health Facility's Med-Dispense Unit.  |
| 20.9 Educating and performing research   | Providing educational materials and researching drugs.   |
| 20.10 Generating report  | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc). Generated reports should be based on formulary and diagnostic code.   |
| <b>21.0 Dietary</b>  |  |
| Dietary is the provision of snacks and meals to clients and supports the therapeutic monitoring of a client's dietary intake and output. Both the PHF and DA/S serve meals and snacks to clients. Dietary includes setting aside food for PHF patients in case of disaster. Dietary functions are out-sourced. |  |
| 21.1 Identifying special dietary needs   | At the time of admission, assessing an individual's dietary needs, taking in to consideration medical condition, allergies, drugs, treatment plan, etc.  |
| 21.2 Inventorying snacks   | Counting and categorizing snacks kept on site; distributing to inpatients and clinic clients on a daily basis; maintaining a reserve for inpatients.   |
| 21.3 Generating reports  | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc).   |



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## 22.0 Case Management

Case Management is the process of linking and monitoring the appropriateness of treatment or ancillary services to an individual client throughout the client’s episode of care. Services may include housing, dental care referral, etc. Case management often involves referral to providers outside of the Health Agency’s purview (e.g., to IMDs, state hospitals, after care).

|   |  |
|---|--|
| 22.1 Initial/ ongoing development of case management plan | The process of developing individual client treatment or service plans based on the client’s unique needs. Revising and updating the plan as needed, as the case progresses and various steps and activities are performed, and as new needs or issues arise.  |
| 22.2 Case management and monitoring                       | The process of actively managing a client’s case according to the individual client treatment or service plan, including making referrals as appropriate. Coordinating and monitoring all service delivery in compliance with the plan to improve outcomes, quality of care, and cost-effectiveness. |
| 22.3 Documenting  | Documenting the activities, outcomes, results, issues, etc. of activities performed.   |

## 23.0 Program/Payer Management

Entering and maintaining information on the program, payer, or guarantor that is responsible for the cost of a client’s care. A client may have one or more guarantors depending on the client, program, service, or source(s) of payment.

|   |  |
|---|--|
| 23.1 Entering and maintaining payer, guarantor, program, plan information | Capturing information on an unlimited number of Payers/Programs/Plans, including specific benefit or payment limits. Maintaining numerous, complex rules that establish the sequence in which various payers can be billed for services rendered. Associates funding to programs and accommodates payer funding and source cascades. |
| 23.2 Maintaining history  | Maintaining a history of eligibility data for each payer and appropriately assigning primary, secondary, and tertiary payers for services based on County-defined business rules. Maintaining historical rate tables.  |
| 23.3 Updating all information   | Adjusting information at any time, with changes effected in real-time (e.g., tracks retroactive adjustments for cases in which a client is added to a program with an effective date prior to the date of service).  |
| 23.4 Generating reports   | Generate appropriate reports as needed and on a timely basis (via paper forms, on-line screen, etc).   |

## 24.0 Managed Care

Managed Care is the process of determining the necessity, appropriateness, and efficacy of services provided to clients. Managed Care includes utilization management (UM), which involves managing the use of services through prospective, concurrent, or retrospective review of care/service.

Service authorization or certification is the process of obtaining approval for treatment or services— based on medical necessity for MHS— prior to receiving treatment/service. Without prior service authorization, a client may be deemed not eligible, the treatment/service may not be covered, or must be paid for out-of-



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pocket by the client.

| Sub-Function/Process                                    | Function/Process Description   |
|---|--|
| 24.1 Recording service requests                         | A request for service may be received via telephone, e-mail, fax, or online. Mental health service requests are documented on the Service Request Form.  |
| 24.2 Determining authorization                          | Deciding whether to authorize a service request based on established criteria or standards (e.g., medical necessity and financial eligibility). For medical necessity, authorization decisions are based on acuity information collected through the Service Request Form. For financial eligibility, authorization decisions are based on determining if a client meets payer or program requirements or thresholds.  |
| 24.3 Completing Treatment Authorization Requests (TARs) | Completing State-mandated Treatment Authorization Request forms (for inpatient PHF and outpatient mental health services). The MHP authorizes psychiatric inpatient hospital service admissions, continued stay services and administrative days for all Medi-Cal recipients based on county of residence. Emergency admissions are exempt from prior authorization. However, the hospital must notify the MHP in the recipient's county of residence within 24 hours of admission. If notification is not received within 24 hours, the MHP may deny the hospital stay. |
| 24.4 Managing utilization                               | Proactively ensuring appropriate use of services, including establishing medical necessity, obtaining or requiring prior authorizations, obtaining treatment authorizations, and performing prospective/ concurrent/ retrospective utilization review.   |
| 24.5 Managing network providers                         | The Health Agency functions as a health plan for Medicaid mental health services. In this capacity, the County contracts with individual providers in the community who have applied and been accepted as Health Agency network providers. These network providers have signed contractual agreements that specify service, documentation, claims, reimbursement, and reporting terms and conditions. [See 35.0 Provider Network Management]   |
| 24.6 Generating report                                  | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc).   |

## 25.0 Census

The census is the official count of the number of active clients or patients as of a specific date/time or date range. Some programs require a daily census (e.g., inpatient PHF and intensive day care services) whereas others may require less frequent, periodic census counts (e.g., DUI programs). The census is essential to manage capacity and to comply with payer requirements that may be driven by room and board.

| Sub-Function/Process                     | Function/Process Description  |
|--|---|
| 25.1 Counting inpatients/ active clients | Counting the number of active clients in a specific program or setting as of a pre-determined day/date/time, based on a pre-determined frequency. In the inpatient PHF setting, the census is captured three times a day. |



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| 25.2 | Managing census   | Managing inpatient discharges and transfers to accommodate new or pending admissions (PHF). Managing active clients to accommodate clients on the wait list (D/AS). |
| 25.3 | Generating report | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc).                            |

## 26.0 Coding

Selecting, documenting, maintaining and updating standard, industry-wide HIPAA compliant codes related to diagnoses (e.g., DSM-4TR, ICD-9) and procedures (e.g., CPT, HCPCS). Accurate and appropriate coding is essential to timely and optimal reimbursement for services rendered. Coding includes mapping proprietary vendor, County, and other program, payer, or plan codes to industry standard codes.

NOTE: excludes industry standard codes related to electronic data exchange (e.g., SNOMED, LOINC).

| Sub-Function/Process | Function/Process Description          |  |
|----------------------|---------------------------------------|--|
| 26.1                 | Selecting appropriate code            | Treating clinician selecting appropriate diagnosis or service code based on clinical judgment, including CPT, DSM, HCPCS, ICD, E&M codes.                                    |
| 26.2                 | Grouping codes (PHF)                  | Aggregating individual codes to map to established DRGs.   |
| 26.3                 | Validating charges                    | Ensuring that provider documentation in the health record supports diagnosis and all billing-related codes included in claims, bills, or invoices.                           |
| 26.4                 | Maintaining HIPAA-compliant code sets | Maintaining and periodically updating codes as needed (e.g., ICD-10).  |
| 26.5                 | Maintaining proprietary codes         | Entering and maintaining local or State-specific codes (e.g., creating and maintaining disallowance codes in the new system that map to State codes for disallowed services. |

## 27.0 Billing/Claims (MHS) and Client Statements (DA/S)

A billing statement represents a collection of charges for a specific client over a particular period of time. The billing process involves generating a claim document that documents and substantiates a request for payment of provided services. A billing statement can be generated via paper forms or electronically.

A claim represents a request for payment for services/procedures that have been provided to a client. Services/procedures provided must be appropriate for the diagnosis in order to receive maximum allowed reimbursement. Claims may be submitted to institutional payers in paper or electronic format. A bill may be sent to the client for the balance due after claims to all other payer sources have been adjudicated.

Includes preparing and sending client statements to DA/S (fee-for-service) and MHS clients.

Encounter: An encounter is a unit of service (or a collection of services) and is the basis for generating claims and bills.

| Sub-Function/Process | Function/Process Description |
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|----------------------|------------------------------|



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|--|--|
| 27.1 Maintaining fee schedule and structure  | Developing annual fees for each program with placeholders for cost of service, State Maximum Amount, or billed charge, using various methodologies, including creating sliding scales based on UMDAP. Maintaining accurate and up-to-date historical and current information on payer-specific or County charges for all services rendered and programs offered to clients.  |
| 27.2 Identifying program(s)                  | Determining at the point of service, which program(s) a client is eligible for.  |
| 27.3 Deposit/Payment Collection & Receipting | Accepting payments for services at the point of service (e.g., credit card, check, cash, or money order) or via the web (e.g., PayPal, credit card, etc). Creating receipts for client payments that designate, site, type of payment (cash, check, credit etc.), payment amount, date of payment, payment for which Program or service, and indicating whether payment is a deposit or for a specific appointment or group, for testing fees, miscellaneous, etc. |
| 27.4 Capturing fees/charges                  | Capturing billable services by linking back to rosters that document services received by virtue of a client's attendance at group or individual counseling or treatment sessions.   |
| 27.5 Payer and Client statements (billing)   | Generating statements indicating services provided for a specified date range, including client name, payer name, programs, date/time/type of services rendered, date and amount of all deposits/payments received, outstanding balance, due date, etc.  |
| 27.6 Payer invoice (billing)                 | Generating invoices to payers for Contracts and Grants for internal services provided.   |
| 27.7 Daily Cash Journal                      | Reconciling payments received during a given date range. Reconciling by site/location (e.g., Atascadero, Arroyo Grande, San Luis Obispo), program (e.g., DUI, TX, P36), pay source type (e.g., cash, credit, money order, web, check), and payment for (e.g., program, testing, miscellaneous).  |
| 27.8 Generating report                       | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc). <b>See list of reports.</b>   |

## 28.0 AR/Collections

The process of monitoring outstanding claims/bills, associating payments received with claims/bills issued, and following up on delinquent accounts. D/AS outsources its collections function to the Probation Department.

| Sub-Function/Process                      | Function/Process Description   |
|---|--|
| 28.1 Monitoring status of client accounts | On an ongoing basis, tracking deposits and payments received from clients against programs/services rendered and client's liability, and determining accounts and amounts due that are current, >30 days, >60 days, etc. |



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| 28.2 Identifying delinquent accounts | Identifying clients who have either not had a face-to-face encounter in 60 days, or who have not made a payment in 60 days.  |
| 28.3 Sending accounts to Collections | Since DA/S collection is outsourced, collections involves sending delinquent account information to Probation Collections, and receiving and posting collections payments. |
| 28.4 Generating report               | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc). <b>See list of reports.</b>       |

## 29.0 Electronic Transactions

Exchanging structured data, using agreed-upon HIPAA-compliant transaction and code sets, from one entity to another (e.g., electronic claims submission).

| Sub-Function/Process                              | Function/Process Description                                     |
|---|--|
| 29.1 Maintaining all HIPAA-compliant transactions | Sending and receiving HIPAA-compliant transactions, as required. |
| 29.2 Internet payments                            | Accepting online credit card payments from active clients.       |

## 30.0 Compliance / Auditing

Meeting accreditation, regulatory, legal, and payer requirements. Compliance includes:

- implementing written P&P and standards of conduct
- designating officer and committee
- conducting effective training and education
- developing effective lines of communication
- enforcing standards through well publicized disciplinary guidelines
- developing policies addressing dealings with sanctioned individuals
- conducting internal monitoring and auditing
- responding promptly to detected offenses; developing corrective actions
- reporting to the Government

Auditing is a process of examining current practices to ascertain or verify conformance with pre-established requirements.

Supporting all data analysis and reporting needs related to certifications, regulation, legislation, legal, DMH, WIC, Title IX, NNA, Medicare, Medi-Cal, grants, HIPAA, County policies and procedures, internal/external chart audits, CBO security access, and audit criteria setting.



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## 31.0 Reporting

Reporting is the aggregation of financial, operational, and clinical data into meaningful information that facilitates decision-making, supports compliance/auditing needs, and meets mandated reporting requirements (e.g., CSI, CalOMS, and Medi-Cal cost reports). Standard reporting adheres to a pre-determined format and data types and is produced on a routine basis. Ad-hoc reporting generates reports containing user-requested data on an as-needed or on-demand basis.

NOTE: This does not include clinical decision support which may include clinical protocols, evidence-based practice, etc.

| Sub-Function/Process    | Function/Process Description  |
|-------------------------|---|
| 31.1 Generating reports | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc). Reports may be standard reports that are routinely produced or ad hoc reports that are produced on-demand. <b>See list of reports.</b> |
| 31.2 Querying           | Accessing any combination of user-defined data elements on a real-time basis. Queries may be viewed online or printed out.  |

## 32.0 Complaints, Grievances, Appeals, Notice of Actions, State Hearings

Complaints, grievances, appeals, Notice of Actions, and State Hearings represent escalating levels of action available (depending on payer, program, and county policies and procedures) that can be taken when a client, provider, family member, or advocate contests a decision concerning denial of services or other issues deemed as unacceptable. The following are definitions:

Complaints are either informal verbal or formal, written expressions of dissatisfaction. DA/S requires that verbal complaints be put in writing.

Grievances are formal, written expression of a complaint, typically initiated by a client against a provider or payer, concerning an alleged breach of agreement or an alleged injustice.

Appeals are filed when a client disagrees with the adjudication of a grievance.

A Notice of Action (NOA) is typically generated by a health plan, and constitutes notification to a client or other appropriate party regarding a denial, termination, reduction, or modification of requested services.

State Hearings represent a formal State process that an individual may initiate against the county if he/she believes the county action is not correct.

NOTE: A separate Patients' Rights database is maintained and is assumed to be outside the scope of this system.

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| 32.1 Responding to a case                    | Certain process and procedures are set up to respond to an incidence/case on a timely basis (via telephone, letters, e-mail, fax, Internet, intranet, etc.). The response has significant implication on legal, clinical, and financial risk management.  |
| 32.2 Documenting appeals, grievances, & NOAs | All relevant information about the appeals, grievances, and NOAs (NOA-A, NOA-B, NOA-C) are compiled and analyzed. Certain incidence can be related to quality or utilization management, HIPAA-compliant (privacy, security), and litigation, so appropriate and accurate information needs to be documented on a timely basis. |



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|  | Notice of Action (NOA) informs Medi-Cal beneficiaries of denial of eligibility based on medical necessity criteria (NOA-A), or changes in provider-requested mental health services from the MHP (NOA-B), and the beneficiary's rights for appeal if they don't agree with the MHP decision. Note: NOA-A and NOA-B are interim forms that are translated into other languages after they have been finalized. |
| 32.3 Determining the response                        | Based on results from available information or from research, responses to appeals, grievances, and NOAs are identified and documented.   |
| 32.4 Communicating the response                      | Timely communication to Client concerning the outcome or decision rendered (e.g., Managed Care sends the Client a Notice of Action that informs the Client that they are not eligible to receive services).   |
| 32.5 Performing tracking and follow-up               | For each unresolved issue, incidence, or case, its status is tracked and monitor for completion. Follow-up efforts are made to complete or close an issue or case.  |
| 32.6 Managing quality and performance of the process | Evaluating the quality and performance of the process for improvements.   |
| 32.7 Generating reports                              | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc).  |

### 33.0 Licensing/Credentialing

Credentialing is the administrative process of validating the qualifications of licensed professionals (including Health Agency staff, contract and network provider staff, organizational members or organizations) and checking their background and legitimacy. The process is generally an objective evaluation of a subject's current licensure, training or experience, competence, and ability to provide particular services or perform particular procedures. Certain unlicensed County clinicians (e.g., medical case staff, recreational therapists, social workers, case management personnel, psychiatric technicians) are subject to credentialing requirements.

Credentialing is undertaken at the beginning of employment/contract (initial granting) and at regular intervals thereafter (re-credentialing). It may include initial granting and subsequent reviewing of specific clinical privileges and medical staff membership.

Licensing/credentialing also involves ensuring that providers are practicing within their scope of practice, are appropriately supervised, and do not appear on excluded lists (e.g., OIG and Medi-Cal). The responsibility for credentialing and licensing of contract provider staff will be managed by the contract provider.

The County outsources some licensing/credentialing activities to an outside credentialing organization and performs some activities in-house.

Licensing/credentialing includes checking, certifying, and credentialing **facility** licenses.

NOTE: This may be provided by an interface with another County system.

| Sub-Function/Process       | Function/Process Description  |
|----------------------------|---|
| 33.1 Establishing criteria | Establishing the criteria that a clinician must possess in order to provide services. Such criteria include education, training (residency), experience, license (board certification), accreditation, hospital privileges, malpractice insurance, malpractice liability and claim history, provisions of emergency |



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|   | care and backup, tax information, and other profile data.   |
| 33.2 Submitting application/ credential request | The process for provider to request authorization to practice, such as completion of application or letter of request (paper form, electronically), and conversation with County Medical Director or other appropriate executive or committee.  |
| 33.3 Obtaining and verifying data               | Obtaining and verifying the required credentialing information [e.g., using credential verification organization or other external sources; obtaining DEA (Drug Enforcement Agency) certification with expiration, current malpractice insurance, response from National Practitioner Data Bank, lawsuits, and from the State]. |
| 33.4 Communicating result to applicant          | After reviewing all collected information, notifying the applicant clinician of the credentialing decision.   |
| 33.5 Maintaining credential data                | Credentialing information is stored and periodically updated in the system.   |
| 33.6 Generating reports                         | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc).  |

## 34.0 Provider Contract Management

Provider contract management involves the process of monitoring contractual agreements between service organizations, providers, and various agencies (e.g., State, EOC, CHC) that facilitate service delivery and financial obligations. A contract is a legal, binding agreement that stipulates terms and conditions between the County and another party. One of the major objectives for contract management is the development of a business partnership with providers to ensure the delivery of quality services, proper reimbursement, risk mitigation, facilitation of administrative functions (e.g., authorizations, claims), and availability of funding.

NOTE: Some Provider Contract Management functions will be included in 24.0 Managed Care.

| Sub-Function/Process                             | Function/Process Description   |
|--|--|
| 34.1 Establishing contract criteria/requirements | There are certain requirement criteria, terms, or conditions that the contract stipulates, which may include review of parties, mental health services provided, location of services, policy/procedures, credentialing standards, certification standards, medical records, no recourse against client, liability coverage, marketing, client grievance, arbitration, assignment/delegation, offset, hold harmless, effective dates, provider responsibility, payment arrangement, and term and termination. Contracts can be categorized as clinic or 24-hour facility. With any appropriate provisions that requires contractors to participate in federal/state audits and/or compliance requirements. |
| 34.2 Executing contract negotiation              | A key challenge in contract negotiation is to balance cost, quality, risk, and care management. The success of contract negotiation depends on many factors, which may include these strategies: be persuasive, aim high but realistic, prepare thoughtfully to achieve goals, and having accurate and reliable data.  |



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| 34.3 Maintaining and tracking contract status | Contract maintenance involves keeping contract terms and conditions accurate, up-to-date, and in compliance with applicable rules and regulations. Track contracts with network providers and CBOs based on clinical outcome measures defined by the program-- measures depend on type of program. Includes tracking the arbitration/dispute progress, insurance requirements, quality and utilization performance, financial condition (reimbursement, payment, cash flow), licensure status and other factors important in monitoring provider contract-compliance. |
| 34.4 Maintaining history                      | Establishing and maintaining historical and current fee schedules.  |
| 34.5 Generating report                        | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc).  |

## 35.0 Provider Network Management

The purpose of provider network management is to ensure that the proper mix of providers (clinicians) is available to deliver necessary, covered services to clients throughout the service area. Network management involves determining client needs, screening potential provider applicants, verifying potential provider applicants' credentials, license, and qualifications, writing contracts, ensuring contract compliance, and re-credentialing and renewing provider contracts as appropriate to maintain the provider network.

NOTE: Provider Network Management functions apply to 24.0 Managed Care clients.

| Sub-Function/Process                     | Function/Process Description  |
|--|---|
| 35.1 Determining client needs            | Determining and understanding the needs of Clients in the service area, including behavioral and clinical service, care, or treatment needs, language(s) spoken, cultural considerations, and geographic location. Includes producing profiles on Clients by program, primary language spoken, and zip code.  |
| 35.2 Establishing provider network/panel | Determining the type(s), quantity, location, and desired education, experience, professional qualifications, and attributes of providers who will deliver services, care, or treatment to clients. Network providers represent a range of specialties (e.g., psychology, psychiatry) and sub-specialties (e.g., child psychology and child and adolescent psychiatry). Using a ratio of providers to clients is one way to determine network provider requirements. A database of providers is maintained to identify gaps in service area needs. |
| 35.3 Assigning providers                 | Assigning a provider to a client based on client need and network provider availability. In the future, it is envisioned that following the assessment, referral process, and eligibility process, a client will be able to search for providers by specialty, gender, language spoken, and geographic location (e.g., zip code) via the County Portal. See 11.0 Portal.  |
| 35.4 Screening providers                 | At this time, the County does not recruit providers. Rather, potential applicants initiate contact with the County which then conducts an initial screening that includes: requesting a CV, checking licensure status with applicable professional Board, and contacting Program Supervisors at each clinic via e-mail to request feedback on potential applicants based on prior knowledge of the individual or previous experience working with the individual.   |



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| 35.5 Sending application packet             | Sending an application packet to potential providers who have successfully completed the screening process. The application packet includes a Scope of Practice form, Reference form, and Rate Schedule.   |
| 35.6 Reviewing potential applicants         | Reviewing the completed packet to see if it meets Mental Health policy requirements.   |
| 35.7 Verifying credentials (outsourced)     | The County uses Med Advantage as its credentialing verification organization (CVO). The County sends a copy of the license, insurance face sheet, and application to the CVO which verifies DHHS (exclusions list), National Practitioner Data Bank (NPDB) malpractice judgments and lawsuits, Drug Enforcement Administration (DEA) number, licensing Board, malpractice insurance (litigation and claims), and education and training. |
| 35.8 Verifying qualifications (in-house)    | Verifying professional references, call coverage, adequate insurance limits, disciplinary actions, requests explanations, and CV.  |
| 35.9 Reviewing and deciding                 | Reviewing all documentation and deciding whether to negotiate a contract with the provider.  |
| 35.10 Preparing contract                    | Drafting a contract using a MS Word template, inserting provider-specific terms and conditions as appropriate. The contract may include quantitative and qualitative performance metrics to which one or both parties must meet.   |
| 35.11 Fulfilling contractual obligations    | County and network provider fulfill all contractual obligations (e.g., timely completion of documentation and timely reimbursement). May include monitoring provider performance according to performance metrics established during contract negotiations.  |
| 35.12 Maintaining provider relations        | Monitoring and ensuring provider satisfaction via self-administered client satisfaction surveys, self-administered provider satisfaction surveys, and following-up on client claims of inappropriate conduct.  |
| 35.13 Maintaining network provider database | Maintaining accurate and current data on provider status (e.g., provider name, type, address, ages served, therapeutic modalities, experience with cultural groups, experience with spiritual groups, languages spoken, specialty services, specific areas of practice, and whether accepting new referrals).  |
| 35.14 Generating reports                    | Generating appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc). For example, re-credentialing reports, tracking of license and insurance reports, and vendor reimbursement reports.   |

**36.0 Share of Cost/UMDAP/Sliding Scale/Co-Pay/ABN**

Share of cost is a mechanism by which a client's ability to pay for services received is calculated. Usually applicable to lower income clients, fees may be calculated according to the Uniform Method for Determining Ability to Pay (UMDAP) or another method, depending on the payer source.

Sliding fee scales are calculated for DA/S (not UMDAP) based on gross income.

Co-pay is the amount an insured person is expected to pay for a medical expense at the time of the visit.

An Advanced Beneficiary Notice (ABN) is a written notice made available to Medicare beneficiary Clients from the County (based on the standard government form CMS-R-131). An ABN must be given to every



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Medicare patient regardless of age. For minors, the person financially responsible for payment receives a copy.

An ABN is given to a client before receiving certain items or services, and notifies the client that:

- Medicare may deny payment for that specific procedure or treatment.
- Client will be personally responsible for full payment if Medicare denies payment.

An ABN gives the Client the opportunity to accept or refuse the item or service and protects him/her from unexpected financial liability in cases where Medicare denies payment. It also offers a Client the right to appeal Medicare's decision.

| Sub-Function/Process                                   | Function/Process Description   |
|--|--|
| 36.1 Maintaining fee schedule and structure            | Developing annual fees for each program, using various methodologies, including creating sliding scales based on UMDAP. Maintaining accurate and up-to-date information on payer-specific or County charges for all services rendered and programs offered to clients. |
| 36.2 Calculating share of cost                         | Automatically calculating a client's share of their service/program costs.   |
| 36.3 Determining client's fulfillment of share of cost | Automatically calculating a client's total payments made toward his/her account and indicating to what extent payments made fulfill their share of cost.   |
| 36.4 Calculating sliding fee                           | Automatically calculating a client's fee on the basis of client income and number of people applied to a standard (full) fee schedule.   |
| 36.5 Generating Advanced Beneficiary Notices (ABNs)    | Generating ABNs and tracking whether client signatures have been obtained. ABNs mostly include standard language but include some client-specific information such as name and medical record number.  |
| 36.6 Generating report                                 | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc).   |

## 37.0 AP/Reimbursement

The process of monitoring and making payments (e.g., reimbursement or compensation) due to providers for services rendered to clients. Provider reimbursement methodologies may include fee-for-service (FFS) agreements, under which a provider is paid full charges for each service rendered; a capitation agreement under which the provider receives a set fee per month for each client under his/her care; a mixture of both FFS and capitation; cost-based reimbursement; negotiated rate reimbursement; or other contractual arrangements.

| Sub-Function/Process                    | Function/Process Description   |
|---|--|
| 37.1 Determining types of reimbursement | Support the different methods of provider reimbursement, which may be based on salary, fee schedules, fee-for-service, and capitation with performance/risk factors. |



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| 37.2 | Claims adjudication      | Provider reimbursement is calculated or determined based on contractual agreements, claims submission, and other requirements (e.g., utilization management and risk sharing). Payment can be made via paper check or electronic funds transfer.  |
| 37.3 | Providing payment        | Payment is provided on a timely basis.  |
| 37.4 | Coordination of Benefits | The COB (Coordination of Benefits) process determines the respective responsibilities of two or more health plans or payers that have some financial responsibility for a claim. A coordination of benefits, or "non-duplication," clause in either policy prevents double payment by making one insurer the primary payer, and assuring that not more than 100 percent of the cost is covered. Standard rules determine which of two or more plans, each having COB provisions, pays its benefits in full and which becomes the secondary payer on a claim (also called Cross-Over). |
| 37.5 | Explanation of Benefits  | Explanation of Benefits (EOBs) are paper statements-- or electronic exchange of information-- provided by the payer (including the county) that reconcile the amount billed to the amount paid, and indicate the reason(s) an item was not paid. The EOP also includes the amount of any charges that are the responsibility of the client (e.g., co-payment, coinsurance, deductible).   |
| 37.6 | Disallowances            | Disallowances are services that have not been--or will not be--reimbursed for a variety of reasons. Handling disallowances entails entering the unreimbursed service(s) and the reason(s) for non-payment using State and County codes. Disallowances must be entered in the County system and in the State system to capture detail on the service(s) and reason(s) for non-payment.   |
| 37.7 | Updating records         | Payment records are updated to ensure accuracy and reliability. Payment records are posted to the general ledger, A/P and A/R as needed (e.g., recovery operations).  |
| 37.8 | Generating report        | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc).  |

## 38.0 Performance Quality Improvement

Monitoring processes that affect the quality of client/patient care processes and/or outcomes. PQI identifies areas that need improvement, develops solutions to rectify deficiencies, optimizes resource utilization, and improves processes and outcomes. PQI efforts are integrated with staff training.

| Sub-Function/Process                             | Function/Process Description   |
|--|--|
| 38.1 Collecting, aggregating, and analyzing data | Supporting the systematic capture, analysis, and reporting of data used in process improvement, outcome measurement, and trend analysis. Includes data captured in assessments, treatment plans, discharge summaries, and other areas of the electronic health record. |



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| 38.2   | Generating report           | Generate appropriate reports for internal and external reporting as needed and on a timely basis (via paper forms, on-line screen, etc).  |
| 38.3   | Presenting                  | Graphical presentation of analytical and trends.  |
| <b>39.0 Community Education and Outreach</b>   |                             |   |
| Community Education and Outreach involves initiating communication and contact with the public, and disseminating information to the public, for the purpose of providing health education, health promotion/disease prevention, training and/or skill building, activities, health related screenings, educationally-based early intervention, and awareness of community services and resources. |                             |   |
| 39.1   | Prevention                  | Designed to produce optimal behavioral health outcomes in a cost-effective manner through various approaches (population-based, proactive, disease-specific) in delivering the services. Preventative behavioral health places strong emphasis on new education measures, practitioners, common outpatient procedures, and adherence to prescription drug regimens. |
| 39.2   | Client satisfaction surveys | Generate client satisfaction survey letters with pre-printed address labels to random samples, user-defined populations, or all BHS clients. Capture interview online when client comes in for follow-up and E-mail results back to appropriate department.   |
| 39.3   | Analysis                    | Capture trends, analyzes and disseminates results of client satisfaction surveys.   |