Sacramento County
Adult Documentation Training

Presented By:
Quality Management
and
Adult Mental Health
Training Goals

To familiarize you with the clinical documents
To review standards for completion of clinical documentation
To clarify documentation requirements
To bridge the gap between practice and documentation
Training Outline

Introduction to the Mental Health Plan
Clinical Documentation Overview
Clinical Assessment Package
Progress Notes
Resources and Contact Information
County Philosophy

Vision
Mission
Values
Introduction to the Mental Health Plan

Target Populations
Medical Necessity
Commitment to Cultural Competence
Language Requirements/Interpreting Services

Handouts 2, 3
Sacramento County Target Population

For the purpose of County MH Services, Target Population:
   Refers to individuals with severe disabling conditions that require mental health treatment giving them access to available services based on those conditions.

Major Depression Recurrent, with or without Psychotic Features
Bipolar Disorders
Schizophrenia; Schizoaffective Disorders
Psychotic Disorder NOS (re-evaluation & change within 3-6 months)
Borderline Personality Disorder
Post Traumatic Stress Disorder (effective January 2010)
Medical Necessity

The criteria that identifies service need based on inclusion of specific signs, symptoms, behaviors and conditions and proposed treatment associated with mental illness.

*Determinaton of medical necessity requires inclusion of*

Covered diagnosis;
An established level of functional impairment with an expectation that specialty mental health treatment is necessary to address the condition and;
The condition would not be responsive to physical health care based treatment.
Medical Necessity Cont’d

When recording a client’s condition, staff must document

Onset
Frequency
Duration
Severity of symptoms
Resulting functional impairments
Medical Necessity Cont’d

If client does not meet

**Medical Necessity**, but meets

**Service Necessity** (need for another type of service), you have up to 30 days to link the client to a more appropriate service.

You may bill Case Management/Brokerage
Definition of Cultural Competence

A set of congruent practice skills, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations.
Cultural Competency

Making Cultural Accommodations

Documenting those Accommodations

Use of Interpreters
Threshold Languages

A “Threshold Language” is defined as a primary language other than English spoken by 3,000 Medi-Cal beneficiaries or 5% of the population, whichever is lower in an identified geographic area.

Sacramento is second to Los Angeles in number of beneficiaries who speak a “Threshold Language.”
Threshold Languages Cont’d

Sacramento County has FIVE Threshold Languages

Chinese (Cantonese)
Hmong
Russian
Spanish
Vietnamese
Cultural/Linguistic Requirements

Mandate that oral and written communication be provided in the client’s preferred language and documented for each service.

Recognizes the beneficiary’s RIGHT to culturally/linguistically appropriate services and considers the special needs of adults and families.

Requires documentation of attempts made to accommodate the cultural/linguistic needs of client/caregiver and prohibits the expectation that family members act as interpreters.

Handout 4
Interpreter Services
Area code 916

Southeast Asian Assistance Center
(SAAC) 421-1036,
Language World: 473-0100 Carmazzi 714-7848
(Deaf/Hard of Hearing) Nor Cal 349-7525
A Show Hands 247-8859
Class Act Alliance 759-4594
Sign Language Inter 483-4751

AT&T Line may be used by contractor providers
Pacific Interpreters County staff to use for phone
interpreters only. 1-866-425-0217 need County code
from supervisor.
Clinical Documentation Forms

Client Data Sheet (CDS)
Adult Comprehensive Assessment (ACA)
Adult Service Plan (ASP)
Adult Re-Assessment
Adult Health Questionnaire (AHQ)

Co-Occurring Disorder Assessment (CODA)
LOCUS
Discharge Re-Assessment Summary
Annual Medication Service Plan (AMSP)
Progress Notes

If applicable CODA, LOCUS
An initial complete clinical assessment packet consists of:

- Client Data Sheet (CDS)
- Adult Comprehensive Assessment (ACA)
- Adult Service Plan (ASP)
- Adult Health Questionnaire (AHQ)
- Co-Occurring Disorder Assessment (CODA)
- And LOCUS when applicable
- Annual Medication Service Plan (AMSP)
- Introductory Clinical Progress Note
Staff Classifications

**LPHA** MD, PhD, RN, LCSW, MFT, Waivered Staff (ASW or IMF)

**Graduate Student** Enrolled in accredited program; co-signatures required

**MHRS** Degree & Experience

**MHA I, MHA II and MHA III** Experience and Education beyond High School
The Basics of Clinical Documentation

Handout 6
Consents and Releases

Obtain consent to treat for all clients receiving services, as required by law.

Conservator signature is required if client is conserved.

Acknowledgement of Receipt Form

HIPAA compliant Authorizations to Obtain or Release health records are required.

A current consent is required in the chart for each medication the client is taking.

Handouts 7, 8, 9
Working Definitions

**Authorization Period**  County Access Team gives the “Start” and “End” dates for service reimbursement

**Program Start Date**  First billable service to AVATAR; face-to-face contact, with limited exceptions.

**Paperwork Cycle**  Begins at the Program Start Date through end of the Authorization Period.

**Levels Of Care**  Determined by level of care and support services needed by the client.
Service Coordination & Authorization

All Services must be authorized by the County Access Team.

The “Detailed Authorization” or “Display Managed Care Authorization” printout is required in all charts.

All Services must be delivered within the authorization period for reimbursement.

Requests for re-authorization must be submitted when the client is transitioning from one Level of Care to a different Level of Care outside the legal entity.
Service Levels I, II, III and IV

**Level I** Step-down for Medication services provided by Primary Care physicians in the community.

**Level II** Low Intensity services, primarily medication support, case management, and mental health services (social rehabilitation, collateral, support groups, etc).

**Level III** High Intensity services (LOCUS required for authorization)

**Level IV** Step-down from locked facility placement (LOCUS required)
Levels II & III at Start of Services

County Access Team Authorize services for Levels II and III
Provider completes CDS, ACA, ASP, AHQ, AMSP, and CODA if applicable, as well as Consents/Releases, Acknowledgement of Receipt containing HIPAA, Advance Directive, etc. within 60 days of services start date.
Levels II and III Re-Authorization

**Level II.** Service Plan is required for all clients every year.

**Level III.** Re-Assessments and Service Plan are required for all clients every year.

**Annually Level II and III** also completes: CDS, AMSP, and CODA if applicable.

**Reimbursement** depends on signed Service Plan and Access Authorization that covers date range of each service billed.
Client Data Sheet (CDS)
When to Complete CDS

Complete CDS at start of services along with ACA, ASP, AHQ, CODA and LOCUS if applicable. Plus AMSP (completed by psychiatrist)

Complete CDS at annual paperwork cycle

Complete CDS when diagnosis, address, or other pertinent information changes AND remember to update in AVATAR
Adult Comprehensive Assessment
ACA
ACA Overview

1. Reasons for Service includes symptoms, behaviors, and level of functioning to support service needs and Medical Necessity

2. Psychosocial History, includes Family Support, Socio-Functional, and Culture
3. Mental Health History, includes description of all boxes marked “yes”

4. Substance Use, includes client questions and service provider screening. Follow-up with CODA if any “client questions” with an * are marked yes.
5. Community Functioning: Check all boxes and consider developing a treatment goal for any boxes checked “Mixed” or “Dissatisfied.”

6. Mental Status Exam
7. Risk indicators, includes suicide/self harm and Assault. Follow up with description for any yes boxes and develop a safety plan as needed.

8. Five Axes diagnosis from the most current DSM-IV with a Corresponding ICD-9 Code for the Primary Axis I DSM Diagnosis. Diagnosis source is an LPHA and not the DSM-IV.
9. Updated Diagnosis, includes supporting progress note and updated Client Data Sheet.

Only an LPHA may change a diagnosis.
When documenting change in progress note, include justification, date, and name of staff who changed the diagnosis.
10. Service Coordination Contacts: Complete all boxes that apply including: type, agency, contact person and phone number as needed.
Service Plan
Service Plan Overview

The Plan should be clear and will guide treatment

**Life Goals.** are client quotes or statements indicating hopes, dreams or ambitions that may or may not be related to the mental health condition.

**Strengths, Challenges & Personal Supports.** Explore and document this information with the client. It will be extremely helpful as you and the client work together to achieve goals outlined in the Service Plan.
Service Plan Overview

**Treatment Goals.** address the client’s mental health condition (symptoms and behaviors) and are specific and measurable. **Note status of each goal.**

**Services.** Connect each goal to a service (s) and include frequency and responsibility of client, support person and staff as needed to accomplish the client’s Treatment Goals. **Note completion date of each goal.**

**Service Coordination.** List all needed areas (income, benefits, housing, etc.) identified by the client that require additional assistance/support to accomplish his/her Treatment Goals.
Service Plan Overview

All Signatures must be obtained within 60 days of start of services.

Client signature is required; otherwise use space on form to document reason(s) for no client signature.

Conservator signature required if client is conserved.

Provider signature/Title as required.

Must provide client with copy of the plan at start of services and upon request in the future.
Re-Assessment

Request for Continuation of Services from Access
Required for all MHSA Programs

Handout 15
What are you Re-Assessing?

Current Medical Necessity
Current Level of Functioning
Current Need for Services
Identify Changes in Substance Use
Identify Updates from ACA
Progress toward treatment goals

Submit to Access within 30 days of Authorization expiration
Glossary

The glossary is organized to correspond with the reading order of the ACA/Re-Assessment

The MSE and Substance Abuse sections of the ACA/Re-Assessment are highlighted
Adult Health Questionnaire
AHQ
Linking Physical Health and Mental Health
Important AHQ Elements

Required with ACA and CDS within 60 days of Program Admit Date

General Medical Conditions listed on AHQ need to be consistent with those listed on CDS

Progress note required when linking client to a physician or healthcare provider

Document health updates on the Re-Assessment
Co-Occurring Disorder Assessment
CODA

What is the CODA?
A tool intended to ensure clients receive appropriate assessment, treatment and referrals for co-occurring substance use disorders.

When should the CODA be completed?
Whenever indicators are present

Who should complete the CODA?
Service Providers
CODA Indicators

When the following indicators are present, complete the CODA:

At Admission Interview (if indicated)

At Re-Assessment (if indicated)

When Indicated (Client or Collateral source discloses an issue or problem - i.e. toxicology screen, legal issue, prior assessment)

When there are clear consequences indicating substance abuse problems
CODA Engagement

All interactions should be non-judgmental and supportive

Remind the client that the information is CONFIDENTIAL

Privacy should be maintained to support client disclosure

Assure the client that what they say will not negatively impact their other mental health services
CODA Interview Questions
Based on DSM IV-TR Criteria

Ask the client each question and record a yes/no response in the boxes

Questions 1-4 are the criteria for Substance Abuse

Questions 5-11 are the criteria for Substance Dependence

If any of 1-4 are marked the diagnosis should be “Substance Abuse” Unless:

5, 6, and any of 7-11 are marked then the diagnosis should be “Substance Dependence”
CODA Level of Functioning

In relation to co-morbid substance use/mental health symptoms:

Indicate your assessment of the client’s functioning in the seven domains. For each response include a comment or description.

Indicate your overall rating of client bio/psychosocial functioning by checking low, moderate or high.

A low or moderate overall level of functioning should result in a related goal in client’s treatment plan.
CODA Severity Assessment

Ask the client to respond to the three choices on the Client Self Assessment and indicate his/her response.

Complete the Staff Assessment by indicating your assessment in one of the four boxes.

Be aware of the client’s Stage of Change Readiness as it will affect treatment planning decisions.
CODA Treatment Planning

Clients should be served within their current clinical setting. Transfers from program to program increase the likelihood of disengagement.

All treatment planning must be completed with full client participation and agreement, and needs to reflect consumer choice.
CODA Services
Within the Current Clinical Setting

Sac Port Substance Abuse Management Module (SAMM)

Pre-Treatment Groups

Self-help Groups

Mental Health Rehabilitation Services
CODA Treatment Plan Options
Within the ADS System of Care

Outpatient Counseling
Residential Treatment
Detoxification
Interim Supports

NOTE: Treatment Authorization and Level of Care will be determined by the Alcohol and Drug Services Division, System of Care (ADS SOC)
CODA Documentation

Complete the CODA and file in the client’s chart. Write a progress note documenting CODA completion and other pertinent information.

Complete a related goal and plan in client’s ACA/Re-Assessment

Ensure substance use diagnosis is reflected on Axis I (Secondary diagnosis)
CODA Referrals to ADS SOC

Services through an ADS contracted provider, including outpatient counseling, Residential Treatment and Detoxification require assessment and authorization by ADS SOC staff.

Two methods for obtaining ADS SOC assessment and authorization:

- Drop-In Assessment
- ADS Screening and Service Referral (preferred)
CODA Referrals (Drop In)

Drop in Assessment
Clients may present themselves for an assessment at the public lobby at 3321 Power Inn Rd., Suite 120 at 8:00 AM or 12:30 PM. They will be seen in order of arrival and will receive an assessment, and if indicated, a referral for services.
CODA: Referrals (ADS Screening)

**ADS Screening and Service Referral**

Complete an Alcohol and Other Drug (AOD) Screening and Service Referral and a release of information, naming DBHS ADS SOC as the recipient.

Fax both forms along with the CODA to ADS SOC at 874-9806.

Provide the client with a copy of “Instructions to Client.” Client may be accompanied to the assessment.
Progress Notes Overview
Types of Progress Notes

Collateral
Assessment
Individual Therapy
Group Therapy
Group Session
Rehabilitation

Plan Development
Medication Support
Case Management
Brokerage/TCM
Crisis Intervention
Cancellations
No Shows

Handouts 19, 5
NEW INFORMATION!

Avatar Claims Processing Alert (Denials/Suspended Claims) regarding Maximum Allowable Units.

*Please refer to this handout for clarification.*

Handout 19
Progress Notes

Key topics discussed in the session
Current symptoms and behaviors
Accommodate language and cultural needs
Describe how interventions address the client’s mental health condition
Always assess for risks and document actions taken to ensure safety
Progress Notes  Cont’d

Document collaborative efforts made
Document strengths and barriers toward achieving treatment goals
Document progress made toward achieving treatment goals.
Note

Federal/State laws require documentation for
purposes of reimbursement.

If records are inadequate or nonexistent,
reimbursement is subject to recoupment.
Clinical Introductory Note Assessment

Written at first visit, or very soon thereafter, providing an overview of the client and his/her mental health condition. A complete note includes but is not limited to:

- Identity of client, including age, ethnicity, etc.

Referral Source

Cultural Accommodations
Clinical Introductory Note Cont’d

Presenting condition, including symptoms, behaviors, and level of functioning

Need for Services/Medical Necessity justifications

Client strengths and supports

Plan for services
Assessment Code 93010

Assessing a client for Service/Medical Necessity

Assessing Diagnostic Criteria and Level of Functioning

Always includes cultural considerations and accommodations

Completing ACA, Re-Assessment, as well as CODA and LOCUS if applicable

Use of Testing Procedures
Collateral 95010

Service activity to a significant support person for the purpose of meeting the client’s mental health needs as identified in the Service Plan.

The significant support person should be identified in the Service Plan.

Note: Medi-Cal will NOT reimburse for services that address the support person’s mental health issues.
Rehabilitation 94000

Assisting a client in improving, restoring or maintaining
- Functional Skills
- Daily Living Skills
- Social Skills
- Grooming and Personal Hygiene Skills
- Meal Preparation Skills

Counseling of the client

Notes should reflect interventions, progress and response to skill training
Individual Therapy 97010

Psychotherapeutic intervention to improve symptoms and functional skills

Guided by the treatment plan

Only an LPHA, or a graduate student trainee under the supervision of an LPHA, may provide individual therapy
Group Session Notes

Group Therapy 96510 Vs. Group Session 96520

A group note should include:

Type/Title of group
Goal/Focus of today’s group
Client’s Receptivity or Response in group
Distinct staff roles, if co-facilitated
Plan Development 98500

Service activity involving development and implementation of a plan or intervention

The progress note must clearly document steps for a planned intervention and follow-up
Medication Support 97500/97530

Only MDs, RNs, LVNs, and PTs can bill these services
Case Management Brokerage/Targeted Case Management

CASE MANAGEMENT BROKERAGE

Linkage to Primary Health Care Services
Linkage to other mental health services, also with non-mental health services (outside the MHP),
Intra and Inter Agency staffing (co-staffing must be non-supervisory, non-duplicative, meaningful planning and implementation).
Case Management/Targeted Case Management

Targeted Case-Management: services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services activities may include, but are not limited to:

Communication, coordination, monitoring of client’s progress, placement services, and plan development as well as referrals

Solely for purpose of coordinating placement at time of discharge from hospital, psychiatric health facility or psychiatric nursing facility “may be provided during 30 calendar days immediately prior to the day of discharge, for a maximum of three non-consecutives periods of 30 calendar days or less per continuous stay in the facility”.

Crisis Intervention 95510
Crisis Intervention

CRISIS INTERVENTION: provided when a client requires an immediate response or intervention to help him/her stabilize and maintain a community setting. A crisis intervention note documents an unplanned service to or on behalf of an individual.

Progress note must include the following:
A brief succinct narrative of the crisis situation.
A description of the intervention provided
The client’s response to the interventions
Specific plan to follow-up
Sample Crisis Intervention Note

Client’s significant other phoned and this writer could hear client screaming and breaking furniture in the background. Client’s significant other said that client is not taking his medications and asked for immediate assistance. Worker will go to the home to intervene. Gave worker’s mobile number to client’s significant other. Recommended calling the police immediately or taking client to a local ER for an evaluation if client’s significant other feels safe in transporting the client. Plan is to follow up later today with the client’s significant other to verify client’s status.

Qiana Smith, MHA III
Progress Note Sample 1

This writer met with new co-worker to assist her in completing the initial clinical intake packet, including the ACA, AHQ and CDS.

Huong Tan, MHA III
Discussion with nurse regarding scheduling client for psych med appt. since nurse informed this writer that client “No Showed” for med appt. today. Nurse recommended that I write to client regarding appt date & time. If client does not show for next scheduled appt 1/23/07, and we do not hear from him by 1/27/07, we will close the case.

Jill Scott, ASW
Progress Note Sample 3

This writer spoke with client’s wife regarding client’s interpersonal relationships and his symptoms of depression. Client’s spouse was informed of ways of helping the client develop coping skills when interacting with others with the goal of increasing client’s self esteem and reducing symptoms of depression.

Amar Sarat, LCSW
Progress Note Sample 4

Telephoned client to reschedule appointment. Left a voice message with the new time and date to meet.

Bridget Baas, MHA I
Board and Care called to inform this writer that the client passed away three days ago at the hospital due to chronic physical illness. Worker contacted family. Took F/U actions. Plan: will close case and complete D/C forms.

George Williams, MHA I
MHSA Service Codes

Used for additional services and supports that are not reimbursable to standard Medi-Cal codes
Need **supervisor approval** before using MHSA codes

Individual Traditional Healing Practices  28050
Group Traditional Healing Practices  28051
MHSA Family-Caregiver Services and Supports  28047
MHSA Client Services and Supports  28045
MHSA-Benefits Acquisition  28048
When to Bill for Individual (28050) or Group (28051) Traditional Healing Practices

A Traditional Healing Practice is one that is commonly utilized within a particular culture. Traditional Health Service Providers include but are not limited to:

- **Acupuncturist**
- **Herbalist**
- **Faith Healer**
- **Shaman**
- **Curandero**
- **Religious Leaders**
- **Community Elders**

Accompanying a client to a traditional healing session
Supporting client during a traditional healing session
Mr. Vang has requested to see a Shaman to help him with his depression and chronic physical pain. Picked him up at his daughter’s home and accompanied him to visit the Shaman chosen by he and his family. Provided support and encouragement following the visit. He indicated that he felt better and wants to return to the Shaman next Saturday.

Vu Yang, MHRS
Sample Group Traditional Healing Practices Note 28051

Writer transported the client to a traditional sweat lodge ceremony and processed the client’s experience afterwards. Client reported reduced anxiety during and following the ceremony and thanked writer for supporting her through this experience.

Mary Hamilton, MHA II
When to Bill MHSA Family/Caregiver Services and Supports  28047

When a service is provided to address the specific needs of a family member or significant support person rather than the needs of the client.

Services will not address the client’s mental health plan
Sample MHSA
Family/Caregiver Services and Supports Note

Met with client’s daughter (25 years old), Mrs. Smith, for an individual session. Mrs. Smith is overwhelmed by current stressors of taking care of client’s mental health and parenting her autistic child. She is requesting assistance with obtaining parenting classes. Helped her to find a parenting group and to develop a plan to enhance her parenting skills. Practiced parenting skills. Provided hope and encouragement.

Pamela Arroyo, MHA III
MHSA Family/Caregiver Services and Supports Tracking Index

Records for services provided under MHSA Family/Caregiver Services and Supports (28047) should be filed separately from the primary client’s chart. Indicate family member/caregiver’s name and relationship on Tracking Index and file or attach to primary client’s chart.

Decide: does service provided to the family member represent personal health information (ie: therapy services)
When to Bill MHSA Client Services and Supports  28045

Provision of a Non-Mental Health Service that impacts a client’s overall quality of life.

Examples May Include:

- Legal services (client’s legal needs)
- Recreational Activities (exercising, dancing, golfing, etc)
- Socialization Activities (senior oriented activities /events, amusement park, etc)
- Senior nutrition programs
Sample MHSA Client Services Note

28045

Client requesting assistance after receiving citation for non-payment of fare at Regional Transit Lightrail location. Writer assisted client with transportation to RT administration office and attended hearing with client. Writer assisted client with paperwork needed to complete resolution process. Client will receive response within 10 days and will contact writer if further assistance is needed. Services provided so that client can continue to utilize Lightrail service which is his primary source of transportation.

Steven Atkins, MHRS
When to Bill MHSA
Benefits Acquisition 28048

Assisting in filling out paperwork to obtain benefits (Medi-Cal, Social Security, Senior Discount cards, etc.)

Transporting a client to a benefits office for an interview.

Communication with eligibility workers (i.e. writing letters)
Met with client to assist with completion of SSI packet. Drove to SSI office to pick up the packet. Walked client through filling out the form; clarified information needed on forms.

Andrew Okimoto, MHA II
Medi-Cal Non-Reimbursable Services

These services should be documented even though they are not reimbursable by Medi-Cal

Examples:

- Supervision
- No Shows
- Transportation
- Administrative Activity
Supervision vs. Consultation

**Supervision** (non-billable)
Time spent providing supervision to staff/students for the purpose of:
- Obtaining BBS required clinical hours, and/or
- To monitor/manage a clinician’s learning curve.

**Consultation** (billable)
Inter/intra agency communication and coordination with an experienced professional for the purpose of improving treatment and planning interventions.
Transportation vs. Travel Time

**Transportation (non-billable)** Physically taking clients from one place to another.

**Travel Time (billable)** The time spent traveling to/from a service site where a mental health service was provided.
Administrative Activities
Non-Billable

Filing

Faxing

Scheduling an Appointment

Leaving/Retrieving a Message

Reserving and setting up a room or audio-visual equipment for a session

Studying/Researching a topic
Other Non-Billables

Billing for second staff when the roles appear duplicative, non-essential, or inappropriate for the individual service or group.

Excessive billing for chart review with no documented product such as updated plan or concrete outcome resulting from the review.

Providing mental health services for someone other than the beneficiary.

Providing interpretation services.

Non-Mental Health Services

Services provided during Lock-Out situations.
Annual Medication Service Plan (AMSP)

Coordinating Medication Services with the Psychiatrist and Nursing Staff
Important points to remember regarding AMSP

An AMSP must be completed at the time a psychiatrist initially prescribes or evaluates current medication and annually thereafter.

An AMSP must be completed at the time of admission to Level of Care I (Recovery Services).
Compliance Plan

According to CFR 42 (Code of Federal Regulations) & Title 9 Section 1840.112 all providers of mental health services are required to verify that every service provided is accurately documented, signed and billed appropriately.

Assessments, progress notes, and client plans are required documentation.
Discharge Re-Assessment Summary

Complete Discharge Re-Assessment Summary when client is:
- Discharged
- Transfers from one legal entity to another
- If the client is *Deceased (non-billable)*.
Member Handbook & Problem Resolution Guide

Provide and review Member Handbook and Problem Resolution Guide to client and caregiver at start of services

The Handbook and Guide are available on the web and in Sacramento County threshold languages

For assistance, contact:

Rolanda Reed-Anning: 875-0853
Reed-AnningR@saccounty.net

Member Services
888-881-4881
916-875-6069
916-876-8853 (TTY)
DOCUMENTATION & UTILIZATION REVIEW
QUESTIONS
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Additional Contact Information

**CODA/LOCUS QUESTIONS**

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**MHSA QM QUESTIONS**

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