G. QUALITY ASSURANCE PROGRAM

The MHP's philosophy is that high quality mental health care is client-centered, clinically effective, accessible, integrated, outcome-driven, and culturally competent. The purpose of the MHP Quality Assurance Program is to ensure that all clients **regardless of funding source** receive mental health care in accordance with these principles. In order to achieve this goal, each program in the system must have internal quality improvement controls and activities in addition to those provided by the MHP. These activities may involve peer review, program manager monitoring of charts and billing activity, and/or a formal Quality Improvement department, which offers training and technical assistance to program staff. Internal monitoring and auditing are to include the provision of prompt responses to detected problems. In addition, all providers shall attend regular provider meetings, special forums, in-services/trainings as required by the Contracting Officer Representative (COR), BHS System of Care Executive Leadership and/or Quality Assurance Unit. Attendance at these meetings is essential to keep abreast of system changes and requirements as part of our continuous improvement efforts.

The quality of the MHP's care and service delivery system is ensured by continually evaluating important aspects of care and service, using reliable, consistent, and valid measurements, with the goal of maximizing each program's effectiveness. The basis of this evaluation process rests in State and Federal legislation and regulations including:

- 42 CFR, (Code of Federal Regulations)
- Title 9, Chapter 11, of the California Code of Regulations
- Welfare and Institutions Code 14184.042
- State Department of Health Care Services (DHCS) Letters and Notices
- the MHP Managed Care contract with the State DHCS
- the Annual DHCS State Protocol for MHPs
- Mental Health Services Act (MHSA) requirements, and
- State DHCS mandated Performance Improvement Projects (PIP)
    - The State has mandated that each MHP undertake one administrative and one clinical PIP yearly.

The evaluation process has also expanded to meet a number of Federal regulations and legislative mandates under the new Medi-Cal Transformation as specified in Welfare and Institutions Code 14184.042 effective January 1, 2022, and the **Medicaid and CHIP Managed Care Final Rules**, effective July 5, 2016. The Federal Managed Care Regulations, specifically Part 438 of title 42 Code of Federal Regulations, applies to the provision of Medicaid Managed Care (MMC) programs and managed care organizations (MCOs), Pre-paid Inpatient Health Plans (PIHPs), and Pre-paid Ambulatory Health Plans (PAHPs). Mental Health Plans are PIHPs. Key goals of the final rule are:

- To support State efforts to advance delivery system reform and improve the quality of care
- To strengthen the beneficiary experience of care and key beneficiary protections
- To strengthen program integrity by improving accountability and transparency

- To align key Medicaid and CHIP managed care requirements with other health coverage programs

All providers shall adhere to the rules and regulations as stipulated in the W&I Code 14184.042, Medi-Cal Transformation and Medicaid and CHIP Managed Care Final Rules. Information about the final rule is available at the following link: https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html.

Information about the Medi-Cal Transformation is available at the following link: https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx

Through program monitoring, program strengths and deficiencies are identified, and educational and other approaches are utilized to achieve positive change. To be maximally effective, the Quality Assurance Program must be a team effort. It requires the dedicated effort, responsibility, and involvement of clients, family members, clinicians, paraprofessionals, mental health advocates, and other stakeholders to share information on strengths and weaknesses of services.

Indicators of care and service currently being evaluated include, but are not limited to, client satisfaction, effectiveness of the service delivery system, performance and treatment outcomes, accessibility of services, cultural competency, adherence to health and safety standards, and preservation of client rights.

MEASURING CLIENT SATISFACTION

The MHP is committed to assessing client satisfaction with the quality of care and provision of mental health services. Client satisfaction is measured for the following programs as described below:

***Adult/Older Adult System of Care**:* BHS administers annual mandated client surveys to get this important feedback. The importance of provider participation in the survey process is critical to get an accurate picture of how well each provider and the mental health system as a whole are meeting client needs. It is also a contract requirement.

BHS selects a one-week time period annually in which all Outpatient providers, including Case Management, are required to administer the Mental Health survey. This survey consists of a Mental Health Statistics Improvement Program (MHSIP) section, which measures client satisfaction with services. This survey should be administered to **all** clients receiving services during the one-week period, **including clients receiving medications only.** UCSD Health Services Research Center (HSRC) is contracted by the MHP to handle the adult survey process. HSRC distributes the blank survey forms, collects the completed forms, and compiles provider and countywide satisfaction data. Providers will be notified by HSRC of the exact survey period. Survey returns are scanned and then tabulated, therefore, original printed forms provided by the

MHP must be used. Providers are strongly requested to send in completed surveys according to HSRC instructions at the end of the survey period. Each participating provider will receive a report comparing their results on the survey with the average results for their level of care.

The criteria and guidelines for the Adult MHSIP Survey are subject to change as determined by DHCS. Providers will be notified of changes affecting them.

Children, Youth and Family (CYF) System of Care: A satisfaction survey is conducted annually within all organizational programs (excluding detention programs, medication only cases, inpatient, and crisis services) as required by the State to assess client satisfaction. The Youth Services Survey (YSS) is administered to all clients receiving services during the one-week period by the Child and Adolescent Services Research Center (CASRC). Refer to Section N of the OPOH for additional information regarding the YSS.

Provider Feedback

All providers are also encouraged to provide feedback regarding their interaction with the MHP by direct communication with the Program Monitor/COR, Quality Assurance Team, and MH Contract Administration Unit. Communication can occur at the contractor's request, at scheduled meetings, and through the status report narrative. QA will provides opportunity for provider feedback via an online Provider Feedback Survey offered quarterly via a QR Link during the QA Quality Improvement Partners (QIP) Meeting.

COR Site Reviews are scheduled on an ad hoc basis to ensure that programs remain in compliance with State Standards. However, the Pharmaceutical Review will be completed annually and will be conducted by QA staff during the Quality Assurance Program Review (QAPR) process.

Medi-Cal Certification and Recertification

Contracted and County providers shall be familiar with the Short-Doyle/Medi-Cal delivery system and shall become Medi-Cal certified prior to commencing services and billing Medi-Cal. Providers who bill for Medi-Cal services will be recertified every three (3) years. For contracted programs, the Medi-Cal Site Certification or Recertification Site Review is completed by BHS QA staff; for county-operated programs, these site reviews are completed by DHCS.

At the beginning of the fiscal year, all providers up for their three-year Medi-Cal recertification will be notified they will be recertified at some point during the fiscal year and a fire clearance will be needed to allow them sufficient time to obtain one before their recertification site visit.

Recertification site visits will be scheduled no less than 30 days before the last Medi-Cal certification date.

Providers will be notified of the recertification site visit no less than 45 days before the last Medi-Cal certification date.

The re-certification review will include review of the following:

- Compliance with all pertinent State and Federal standards and requirements
- Maintenance of current licenses, permits, notices and certifications as required
- Policies & Procedures or process
- Compliance with the standards established in the Mental Health Services Quality Improvement Plan
- Physical plant/facility requirements
- Adherence to requirements for ensuring the confidentiality and safety of client records
- Medication service
- Adherence to health and safety requirements
- Fire Clearance Requirements for Short-Doyle Medi-Cal Programs

As part of the Short-Doyle Medi-Cal Certification process for new programs or Recertification of Short-Doyle Medi-Cal programs, the organizational provider will:

- Secure a new fire clearance document from their local fire code authority and submit a copy to the San Diego County Mental Health Service's Health Plan Organization Quality Assurance Unit prior to Certification/ Recertification site visit.
- After receipt of the fire clearance document by QA, a site visit will be scheduled. Note: All fire clearance documents must be kept at the program site and be available to reviewers.

At the Short-Doyle Certification/Recertification site visit, the organizational provider must make available to the reviewer the most recent site fire clearance document. Providers will be in compliance if the most recent fire clearance document has been completed within three (3) years of the previous fire clearance document date. If the most recent fire clearance document has not been completed within the three (3) year period or fire clearance document is not found, the program will receive a Plan of Correction (POC) requesting the appropriate action(s) to be taken by the provider. The action(s) will be included in the POC and sent to San Diego County Mental Health Service's QA Unit for review. For any questions on this process, please contact QIMatters.hhsa@sdcounty.ca.gov.

MONITORING THE SERVICE DELIVERY SYSTEM

Uniform Medical Record – Forms and Timelines

All programs are required to utilize the forms specified in the San Diego County Mental Health Services Uniform Clinical Record Manual, and any updated forms, which are issued on an interim basis. The standards for documentation shall be consistent across all clinical programs, regardless of funding source. Programs may adapt forms for specific program needs upon review and

approval by the Health Plan Organization Quality Assurance Unit. The Hybrid Medical Record for each client must be maintained in a secure location, must be filed in the prescribed order, and must be retrievable for County, State, or Federal audit upon request, during and after the provision of services up to the limits prescribed in California law. Each legal entity shall develop forms for legal consents and other compliance related issues. **Out-of-county** mental health programs may utilize non-San Diego County medical record forms, but they must comply with all State and Federal and requested County guidelines.

DHCS, CMS, the Office of the Inspector General, the Comptroller General, the County, and their designees may, at any time, inspect and audit any records or documents, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related services (i.e., Drug Medi-Cal) are conducted. The right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. County providers are required to retain all Billing Records for a minimum of 10 years when the program is funded with State or Federal dollars. Therefore, contracted providers are to retain medical records for no less than ten (10) years after discharge date for adults. For minors, records are to be kept until they have reached the age of 18, plus seven (7) years. [ref: *MHSUDS IN 18-012; 42 CFR §425.314; 22 CCR* §77143; *CCR 438.3(u)*]

Documentation and in-service trainings are offered by QA to keep providers informed of the latest County, State and Federal standards. The Uniform Clinical Record Manual may be obtained on the Optum Public Sector website.

Staff Signature Logs

All organizational providers are required to maintain an accurate and current staff signature log that includes all staff that document within the program's clinical records. The MHP requires that this staff signature log include the following elements for each staff person:

- Typed name
- Signature
- Degree and/or licensure
- Job title
- Language capability, if applicable

It is very important that the signature on the log be readily identifiable to the staff person's signature, as it appears on hard copy documents in the hybrid medical record. A staff log signature that is not readily identifiable to the staff's signature within the medical record could place the service provided at risk of disallowance.

To ensure that the log is kept current, it is the organizational provider's responsibility to update and maintain the log in a timely manner to reflect any changes, i.e., licensure, degree, job title, name, or signature. The staff signature log must be maintained onsite at the organizational

provider's program location, and be made available at the request of the MHP for purposes of site visits, medical record reviews, etc. Failure to maintain a staff signature log that is accurate and current will result in a plan of corrective action being issued to the organizational provider.

Timeliness of Documentation Standard

All services provided to a client shall be documented into the client's medical record within 3 business days of providing the service with the exception of notes for crisis services, which shall be completed within 24 hours. Best clinical practice dictates progress notes be completed as soon as possible after a service is provided. With timely documentation, details and relevant information are captured that otherwise may be lost if too much time lapses between service provision and documentation of the service.

Medical Record Reviews

Quality improvement of documentation is an ongoing process shared between programs and County QA. As such, each plays an important role in the Medical Record Review Process.

Program Responsibility

Providers are required to conduct internal reviews of medical records on a regular basis in order to ensure that service documentation meets all County, State and Federal standards, and that all Short-Doyle Medi-Cal billing is substantiated.

If the clinical documentation does not meet documentation standards as set forth in the current California State Department of Mental Health "Reasons for Recoupment" the provider shall be responsible for addressing the issue by filing a Void-Service Request form with the Mental Health Billing Unit (MHBU).

All services that are voided will be identified as such and the units removed from the Medi-Cal and the Total units. These are automatically repaid to the State once the billing unit submits the void request. Providers are responsible for re-entering the non-billable service code for services that are identified as a Medi-Cal billing disallowance and is voided based on the Void Reasons found on the Optum website. Corrected service information may only be entered once the provider has confirmed that the incorrect service has been voided.

Providers shall ensure that the services listed on the Void Request Form as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services listed must be listed on the form exactly as they were billed.

County Quality Assurance Program Reviews

The MHP mandates site and medical record monitoring of providers to ensure that all clients receive the highest quality clinical care at the most appropriate levels of service. The Health Plan Organization Quality Assurance Unit conducts program site and Quality Assurance Program reviews (QAPRs). Site visits and Quality Assurance Program reviews are scheduled and coordinated with the Program Manager at each provider site. A copy of the site and QAPR review tool is distributed to the Program Manager prior to the scheduled review.

As part of the coordination process for a QAPR with the program, the QA Specialist will notify the program manager of the designated audit period for the billing claims review. All billings for the designated period will be reviewed on those providers/services that are selected for review. Once the program manager has been informed of the designated billing claims period, no provider self-reports of disallowances will be processed for the program that fall within the billing period until completion of the Quality Assurance Program Review and resulting final written report by the QA Specialist. At the conclusion of each Quality Assurance Program Review, the QA Specialist will present preliminary findings of the review at an exit conference.

For additional record reviews that are conducted by entities other than the MHP [i.e., Department of Mental Health Care Services (DHCS) as part of the Mental Health Plan's compliance review or for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical record reviews] the same standard will apply. Once the program or legal entity has been notified of an upcoming medical record review and the billing period has been designated, no provider self-report of disallowances be processed for any of the designated program's medical records until completion of the review and receipt of the final report.

During the Quality Assurance Program Review, a Quality Assurance Specialist will review clinical records for:

- Assessment/Appropriateness of Treatment
- Access Criteria/Medical Necessity
- Diagnosis(es)
- Clinical Quality
- Problem List, evidence of Care Planning, and Client Involvement
- Compliance with Medi-Cal, State, Federal, and County Documentation Standards
- Billing Compliance
- Medication Treatment/Medical Care Coordination
- Administrative/Legal Compliance
- Care Coordination
- Discharge

In addition, the QA specialist may conduct a Pharmacy review of the medication service at each site.

Program Quality Improvement Plan (QIP)

If patterns or trends related to meeting documentation or billing standards, , or other identified Quality of Care concerns such as coordination of care with other service delivery providers, client engagement, are identified, a request for a Quality Improvement Plan will be issued by the MHP to the provider. After receipt of the MHP's written report of findings, the provider will have a specified timeframe in which to complete and submit the QIP to the QA Unit. The QIP must describe the interventions or processes that the provider will implement to address items that have been identified out of compliance or that were identified as needing improvement. In some instances, the QA Unit will be making more specific process improvement recommendations to the provider that must be included in the QIP. When appropriate, the QIP must include all supporting documentation (i.e., copy of a policy and procedure that has been written, description of a system that program is implementing, copy of sign-in sheets from a training, etc.). Even when supporting documentation is not requested to be submitted with the QIP, the program is still required to keep this documentation on-file at their program. The QIP must also include identified timelines and/or dates as to when the out of compliance item or area needing improvement will be implemented or completed. Pursuant to the "Withholding of Payment" clause of the contract, failure to respond adequately and in a timely manner to a request for a QIP may result in withholding of payment on claims for non-compliance.

Upon receipt of a QIP, the QA Unit will review what has been submitted to ensure that it adequately addresses the identified items. If the determination is made that the QIP does not adequately address these items, the QA Unit may request that the QIP be re-submitted within a specified period.

Programs will be monitored for trends and patterns in any areas found out of compliance or areas needing improvement. Additional QA reviews may occur if a program has an inordinately large number of variances, certain trends and patterns are noted, or is largely out of compliance with standards or contract requirements. Determination of an additional review will be made under the direction of the QA Program Manager and may take place within 30 days, 60 days or some other identified period depending upon the severity of the noncompliance.

To track progress of QIP implementation and offer technical assistance and support toward increased quality improvement efforts, the QA Unit will request a written summary from the program on the impact of the QIP on identified deficiencies. This summary will be requested approximately three months after the QIP has been accepted. Details of this process will be discussed with the program during the on-site exit conference after the review.

When a program's compliance issues are not improving as detailed in the program's written QIP, QA may request that the Program COR issue a Corrective Action Notice (CAN) to the program's Legal Entity. The CAN, given to the Legal Entity, will include a description of the noncompliance categories, history of program's QIP actions, and a statement about insufficient improvement

having been made. QA may recommend identified interventions or process changes to be implemented. If a CAN is issued to a Legal Entity, additional County Departments become involved in monitoring remedial activities. Failure to respond adequately and in a timely manner to a required Corrective Action Notice may result in a withholding of payment on the claims for non-compliance and could result in putting the contract at risk.

For billing disallowances or service corrections identified in the Medical Record review, programs will be required to submit evidence of correction as delineated in the medical record review protocol for that fiscal year as part of their QIP. Programs are responsible to follow-up on any pending corrections at QA Specialist direction. If there are additional billing concerns, the QA Specialist may conduct another medical record review prior to the next fiscal year.

Providers shall ensure that the services listed on the Void Request Form as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services listed must be listed on the form exactly as they were billed.

Medi-Cal Recoupment and Appeals Process

In alignment with DHCS Compliance Monitoring requirements and CalAIM Medi-Cal Transformation initiatives, recoupment shall be focused on identified overpayments and patterns in documentation suggestive of fraud, waste or abuse. Fraud and abuse is defined in CFR, Title 42, section 455.2. W&I, section 14107.11, subdivision (d) also addresses fraud. Definitions for "fraud," "waste," and "abuse," as those terms are understood in the Medicare context, can also be found in the Medicare Managed Care Manual.

Evidence of fraud, waste, abuse may include but is not limited to:

- Billing for services not rendered or not medically necessary
- Billing separately for services that should be a single service
- Falsifying records or duplicate billing
- Overpayment may include but is not limited to:
    - Missing documentation of allowable service
    - Services not billable under Title 9
    - Medical Necessity
    - Claims submitted for service during a lock out

Located on the Optum website is the complete listing of recoupment criteria based on the above categories. Organizational and County providers shall be responsible for ensuring that all medical records comply with Federal, State and County documentation standards when billing for reimbursement of services.

At the conclusion of each Quality Assurance Program Review, the provider will receive a Medi-Cal Recoupment Summary listing all disallowed billings based on the DHCS reasons for recoupment criteria. If the provider disagrees with a Medi-Cal recoupment, QA has developed a 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision. Providers must submit their appeals in writing to the QA Unit within required timelines. The appeal process is described in the final Quality Assurance Program Review (QAPR) Report received by the program.

Medi-Cal Certification Site Reviews

Providers must comply with all Federal and State regulatory requirements and MHP contract requirements with DHCS. Site reviews are conducted to ensure that providers comply with necessary licenses/certification requirements, maintain a safe facility, and store and dispense medications in compliance with all pertinent Federal and State standards. During the site review visit, a Quality Assurance Specialist may review:

- Physical Plant/facility
- Health and Safety Requirements
- Licenses and Permits
- Required Program Documents
- Personnel
- Medication Service
- Cultural Competence
- Consumer Orientation
- Staff Training & Education
- Client Rights, Grievance & Appeals Process, and Advance Directives
- Staff knowledge of current Organizational Provider Operations Handbook

Medication Monitoring for CYF and AOA SOC

State and County regulations require all organizational providers with programs prescribing medication in the course of their services to have a medication monitoring system. **Out of County Providers shall adhere to their own County's Medication Monitoring process.** Current State Department of Health Care Services (DHCS) requirements for Medication Monitoring are set forth in CCR, Title 9, Chapter 11, Section 1810.440; MHP Contract with DHCS, Exhibit A, Attachment 5, 1.H. The primary purpose of medication monitoring is to ensure the most effective treatment. Areas monitored include:

- Medication rationale and dosage consistent with community standards
- Appropriate labs
- Consideration of physical health conditions

- Effectiveness of medication(s) prescribed
- Adverse drug reactions and/or side effects
- Evidence of informed consent for use of psychotropic medication within prescriber documentation in client record
- Client adherence with prescribed medication and usage
- Client medication education and degree of client knowledge regarding management of medications.
- Adherence to state laws and guidelines

Within the SDC BHS system of care, programs are required to review one percent (1%) of their active medication caseload each quarter, with a minimum of one chart reviewed. Closed cases, cases in which the client has not returned for recent services and clients that are not receiving medication are not to be reviewed. The sample shall include representation from all psychiatrists and/or nurse practitioners who prescribe.

The Medication Monitoring Committee function shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. The Medication Monitoring Committee may be comprised of two or more representatives from different disciplines but at least one of the members must be a psychiatrist or pharmacist. Psychiatrists may not review their own prescribing practices. It is the programs responsibility to assure that there is another psychiatrist to review the charts.

Contracted providers are required to perform the first-level screening of medication monitoring for their facility. Programs will use the Medication Monitoring Report, Medication Monitoring Screening tool (either Adult or Children's), and the Medication Monitoring Feedback Loop (McFloop) for their screening. If a variance is found in medication practices, a McFloop form is completed, given to the psychiatrist for action, and then returned to the Medication Monitoring Committee for approval.

Procedures for Medication Monitoring Reporting:

- Send the following forms via secure email QIMatters.hhsa@sdcounty.ca.gov or fax (619) 236-1953 to QA:
    - Medication Monitoring Report
    - Medication Monitoring Screening Tools
    - Medication Monitoring Feedback Loop (McFloop)

Results of medication monitoring activities are reported quarterly to the QA unit by the 15th of each month following the end of each quarter (First quarter due October 15, second quarter due January 15, third quarter due April 15 and fourth quarter due July 15). The QA Medication Monitoring Reports for the CYF and Adult's Mental Health Systems of Care are located on the Forms Tab on the Optum Website: https://www.optumsandiego.com/ . For AOA SOC be sure the

criteria are met before completing the Benzodiazepine section of the Adult Medication Monitoring Tool.

Report Instructions: Variances are totaled by type of variance. For example, if you reviewed 10 charts, and one chart had a variance for variance #2b, then a "1" would be entered in the *variance 2b* box. If three charts had a variance for variance #6, then a "3" would be entered in *variance 6* box. Keep in mind when filling out the forms:

- Under the **Description of Activities Section,** all fields must be completed.
- Question 2a on both Adult and Children's form is for answering if labs were required. If no labs were required and it has been answered NO – this would not be a variance.

Due to the number of missing consents and lab reports, BHS is establishing a standard for monitoring these two issues.

- All programs shall have a procedure in place to ensure the following:
  - Evidence that the prescriber has reviewed and obtained informed consent with the client is documented within the client record. (*See section L for Practice Guidelines*).
  - Labs are ordered and those results are returned in a timely manner. Programs shall ensure that lab results have been reviewed and filed in the hybrid record a timely manner.
  - Ensure there is sufficient follow up with clients/family members in keeping their appointments for labs.

Quality Assurance (QA) monitors the compliance of each program's medication monitoring practices. By completing the submission Quarterly, QA can monitor compliance during quarterly desk reviews and therefore not require the documents to be reviewed during the annual Quality Assurance Program Review process.
The assigned QA Specialist reviews the quarterly medication monitoring report, screening tools and McFloops for any identified variances and corrective actions taken. Programs will be monitored for trends and patterns in any areas found out of compliance or areas needing improvement and a QIP may be required.

A second level review by the QA Medication Monitoring Oversight Committee (MMOC), working in collaboration with the Medical Director(s) may occur if a program has an inordinately large number of variances, certain trends and patterns are noted, or is largely out of compliance with standards or contract requirements. Determination of an additional corrective actions will be determined by the MMOC and Medical Director(s).

The Health and Human Services Agency Pharmacy is responsible for performing the medication monitoring for County-operated facilities. The Chief of Pharmacy submits a written quarterly

report that includes results of screening and clinical review activities to the clinic program managers and the Health Plan Organization Quality Assurance Unit.

The QA Unit evaluates the reports from both the contractors and Chief of Pharmacy for trends, compiling a summary report submitted to the Quality Review Committee (QRC), Program Monitor/COR, and the Pharmacy and Therapeutics Standards and Oversight Committee (P&T) quarterly. If a problematic variance trend is noted, the report is forwarded to the Medical Director for recommendations for remediation. Programs with severe or recurrent problems will have additional reviews and/or recommendations for a quality improvement plan.

CYF System of Care: Storage, Assisting with Self Administration, and Disposal of Medications

Only authorized California licensed personnel within the scope of their practice and in accordance with all Federal laws and regulations governing such acts shall administer medications. These licensed personnel include physicians, physician assistants, nurse practitioners, registered nurses, licensed vocational nurses, and licensed psychiatric technicians.
In instances where clients must take medications during the provision of mental health services, and licensed personnel are not present, the following procedures shall be in place:

1) ***Storage of Medications***
   a) The client's parent/guardian shall bring in the prescribed medication, which is packaged and labeled in compliance with State and Federal laws.
   b) All medications shall be stored in a locked, controlled, and secure storage area. Access to the storage area shall be limited to authorized personnel only.
   c) The storage area shall be orderly, well-lit, and sanitary. It shall have the proper temperature, light, moisture, ventilation, and segregation that are required by Federal, State and County laws, rules, and regulations.
   d) All controlled substances shall be double locked for security and shall only be accessible to authorized personnel.

2) ***Assisting in the Self Administration***
   a) Careful staff supervision of the self-administration process is essential. Program staff shall provide the individual dose from the packaged and labeled container for client to self-administer.
   b) Staff shall record the self-administration of all medications on the **Medication Dispensing Log**.

3) ***Disposal of Medications***
   a) Disposal shall occur when the medications are expired, contaminated, deteriorated, unused, abandoned, or unidentifiable. Programs may return medications to pharmacy representatives for disposal or dispose of medications by placing them in biohazard

sharps containers for transportation to incineration. If neither of these methods is available, the program can contact a pharmaceutical disposal company for transport and disposal. Examples include Stericycle 1 (866) 783-9816 and KEM (619) 409-9292. Disposal by flushing medications into the water system or placing in the trash are both prohibited under environmental and safety regulations.

b) Disposal shall be documented and co-signed on "**Medication Disposal Log"** (Optum Website Forms Tab: https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/orgpublicdocs.html).

ACCESS TIMES MONITORING

BHS will monitor program data for compliance with access times standards monthly, that includes a review of NOABD data to ensure NOABD's are issued when lack of compliance is indicated. When noncompliant, programs will be notified, technical assistance will be provided. A written report documenting noncompliance will be issued by BHS and providers are required to submit a Corrective Action Plan (CAP) to BHS within 30 days of the report for approval. BHS shall verify corrections as resolved.

CLIENT AND PERFORMANCE OUTCOMES

Adult System of Care:

In conjunction with new State and Federal mandates to show program effectiveness and client progress in rehabilitation and recovery, the MHP has extended the Client Outcomes tracking to almost all Outpatient and Case Management programs. If you think client outcomes tracking may not be feasible due to the special nature of your program, please contact your System of Care Monitor (COR, RPC) to discuss a possible exemption.

New outcome measures were chosen in June-2009 to better reflect the recovery orientation of the MHP. A provider advisory group, the Health Services Research Center (HSRC), and Mental Health Administration worked together for two years to select and pilot tools to make the most appropriate choice for the San Diego MHP. Beginning in July 2009, HSRC brought the new measures to each provider. After an on-site provider staff training, each organization implemented the new measures.

In determining what indicators to select as part of the performance measurement system, San Diego County A/OAMH continued to use the following criteria: meaningfulness, applicability, availability, compatibility with California programs and priorities, and ease of use.

The A/OA outcomes measures include the Milestones of Recovery Scale (MORS). MORS is an evaluation tool used to assess clinician perception of a client's current degree of recovery. Level

of Care Utilization System (LOCUS). LOCUS is a short assessment of client current level of care needs. Recovery Markers Questionnaire (RMQ). RMQ is used to assess personal recovery of the client from the perspective of the client. Illness Management and Recovery (IMR). IMR is a 15-item assessment addressing differing aspects of the client's illness management and recovery from the perspective of the clinician.

Section N details the system-wide outcome measures. Additional performance requirements are described in that section. The outcomes measures manual is available on the Optum website at: https://www.optumsandiego.com Go to "BHS Provider Resources" "MHP Provider Documents" then the "Manuals" tab.

Child, Youth and Family System of Care:

In November 2017, the California Department of Health Care Services selected new statewide outcome measures for Children's Mental Health programs. These measures include the Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptom Checklist (PSC and PSC-Y).The State's primary purpose for the data obtained from the functional assessment tools is for quality improvement efforts. Section N details the system-wide outcome measures. Additional performance requirements are described in that section. The outcomes measures and data entry trainings are available on the CASRC website: https://medschool.ucsd.edu/som/psychiatry/research/CASRC/resources/SOCE/Pages/CYFmHOMS-DES.aspx

Information on CANS certification, a requirement for administration, is available on the BHS CYF Outcomes website: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/workforce/cyf_outcomes.html

All outcomes' data will be completed within the electronic health record and then entered in the Other data is manually collected by providers and submitted on a quarterly basis (QSR).). The data is useful in determining trends and patterns in service provision and demand, as well as, identifying opportunities for improvement.

In conjunction with new State mandates for quality improvement and monitoring client progress, the MHP is extending the Client Outcomes tracking to all programs through data reports and the QSR. See section N – Data Requirements and Section A – Systems of Care for client outcomes indicators determined by the MHP.

Participating programs shall report their outcomes data according to defined timelines. The Program Monitor/COR will review the results, check for adherence to the outcome standard, and identify if a plan of correction is needed. The QA unit will track trends for the data provided on the QSR and the quarterly CYF mHOMS DES report produced by CASRC. The specific outcomes procedures by level of care, the outcomes tools, and reporting requirements can be obtained by

contacting your Program Monitor/COR and/or the Child and Adolescent Services Research Center (CASRC).

Monthly/Quarterly Status Report (M/QSR)

Providers are required to submit a monthly/quarterly status report to the COR which gives the MHP vital information about provider services. All sections of the report must be completed. Instead of twice-yearly reports on staffing for cultural competence, the new form includes a place to report monthly/quarterly on staffing and training. This report form is updated periodically in accordance with changing State, Federal and County regulations.

Mental Health Services Act (MHSA) Outcomes

Under the MHSA in San Diego, new programs are being started while others are expanding. As the MHSA is implemented across the State, new requirements for outcome reporting are anticipated to document how these funds are changing the lives of mental health clients. Providers receiving MHSA funding will be responsible for complying with any new requirements for additional outcome data. Currently, programs that have entered into Full-Service Partnerships under the MHSA are required to participate in a direct State data collection program, which tracks initial specialized client assessments, ongoing key incident tracking, and quarterly assessments.

Performance Improvement Projects (PIPs)

The State has mandated that each county be engaged in one administrative and one clinical performance improvement project each year in order to improve processes and outcomes of care. A PIP is a comprehensive, long-term quality improvement project includes a commitment to improving quality through problem identification, evaluating interventions, and making adjustments as necessary. It may provide support/evidence for implementing protocols for "Best Practices". The External Quality Review Organization (EQRO), contracted by the State, evaluates progress on each PIP annually.

The MHP may ask for your involvement in the PIP by:

- Implementing current PIP interventions/activities/procedures at your programs
- Supporting survey administration and/or focus group coordination at your programs
- Developing your own program's PIP projects

SERIOUS INCIDENT REPORTING (SIR)

An incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community shall be reported to the BHS Health Plan Organization Quality Assurance Unit. There are two types of reportable incidents, 1) Serious

Incidents are reported to the BHS QA Unit and 2) Unusual Occurrences are reported directly to the program's Contracting Officer Representative (COR).

All providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less. Required reports shall be sent to the QA Unit who will review, investigate as necessary, and monitor trends. The QA team will communicate with program's COR and BHS management. The provider shall also be responsible for reporting serious incidents to the appropriate authorities.

Serious Incident Categories: Level One and Level Two

Serious incidents shall be classified into two levels with Level One being most severe and Level Two less severe.

A Level One incident is the most severe type of incident. A level One incident must include at least one of the following:

- Any event that has been reported in the media/public domain (television, newspaper, internet), current or recent past, regardless of type of incident.
- The event has resulted in a death or serious physical injury on the program's premises.
- The event is associated with a significant adverse deviation from the usual process for providing behavioral health care.

A Level One serious incident shall be reported to the QA SIR Line at 619-584-3022 immediately upon knowledge of the incident. The provider shall submit the Serious Incident Report to the QA Unit within 24 hours of knowledge of incident.

A Level Two serious incident shall be reported to the QA SIR Line at 619-584-3022 no later than 24 hours of knowledge of the incident. The provider shall submit the Serious Incident Report to the QA Unit within 72 hours of knowledge of incident. A level two incident is any serious incident that does not meet the criteria of a Level One serious incident.

After review of the incident, QA may request a corrective action plan. QA is responsible for working with the provider to specify and monitor the recommended corrective action plan.

The QA unit will monitor serious incidents and issue reports to the Quality Review Committee and other identified stakeholders.

Serious incidents are categorized as follows:

- Incident reported in the media/public domain (e.g. on television, newspaper, internet)
- Suicide attempt by client that requires medical attention or attempt is potentially fatal

and/or significantly injurious.

- Death of client by suicide (includes overdose by alcohol/drugs/medications, etc.)
- Death of client under questionable circumstances (includes overdose by alcohol, drugs, medications, etc.)
- Death of client by homicide
- Alleged homicide attempt on a client (client is victim)
- Alleged homicide attempt by a client (client is perpetrator)
- Alleged homicide committed by a client (client is perpetrator)
- Injurious assault on a client (client is victim) occurring on the premises of the program resulting in death, severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.
- Injurious assault by a client (client is perpetrator) occurring on the premises of the program resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.
- Tarasoff Notification, the duty to protect intended victim, is made to the appropriate person(s), police, or other reasonable steps have been taken to protect the intended victim. ***Note:*** *Serious Incident Report of Finding not required unless indicated.*
- Tarasoff Notification, the duty to protect intended victim, is received by the program that a credible threat of harm has been made against a staff member(s) or program and appropriate safety measures have been implemented. ***Note:*** *Serious Incident Report of Finding not required unless indicated.*
- Serious allegations of or confirmed inappropriate staff (includes volunteers, interns) behavior such as sexual relations with a client, client/staff boundary issues, financial exploitation of a client, and/or physical or verbal abuse of a client.
- Serious physical injury to a client which may require hospitalization where the injury is directly related to the client's mental health or substance use functioning and/or symptoms. **Serious bodily injury** means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, limb, organ or of mental faculty (i.e., fracture, loss of consciousness), or requiring medical intervention,

including, but not limited to, hospitalization, surgery, transportation via ambulance, or physical rehabilitation.

- Adverse medication reaction resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.

- Medication error in prescription or distribution resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.

- Apparent overdose of alcohol/illicit or prescriptions drugs, whether fatal or injurious, requiring medical attention.

- Use of physical restraints (prone or supine) only during program operating hours (applies only to CYF mental health clients during program operating hours and excludes SUD programs, Hospitals, Long-Term Care Facilities, San Diego County Psychiatric Hospital/EPU, ESU and PERT)

- The Event has resulted in death on the program premises

- The event resulted in serious physical injury on program premises

- SIRs are not required for deaths that are a natural occurrence. Instead, the program shall maintain a Natural Death Log that QA will review during the Medi-Cal recertification site visit. However, if a death that is a natural occurrence happens on a program's premises an SIR is required.

- For Serious Incidents related to an overdose by an opioid or alcohol, the client must be provided an opportunity for a referral to Medication Assisted Treatment (MAT) if the client is not already receiving MAT services. Information on MAT programs can be access through the Provider Directory on the Optum website (www.optumsandiego.com) or by calling the Access and Crisis Line.

Serious Incident Reporting Procedures

1. Upon knowledge of incident, program shall report the incident and all known details to the SIR Line at 619-584-3022

2. All providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less.

3. A Level One serious incident shall be reported to the SIR Line immediately upon knowledge of the incident and followed up with the written SIR report to QA no later than 24 hours.

4. A Level Two serious incident shall be reported to the SIR Line no later than 24 hours of knowledge of the incident and followed up with the written SIR report to QA within 72 hours.

5. In the event of a serious incident, the program manager or designee will immediately safeguard the client's medical record. Program manager shall review chart as soon as possible. The client medical record shall not be accessed by unauthorized staff not involved in the incident.

6. All program staff will maintain confidentiality about client and serious incident. The serious incident should not be the subject of casual conversation among staff.

7. All serious incidents shall be investigated and reviewed by the program. The program shall submit a complete Report of Findings to QA within 30 days of knowledge of the incident. In the case of a client death, there is an exception to the Report of Findings report being due to QA within 30 days of knowledge of the incident when the program is waiting on the CME report. The provider must inform QA that the CME report is pending and request an extension.

8. Reports of Sexual Misconduct by a Healthcare Provider (SB 425, Business & Professions Code Section 805.8) Effective 1/1/20, a healthcare facility, health plan, or other entity that grants privileges or employs a healthcare professional must, within 15 days of receiving a written allegation of sexual abuse or sexual misconduct (inappropriate contact or communication of a sexual nature) against one of its healthcare providers, file a report with that professional's licensing board.

9. Tarasoff incidents do not require a SIROF unless the Program Manager, after review, has concluded one is indicated due to a systemic or client related treatment issue.

10. An SIR is never to be filed in the client's medical record. A Serious Incident Report shall be kept in a separate secured confidential file.

11. A serious incident that results in 1) a completed suicide or 2) an alleged client committed homicide will automatically trigger a chart review by the QA Unit and require the completion of a Root Cause Analysis (RCA) within 30 days of knowledge of the incident.

12. The Action Items because of the RCA shall be summarized and submitted to the QA unit with 30 days of knowledge of the incident. Do not submit the RCA worksheet, only a summary of action items.

Clinical Case Reviews

Under the direction of the BHS Clinical Director, a clinical case review convenes regularly to review cases involving a completed suicide, homicide, and other complex clinical issues. The purpose of the review is to identify systemic trends in quality and/or operations that affect client care. Identified trends are utilized to provide opportunities for continuous quality improvement. Program shall comply with requests for medical records that are reviewed in clinical case conference.
Stakeholders, including BHS Director, CORs, Deputy Directors, QA Chief, Program Managers, County or Contractor QA staff, or other designated staff may make a request at any time for a clinical case review. Specific requests for case reviews should be coordinated through the QA Unit by contacting QIMatters.hhas@sdcounty.ca.gov.

Please Note: The Serious Incident RCA Worksheet is required for San Diego County operated programs per current HHSA/MHS General Administration Policies and Procedures. San Diego County Contracted programs may use the Serious Incident RCA Worksheet or some other process that is approved by their Legal Entity. It is recommended that programs not choosing to use the Serious Incident RCA Worksheet ensure that the process they do use incorporates best practices for their analysis of findings. Technical assistance is available by request through QIMatters.hhsa@sdcounty.ca.gov. RCA training is offered quarterly.

Level One Serious Incident Reporting on Weekends and Holidays

Level One Serious Incidents are required reporting for Legal Entity (LE) behavioral health programs on weekends and holidays to the QA Unit and Designated County Staff. This requirement does not apply to Level Two serious incidents.

Follow this procedure for reporting a **Level One** Serious Incident on Weekends and Holidays.

1. For a Level One Serious Incident, call the QA SIR Line and report the incident.

2. Each LE will identify key Senior Level staff (1-3) that are designated as the main contact person(s) for their programs needing to report a Level One incident on weekends and holidays. This LE designated staff will report the Level One incident by calling or leaving a message with all required information including a call back number for the County Designated Staff. Each LE will be provided the contact phone numbers of the County Designated Staff.

3. Program staff should only be reporting the Level One Serious Incident to their LE designated staff. Program staff should not be directly contacting the County Designated Staff.

4. Report Level One Serious Incidents to the County Designated Staff on weekends and holidays between the hours of 8:00am – 8:00pm (reporting hours). If you have a Serious Incident that occurs outside of reporting hours, then report the Serious Incident on the next or same day during reporting hours. This requirement is only for Level One Serious Incidents.

5. Weekend Coverage is defined as Saturday and Sunday. Holiday Coverage is defined as any designated County Holiday.
6. County designated staffs are identified in priority contact order as:
   1) Adult SOC Assistant Deputy Director – A/OA Providers
   2) CYF SOC Assistant Deputy Director – CYF Providers
   3) Director; BHS (third back up).

Privacy Incident Reporting (PIR) for Staff and Management

Programs shall follow the HHSA Privacy Incident Reporting Policy. When staff becomes aware of a suspected or actual privacy incident. Staff notifies Program Manager immediately. Program Manager immediately notifies COR.

If a County incident, Program Manager will:

1. If suspected or actual privacy incident involves 500 or more individuals, notify Agency Privacy Officer (APO) immediately by emailing: angie.devoss@sdcounty.ca.gov and Kathryn.Mahan@sdcounty.ca.gov. For all other suspected or actual privacy incidents, follow steps below.
2. Submit an Initial HHSA Privacy Incident Report (PIR) online via the web portal: https://www.sandiegocounty.gov/content/sdc/hhsa/hhsa-privdb-landing.html.
   Complete initial PIR web-form to the best of your ability and submit within one business day. The PIR web-form landing page link is also available on the Agency Compliance Office's website: www.cosdcompliance.org. Upon submittal, a PIR Tracking # will appear on the confirmation screen. This number should be recorded by the reporting party as it will be needed to access the report in the future.
3. Submitter will receive an email with an Access Code. Use this information, along with the PIR # to access your PIR via the same web link above.
4. Continue to investigate and Update the PIR online within 72 hours, including required information missing from initial report and any additional information requested by APO.
5. Provide any pending or additional information needed to submit Final completed PIR within seven business days of initial discovery.

If a Contractor incident, COR will:

1. Direct Contractor to complete HHSA Privacy Incident Report Web-Form online and updates, as outlined above.
2. Direct Contractor to complete any other steps as directed by APO, including, but not limited to notifications or external reporting.

San Diego County contracted providers should work directly with their agency's legal counsel to determine external reporting and regulatory notification requirements and provide their determination to the HHSA Privacy Officer.

UNUSUAL OCCURRENCE REPORTING

An unusual occurrence is reported directly to your COR/Program Monitor within 24 hours of knowledge of the incident. An unusual occurrence is defined as an incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community that does not meet the criteria of a serious incident. Unusual occurrences may include but are not limited to:

- Alleged child abuse
- Police involvement
- Inappropriate sexual behavior
- Self-injury
- Physical injury
- Physical abuse
- AWOL
- Fire setting
- Poisoning
- Major accident
- Property destruction
- Epidemic or other infectious disease outbreak
- Loss or theft of medications from facility

Safety and Security Notifications to Appropriate Agencies

When an Unusual Occurrence occurs or are identified, the appropriate agencies shall be notified within their specified timeline and format:

1. Child and Elder Abuse Reporting hotlines.
2. Tarasoff reporting to intended victim and law enforcement
3. Law enforcement (police, sheriff, school police, agency security, military security/Naval Investigative Service, etc.) for crime reporting or requiring security assistance and inquiries.

4. Every fire or explosion that occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshall.

Child, Youth and Family: Additional Reporting

CYF providers may notify other outside agencies who serve the client upon consideration of clinical, health and safety issues. Notification should be timely and within 24 hours of knowledge of the incident. The required agencies include but are not limited to:

- Children Welfare Services
- Probation Officer
- Regional Center
- School District
- Therapeutic Behavioral Services (TBS) – Both County and Contractor
- Other programs that also serve the client

Reportable issues may include:

1. Health and safety issues
2. A school suspension
3. A student is taken to a hospital due to an injury or other medical issue which occurs at the program site or when the TBS worker is present
4. A referral for acute psychiatric hospital care
5. An issue with direct service provider staff, which may lead to worker suspended or no longer providing services
6. A significant problem arising while TBS worker is with the child

QUALITY REVIEW COMMITTEE (QRC)

The Quality Review Committee (QRC), mandated by State regulation, is a collaborative group that is chaired by the MHP Clinical Director and consists of MHP stakeholders including clients and family members, County and contracted providers, associations and advocacy groups representing the mental health community, and hospital providers. The QRC meets regularly to review, discuss, and make recommendations regarding quality improvement issues that affect the delivery of services through the MHP. Participation in the QRC is encouraged. If you would like to participate in the QRC, email QIMatters.hhsa@sdcounty.ca.gov

NATIONAL VOTER REGISTRATION ACT (NVRA)

Per the National Voter Registration Act (NVRA) of 1993, providers are required to offer voter registration materials at intake (except in a crisis), renewal and anytime a change of address is reported. For TAY and Adult programs, voter registration services shall be provided to clients who are:

- A citizen.
- Live in California

- At least 18 years of age by the date of the next election; and
- Not currently on parole for a felony conviction or formally judged by a court to be mentally incompetent to vote.

For Children's programs, voter registration services shall be offered to parents/guardians of clients less than 18 years of age.

Mental Health Programs shall have Voter Registration Forms and General Instruction Forms available to clients in English, Spanish and Tagalog as required by the County of San Diego Registrar of Voters. An attached Voter Registration Form, General and State Instructions Form and DSS 16-64 form shall be included in all intake/admission packets. Additionally, the same level of assistance shall be provided to mental health consumers registering to vote as is provided for completing other forms for mental health services. When a client requests a form in a language other than those available from the County's Registrar of Voters, staff shall provide the client with the Secretary of State's toll-free number: 1-800-345- VOTE. Voter Registration forms in the threshold languages can be found on the Optum Website under the Forms Tab: https://www.optumsandiego.com/content/SanDiego/sandiego/en/county-staff---providers/orgpublicdocs.html

Training on the legal requirements and County expectations under this Act is required to be taken by provider staff once each year. The NVRA training is available on the HHSA BHS webpage: http://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/. For more information, refer to Medi-Cal Eligibility Division Information Letter I 12-02 (https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/cI12-02.pdf).If you have additional questions about this requirement, please contact your Contracting Officer Representative (COR). Failure to implement the NVRA may subject the agency to legal liability.