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 Assurance 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: Medicaid and CHIP Managed Care Final Rules

- Information about the Medi-Cal Transformation is available at the following link: CalAIM: Transforming Medi-Cal

- 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. 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. 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.

Medi-Cal Certification Site Reviews

- Providers must comply with all Federal and State regulatory requirements and MHP contract requirements with DHCS.. 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

- 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 (see required posted brochures/notices below)

    - Policies & Procedures or process (see specific policies and procedures below)

    - 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

Policies and Procedures

- Confidentiality and Protected Health Information
- Emergency Evacuation
- Personnel policies and procedures specific to screening licensed personnel/providers
- General operating procedures
- Maintenance policy
- Service delivery policies
- Incident Reporting
- Procedures for referring individuals to a psychiatrist, when necessary
  Effective 1/1/25- Policy for providing clients with a notice that the Board of Behavioral Sciences responds to complaints about licensees and how to contact, prior to the provision of psychotherapy services.

Posted Brochures and Notices

- Please note that all of the following brochures and notices must be in all available threshold languages and prominently displayed unless otherwise stated:
  - Mental Health Plan (MHP) Beneficiary Handbook
  - Current Provider Lists with instructions for accessing in all languages
  - Current Limited English Proficiency Posters
  - Current Notice of Privacy Practices
  - Current Grievance/appeal brochures (without requiring consumer to request from staff)
  - Current Grievance/appeal posters (with fair hearing process)
  - Current grievance/appeal forms with self-addressed, stamped envelopes available (without requiring a consumer to request them from staff)
  - Open Payments Database Notice
  - Open Payments Database Notice is included on provider/legal entity's website (if applicable).
  - Physician Notice to Patients from the Medical Board of California (with QR Code)
  - California Board of Psychology Consumer Statement
  - Human Trafficking Model Notice (For facilities that provide pediatric care)

- See the Optum website "*Beneficiary*" tab for most up to date list of threshold languages and available translated documents.

- 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 (UCRM), 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.

Quality Assurance Program Reviews (QAPRs)

Quality improvement of documentation is an ongoing process shared between programs and County QA..

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.

QUALITY ASSURANCE PROGRAM

- 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 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.

Medication Monitoring for CYF and A/OA 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 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.

- As of FY 24-25, the Clinical Director of Behavioral Health Services has advised that Nurse Practitioners (NPs) who fully qualify for the 103 path may be permitted to review other qualified NPs in the quarterly Medication Monitoring process. 103 NP Eligibility is outlined in Assembly Bill 890 (ca.gov) . This provision does not currently extend to Physician's Assistants (PAs).

- 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. The QA Medication Monitoring Reports for the Systems of Care are located on the Optum Website > BHS Provider Rsources > *Forms.* For A/OA program be sure the criteria are met before completing the Benzodiazepine section of the Adult Medication Monitoring Tool.

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)..

- **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 forms are to be answered if labs were required. If no labs were required, the appropriate answer is "*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.

- 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, 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.* Optum Website > BHS Provider Resources > *Forms*

    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**", located on the Optum Website > BHS Provider Resources > *Forms*

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 June2009 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/OA MH 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. Go to "BHS Provider Resources" > "MHP Provider Documents" > "*Manuals*".

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).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.

- Information on CANS certification, a requirement for administration, is available on the BHS CYF Outcomes website.

- 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

Critical Incident Reporting (CIR)

- 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)

Critical Incidents are reported to the BHS QA Unit and 2) Non-Critical Incidents which are reported via an online submission form that report directly to the program's Contracting Officer Representative (COR) and reviewed by the Quality Assurance Unit.

- All providers are required to report critical 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 critical incidents to the appropriate authorities, when warranted.

QI Matters email address: **qimatters.hhsa@sdcounty.ca.gov**
QA Critical Incident fax number: **619-236-1953**

Critical Incident Information

- A Critical incident is the most severe type. Counties are required to implement procedures for reporting incidents related to health and safety issues and develop mechanisms to monitor appropriate and timely interventions of incidents that raise quality of care concerns. Critical Incident categories are related to significant clinical health, safety, and risk concerns.

- The Critical Incident Report must be submitted to the QA Unit within 24 hours of knowledge of incident completed in full. This can be sent to the QI Matters inbox via secure email or faxed to the secure QA fax at **619-236-1953**. The Critical Incident report form can be found on the Optum Site under the SMH & DMC-ODS Health Plans Page under the 'Incident Report' Tab. Additionally, consultation can be requested by contacting the QI Matters email address.

- Critical Incidents are categorized as the following:

    - Death/Pending (Pending CME investigation)
    - Death/Natural Causes (Confirmed)
    - Death/Overdose (Confirmed)
    - Death/Suicide (Confirmed)
    - Death/Homicide (Confirmed)
    - Suicide Attempt
    - Non-Fatal Overdose
    - Medication Error
    - Alleged abuse/inappropriate behavior by staff
    - Injurious assault by a client resulting in hospitalization
    - Critical Injury on site (MH/SUD related)
    - Adverse Media/Social Media Incident (only; no leading incident)

- Any incident that does not fall within these categories will be reported as a **Non-Critical Incident**.

- Death/Pending (Pending CME investigation) would be chosen for instances of client death in which the actual reason for death is not yet confirmed. The subsequent 'Confirmed' reasons for client death should only be chosen when the actual reason for death is known by the Program.
- CIRs 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 CIR is required.

- 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

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

- Critical injury is defined as injury to a client where the injury is directly related to the client's mental health or substance use functioning and/or symptoms. Critical injury means any 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. Any injury not falling in these categories and/or not related to client mental health or substance use Sxs would be reported under the Non-Critical Incident process.

- For Critical 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 or by calling the Access and Crisis Line.

- QA Unit shall monitor critical incidents and issue reports to the Quality Review Committee and other identified stakeholders as indicated.

- 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.

Critical Incident Reporting Procedures

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

2. A Critical Incident Report must be sent to QA no later than 24 hours from the incident notification.

3. In the event of a critical 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.

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

5. All critical 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.

6. In instances where an ROF is required for a Critical Incident and there are multiple program assignments, an ROF will be required for the primary client assignment and/or the Program where the critical incident took place. The primary assignment may be viewed in the EHR if the permissions have been granted. Any other client program assignments submitting a CIR for the same incident may require an ROF per QA or COR request.

7. 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.

8. Tarasoff incidents will no longer fall under Critical Incidents and will be reported via the online submission form as a Non-Critical Incident. Tarasoff 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.

9. A CIR is never to be filed in the client's medical record. A Critical Incident Report shall be kept in a separate secured confidential file.

10. A critical 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.

11. In instances where the RCA is required for a Critical Incident where a client has multiple program assignments, the RCA will only be required for the primary client assignment and/or the program where the critical incident requiring the RCA took place. An RCA for any other client assignments may be requested by QA or your COR as clinically indicated. The primary assignment may be viewed in the EHR if the permissions have been granted.

12. The Action Items 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.hhsa@sdcounty.ca.gov .Please Note: The Critical Incident RCA Worksheet is required for San Diego County operated programs per current HHSA/MHS requirements.

    - General Administration Policies and Procedures. San Diego County Contracted programs may use the Critical Incident RCA Worksheet or some other process that is approved by their Legal Entity. It is recommended that programs not choosing to use the Critical 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.

Critical Incident Reporting on Weekends and Holidays

- Critical 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 Non-Critical incidents.

- Follow this procedure for reporting a **Critical Incident** on Weekends and Holidays.

1. For a Critical Incident, submit the notification to QI Matters as soon as possible from awareness of the incident occurrence.

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 Critical incidents on weekends and holidays. This LE designated staff will report the Critical Incident by calling and/or leaving a message with all required information including their call back number to the County Designated Staff. Each LE will be provided the contact phone numbers of their County Designated Staff.

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

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

Non- Critical Incident Reporting

- A Non-Critical Incident is reported directly to your COR/Program Manager and to QA via an online submission form within 24 hours of knowledge of the incident. A Non-Critical Incident is defined as an adverse 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 critical incident. Any incident that represents "adverse

deviation from usual program processes for providing behavioral health care" and not falling into the Critical Incident categories will be considered Non-Critical Incident. Previously, these incidents were classified as 'Unusual Occurrences' or may have been reported as a 'Serious Incident Report Level 2'. *Protected Health Information (PHI) should not be shared when completing a N-CIR submission, this will require a Privacy Incident Report (PIR) to be completed.

- Non-Critical Incidents may include but are not limited to:
  - AWOL
  - Contract/Policy violations by staff (unethical behavior)
  - Loss or theft of medication from the Facility
  - Physical Restraints (prone/supine)
  - Tarasoff Reporting
  - Non-critical injury onsite
  - Adverse Police/PERT Involvement onsite
  - Property destruction onsite
  - Other

- A program may be asked at any time to complete a Report of Findings for a Non-Critical Incident by the program COR or Quality Assurance Unit.

- Any incident involving Police/PERT including but not limited to arrests on program site, use of restraints of clients/members, and any notable "adverse deviations" from program processes related to PERT/police engagement will require an N-CIR report.

- Use of physical restraints (prone or supine) is reported 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). If use of physical restraints leads to client injury, this would be reported as a **Critical Incident**

- Non-Critical injuries refer to injuries that require medical treatment greater than first aid and which occur on program premises.

- Epidemic, other infectious disease outbreak, and poisoning will be reported under the Non-Critical Incident Reporting process utilizing the "Other" incident category.

Non-Critical Incident Reporting Procedures

1. All providers are required to report non-critical incidents involving clients in active treatment or whose discharge from services has been 30 days or less.

2. Non-Critical Incidents are reported via and online submission form that can be found HERE and on the Optum Site under the SMHS & DMC-ODS Health Plans Page under the "*Incident Reporting*" Tab.

3. Complete the submission via the online form within 24 hours of program knowledge of the incident and complete the form in its entirety.

4. Do **NOT** include PHI within the online submission form—This includes client first and last names, EHR numbers, or any other Protected Health Information.

5. Ensure correct spelling for CORs email information as this will be submitted to them directly through the application, non-submission based on incorrect contact or spelling information will not be tolerated.

- Please review the **Non-Critical FAQ/Tip Sheet** posted on Optum for additional information for submission of Non-Critical Incidents and completion of the form.

- Consultation may be requested by emailing QI Matters. If an incident is submitted as a Non-Critical Incident that meets criteria for a Critical Incident, your program will be contacted by your COR or QA staff, and the appropriate submission must occur.

Safety and Security Notifications to Appropriate Agencies

- When a Non-Critical Incident 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 shall 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

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. 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. 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.

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 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.

- 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. For more information, refer to Medi-Cal Eligibility Division Information Letter I 12-02. 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.