New Program Manager Orientation

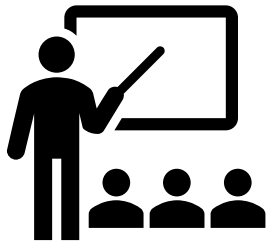
BHS Quality Assurance

FY 25-26

Welcome!

- This presentation offers a brief overview of several important topics related to program management and quality improvement in the County of San Diego's Behavioral Health Plan (BHP).

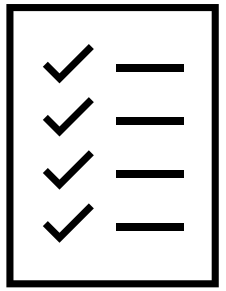
- Please note that this presentation does not take the place of the various provider manuals and resources that will be discussed.



Topics

This orientation will cover the following topics:

- Federal and State Regulations
- Compliance & Confidentiality Requirements
- Network Adequacy
- Access to Medical Necessity/ Specialty Mental Health Services
- Documentation Requirements
- Staff Requirements
- Quality Improvement Actions
- Program Responsibilities
- Beneficiary Grievances and Rights
- Resources



Federal and State Regulations

- Federal and State regulations and County policies and procedures, are an integral part of a program manager's knowledge base.

You should be familiar with the following regulations:	
Title 9, California Code of Regulations, Chapter 11	Federal Managed Care Regulations
California's Medicaid State Plan (Title XIX)	Health Information Portability and Accountability Act (HIPAA)
California State Plan Amendment - Number 10-012B (SPA)	Title VI, Civil Rights Act of 1964
Code of Federal Regulations, Title 42 (42 CFR)	

County Policies & Procedures

The County of San Diego Health and Human Services Agency (HHSA) is the broader agency that includes Behavioral Health Services.

All County and County Contract program managers should be familiar with the following policies and procedure resources:	
Agency Compliance Office (ACO) policies and procedures	Outpatient Program Operations Handbook (OPOH)
HHSA Code of Conduct	Uniform Clinical Record Manual (UCRM)

San Diego County BHS Leadership

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Chief Operations Officer
Aurora Kiviat
Asst Director, Dept Operations

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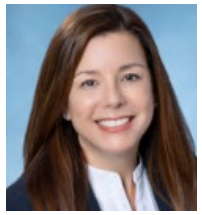

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Chief Strategy & Finance Officer
Liberty Donnelly
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Chief Population Health Officer
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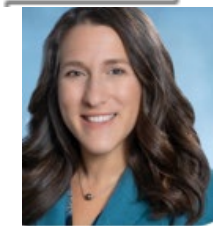


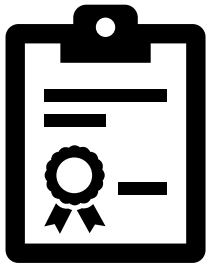
Operations
Chief Operations Officer
Aurora Kiviat
Asst Director, Dept. Operations

[BHS Org Chart High Level]

Compliance & Confidentiality

Program Quality Assurance Responsibilities

- Programs will be monitored for quality and compliance by the BHS Quality Assurance Unit.
- Quality Assurance Performance Reviews (QAPRs) occur annually
- Medication Monitoring occurs quarterly
- Medi-Cal site certifications occur initially and every three years thereafter for site re-certification. Change of address warrants a re-certification.
- The QA unit monitors trends and/or patterns that may result in quality improvement recommendations



The Medical Record

- "*Medical Record*" refers to both the EHR as well as the physical paper chart. If client documents are maintained in both, the medical record is referred to as a "hybrid chart"

- All records must be maintained in a secure location, filed in a prescribed order, and be retrievable for audits by QA, DHCS or other required entities

Transporting Client Information

- All programs will securely store and transport medical records, including laptops, phones, and tablets, which may contain client identifying information in accordance with applicable laws and the State Agreement.
    - Programs should only remove client information from program offices for approved business purposes, with prior management approval, and information shall be stored in an appropriate manner.
    - Programs shall sign in and out records, as needed.
    - Client information must not be stored on a non-encrypted device . When saving client contact information on an encrypted device, such as a phone or laptop, or transporting client information out of the office/clinic, only include the minimum client identifying information necessary.
    - No workforce member may ever leave client information unattended in a car for any amount of time.

Please reference OPOH *Section B* for more detailed information.

Privacy Incident Reports (PIRs)

- A *privacy incident* is an incident that involves the following:
    - Unsecured protected information in any form (i.e. Sending unencrypted email with client information outside of your legal entity)
    - Any suspected incident, intrusion, or unauthorized access, use, or disclosures of protected information (i.e. Sending emails with client information to the wrong person
    - Any potential loss or theft of protected information (i.e. Lost/ stolen charts, laptops, or phones)
    - If any Program believes a privacy incident has occurred, they shall immediately notify the BAC Privacy Officer and COR via email, complete the BAC approved Privacy Incident Report and send it within one (1) business day to the BAC Privacy Officer and COR via email.
        - State laws and regulations require notification to patients “without reasonable delay” but no later than 60 days after discovery of a privacy breach.

Network Adequacy

System of Care (SOC) Application

- As part of Network Adequacy Requirements (BHIN 22-032 and 25-013) providers have been asked to utilize the System of Care (SOC) application to collect the information needed to assist with County routine submission

- Program Managers and Providers are required to attest to all SOC information **monthly**

- Please reference the Optum Website- SOC Tips and Resources (optumsandiego.com) or email sdhelpdesk@optum.com for more information.

Accessibility of Services

- *Access time* refers to how long a client must wait to get a service at your program from the date the service was requested. This means that there are limits on how long clients must wait to get care appointments

    - It is required at the State and Federal level for managed care plans to provide timely access to care, making it required for SMH Medi-Cal certified providers.

- *Timely access* refers to the number of business days in which an appointment is available to a client from the date the client requests a service.

    - It is required at the State and Federal level for managed care plans to provide timely access to care, making it required for SMH Medi-Cal certified providers.

    Please note, timely access is based on program availability, not whether the person requesting the service accepts the appointment.

Timely Access Data Standards (TADT)

In accordance with BHIN 26-015, Behavioral Health Plans (BHPs) are required to have a system in place for tracking and measuring timeliness of care. Requests are documented in the EHR.

Service Type	Standard
Outpatient non-urgent with nonphysician (routine) – Adults, Children/ Youth	Offered appointment within ten (10) business days from request for services
Psychiatric Services – Adults, Children/ Youth	Offered appointment within fifteen (15) business days of request for services.
SMHS Urgent Appointments- Adults, Children/ Youth	Offered appointment within forty-eight (48) hours from request for services
Children / adolescents requiring emergency services	Seen within one (1) hour of contact with program
Children / adolescents being discharged from acute psychiatric hospital care	Assessed by program within seventy-two (72) hours

Please reference OPOH *Section C* as well as the MH Access Times FAQ and Tip Sheet on the Optum Website > *References* tab.

Providing Specialty Mental Health Services

Behavioral Health Information Notices (BHINs)

- Behavioral Health Information Notices (BHINs) are guidance documents by the Department of Health Care Services (DHCS) that inform counties and contractors of changes in policy or procedures at the federal or state levels.

- BHINs are available on the DHCS website (DHCS Informational Notices) but the info is also summarized and threaded throughout the system of care by the QA department via QIP meetings, Memos, UTTMs and other communications.

- Important BHINs:
  - BHIN 23-068- Documentation requirements for SMH DMC/DMC-ODS Services
  - BHIN 26-002 Access Criteria to SMHS Delivery System
  - BHIN 22-011 No Wrong Door for Mental Health Services Policy

Target Populations

Who do we serve in the County of San Diego?

Adult / Older Adults	Children, Youth & Families	Transitional Age Youth (TAY)
Medi-Cal eligible or indigent individuals aged 18-59 and older adults aged 60 and older with a serious psychiatric illness/diagnosis or suspected diagnosis (with or without co-occurring substance use) that threatens personal or community safety or that places the individual at significant risk of grave disability due to functional impairment.	Individuals under 21 years of age who have diagnosis or suspected diagnosis a DSM mental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms.	Individuals aged 18-25 transitioning from the children's behavioral health system into the adult behavioral health system

Med-Cal Transformation

- **CalAIM (California Advancing and Innovating Medi-Cal)** is a multi-year initiative (beginning 01/22) led by DHCS to modernize the Medi-Cal program to create a **more coordinated, person-centered, and equitable health system** that addresses both physical and behavioral health needs.

- Behavioral Health Reforms:

  - Updated Criteria for Access to SMHS: New statewide standards clarify who qualifies for county-level Specialty Mental Health Services, reducing variation and improving consistency of access.

  - “No Wrong Door” Policy: Aims to ensure that individuals seeking help can access the right level of care regardless of where they enter the system.

  - Documentation Redesign: Simplifies clinical documentation to reduce administrative burden and allow providers to focus more on patient care.

Access Criteria for SMHS

Members 21 Years of Age or Older	Members under Age 21
Must meet **both** of the following: (1 **and** 2)	Must meet **either** of the following: (1 **or** 2)
1. The member has <u>one or both</u> of the following: (a **or** b) a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities a. A probability of significant deterioration in an important area of functioning.	1. Scoring in the high-risk range under a trauma screening tool, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness
2. The member's condition is due to **either** of the following: (a **or** b) a. A diagnosed mental health disorder or a. A suspected mental disorder that has not yet been diagnosed	2. The member meets **both** of the following requirements: (a **and** b) a. One of the following: i. A significant impairment. ii. A probability of significant deterioration in an area of functioning. iii. A reasonable probability of not progressing developmentally. iv. A need for SMHS b. The member's condition is due to one of the following: i. A diagnosed mental health disorder ii. A suspected mental health disorder iii. Significant trauma

BHIN 26-002

Staffing Requirements

Staff Requirements

Clinical staff that can provide behavioral health services:

1. Physicians/ Psychiatrists
2. Licensed Psychologists (or licensed waivered Psychologist)
3. Licensed Clinical Social Workers (or registered ASWs)
4. Licensed Marriage and Family Therapists (or registered AMFTs)
5. Licensed Professional Clinical Counselors (or registered APCCs)
6. Master's level student interns (Trainees)
7. Registered Nurses (RNs)
8. Mental Health Rehabilitation Specialists (MHRS)
9. Para-professionals & Other Qualified Providers (Para Pros & OQPs)
10. Peer Support Specialists (PSS)
11. Enhanced Community Health Workers (ECHW)

It is a Program Manager's responsibility to ensure that all staff are licensed, registered or waivered and/or receive appropriate co-signature on documentation.

Staff Signature Logs

- A Signature Log is a list of all current staff providing direct services, their degree/licensure, job title, language capability (if applicable) and a copy of their typical signature.
- All providers are required to maintain an accurate and current staff signature log.
- Logs must reflect any changes in staff licensure, degree, job title, name, or signature.
- Logs shall be made available at request of QA or DHCS during reviews, visits, etc.

Please reference OPOH *Section M* for more information.

Criteria to Provide Services

- For staff to provide services, several criteria must be met:
  - NPI Number
  - License/ registration (if applicable)
  - Credentialing and ongoing Recredentialing with Optum
  - Access to the Electronic Health Record system (SmartCare)
  - License waiver (if applicable)
  - Registration (if applicable)

NPI & Taxonomy Numbers

- The NPI is a unique identification number for covered health care providers.
  - Clinical Staff must have an NPI (National Provider Identifier) number per HIPAA requirement.
  - NPI Application
- Taxonomy numbers are essential for providers to classify their services and apply for the NPI.
- For more detailed information on taxonomy codes and how to access them, you can refer to the DHCS Billing Manual as well as MH Guidelines for Choosing Taxonomies located on the Optum Website> *MH Resources* tab.

License Registration

- LCSW and LMFT candidates must remain registered with his/her licensing board until the candidate is licensed.

- Masters level student interns (Trainees) may provide mental health services as long as they receive appropriate supervision and have their work co-signed based on requirements from DHCS as well as related found in:

  - SMHS FY2025-26 Billing Manual
  - SMHS-Clinical-Documentation-Guide-09.2025.pdf and Appendix III (p.39)
  - Optum Website> *UCRM* tab
  - OPOH *Section M*

Initial Credentialing & Re-Credentialing

Initial Credentialing	Re-credentialing
Initial credentialing processes begin with submission of completed and signed applications, along with all required supporting documentation. Providers are to call Optum's Behavioral Health Services Credentialing Department at (800) 482-7114 or send a notification email to BHSCredentialing@optum.com.	Individual practitioners and Residential Programs Sites undergo recredentialing every three (3) years.

For more information please reference OPOH *Section J*

SmartCare Staff Setup

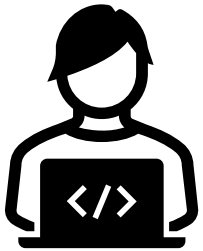
Training

- All new users must successfully complete the required SmartCare Training Modules after creating a CalMHSA LMS Account.
- Staff will be responsible for trainings according to their Staff Role via the CalMHSA Required Trainings by Role Grid no later than 90 days from hire date.
- For additional resources, please see: SmartCare User Training Registration and SmartCare Training Registration Tip Sheet

Please reference OPOH *Section I* for additional information.

User Account Access

SmartCare Access Request Form- ARF



- All individuals who provide services or perform some other activity to be recorded SmartCare as well as those who are authorized to access SmartCare must have a staff account.

- The program manager completes the “SmartCare Access Request Form” (ARF) located on the Optum Website> *SmartCare* tab.

Please reference OPOH *Section I* for additional information.

Waivered Staff

- Each CA licensed psychologist candidate and/or LCSWs or LMFTs from out of state must obtain a license waiver.
  - Psychologists - waivered for five (5) years from the first date of employment
  - Out of state Waivers - effective for three (3) years

- The director / designee of a BHP or county mental health department may apply on behalf of an individual seeking a PLW. The employer shall not allow an individual seeking a waiver to begin work for which a license or waiver is required until DHCS has approved the PLW application.

  - Applicants must complete the DHCS Form 1739 - PLW Application and submit to QIMatters.hhsa@sdcounty.ca.gov. QA will review the application, submit to BHS for required approval and signatures, and submit to DHCS for final review.

- Complete professional licensing waiver information and requirements are available on the DHCS website (Professional Licensing Waivers) and in BHIN 24-033.

Serving Medicare Clients

- Programs are required to have approved Medicare Provider Numbers known as PTAN for Psychiatrist, LCSW, LMFT, MHC (LPCC), Licensed Psychologist and Nurse Practitioners
- Programs must have Medicare eligible providers to provide services
- CMS 855 I and CMS 855R are required to be completed and submitted to the Medicare Intermediary Noridian
- There are specific documentation requirements for Medicare, such as care plan elements.
  - See documentation resources throughout this presentation for further guidance.

Documentation Standards

Documentation Standards

- Familiarity with Documentation Standards is a critical function of all Program Managers as services are billed to the State and federal government. All documentation must adhere to minimum standards to reduce the risk of compliance issues.

- Services must document how the intervention or service will address the person in care's identified behavioral health need alongside meeting criteria for continued access to services.

BHIN 23-068

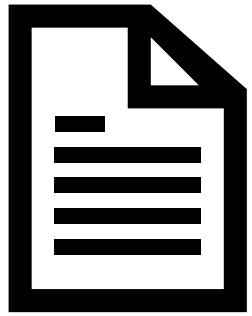
Documentation Requirements for all SMHS, DMC, and DMC-ODS

Documentation	Guidance
Assessments	Providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice. Assessments shall be updated as clinically appropriate.
Problem Lists	All clients receiving services are required to have a Problem List documented within the EHR.
Progress Notes	Providers shall create service notes for the provision of all services. Each service note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.
Treatment and Care Planning	DHCS no longer requires prospectively completed, standalone client plans for Medi-Cal SMHS. Certain service lines are still required by federal / state laws to have care plans and/or specific care planning activities in place. Please reference the following for a list of these services: Enclosure 1a of BHIN 23-068.
Telehealth Consent	DHCS has outlined specific elements that telehealth providers must Include in their consent forms. See the following for specific guidance: Patient Consent for Telehealth Services

For full guidance please reference BHIN 23-068

Other Documentation Resources

- OPOH *Section B*
- CalMHSA Clinical Documentation Guides
- Optum Website- *UCRM* Explanation Sheets
- QA Documentation Trainings (held Live, Quarterly)
  - Audit Leads
  - Progress Notes Practicum Training



Utilization Review

- The BHP has delegated responsibility to outpatient County operated and contracted organizational providers to perform utilization management for specialty mental health services, outpatient services, medication services, and case management services.

- Program Managers are responsible for ensuring that their programs are following the various UR/UM Standards for their client population (i.e. Adult/Older Adult or Children, Youth & Families) as well as service line (i.e. Outpatient, Crisis Residential, etc).

- Programs are required to have an internal URC in place to review records (a minimum of 5 quarterly) and conduct the UM process.

- Please refer to the OPOH *Section L* and consult with your COR for your specific program's UM/UR requirements.

Site Credentialing

Site Reviews

- Contracted and County providers who bill for Medi-Cal services will be initially certified prior to the program providing any billable services.

- Programs are typically recertified every three (3) years.

- Site reviews are conducted to ensure that providers comply with necessary licenses/certification requirements, maintain a safe facility, have appropriate fire clearance, and store and dispense medications in compliance with all pertinent Federal and State standards.

    - Contracted programs: Site Certification or Recertification Site Review is completed by BHS QA staff
    - County-operated programs: Site reviews are completed by DHCS.

Please refer to the OPOH *Section K* for more detailed information about the certification & recertification process .

Site Review Categories

Review Topics

- Maintenance of current licenses, permits, notices and certifications
- Policies & Procedures or written process
- Compliance with standards in the MHP's Managed Care Contract with the State of California.
- Physical facility requirements
- Adherence to health and safety requirements
- Compliance with fire authority requirements
- Medication services
- Cultural competence
- Consumer orientation
- Staff Training & Education
- Client Rights, Grievance & Appeals Process

Policies & Procedures

- Emergency Evacuation
- Confidentiality and Protected Health Information
- Personnel P&P's 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
- Policy for providing clients with a notice that the Board of Behavioral Sciences responds to complaints, prior to the provision of psychotherapy services.

Required Clinic Postings

Required Notifications, Posters & Brochures		
Behavioral Health Plan (BHP) Member Handbook	Current Problem Resolution Process posters (with fair hearing process)	BBS Notice Display of License/Registration Notice to Consumers (SB 1024)
Current Provider Lists with instructions for accessing in all languages	Current grievance/appeal forms with self-addressed, stamped envelopes available	BBS Notice- Updated Requirement to Provide Notice to Psychotherapy Clients (Notice to Clients- AB 630)
Current Limited English Proficiency Posters	Open Payments Database Notice- included on provider/legal entity's website (if applicable).	Human Trafficking Model Notice (For pediatric)
Current Notice of Privacy Practices	Physician Notice to Patients from the Medical Board of California (with QR Code)	Voter registration materials
Current Problem Resolution Process brochures		

Program Changes

- The following changes may require a new certification/recertification or additional applications:

  - Adding or Revising Services
  - Location Changes
  - Relocation, Remodeling or Change in Ownership
  - Other Changes:(e.g., a change in ownership less than 50% and a change with the Medical Director, staff, and/or service modality)

Please refer to the OPOH *Section K* for more detailed information about program changes.

QA Review

Quality Improvement

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

Internal Review	QAPR
Providers are required to conduct internal reviews of medical records on a regular basis to ensure that service documentation meets all County, State and Federal standards, and that all Short-Doyle Medi-Cal billing is substantiated	The QA Unit conducts program site and Quality Assurance Program Reviews (QAPRs) annually during which an assigned QA staff member reviews various documentation and services from a selected period in the client's medical record. At the conclusion of each QAPR, the QA Specialist will present preliminary findings at an exit conference

Please refer to the OPOH *Section G* for more detailed information about the QAPR. Staff may also attend the quarterly QA Audit Leads training for a step-by-step explanation of the QAPR process and tool.

Reviewed Areas of the QAPR

Reviewed Area Examples		
Assessment	Appropriateness of Treatment	Access criteria/ Medical Necessity
Diagnosis	Care Coordination	Utilization Management/ Authorization
Problem List	Care Planning	Outcomes Measures
Safety Issues/ Risk Assessment	Fraud, Waste, Abuse	Service Indicators
Progress Note Review	Billing indicators/ services	Quality of Care

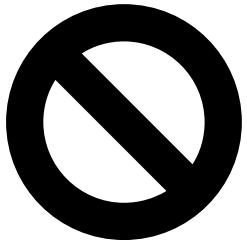
Please refer to the OPOH *Section G* for more detailed information about program changes. Staff may also attend the quarterly QA Audit Leads training for a step-by-step explanation of the QAPR process and tool.

Medi-Cal Recoupment & Disallowance Process

Preventing Fraud, Waste & Abuse

- If 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 following the current error correction processes as indicated on the Optum Website> "*SmartCare*" tab.

- DHCS Requires overpayments to be reported within 60 days of being identified as a disallowance to be recouped.



Reasons for Recoupment

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		

Payment Recovery Form (PRF)

- Overpayment is typically identified either via program internal review (self-report) or during the annual QAPR.

- The Payment Recovery Form (PRF) is required for reporting overpayments to the billing unit. Programs should fill out the PRF located on the Optum website > *Billing* tab. A tip sheet on to use the form is on the second tab of the PRF excel form.

Please reference OPOH *Section Q* and the Optum website > *Billing* tab for more information on the recoupment process.

Incident Reporting

Incident Reporting

- A *reportable incident* is an incident that may indicate potential risk/exposure for the County operated or contracted providers (per Statement of Work), client, or community.

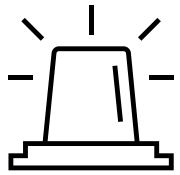
- There are two primary types of Incidents – *Critical* and *Non-Critical*

- When an Incident occurs or are identified, the appropriate agencies must also be notified within their specified timeline and format (i.e. police, child/elder abuse hotlines, other law enforcement, fire department, etc.

- All information for Incident Reporting: webinar trainings, submission forms, tip sheets and further resources are located on the Optum Website> *Incident Reporting* tab and OPOH *Section G*.

<u>Please reference the tip sheets and webinars posted on Optum for step-by step instructions on how to fill out each document.</u>

Critical Incidents



- A “**Critical Incident**” is the most severe type and related to significant clinical health, safety, and risk concerns.
- All providers are required to report critical incidents involving clients in **active treatment** or whose discharge from services has been **30 days or less.**
- All Critical Incidents shall be reported to the BHS Health Plan Organization Quality Assurance Unit **within 24 hours of program notification.**
- Critical Incidents are reported using the CIR Form located on the Optum Website > *Incident Reporting* tab

CIR Categories

Critical Incident Categories			
Death/Pending (Pending CME investigation)	Suicide Attempt	Critical Injury on site (MH/SUD related)	Death/Natural Causes (Confirmed)
Death/Overdose (Confirmed)	Non-Fatal Overdose	Medication Error	Death/Homicide (Confirmed)
Death/Suicide (Confirmed)	Alleged abuse/inappropriate behavior by staff	Injurious assault by a client resulting in hospitalization	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”

Report of Findings (ROF)

- All critical incidents shall be investigated and reviewed by the program.
- The program shall submit a **Report of Findings** to QA **within 30 days** of knowledge of the incident.
- The ROF document is located on the Optum Website> *Incident Reporting* tab.
- A **Root Cause Analysis** is required for any death by suicide, alleged homicide committed by client, or as requested by County QA for any other critical incident.

Non- Critical Incidents (NCIRs)

- A "**Non-Critical Incident**" (N-CIR) is an adverse incident that may indicate potential risk/exposure for the County provider and represents "adverse deviation from usual program processes for providing behavioral health care" and not falling. It does not meet criteria for a CIR.

- 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.**

- N-CIRs are reported directly to your COR/Program Manager and to QA via an online submission form located on the Optum Website> Incident Reporting tab **within 24 hours** of knowledge of the incident.

- It is VERY IMPORTANT that **NO PHI** is included on the online submission form for N-CIRs. If so, a *privacy incident report* will need to be completed.

NCIR Categories

Non- Critical Incident Categories			
AWOL	Contract/Policy violations by staff	Loss / theft of medication from the Facility	Physical Restraints
Tarasoff Reporting	Adverse Police/PERT Involvement onsite	Medication Error	Non-critical injury onsite
Property destruction onsite	Other		

**You may always contact QI Matters if you are unsure if an incident meets IR criteria.

Medication Monitoring

Medication Monitoring

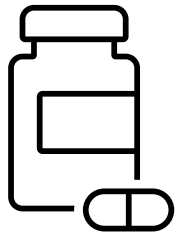
- All providers with programs prescribing medications are required to have a medication monitoring system.

- Programs are required to review one percent (1%) of their active medication caseload for each prescriber each quarter, with a minimum of one chart reviewed.

- 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
  - Member adherence with prescribed medication and usage
  - Member medication education and degree of member knowledge regarding management of medications.
  - Adherence to state laws and guidelines

Medication Monitoring Tools

- Programs are required to submit medication monitoring via the following documents located on the Optum Website> *Monitoring* tab:
  - Medication Monitoring Submission Form
  - Medication Monitoring Screening Tool (Child/Youth or Adult SOC)
  - Medication Monitoring Feedback Loop (McFloop)



Due to qimatters.hhsa@sdcounty.ca.gov by the fifteenth of each month following the end of each quarter	
Q1: July- September	October 15th
Q2: October- December	January 15th
Q3: January- March	April 15th
Q4: April- June	July 15th

Please reference OPOH *Section G* for more information

Grievance and Appeals

Member Rights

Clients have the right to:			
Easily understandable information	*Participate in decisions*	*Right to health care services*	*Right to provider selection*
Dignity, respect, and privacy	*Be free from restraint or seclusion.*	*Free exercise of rights.*	*Right to a second opinion*
Receive information on the managed care plan and available treatment options	*Right to access their health Information*	*Right to transfer services*	*Right to language, visual and hearing assistance*
Right to a patient advocate	*Right to direct PHI to another Person*	*Right to direct PHI to another person*	*Refuse treatment*

Expressing Grievances

- Clients are encouraged to express concerns, complaints or suggestions to the program orally or in writing.

- Providers shall inform all clients about their right to file a grievance with one of the BHP's contacted advocacy organizations (JFS/ CCHEA) if the client has an expression of dissatisfaction about any matter, is uncomfortable approaching program staff, or the dissatisfaction has not been successfully resolved at the program.

- Grievance and Appeal information must be readily available for clients to access without the need for request.

- Each provider site shall have posters, brochures, and grievance/appeal forms in threshold languages with stamped, addressed envelopes available to clients, displayed in a prominent place. These self-addressed envelopes with postage are available from CCHEA or JFS respectively.

Please reference OPOH *Section F* for more information as well as the Optum Website > Beneficiary tab.

Support Agencies

If members unable resolve their concern at the program level, or want to appeal a decision that limits care, they should be assisted to contact one of the agencies listed below:

Jewish Family Services (JFS)	Consumer Center for Health, Education and Advocacy (CCHEA)
For problems with inpatient or 24-hour residential services	For problems with outpatient and any other type of mental health service
800.479.2233 or locally at 619.282.1134	**877.734.3258**
For more information: JFS- Patient Advocacy	For more information: Legal Aid Society of San Diego

There can be absolutely **no** retribution or retaliation against a client or family member who has filed a complaint or grievance against a program or staff

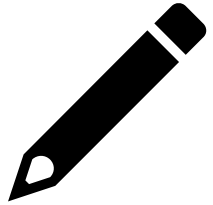
Outcome Measures

Consumer Satisfaction Surveys

- On an annual basis, BHS selects a one-week period in which all Outpatient providers are required to administer the Mental Health survey.

- The MHSIP is a tool designed to gather feedback from individuals who have received mental health services. It aims to assess their satisfaction with various aspects of care and their experiences with mental health providers.

- HSRC/CASRC are responsible for handling the survey process.



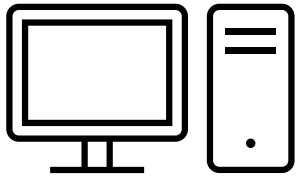
Monthly/ Quarterly Status Report (M/QSR)

- Providers are required to submit a monthly/quarterly status report to the COR which gives the BHP vital information about provider services.

- MSRs/QSRs are required from each program, county or contract, by the 15th of month.

- All sections of the report must be completed. This report form is updated periodically in accordance with changing State, Federal and County regulations.

For more information, please contact your COR or designated analyst.



Client Outcomes

- Measuring outcomes is an integral aspect of the System of Care principles. Standard outcomes have been established for all Child, Youth & Families treatment providers. Specialized programs may have other outcomes in addition to or in lieu of standard outcomes.

Please note that as of 07/01/2026 only the LOCUS will be required for Adult Outcome Measures.

Adult Outcome Measures	Frequency
Milestones of Recovery Scale (MORS)	Intake, 6 Months, Discharge
Level of Care Utilization System (LOCUS)	Intake, 6 Months, Discharge
Recovery Markers Questionnaire (RMQ)	Intake, 6 Months, Discharge
Illness Management and Recovery (IMR)	Intake, 6 Months, Discharge

Child/ Youth Outcome Measures	Frequency
CANS-Child and Youth	Intake, 6 Months, Discharge (ONLY if discharging from the system of care)
Pediatric Symptom Checklist, Parent/Caregiver (PSC)	Intake, 6 Months, Discharge
Youth Services Survey, Youth (YSS-Y)	Annually
Youth Services Survey, Family (YSS-F)	Annually

Please reference OPOH *Section N* and the Optum Website > *UCRM* tab for more information.

Utilization Review/ Utilization Management

- The BHP has delegated responsibility to outpatient County operated and contracted organizational providers to perform utilization management for specialty mental health services, outpatient services, medication services, and case management services.

- The UM process is in addition to BHIN 22-016, which outlines that for outpatient services prior authorization is required for Intensive Home-Based Services, Day Treatment, Therapeutic Behavioral Services, and Therapeutic Foster Care.

- Utilization Management for all service providers includes establishing a Utilization Review Committee (URC),.

Please reference OPOH *Section L* and the Optum Website > *UCRM* tab for more detailed information.

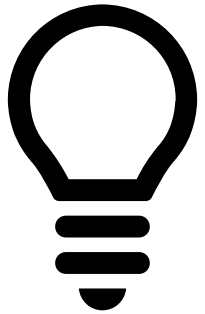
Resources

Where to Find Assistance

- Your program's contract or assigned **Contracting Officer's Representative (COR)**

- **Monthly Up To The Minute (UTTMs)** - QA publishes a monthly newsletter to inform providers of important changes to regulations and/or requirements. It is the Program Managers responsibility to disseminate the information to line staff.

    - **To receive these notices as well as other important meeting invites and communications, c**lick below to subscribe:
        - Specialty Mental Health Services
        - SmartCare



- **Quality Improvement Meetings-** QA facilitates the monthly QIP meeting to discuss important regulatory and/or requirement changes. Program Managers and QA staff are encouraged to attend. The meeting is held virtually on the last Wednesday of every month from 1pm – 3pm. See the UTTM for further details.

- **Uniform Clinical Record Manual (UCRM)-** Located on the Optum Website> UCRM tab. A resource for and link to information on forms and documentation timelines /standards.

Other Resources

- **Uniform Clinical Record Manual (UCRM)-** Located on the Optum Website> UCRM tab. A resource for and link to information on forms and documentation timelines /standards.

- **QI Matters** email: QIMatters.HHSA@sdcounty.ca.gov- Primary email for the QA department. Staff are available for questions and consultation regarding various documentation and quality assurance issues.

- **Optum San Diego Website**

- **BHS Billing Unit:** mhbillingunit.hhsa@sdcounty.ca.gov

- **BHS Acronym List**: SMH & DMC-ODS Health Plans> MH Resources > *References* – Current list of accepted acronyms within the County of San Diego.

Organizational Providers Operations Handbook (OPOH)

- The OPOH is a document containing a broad source of information for all topics involved in managing a program within the County of San Diego.

- The OPOH is managed by the QA Department as well as various department leads within HHSA and BHS. It is a “living document” and constantly updated as new guidance, information and changes occur at a federal, state and County level.

    - The most current version is always found on the OPTUM San Diego Website > OPOH tab.

Sections of the OPOH

Sections of the OPOH	
Table of Contents	I: Management Information System
Customer Service Mission	J: Provider Contracting
A: System of Care	K: Facility Requirements
B: Compliance and Confidentiality	L: Practice Guidelines
C: Accessing Services	M: Staff Qualifications
D: Providing Specialty Mental Health Services	N: Data Requirements
E: Integration with Physical Health Care	O: BH Connect (pending)
F: Member Rights, Grievance and Appeals	P: Behavioral Health Services Act – BHSA (pending)
G: Quality Assurance	Q: Payment Schedule and Budget Guidelines
H: Cultural Competence	

Billing & Service Code Resources

- Financial Eligibility and Billing Manual
- DHCS CalAIM References and Manuals – Service Tables, Billing Manuals, Medi-Cal Behavioral Health Fee Schedules
- CalMHSA Procedure & Service Code Grid
- CalMHSA Scope of Practice Matrix Appendix III (p.39)

QA Unit Leadership Team

QA Supervisors

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QA Unit Administrator

- Tabatha Lang: Tabatha.lang@sdcounty.ca.gov

Thank you!