QUALITY ASSURANCE

I. QUALITY ASSURANCE

Quality assurance and monitoring constitutes the processes by which the County will ensure improvement and high quality of care provided to clients. The County of San Diego's quality assurance and monitoring will adhere to the larger framework established by the County of San Diego Behavioral Health Services with DHCS DMC-ODS and EQRO oversight. The processes by which the County will perform involve ensuring compliance of regulations set forth by governmental and/or administrative entities. Essentially, the goal of quality assurance is to assess and evaluate quality of services, recognize and address issues with service delivery, construct plans of action to overcome issues and maintain quality improvement, continuing to follow-up and monitor that plans of action meet their anticipated objectives.

The County of San Diego is committed to providing high quality substance use disorder services that follow harm reduction principles, client-centered, clinically effective, accessible, integrated, outcome-driven, and culturally competent. In order to achieve the goal, each program in the system must have internal quality improvement controls and activities in addition to those provided by the County of San Diego. These activities may involve peer review, program manager monitoring of charts and billing activity, and/or a formal Quality Improvement department or position, which offers training and technical assistance to program staff. Internal monitoring and auditing are to include the provision of prompt responses to detected problems. Staff shall participate in activities that promote quality assurance and quality improvement and bring concerns regarding possible deficiencies or errors \in the quality of care, treatment or services provided to clients to the attention of those who can properly assess and resolve the concern.

Each program shall develop written policies and procedures regarding internal quality assurance and improvement controls and activities and maintain internal systems of controls and monitoring to ensure that all aspects of the program including, but not limited to, personnel files, client files, billing and fiscal, data, and programming are in compliance with the contract and maintain the highest possible standards.

Programs shall conduct an internal review and evaluation at least once every fiscal year as it relates to the statement of work. Results of the review and any plans for correction shall be available for review by the County of San Diego.

In addition, all provider programs are required to attend regular Program Manager Meetings, quarterly Leadership Plus meetings, QA In-Service, Documentation trainings and other behavioral health meetings as required. Attendance at these meetings is essential to keep abreast of system changes and requirements as part of our continuous improvement efforts. Since communication is vital to ongoing quality improvement, programs are also required to read and disseminate information that is provided by the County of San Diego, including (but not limited to) materials such as the BHS QA monthly newsletter, "Up to the Minute" (UTTM) as these communications are relied upon as mechanisms for sharing updated information from DHCS, form revisions, and other important announcements related to providing quality SUD services within the County.

The quality of the SUD system of 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 22 of the California Code of Regulations
- State Department of Health Care Services (DHCS) Letters and Notices,
- The Intergovernmental Agreement between DHCS and the County of San Diego, and

- The Special Terms and Conditions (STCs) of the DMC-ODS Waiver

Quality Improvement Plan
The purpose of the County of San Diego's BHS Quality Improvement (QI) Program is to ensure that all clients and families receive the highest quality and most cost-effective mental health, substance use, and administrative services available.

The QI Program delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance use services provided. The QI Program encompasses the efforts of clients, family members, clinicians, behavioral health advocates, substance use treatment programs, quality improvement personnel, and other stakeholders.

The QI Program and QI Work Plan (QIWP) are based on the following values:

- Development of QI Program and QIWP objectives is completed in collaboration with clients and stakeholders.
- Client feedback is incorporated into the QI Program and QIWP objectives.
- QI Program and QIWP are mindful of those whom data represent and, therefore, integrate client feedback to improve systems and services.

The QI Unit monitors the services provided for safety, effectiveness, responsiveness to clients, timeliness, efficiency, and equity. Key variables related to practices and processes performed or delivered by service providers that affect the outcome of services to client and family members are measured and analyzed on a weekly, quarterly, or annual basis. QI staff perform client record reviews and work with contracted providers on continuous improvement activities. Access times, serious incidents, and grievances are tracked and trended. Surveys are conducted to monitor client and provider satisfaction.

Monitoring
SUD programs are monitored by DHCS for Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) and DMC compliance and by the County of San Diego for these and additional standards, such as the DMC-ODS STCs. For the audit, evaluation, or inspection purposes, all providers shall make available their premises, physical facilities, equipment, books, record, contracts, computer and other electronic systems related to their Medi-Cal clients. All programs shall comply with requirements established within the State of California and DHCS standards, and the County of San Diego shall utilize their requirements to monitor program compliance and provision of services.

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. Therefore, contracted providers are to retain medical records for no less than ten (10) years after discharge date. This includes member grievance and appeal records in 42 CFR §438.416, and the data, information, and documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610.

<u>Cultural Competence Requirement Monitoring</u>
Providers are expected to provide services that are suitable for and sensitive to clients' cultural, developmental, and linguistic needs. Providers are required to adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) and shall implement policies and procedures to ensure that all methods utilized, and services provided are in line with this expectation. In order to provide appropriate and adequate services, it is vital that Providers ensure that these values are ingrained in the structural and daily practices of their organization. The County of San Diego's QI Unit and CORs are

responsible for monitoring and evaluating compliance with cultural competence standards as outlined in the County's Cultural Competence Plan and with State and Federal requirements. For more information see Staff Development & Training Plans in Section M: Staff Qualificators & Requirements.

Provider Selection

Selection and monitoring of organizational agencies is governed by contracting procedures, which require a review of the organization's fiscal soundness, resumes of principal administrators and supervisors, the agency's experience with similar services, proposed program design, outcomes, staffing plan and budget. All contracted providers are expected to adhere to contractual requirements which are routinely monitored by BHS.

Contractor Orientation

Once providers are contracted with BHS, they will receive a contractor orientation to review all contract requirements. Providers will also have assigned to their program a designated Program Monitor (also known as Contracting Officer's Representative - COR) to assist with all questions related to contract compliance.

Program Monitoring

At the beginning of each Fiscal Year a risk assessment is conducted for each program and a monitoring plan is developed based on the risk level determined. The designated COR monitors compliance with outcome measures, productivity requirements and other performance indicators, analyzes reports from providers, and provides programmatic review for budgets and budget variances in accordance with contract terms and conditions. Program monitors/CORs hold regular providers meeting to keep providers informed on the System of Care. All provider contract questions should be directed to the assigned Program Monitor/COR.

An additional note: Contractor's Program Manager shall be available during regular business hours and respond to the Program Monitor/COR or designee within 2 business days. Contractor shall have the technological capability to communicate, interface and comply with all County requirements electronically using compatible systems, hardware and software

Notification in Writing of Status Changes

Providers are required to notify BHS Contract Support, (BHSCS) COR and QA in writing if any of the following changes occurs:

- Change in office address, phone number or fax;
- Addition or deletion of a program site;
- Change of tax ID number or check payable name (only to BHSCS);
- Additions or deletions from your roster of Medi-Cal billing personnel (BHSCS & MIS); or
- Proposed change in Program Manager, Head of Service, or Medical Director.
    - NOTE: Programs are required to provide the following evidence to the COR team for Medical Director candidates to ensure compliance with DMC requirements:
        - Enrolled with DHCS under applicable state regulations.
        - Screened as a "limited" categorical risk within a year prior to serving as Medical Director.
        - Signed a Medicaid provider agreement with DHCS.

Site Visits

The County of San Diego will conduct, at a minimum, annual site visits to all organizational providers from various County HHSA departments. Site visits include BHS Program Monitor/COR/Designee, BHS Administrative Services Unit, BHS Quality Assurance (QA) Unit, and the Health and Human Services Agency (HHSA) Contract Support Unit. All site visits are part of the contract monitoring process.

The site visit may include, but is not limited to, a review of:

- Compliance with contractual statement of work;
- Review of client files for compliance with:
  - Documentation Standards
  - ASAM principles
  - Evidence Based Practice requirements
  - Substantiation of medical necessity
  - Care coordination and case management activities
- Building and safety issues;
- Staff turnover rates;
- Insurance, licensure, NPI, and certification validation;
- Fiscal and accounting policies and procedures (including Policies on preventing Fraud, Waste and Abuse and paid claims verification);
- Member informing materials requirement;
- Compliance with DHCS required processes for credentialing/re-credentialing
- Compliance with standard terms and conditions.

Also, to ensure program compliance with confidentiality procedures and protocols, SUD QA will monitor the following as part of site visits:

- Program written confidentiality policy and procedures
- Workforce member initial and renewed, signed Confidentiality Agreement
- Workforce member Confidentiality Training and/or communication of updated Confidentiality Laws and/or Regulations
- Client consent/authorizations/release of information forms (content and signatures)

Additionally, BHS Program Monitor/COR/Designee and BHS Quality Assurance Unit will monitor for compliance with the Minimum Quality Drug Treatment Standards for DMC and SUBG. These standards are required in addition to CCR Title 9 and 22 regulations for all SUD treatment programs either partially or fully funded through DMC and/or SUBG. If conflict between regulations and standards occurs, the most restrictive shall apply. These standards include the following:

A. Personnel Policies

1. Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
   a) Application for employment and/or resume;
   b) Signed employment confirmation statement/duty statement;
   c) Job description;
   d) Performance evaluations;
   e) Health records/status as required by program or Title 9;
   f) Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries);
   g) Training documentation relative to substance use disorders and treatment;
   h) Current registration, certification, intern status, or licensure;
   i) Proof of continuing education required by licensing or certifying agency and program; and
   j) Program Code of Conduct and for registered/certified SUD counselors, a copy of the certifying/licensing body's code of conduct as well.
2. Job descriptions shall be developed, revised as needed, and approved by the Program's governing body. The job descriptions shall include:

a) Position title and classification;
b) Duties and responsibilities;
c) Lines of supervision; and
d) Education, training, work experience, and other qualifications for the position.

3. Written code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
   a) Use of drugs and/or alcohol;
   b) Prohibition of social/business relationship with member's or their family members for personal gain;
   c) Prohibition of sexual contact with member's;
   d) Conflict of interest;
   e) Providing services beyond scope;
   f) Discrimination against member's or staff;
   g) Verbally, physically, or sexually harassing, threatening, or abusing member's, family members or other staff;
   h) Protection member confidentiality;
   i) The elements found in the code of conduct(s) for the certifying organization(s) the program's counselors are certified under; and
   j) Cooperate with complaint investigations.

4. If a program utilizes the services of volunteers and or interns, procedures shall be implemented which address:
   a) Recruitment;
   b) Screening;
   c) Selection;
   d) Training and orientation;
   e) Duties and assignments;
   f) Scope of practice;
   g) Supervision;
   h) Evaluation; and
   i) Protection of member confidentiality.

   Written roles and responsibilities and a code of conduct for the medical director shall be clearly documented, signed and dated by a program representative and physician.

B. Program Management

1. Admission or Readmission
   a) Each program shall include in its policies and procedures written admission and readmission criteria for determining member's eligibility and suitability for treatment. These criteria shall include, at minimum:
      i. DSM diagnosis;
      ii. Use of alcohol/drugs of abuse;
      iii. Physical health status;
      iv. Documentation of social and psychological problems;
      v. Level of Care determination

   b) If a potential member does not meet the admission criteria, the member shall be referred to an appropriate service provider.

c) If a member is admitted to treatment, a consent to treatment form shall be signed by the member.

d) The Medical Director or LPHA shall document separately from the treatment plan/problem list, the basis for the diagnosis in the member's record within timelines specified for the respective treatment modality. The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each member's assessment and intake information, including their personal, medical, and substance use history. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

e) All referrals made by program staff shall be documented in the member record.

f) Copies of the following documents shall be provided to the member upon admission:
   i. Member rights share of cost if applicable, notification of DMC funding accepted as payment in full, and consent to treatment.

g) Copies of the following shall be provided to the member or posted in a prominent place accessible to all members:
   i. A statement of nondiscrimination by sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation., and ability to pay, if the client meets the County's eligibility population requirements;
   ii. Grievance process and procedures;
   iii. Appeal process for involuntary discharge; and
   iv. Program rules, expectations and regulations.
   v. Notice of Privacy Practices

h) Where drug screening by urinalysis is deemed medically appropriate the program shall:
   i. Establish procedures which protect against the falsification and/or contamination of any urine sample; and
   ii. Document urinalysis results in the member's file.

2. Treatment
   a) Assessment for all members shall include:
      i. Drug/Alcohol use history;
      ii. Medical history;
      iii. Family history;
      iv. Psychiatric/psychological history;
      v. Social/recreational history;
      vi. Financial status/history;
      vii. Educational history;
      viii. Employment history;
      ix. Criminal history, legal status; and
      x. Previous SUD treatment history.

   b) Treatment plans (if required) shall be developed with the member and include:
      i. A problem statement for all problems identified through the assessment whether addressed or deferred;
      ii. Goals to address each problem statement (unless deferred);

iii. Action steps to meet the goals that include who is responsible for the action and the target date for completion;
iv. Typed or legibly printed name, signature, and date of signature of primary counselor, member, and medical director or LPHA;
v. All treatment plans shall be reviewed in accordance with CCR Title 22 requirements and updated to accurately reflect the member's progress or lack of progress in treatment.

c) Progress notes shall document the member's progress toward completion of activities and achievement of goals on the treatment plan (if required), or plan of care.

d) Discharge documentation shall be in accordance with CCR Title 22 51341.
i. A copy of the discharge plan shall be given to the member.

Monthly/Quarterly Status Reports

Programs shall be responsible for data collection and completion of the Monthly or Quarterly Status Report (MSR/QSR). Due date for submission shall be directed by the program COR. All sections of the report must be completed. In addition to outcome measures and compliance, programs that provide SUD treatment are required to report Charitable Choice referrals and specific staff licensure/certifications.

Quality Assurance Program Review (QAPR) [formerly known as Medical Record Reviews (MRR)]

DHCS requires SUD QA to complete annual reviews for every contracted program. The QAPR is the official review that meets this requirement. The focus of the QAPR is on documentation of medical necessity in the clinical record and review of appropriate billing to DMC (Drug Medi-Cal) standards. Results of each QAPR is reported to assigned contract officers. This includes overall compliance rates, disallowance rates, Quality Improvement Plans requirements, and Focus Review requirements.

QAPR Results, Billing Corrections and QIP

Results from both reviews shall be returned to each provider within 14 days. If applicable, billing corrections and a QIP are due to QA within 14 days of receiving the results. For more information on the billing correction process, see Billing Disallowances in Section O.

Focus Review

For programs who are identified as needing additional assistance due to a high disallowance and/or low compliance rate during the QAPR process, in addition to a QIP a focus review process may be implemented. This can include an intensive chart review, Technical Assistance and training provided by the assigned Quality Assurance Specialist, and other assistance as identified during the QAPR. If a program is unable to demonstrate improvement during the focus review, a Corrective Action Notice (CAN) may be implemented by the program's BHPC.

Technical Assistance (TA)

Programs who are not DMC certified and/or not approved by SUD QA to bill for services are assigned a QA Specialist to provide ongoing monitoring and technical assistance. This includes on-site discussions or TA on documentation standards, chart reviews for documentation standard compliance, billing reviews to assure all services are billable per regulation, and clinical chart review for adherence to ASAM principles and Evidence Based Practices. QA Specialists will work with residential programs regularly to meet program specific needs.

TA Results and Billing Corrections

Results from both reviews shall be returned to each provider within 14 days. If applicable, billing corrections are due to QA within 14 days of receiving the results. For more information on the billing correction process, see Billing Disallowances in section O.

Timely Access Compliance Monitoring
Per DHCS Info Notice BHIN25 013-https://www.dhcs.ca.gov/Documents/BHIN-25-013-2025-Network-Certification-Requirements.pdf DHCS calculates compliance of timely access standards using the "Date of First Contact to Request Services" and the number of business days between that date and the date of the first offered available appointment that qualifies as a billable serviceCompliance monitoring will be a joint effort between the SUDQA team and assigned program COR's. Non-compliance will result in official notification from and technical assistance from assigned COR's and a submission of a Performance Improvement Plan (PIP) within 30 days to assigned COR's for approval.

QA Consultation
In addition to the many monitoring reviews, QA specialists are available to assigned programs for regular and ongoing consultation upon request for various clinical and compliance needs. This may be limited to QAPR or TA questions, reviewing documentation standards or reviewing progress notes not associated with other reviews. QA Consultation excludes clinical input, programmatic workflows, or staffing.

Medication Monitoring
The County of San Diego Quality Assurance Unit will also conduct annual program site reviews and results will be forwarded to appropriate program COR's. The annual program compliance site review will include a medication monitoring component, as applicable. Program's policies, procedures and practices will be evaluated and reviewed to ensure proper compliance with State and Federal regulations regarding prescription medication storage, handling, disposal and dispensing; maintenance of a current Drug Diversion Control Plan; and documentation of initial and on-going staff training relevant to Medication Assisted Treatment (MAT), if applicable. Any areas of concern will be reviewed and may result in issuing program corrective action and resolution.

Prescribers are required to report dispensing of Schedule II-V drugs to the CURES 2.0 database within one working day. The prescriber must consult the patient activity report obtained from the CURES 2.0 database to review a patient's controlled substance history for the past 12 months before prescribing a Schedule II, III, or IV controlled substance to the patient for the first time and at least every 4 months thereafter if the prescriber renews the prescription and the substance remains part of the treatment of the patient.

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.*

NTP services and regulatory requirements shall be provided in accordance with CCR Title 9, Chapter 4.

The provider shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. The IA requires all counties to have a medication monitoring process (Reference: IA Exhibit A, Attachment I A1 Program Specifications, Quality Assurance Program and Requirement for Services).

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 signed informed consent
- 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 County of San Diego 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 physicians who prescribe.

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 physician. Physicians may not review their own prescribing practices. It is the program's responsibility to assure that there is another physician to review the charts. The Medication Monitoring Committee function shall be under the supervision of a person licensed to prescribe or dispense prescription drugs.

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 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 physician for action, and then returned to the Medication Monitoring Committee for approval.

QI Medication Monitoring Report

- Address all applicable prompts on the form, for example program name, date, contract, DMC ID, quarter.
- Under the Description of Activities Section, all fields must be completed.
- Enter a number for the variances for each no answer found on the tool.

QI Report Instructions

Variances are when questions on the tool are answered with a "No". Variances or "No's" are totaled by type of variance. For example, if you reviewed 10 charts, and one chart had a variance for variance #2, then a "1" would be entered in the *variance* 2 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

- Email/fax the Medication Monitoring Report to SUD QA.
- Do not submit your Medication Monitoring tools or approved McFloop forms. Keep these forms on file at your clinic.
- If you have any unapproved McFloop forms, send in by secure email or by fax (619-236- 1953) as they contain PHI.
- At the time of your Medical Record Review, QA Specialists will review your medication monitoring submissions for the last quarter, if the submission falls into the quarterly submission time.

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). All programs shall have a procedure in place to ensure the following:

- Signed and updated consents are completed and filed in the hybrid record in a timely manner.
- 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 enough follow up with clients/family members in keeping their appointments for labs.

The QA Unit evaluates the reports from the providers for trends, compiling a summary report submitted to the Quality Review Council (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 Assistant Clinical Director for recommendations for remediation. Programs with severe or recurrent problems will have additional reviews and/or recommendations for a quality improvement plan.

Note: Medication Monitoring process requires that a staff physician not review their own charts. For programs that have only 1 doctor. Contact your COR for approval to have the staff physician review their own chart. CC QI Matters to coordinate CORS approval.

Program Integrity Process and Monitoring
It is recommended that programs have an Internal Compliance Program that:

- Is commensurate with the size and scope of their agency. Further, contractors with more than $250,000 annually in agreements with the County must have a Compliance Program that meets the 42 CFR guidelines:
    - Development of a Code of Conduct and Compliance Standards.
    - Assignment of a Compliance Officer, who oversees and monitors implementation of the compliance program.
    - Design of a Communication Plan, including a Compliance Hotline, which allows workforce members to raise grievances and concerns about compliance issues without fear of retribution.
    - Creation and implementation of Training and Education for workforce members regarding compliance requirements, reporting, and procedures.
    - Development and monitoring of Auditing Systems to detect and prevent compliance issues
    - Creation of Discipline Processes to enforce the program.
    - Development of Response and Prevention mechanisms to respond to, investigate, and implement corrective action regarding compliance issues.

- All Programs, regardless of size and scope, shall have processes in place to ensure at the least the following standards:
    - Staff shall have proper credentials, experience, and expertise to provide client services.
    - Staff shall document client encounters in accordance with funding source requirements and County of San Diego Health and Human Services policies and procedures.
    - Staff shall bill client services accurately, timely, and in compliance with all applicable regulations and HHSA policies and procedures.

- Also, all programs shall have processes for:
    - Staff to promptly elevate concerns regarding possible deficiencies or errors in the quality

of care, client services, or client billing.
    - And for Staff to act promptly to correct problems if errors in claims or billings are discovered.

- Program Reporting of Fraud, Waste and Abuse
    - Concerns about ethical, legal, and billing issues, (or of suspected incidents of fraud, waste and/or abuse) should be reported directly to:
        - The HHSA Business Assurance and Compliance (abbreviated BAC) by phone at 619-338-2807, or by email at Compliance.HHSA@sdcounty.ca.gov.
        - Or report to the Compliance Hotline at 866-549-0004
    - In addition, any potential fraud, waste, or abuse shall be reported directly to DHCS' State Medicaid Fraud Control Unit. Reporting can be done by phone, online form, email or by mail.
        - 1-800-822-6222
        - fraud@dhcs.ca.gov
        - Online form
        - Medi-Cal Fraud Complaint – Intake Unit
          Audits and Investigations
          PO Box 997413, MS 2500
          Sacramento, CA 95899-7413
    - All reporting shall include contacting your program COR immediately, as well as the SUD QA team at QIMatters.HHSA@sdcounty.ca.gov to report any of these same concerns, or suspected incidents of fraud, waste, and/or abuse.

- Paid Claims Verification - Verification of paid claims is an important means of monitoring for instances of fraud, waste and/or abuse. The County requires that each program develop a P & P on Paid Claims Verification – which is how programs will verify whether services reimbursed by Drug Medi-Cal were actually provided to clients.
    - Programs must submit their Policy and Procedure for Paid Service Verification to BHS SUD QA. These are filed to help assist with monitoring activities.

- Monitoring:
    - Programs are expected to conduct their own regular program integrity activities and to maintain records for QA audit purposes.
    - The BHS SUD QA team will run reports regularly on random samples of clients, comparing billing entered to supporting documentation in the system (such as ASAM risk ratings/levels of care determinations). This will help to identify any potential issues (such as data entry errors, any obvious discrepancies between LOC documentation and services provided, etc.) so that the SUD QA team will be able to provide ongoing technical assistance to programs.
    - The BHS QI team will provide tip sheets for programs to run regular SmartCare reports to help with their own internal monitoring processes.

Department of Health Care Services (DHCS) Reviews

There are three divisions within DHCS related to SUD services:

- SUD Compliance - responsible for licensing and certification
- SUD Performance Management - responsible for Post Service/Post Payment (PSPP) reviews, Post Service/Pre-Payment (PSPP), and annual contract monitoring of the County of San Diego.

- Audits and Investigations

The mission of Audits and Investigations (A&I) is to ensure the fiscal integrity of the health programs administered by the Department of Health Care Services (DHCS) and ensure quality of care provided to the members of these programs. The overall goal of A&I is to improve the efficiency, economy, and the effectiveness of DHCS and the programs it administers. To carry out its mission A&I will:

- Perform special audits as needed by DHCS program managers, executive staff, California Health and Human Services Agency (CHHS), or the Governor's Office.
- Perform internal audits of DHCS organizations to ensure that various internal controls are operating and effective.
- Perform medical reviews of Medi-Cal and public health providers.
- Provide technical assistance (financial and medical) in the development and expansion of the Managed Care program.
- Identify and investigate Medi-Cal member and provider fraud and abuse, emphasizing fraud prevention.
- Participate in the development or modification of DHCS policies.

A&I is divided with three branches along with Internal Audits. In addition, the division includes the Administrative Management Services Section (AMSS) and Information Technology Unit (ITU) which provides centralized administrative functions and technology services to A&I, respectively.

- Financial Audits Branch (FAB) ensures, through financial audits, that payments made to providers of Medi-Cal or other State or federally funded health care programs are valid, reasonable, and in accordance with laws, regulations, and program intent.

- Investigations Branch (IB) is mandated by the Code of Federal Regulations and California State law as the organization responsible for investigating allegations of member fraud and abuse of the Medi-Cal program.

- Medical Review Branch (MRB) is charged with the responsibility of performing federal mandated post service, post payment utilization reviews.

- Internal Audits (IA) is an independent organization housed within A&I that is charged with department-wide program audit responsibilities.

Other units within DHCS may also conduct audits or reviews (for example, the Licensing and Certification units of DHCS). When a program is contacted by DHCS for any type of review, be it a scheduled or unannounced visit, it is expected that the program will immediately notify the program COR and the BHS SUD QA unit. The QA can be notified via email at QIMatters.HHSA@sdcounty.ca.gov

If a Corrective Action Plan (CAP) is required for any type of review, programs are to submit drafts directly to the BHS SUD QA unit for review and technical assistance. Once finalized, the BHS SUD QA unit will submit the CAP to DHCS on behalf of the program and will follow-up with the program periodically for monitoring of CAP implementation and continued technical assistance until the CAP is fully implemented.

Post Service Post Payment (PSPP) Reviews
PSPP reviews involve chart reviews by DHCS staff at the program location. When documentation does not meet Title 22 requirements, and/or other relevant regulations, standards, and State-County contract requirements, recovery of funding (via recoupment) can occur.

QUALITY ASSURANCE

The review process involving DHCS, the Program COR and the SUD Quality Assurance (QA) unit is as follows:

- DHCS SUD Performance Management Unit will contact the DMC certified SUD program one week prior to the scheduled PSPP review.
- Program will contact the program COR and the QA SUD unit to notify them of the review.
- DHCS will conduct an Entrance Conference the first day of the review to discuss the review purpose and process, and request charts for the review. The program COR (or designee) and QA SUD unit designee will attend, if possible.
- DHCS will conduct an exit conference with a summary of findings on the last day of the review. The COR or their designee and QA SUD designee will attend the exit conference, if possible.
- DHCS will send a final PSPP Report to the SUD provider and to the QA SUD unit. DHCS may request a Corrective Action Plan (CAP). **BHS QA SUD unit has 60 calendar days from the date of the letter to return the CAP to DHCS SUD Performance Management**.

    - QA coordinates the whole process and is responsible for initially contacting the provider via e-mail to inform them of the 30-day requirement to submit the draft of the CAP to QA. Technical assistance is available for programs from the BHS SUD QA unit in drafting the CAP.
    - The program will write an initial draft of the CAP and send it to QA for review within 30 days of the final PSPP Report. Then, QA will forward the draft of the CAP to the COR for review and feedback. QA will continue to provide technical assistance as necessary to the provider.
    - After the CAP is "final approved" by the COR and the QA unit, QA staff will write and sign the cover letter for the CAP. The cover letter and CAP is sent to DHCS via encrypted email. The email communication will include a CC to the COR, the Provider Program Manager and the QI Chief.
    - The County is responsible to ensure the CAP is completed and submitted within the 60-calendar daytime requirement. In rare instances, if additional time is needed, an extension may be requested by the County.
    - Providers shall forward all DHCS correspondence associated with the CAP to the County.
    - Upon DHCS acknowledgement letter of the CAP submitted, the provider shall continue to work the County regarding an Implementation Plan and the County may provide additional technical assistance.
    - The provider shall maintain records verifying that actions denoted in the CAP are being aptly adhered to.
    - Providers shall provide the County annually documentation exhibiting that the provider is complying with implementation of the DHCS-approved CAP.
    - Documentation of any and all evidence referred to in the DHCS-approved CAP must be submitted to the County; including but not limited to:
        - Copy of DMC Certification
        - Revised and/or New Form Templates (different than what was submitted with the CAP)
        - Revised and/or New Policy and Procedures (different than what was submitted with the CAP)
        - Documentation of compliance to policy and procedures (i.e., supervision, chart utilization reviews, monthly reports, etc.)
        - List of direct services staff with credentials and hours of work per week. This request includes copies of licenses and certifications for Licensed Professionals of the Healing Arts (LPHA) and SUD Counselors - both certified and registered and

the full time equivalent (FTE) spent in direct service for each staff person. The list must include all staff, and includes staff who no longer work for the organization but who provided services during the specified time frame of the review
- Templates of all forms related to the client files (Health Questionnaire and Screening, Intake, Diagnosis Determination/Medical Necessity, Treatment Plans, Discharge Summary & Plan)
- Copy of Group sign-in sheets
- Copy of a random sample of requested charts which includes: Intake/Assessment, Medical Records & Health Questionnaire, Medical Necessity, Stay Reviews, Treatment Plan(s), Progress Notes, Discharge Plan, Discharge Summary
- Copy of staff training agendas, training material and staff training sign-in sheets, and
- Copy of internal monitoring reports that reflect monitoring activities for the specified review period

Post Service Pre-Payment (PSPP) Reviews
Post Service Pre-Payment reviews, formally known as DMC Monitoring Reviews, differ from PS Post Payment reviews in that there is no financial recovery (i.e., recoupment) associated with these types of reviews. Rather, they are conducted as part of the DHCS requirement to provide programmatic, administrative, and fiscal oversight of statewide DMC SUD services. The Post Service Pre-Payment reviews include an on-site review of certain DMC charts, employee files, policy and procedures, and the physical location of the program. These monitoring reviews are a helpful resource to programs as technical assistance for compliance and recommendations is provided directly to programs by DHCS staff.

The review process involving DHCS, the program COR and the SUD QA unit is as follows:

- DHCS DMC Monitoring Unit will contact the DMC certified SUD program approximately two weeks prior to the scheduled Post Service Pre-Payment review.
- DHCS will notify the program of the types of materials to make available for the review (i.e.
- Policies and Procedures, copies of staff certifications/licenses, internal monitoring reports, etc., and will provide forms for completion prior to the review.
- Program will contact the program COR and the QA SUD unit to notify them of the review.
- The DHCS analyst will conduct an Entrance Conference the first day of the review to discuss the review purpose and process. The program COR (or designee) and QA SUD unit designee will attend, if possible.
- The DHCS analyst will conduct an exit conference on the last day with a summary of findings.
- The COR or their designee and QA SUD unit designee will attend.
- The DHCS analyst will send a final Monitoring Report to the Provider and to the QA SUD unit. DHCS may request a Corrective Action Plan (CAP). **BHS has 60 calendar days from the date of the report to return the CAP to the DHCS DMC Monitoring Unit.**

    - QA coordinates the whole process and is responsible for initially contacting the provider via e-mail to inform them of the 30-day requirement to submit the draft of the CAP to QA. Technical assistance is available for programs from the BHS SUD QA unit.
    - The program will write an initial draft of the CAP and send it to QA for review within 30 days of the final Monitoring Report. Then, QA will forward the draft of the CAP to the
    - COR for review and feedback.
    - After the CAP is "final approved" by the COR and the QA unit, QA staff will write and sign the cover letter for the CAP. The cover letter and CAP is sent to DHCS via encrypted email. The email communication will include a CC to the COR, the Provider Program

Manager, and the QI Chief.
- The County is responsible to ensure the CAP is completed and submitted within the 60-calendar daytime requirement. In rare instances, if additional time is needed, an extension may be requested by the County.

PSPP Appeals
The County may appeal DMC dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims (such as those resulting from a PSPP review). Such appeals shall be handled as follows:

Requests for first-level appeals
- The County shall initiate action by submit a letter on the official stationery of the County and it shall be signed by an authorized representative of the County.
- The letter shall identify the specific claim(s) involved and describe the disputed (in)action regarding the claim. Letter sent to:

  Division Chief DHCS SUD-PPFD
  P.O. Box 997413, MS-2621
  Sacramento, CA 95899-741

The County may initiate a second level appeal to the Office of Administrative Hearings and Appeals (OAHA).
- The second level process may be pursued only after complying with first-level procedures and only when:
  - DHCS has failed to acknowledge the grievance or complaint within 15 calendar days of its receipt, or
  - The County is dissatisfied with the action taken by DHCS where the conclusion is based on DHCS' evaluation of the merits.
- The second-level appeal shall be submitted to the Office of Administrative Hearings and Appeals within 30 calendar days from the date DHCS failed to acknowledge the first-level appeal or from the date of DHCS' first- level appeal decision letter.
- All second-level appeals made in accordance with this section shall be directed to:

  Office of Administrative Hearings and Appeals
  1029 J Street, Suite 200, MS 0016
  Sacramento, CA 95814

In referring an appeal to the OAHA, the County shall submit all of the following:
- A copy of the original written appeal sent to DHCS.
- A copy of the DHCS report to which the appeal applies.
  - The appeal process listed here shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Exhibit B of the Intergovernmental Agreement.
  - State shall monitor the provider's compliance with County utilization review requirements, as specified in the Intergovernmental Agreement (Article III.EE.) Counties are also required to monitor the subcontractor provider's compliance pursuant to Article III.AA of this Intergovernmental Agreement. The federal government may also review the existence and effectiveness of DHCS' utilization review system.
  - The County shall, at a minimum, implement and maintain compliance with the requirements described in Article III.PP of the Intergovernmental Agreement for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.

- The County shall ensure that subcontractor provider sites shall keep a record of the members/patients being treated at that location.
- The County and provider shall retain member records for a minimum of 10 years, in accordance with 438.3(h), from the finalized cost settlement process with DHCS. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the member records shall be maintained until completion of the audit and the final resolution of all issues.

Additional Review Considerations
Per DHCS, programs shall keep sufficient financial records and statistical data to support year-end documents filed with DHCS. Programs shall include in any contract with an audit firm a clause to permit DHCS access to the working papers of the external independent auditor.

Follow-up and Monitoring
Programs will be asked to provide a summary follow-up report to QA of their monitoring efforts and results of their corrective action plans. Once notified via email, they shall provide a summary report to QA within seven calendar days.

Critical Incidents/Non-Critical Incidents (formerly known as Serious Incident Reports)
Critical Incidents/Non-Critical Incidents are defined as incidents that have a direct or indirect impact on the community, patients, staff, and/or the SUD treatment provider agency as a whole and are required to be investigated and evaluated at the provider agency level. This information should be used on a routine basis to improve accessibility, health and safety, and address other pertinent risk management issues.

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 Quality Assurance (QA) Unit. There are two types of reportable incidents:

- Critical Incidents will be sent securely to the *QI Matters* email or via fax 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.
- Non-Critical Incidents will be reported via an online submission form that is sent to QA and the Contracting Officer's Representative (COR)
- **All incidents will require submission of reports within 24 hours of incident knowledge.**

Critical Incident Categories
- 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.
- Death/Natural Causes (Confirmed)
- Death/Overdose (Confirmed)
- Death/Suicide (Confirmed)
- Death/Homicide (Confirmed)
- Death/Assault by another client (Confirmed)
- Suicide Attempt
- Non-fatal Overdose
- Medication Error in prescription or distribution resulting in severe physical damage and/or loss or

consciousness; respiratory and/or circulatory difficulties requiring hospitalization.

- Alleged Abuse/inappropriate behavior by staff would be chosen for 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
- Injurious assault by a client resulting in hospitalization
- Critical Injury on site (MH/SUD related) is defined as injury to a client which may require hospitalization where the injury is directly related to the client's mental health or substance use functioning and/or symptoms. Critical bodily 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 or not related to client mental health would be reported under the Non-Critical Incident process.
- Adverse Media/Social Media Incident (only; no leading incident))

Non-Critical Incident Categories

- Contract/policy violations by staff (unethical behavior)
- AWOL
- Non-critical injury on-site refers to injuries that require medical treatment greater than first aid and which occur on program premises.
- Adverse Police involvement/PERT
- Property destruction
- Loss or theft of medications from facility
- Physical Restraints (prone/supine)-SME CYF only
- Other

Reporting

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 the program's COR and BHS management. For any client that is connected with or receiving services from other agencies or departments, such as (i.e. CWS, Probation, APS, Law Enforcement, Public Conservator) the program submitting the Critical Incidentmust notify the aforementioned program/department and are required to indicate the notification occurred on the Critical Incident report form with the date the notification took place. After review of the incident, QA may request a corrective action plan. QA is responsible for working with the provider to specify and monitor the recommended corrective action plan. The QI unit will monitor critical incidents and issue reports to the Quality Review Council and other identified stakeholders.

San Diego County contracted programs may use the Critical Incident Root Cause Analysis (RCA) Worksheet, located on the Optum site, or some other process that is approved by their Legal Entity. It is strongly 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 through the BHS QA Unit by email at QIMatters.HHSA@sdcounty.ca.gov. RCA training is also offered on a quarterly basis.

Reporting Procedures

1. Within 24hrs upon knowledge of incident, program shall report the incident and all known details via secure email or fax. 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. In the event of a Critical incident, the client's medical record/s will immediately be safeguarded by the program manager or designee. 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.
3. All program staff will maintain confidentiality about client and critical incident. The critical incident should not be the subject of casual conversation among staff.
4. All critical incidents shall be investigated and reviewed by the program. The program shall submit a complete Report of Findings (ROF) to QA within 30 days of knowledge of the incident. (See Optum site for the ROF Form). 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. In the case of a client death, there is an exception to the ROF 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 may request an extension.
5. A critical incident report is never to be filed in the client's medical record. A critical incident Report shall be kept in a separate secured confidential file.
6. A critical incident that results in 1) a death by 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 or at the request of QA. 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
7. The Action Items because of the RCA shall be summarized and submitted to the QA unit with 30 days of knowledge of the incident. Do not submit the RCA worksheet, only a summary of action items.

Residential Requirement to Report to DHCS

Certain Incidents must also be reported by Residential SUD Programs to DHCS; these incidents include the following:

- Death of any resident from any cause – even if death did not occur at facility
- Any facility related injury of any resident which requires medical treatment
- All cases of communicable disease reportable under Section 3125 of the Health and Safety Code or Section 2500, 2502, or 2503 of Title 17, California Administrative Code shall be reported to the local health officer in addition to the Department
- Poisonings
- Natural disaster
- Fires or explosions which occur in or on the premises

Residential and outpatient programs must report the incident via phone, as well as submission of form DHCS 5079 titled "Unusual Incident/Injury/Death Report" (please refer to the form for further instructions). These incidents shall be reported to DHCS as follows:

a. Programs must make a telephonic report to DHCS Complaints and Counselor Certification Division at (916) 322-2911 within one (1) working day.

b. The telephonic report must be followed with a written report to DHCS within seven (7) days of the event.
c. Death reports must be submitted via fax to the DHCS Complaints and Counselor Certification Division at (916) 445-5084 or by email to DHCSLCBcomp@DHCS.ca.gov.

Critical Incidents (formerly Level One) The Critical Incident is the most severe type. A critical incident must include at least one of the following:

- Any event that has been reported in the media/public domain (television, newspaper, internet), current or recent past, regardless of type of incident.
- The event has resulted in a death or serious physical injury on the program's premises.
- 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" reason for client death should only be chosen when the actual reason for death is known by the Program.
- 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.

A critical incident shall be reported to QI Matters immediately upon knowledge of the incident.

Non-Critical Incident (formerly Level Two and Unusual Occurrence) A non-critical Incident is defined as an incident that may indicate potential risk/exposure for the county operated contracted provider, client or community that does not meet the criteria of a critical incident. Note: Submission should exclude PHI to avoid privacy breach. If PHI is disclosed, a Privacy Incident Report (PRA) to BAC is required. PHI stands for Protected Health Information. It's any health data that can be used to identify a person. PHI can be in many forms, including written records, electronic records, and images.
What is considered PHI?

- Patient names
- Social Security numbers
- Phone numbers
- Email addresses
- Dates related to health or identity
- Biometric identifiers
- Electronic health records
- Images that could identify the subject

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. 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, email QI Matters and report the incident.
2. Each LE will identify key Senior Level staff (1-3) that are designated as the main contact person(s) for their programs needing to report a Critical incident on weekends and holidays. This LE designated staff will report the Critical incident by calling or leaving a message with all required

information including a call back number for the County Designated Staff. Each LE will be provided the contact phone numbers of the County Designated Staff.
3. Program staff should only be reporting the 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.

County designated staff are identified in priority contact order as:

1. Adult SOC Deputy Director – Adult Providers
2. CYF SOC Deputy Director – Child Providers
3. Director, BHS (third back-up)

Clinical Case Reviews

Under the direction of the BHS Clinical Director, a clinical case review convenes regularly to review cases involving a death by 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 client records that are reviewed in clinical case conference.

Stakeholders, including BHS Director, CORs, Deputy Directors, QI Chief, Program Managers, County or Contractor QI 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.

Safety and Security Notifications to Appropriate Agencies

When a Non-Critical Incident is identified, the appropriate agencies shall be notified within their specified timeline and format:

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

Programs Serving Child, Youth & Families Additional Reporting

Programs Serving Child, Youth & Families providers may notify other outside agencies who serve the client upon consideration of clinical, health and safety issues. Notification should be timely and within 24 hours of knowledge of the incident. These agencies include but are not limited to:

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

Reportable issues may include:

- Health and safety issues
- A school suspension
- 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
- A referral for acute psychiatric hospital care
- An issue with direct service provider staff, which may lead to worker suspended or no longer providing services
- A significant problem arising while TBS worker is with the child

Client Satisfaction

An annual survey conducted by UCLA as part of the DMC-ODS Waiver, will be conducted for adolescent and adult SUD treatment programs. Specific instructions on the designated period for conducting the surveys, as well as data collection methods, will be specified by UCLA and communicated to programs via the Population Health Team. This will generally take place sometime during the October of each year.

Quality Review Council (QRC)

The Quality Review Council (QRC), mandated by State regulation, is a collaborative group that is chaired by the SUD Clinical Director and consists of SUD 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 DMC-ODS. Participation in the QRC is encouraged. If you would like to participate in the QRC, email QIMatters.HHSA@sdcounty.ca.gov.

Performance Improvement Projects (PIPs)

The State mandates 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 DMC-ODS 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