G. Quality Assurance

The BHP's philosophy is that high quality mental health care is client-centered, clinically effective, accessible, integrated, outcome-driven, and culturally competent. The purpose of the BHP Quality Assurance Program is to ensure that all members *regardless of funding source* receive mental health care in accordance with these principles. To achieve this goal, each program in the system must have internal quality improvement controls and activities in addition to those provided by the BHP. These activities may involve peer review, program manager monitoring of charts and billing activity, and/or a formal Quality Assurance department, which offers training and technical assistance to program staff.

Through program monitoring, program strengths and deficiencies are identified and educational and other approaches are utilized to achieve positive change. To be maximally effective, the Quality Assurance Program must be a team effort. It requires the dedicated effort, responsibility, and involvement of members, family members, clinicians, paraprofessionals, mental health advocates, and other stakeholders to share information on strengths and weaknesses of services. Indicators of care and service evaluated include, but are not limited to, member satisfaction, effectiveness of service delivery, performance and treatment outcomes, accessibility of services, cultural competency, adherence to health and safety standards, and preservation of member rights.

Internal monitoring and auditing should include the provision of prompt responses to detected problems. All providers shall attend regular provider meetings, special forums, in-services/trainings as required by the Contracting Officer Representative (COR), BHS System of Care Executive Leadership and/or Quality Assurance Unit. Attendance at these meetings is essential to keep abreast of system changes and requirements as part of our continuous improvement efforts. The quality of the BHP's care and service delivery system is ensured by continually evaluating important aspects of care and service, using reliable, consistent, and valid measurements, with the goal of maximizing each program's effectiveness. The basis of this evaluation process rests in State and Federal legislation and regulations including:

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

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

Key goals of the final rule are:

- Support state efforts to advance system reform and improve quality of care
- Strengthen the member experience of care and key member protections
- Align key Medicaid and CHIP managed care requirements with other health coverage programs
- Strengthen program integrity by improving accountability and transparency

All providers shall adhere to the rules and regulations stipulated in the W&I Code 14184.042, Medi-Cal Transformation and Medicaid and CHIP Managed Care Final Rules. Information about the final rule is available at the following link: Medicaid and CHIP Managed Care Final Rules.

Quality Improvement Work Plan (QIWP)

The purpose of the County of San Diego's BHS Quality Improvement (QI) Program is to ensure that all members 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 members, 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 members and stakeholders.
- Member feedback is incorporated into the QI Program and QIWP objectives.

- QI Program and QIWP are mindful of those whom data represent and, therefore, integrate member feedback to improve systems and services.

The QI Unit monitors the services provided for safety, effectiveness, responsiveness to members, timeliness, efficiency, and equity. Key variables related to practices and processes performed or delivered by service providers that affect the outcome of services to members and family members are measured and analyzed on a weekly, quarterly, or annual basis. QI staff perform member 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 member and provider satisfaction.

COSD QA Program Monitoring

The BHS Quality Assurance Unit shall monitor each organizational provider and county operated program for compliance with requirements, to assure that activities are conducted in accordance with both State and BHP standards. If the delegated entity's activities are found to be out of compliance, the BHP shall require that a corrective action plan be formulated. Progress toward change will be affected through direct management in the case of a County operated program, or through contract monitoring in the case of a contractor. The Quality Assurance Unit will prioritize and discuss opportunities for improvement with any provider having performance problems. Corrective action plans shall be monitored for implementation and appropriateness as deemed necessary, between annual reviews. If the provider does not successfully correct the problems within the stated timeframe, the County will take appropriate remedial action.

Program Monitoring

A program's 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 meetings to keep providers informed on the System of Care. All provider contract questions should be directed to the assigned Program Monitor/COR.

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

Cultural Competence Requirement Monitoring

Providers are expected to provide services that are suitable for and sensitive to members' 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. 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 QA 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.

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 occur:

- 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.

Quality Review Committee (QRC)

The Quality Review Committee (QRC), mandated by State regulation, is a collaborative group that is chaired by the BHP Clinical Director and consists of BHP stakeholders including members 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 BHP. Participation in the QRC is encouraged. If you would like to participate in the QRC, email QIMatters.BHS@sdcounty.ca.gov.

Program Integrity- Service Verification

San Diego County Behavioral Health Services (SDCBHS) established Program Integrity (PI) procedures to prevent fraud, waste, and abuse in the delivery, claiming and reimbursement of behavioral health services. County and Contracted Programs shall develop a process of verifying that paid claims were provided to beneficiaries and that services meet criteria for access to SMHS and the services were medically necessary. Programs shall complete service verification as outlined in their P&P. County and Contracted Programs are expected to conduct regular PI activities and maintain records for audit purposes. If discrepancies are found during the service verification process, the program will complete the require reporting and corrections as outlined in their P&P.

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 members. Programs must submit their Policy and Procedure for Paid Service Verification to BHS QA. These are filed to help assist with monitoring activities.

Program Integrity includes:

- Accurate eligibility determination
- Services provided are medically necessary and appropriate
- New/current providers are not on the excluded provider list(s)
- Verify with the member that services reimbursed by Medi-Cal were received by member
- Immediate and corrective actions upon discovery that services claimed by Medi-Cal were not received by members

Service verification activity documents may include:

- Service reports from the EHR
- Verification letters with member signature
- Sign in sheets
- Signature logs
- Call logs with attestation

PI activities will be monitored by QA at a minimum annually during site and Quality Assurance Program Reviews (QAPRs). QA tracks and monitors results of Quality Assurance Program Reviews and may require a program to develop a Quality Improvement Plan (QIP) to address specific documentation concerns. Questions regarding PI can be directed to QI Matters at QIMatters.BHS@sdcounty.ca.gov.

Program Integrity Process

It is recommended that programs have an Internal Compliance Program that is commensurate with the size and scope of their agency. 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 member services.
    - Staff shall document member encounters in accordance with funding source requirements and County of San Diego Health and Human Services policies and procedures.

  - Staff shall bill services accurately, timely, and in compliance with all applicable regulations and HHSA policies and procedures.

- All programs shall have processes for:

  - Staff to promptly elevate concerns regarding possible deficiencies or errors in the quality of care, services, or billing

  - Staff to act promptly to correct problems if errors in claims or billing is discovered.

Program Integrity Monitoring

Programs are expected to conduct their own regular program integrity activities and to maintain records for QA audit purposes. The BHS QA team will run reports on random samples of members, comparing billing entered to supporting documentation in the system. 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 QA team will be able to provide ongoing technical assistance to programs. The BHS QA team will provide tip sheets for programs to run regular SmartCare reports to help with their own internal monitoring processes.

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 your program COR immediately, as well as the QA team at QIMatters.BHS@sdcounty.ca.gov.

  - If there are related complaints that wish to remain anonymous, providers may contact Business Assurance & Compliance (BAC) at (619) 237-8571 or email Compliance.HHSA@sdcounty.ca.gov

- 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 (1-800-822-6222), online form (Stop Medi-Cal Fraud), email (fraud@dhcs.ca.gov) or by mail (Medi-Cal Fraud Complaint – |Intake Unit Audits and Investigations | PO Box 997413, MS 2500 | Sacramento, CA 95899-7413

Staff Signature Logs

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

- Typed name
- Signature
- Degree and/or license
- Language capability, if applicable

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

To ensure that the log is kept current, it is the organizational provider's responsibility to update and maintain the log in a timely manner to reflect any changes, i.e., licensure, degree, job title, name, or signature. The staff signature log must be maintained onsite at the organizational provider's program location, and be made available at the request of the BHP for purposes of site visits, medical record reviews, etc. Failure to maintain a staff signature log that is accurate and current will result in a plan of corrective action being issued to the organizational provider.

Provider Feedback

All providers are encouraged to provide feedback regarding their interaction with the BHP by direct communication with the Program Monitor/COR, Quality Assurance Team, and MH Contract Administration Unit. Communication can occur at the contractor's request, at scheduled meetings, and through the status report narrative. QA will provide an opportunity for provider feedback via an online Provider Feedback Survey offered quarterly via a QR Link during the QA Quality Improvement Partners (QIP) Meeting. COR Site Reviews are scheduled on an ad hoc basis to ensure that programs remain in compliance with State Standards. A Pharmaceutical Review is completed annually and conducted by QA staff during the Quality Assurance Program Review (QAPR) process.

The Medical Record

The Hybrid Medical Record for each member must be maintained in a secure location, filed in the prescribed order, and retrievable for County, State, or Federal audit upon request, during and after the provision of services up to the limits prescribed in California law. Documentation and in-service training are offered by QA to keep providers

informed of the latest County, State and Federal standards. The Uniform Clinical Record Manual may be obtained on the Optum Public Sector website.

Uniform Medical Record – Forms

All programs are required to utilize the forms specified in the San Diego County Behavioral Health Services *Uniform Clinical Record Manual* (UCRM), and any updated forms, issued on an interim basis. Programs may adapt forms for specific program needs upon review and approval by the Health Plan Organization Quality Assurance Unit. Each legal entity shall develop forms for legal consents and other compliance related issues. Out-of-County behavioral health programs may utilize non-San Diego County medical record forms, but they must comply with all State and Federal and requested County guidelines.

Record Maintenance

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 ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. County providers are required to retain all Billing Records for a minimum of ten (10) years when the program is funded with State or Federal dollars. Therefore, contracted providers are to retain medical records for no less than ten (10) years after discharge date for adults. For minors, records are to be kept until they have reached the age of eighteen, plus seven (7) years. [ref: MHSUDS IN 18-012; 42 CFR §425.314; 22 CCR §77143; CCR 438.3(u)]

Quality Assurance Program Reviews (QAPRs)

Quality improvement of documentation is an ongoing process shared between programs and County QA. 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. 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. Providers are responsible for re-entering the non-billable service code for services that are identified as a Medi-Cal billing disallowance and errored out.

The Health Plan Organization Quality Assurance Unit conducts program site and Quality Assurance Program Reviews (QAPRs). Site visits and Quality Assurance

Program Reviews are scheduled and coordinated with the Program Manager at each provider site. A copy of the site and QAPR review tool is distributed to the Program Manager prior to the scheduled review. A QA Specialist will notify the program manager of the designated audit period for the billing claims review. All billings for the designated period will be reviewed on those providers/services that are selected for review. Once the program manager has been informed of the designated billing claims period, no provider self-reports of disallowances will be processed for the program that fall within the billing period until completion of the Quality Assurance Program Review and resulting final written report by the QA Specialist. At the conclusion of each Quality Assurance Program Review, the QA Specialist will present preliminary findings of the review at an exit conference.

For additional record reviews that are conducted by entities other than the BHP [i.e., Department of Mental Health Care Services (DHCS) as part of the Behavioral Health Plan's compliance review or for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical record reviews the same standard will apply.

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

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

Quality Improvement Plan (QIP)

Programs will be monitored for trends and patterns in any areas found out of compliance or needing improvement. If patterns or trends related to meeting documentation, billing standards, or other identified Quality of Care concerns are identified, a request for a Quality Improvement Plan (QIP) will be issued by the BHP to the provider. Determination of an additional review will be made under the direction of the QA Supervisor and may take place within thirty (30) days, sixty (60) days or some other identified period depending upon the severity of the noncompliance. After receiving the BHP's written report of findings, the provider will have a specified timeframe in which to complete and submit the QIP to the QA Unit. The QIP must describe the interventions or

processes that the provider will implement to address items that have been identified as out of compliance or that were identified as needing improvement.

When appropriate, the QIP must include all supporting documentation (i.e., copy of a policy and procedure that has been written, description of a system that program is implementing, copy of sign-in sheets from a training, etc.). Even when supporting documentation is not requested to be submitted with the QIP, the program is still required to keep this documentation on file at their program. The QIP must also include identified timelines and/or dates as to when the out-of-compliance item or area needing improvement will be implemented or completed. Pursuant to the "Withholding of Payment" clause of the contract, failure to respond adequately and in a timely manner to a request for a QIP may result in withholding of payment on claims for non-compliance.

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

QIP Three- Month Follow Up

To track progress of QIP implementation and offer technical assistance and support toward increased quality improvement efforts, the QA Unit will request a written summary from the program on the impact of the QIP on identified deficiencies. This summary will be requested approximately three (3) months after the QIP has been accepted. Details of this process will be discussed with the program during the on-site exit conference after the review.

Corrective Action Plan (CAN)

When a program's compliance issues are not improving as detailed in the program's written QIP, QA may request that the Program COR issue a Corrective Action Notice (CAN) to the program's Legal Entity. The CAN, given to the Legal Entity, will include a description of the noncompliance categories, history of program's QIP actions, and a statement about insufficient improvement having been made. QA may recommend identified interventions or process changes to be implemented. If a CAN is issued to a Legal Entity, additional County Departments become involved in monitoring remedial activities. Failure to respond adequately and in a timely manner to a required Corrective Action Notice may result in a withholding of payment on the claims for non-compliance and could result in putting the contract at risk.

For billing disallowances or service corrections identified in the Review, programs will be required to submit evidence of correction as delineated in the medical record review protocol for that fiscal year as part of their QIP. Programs are responsible to follow-up on

any pending corrections at QA Specialist direction. If there are additional billing concerns, the QA Specialist may conduct another medical record review prior to the next fiscal year.

Providers shall ensure that the services listed on the *Payment Recovery Form* as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services listed must be listed on the form exactly as they were billed. The Payment Recovery Form is located on the Optum website > "*Billing*" tab.

Performance Improvement Projects (PIPs)

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

- The BHP 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

Medication Monitoring Reporting

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

Areas monitored include:

- Medication rationale and dosage consistent with community standards
- Appropriate labs
- Consideration of physical health conditions
- Effectiveness of medication(s) prescribed
- Adverse drug reactions and/or side effects

- Evidence of informed consent for use of psychotropic medication within prescriber documentation in the medical record
- 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

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

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

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

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

QA Medication Monitoring tools for the Systems of Care are located on the Optum Website > *Monitoring* tab.

Send the following forms via secure email QIMatters.BHS@sdcounty.ca.gov or fax (619) 236-1953 to QA:

- Medication Monitoring Submission Form (Via SmartSheet)
- Medication Monitoring Screening Tool (either for Child/Youth or Adult programs)
- Medication Monitoring Feedback Loop (McFloop)

Results of medication monitoring activities are reported quarterly to the QA unit by the fifteenth (15th) of each month following the end of each quarter (First quarter due October 15, second quarter due January 15, third quarter due April 15 and fourth quarter due July 15.

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

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

- Evidence that the prescriber has reviewed and obtained informed consent from the member is documented within the medical record.

- 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 in a timely manner.

- Ensure there is sufficient follow up with members/family members in keeping their appointments for labs.

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

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

Monitoring Psychotropic Medications

The following recommendations are not intended to interfere with or replace clinical judgment of the clinician when assessing members on psychotropic medications. Rather, they are intended to provide guidelines and to assist clinicians with decisions in providing high quality care, ensuring that members receive the intended benefit of the medications, and to minimize unwanted side effects from the medications.

Informed Consent

Per BHS Notice on 09/12/2023, California Senate Bill (SB) 184 updated and superseded state regulations (Cal. Code Regs. Tit. 9, § 852) that required mental health facilities to obtain patient signatures to demonstrate informed consent for antipsychotic medications delivered in specified community mental health settings. (Reference: WIC § 5325.3).

Instead, facilities must maintain written consent records that contain **both** of the following:

1. A notation that information about informed consent to antipsychotic medications has been discussed with the member; **and**

2. A notation that the member understands the nature and effects of antipsychotic medications, and consents to the administration of those medications.

The minimum requirement going forward is to include the above notations within the medical record progress note(s) when prescribing, adding or adjusting antipsychotic or psychotropic medications. Providers may choose to continue using the *Informed Consent for Psychotropic Medications* form to document that they have reviewed consent and the nature and effects of antipsychotic or psychotropic medications however, use of this form is not monitored as part of the medical record review and member signature is not a requirement. SB184 does not supersede JV-220 requirements for dependent youth or youth in an out-of-home placement.

Antipsychotic Medications

Typical Antipsychotics: also know known as First Generation Antipsychotics: such as chlorpromazine (Thorazine), fluphenazine (Prolixin), haloperidol (Haldol), perphenazine (Trilafon), prochlorperazine (Compazine), thiothixene (Navane), thioridazine (Mellaril), and trifluoperazine (Stelazine).

Atypical Antipsychotics: also known as Second Generation Antipsychotics: aripiprazole (Abilify), asenapine (Saphris), clozapine (Clozaril), iloperidone (Fanapt), lurasidone (Latuda), olanzapine (Zyprexa), paliperidone (Invega), quetiapine (Seroquel), risperidone (Risperdal), ziprasidone (Geodon) and any derivatives of these medications (i.e. long acting injectable formulations, extended release formulation, etc.)

Drug Formulary for Mental Health Services

All contracted provider programs and physicians shall adopt the Medi-Cal Formulary as the San Diego County Behavioral Health Services (BHS) formulary. All members, regardless of funding, must receive appropriate and adequate levels of care at

all MHS programs. This includes the medications prescribed. The guidelines below allow for clinical and cost effectiveness.

The criteria for choosing a specific medication to prescribe shall be:

- The likelihood of efficacy, based on clinical experience and evidence-based practice
- Member preference
- The likelihood of adequate compliance with the medication regime
- Minimal risks from medication side-effects and drug interactions

If two (2) or more medications are equal in their satisfaction of the four (4) criteria, choose the medication available to the member and/or the system at the lowest cost. Programs shall provide information to all appropriate staff as to the typical cost for all drugs listed on the Medi-Cal Formulary, at least annually.

For all initial prescriptions, consideration should be given to prescribing generic medication rather than brand name medication unless there is superior efficacy for the brand name medication, or the side-effect profile favors the brand name medication. Providers shall follow the requirements for preparing a Treatment Authorization Request (TAR) as stated in the Medi-Cal Drug Formulary. County-operated programs shall send TARs to the County Pharmacy for any non-formulary medication Contractor operated programs shall develop an internal review and approval process for dispensing non-formulary medication for both Medi-Cal and non-Medi-Cal eligible members. There shall be an appeal process for TARs that are not accepted.

Clinical Advisory for Monitoring Antipsychotic Medications

- Ordering labs and monitoring should be tailored to each member. Members may require more or less monitoring than these recommendations.
- All antipsychotic medications carry a Black box warning for increased risk of mortality for older adult members with dementia-related psychosis.
- Geriatric members may require more frequent monitoring due to changes in metabolism and renal function.
- Obtain baseline assessment for Tardive Dyskinesia and Abnormal Involuntary Movement Scale prior to initiate of antipsychotic and every six (6) months.

- Atypical antipsychotics are associated with abnormal blood work such as elevated serum glucose and lipid levels, and increased prolactin levels. They are also associated with weight gain, increased risk of type 2 diabetes, diabetic ketoacidosis, and cardiovascular side effects.

- Avoid using ziprasidone (Geodon), haloperidol (Haldol), thioridazine (Mellaril), and chlorpromazine (Thorazine) in members with known history of QT_c prolongation, recent Acute Myocardial Infarction, uncompensated heart failure, taking other medications with prolong QT, and alcoholic members on diuretics or having diarrhea which may alter electrolytes.

- All members should be assessed for cardiovascular disease before initiating antipsychotic therapy.

- Refer to Clozapine REMS Program for monitoring Clozaril.

- An initial comprehensive baseline assessment should include a thorough personal and family medical history, including risk factors for diabetes, vital signs, weight, body mass index, waist circumference, metabolic laboratory analysis such as fasting glucose, and lipid profile.

- Fasting blood glucose is preferred, but HbA_{1c} is acceptable if fasting glucose test is not feasible.

- Neutropenia uncommonly occurs in members taking antipsychotic medications. It is recommended to obtain baseline Complete Blood Count and annually.

- Members with a history of a clinically significant low white blood cell count (WBC) or a drug-induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and discontinuation of medication should be considered at the first sign of a clinically significant decline in WBC in the absence of other causative factors (package insert).

Naloxone for Risk of Overdose

Effective January 1, 2019, prescribers are required to offer a prescription for naloxone hydrochloride or similar drug to members and/or family when the member is at risk for overdose (because member is taking ninety (90) mm/day or more; member risk is increased due to prior high dose with no tolerance now or prior overdose; or member is concurrently prescribed an opioid and a benzodiazepine).

As of September 5, 2019, the risk factor related to opioids and benzodiazepine only applies when prescribing an opioid within a year from the date a prescription for

benzodiazepine has been dispensed to the member. AB 714 also added member history of opioid use disorder (OUD) to the list of risk factors for overdose.

Monitoring Controlled Substance Prescriptions

For the past number of years, abuse of prescription drugs has become increasingly prevalent. In September 2016, Senate Bill 482 pertaining to controlled substances and the CURES database was enacted. As of July 1, 2021, this law requires a health care practitioner to consult the CURES database to review a member's-controlled substance history before prescribing a Schedule II, III or IV controlled substance for the first time to that patient and at least once every six (6) months thereafter, if the prescribed controlled substance remains part of the member's treatment, with specified exemptions. Additionally, this law requires reporting the dispensing of Schedule V drugs. This requirement applies to pharmacists and prescribers who dispense controlled substances.

Starting January 1, 2021, the dispensing of a controlled substance must be reported to the Controlled Substance Utilization Review and Evaluation System (CURES) within one working day after the medication is released to the patient or the member's representative. (Previously, the deadline to report was seven days after dispensing.) The County of San Diego expects prescribers to document monitoring efforts consistent with this law.

Psychotropic Medication in Youth

There are continued active legislative changes around the use/monitoring of psychotropic medication in youth. The County of San Diego has and will continue to disseminate information about legislative changes to the Children's System of Care.

In 2018, Department of Health Care Services published "*California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care*. These guidelines target youth involved in county child welfare and probation agencies and is specific to those children and youth who are placed in foster care. Prescribers should be familiar with the linked document as this shall serve as the guideline for provision of care locally.

The *California Guidelines* document also includes reference to the Los Angeles "*Department of Mental Health Parameters 3.8 For Use of Psychotropic Medication in Children and Adolescents*" (Rev. 03.15.2023) DHCS has recognized this living document as the guideline for provision of psychotropic medication. County of San Diego prescribers should be familiar with this linked document as this shall serve as the guideline for provision of care locally.

Foster Care is defined as twenty-four (24) hour substitute care for children placed away from their parents or guardians and for whom the State and/or county agency has

placement care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, childcare institutions, and pre-adoptive homes. County of San Diego prescribers should be familiar with the CA Guidelines as they shall serve as the guideline for provision of care locally to all youth.

The Department of Social Services (CDSS), in collaboration with stakeholders, developed measures to track youth in foster care who received a paid claim for psychotropic medication from the California Department of Health Care Services. These measures will be publicly posted with a goal of improving the health and well-being of youth in care. Those measures include select Healthcare Effectiveness Data and Information Set (HEDIS) measures and Child Welfare Psychotropic Medication Measures. County of San Diego providers shall be familiar with these measures as they shall serve as the guideline for provision of care locally to all youth.

Storage, Assisting with Self Administration, and Disposal of Medications

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

1. Storage of Medications

    - The member's parent/guardian shall bring in the prescribed medication, which is packaged and labeled in compliance with State and Federal laws.

    - All medications shall be stored in a locked, controlled, and secure storage area. Access to the storage area shall be limited to authorized personnel only.

    - The storage area shall be orderly, well-lit, and sanitary. It shall have the proper temperature, light, moisture, ventilation, and segregation that are required by Federal, State and County laws, rules, and regulations.

    - All controlled substances shall be double locked for security and shall only be accessible to authorized personnel.

2. Assisting in the Self Administration

    - Careful staff supervision of the self-administration process is essential. Program staff shall provide the individual dose from the packaged and labeled container for member to self-administer.

- Staff shall record the self-administration of all medications on the "*Medication Dispensing Log",* located: Optum Website > *Forms* tab

3. Disposal of Medications

- Disposal shall occur when the medications are expired, contaminated, deteriorated, unused, abandoned, or unidentifiable. Programs may return medications to pharmacy representatives for disposal or dispose of medications by placing them in biohazard sharps containers for transportation to incineration. If neither of these methods is available, the program can contact a pharmaceutical disposal company for transport and disposal. Examples include Stericycle 1 (866) 783-9816 and KEM (619) 409-9292. Disposal by flushing medications into the water system or placing them in the trash are both prohibited under environmental and safety regulations.

- Disposal shall be documented and co-signed on the "*Medication Disposal Log*"**.**

"Medication Only" Services for Adult/ Older Adult and Children/ Youth Programs

Adult and Child/Youth members who have never had an open assignment in the program receiving the referral should not be opened as "medication-only" without previous approval from the Contracting Officer's Representative (COR).

When the member has a therapist in a different program, the program shall be contacted for justification to why the needed medications are no longer needed.

In the event that: Service goals had been met, Utilization Management (UM) Committee has denied further treatment or In the opinion of the therapist, member, and caregiver, a break in psychotherapy treatment is appropriate, the member shall be assessed for the need for ongoing medication support by the receiving program's staff psychiatrist. clear documentation should be provided in the member's medical record.

When the decision is to continue the case as medication-only, within the same program, the case shall remain open, but the previous therapist shall complete a discharge summary stating that continuing medication support is necessary. In the HER, the name of the server should be updated to reflect the name of the physician. Crisis Intervention visits may be offered by the previous therapist or other staff during a medication-only interval without utilization management requirements.

Documentation: Documentation for a medication only case shall include: a complete and up to date Mental Health Assessment, Psychiatric Assessment (completed on initial medication evaluation and for each follow-up medication management session), and an active *Client Clinical Problem List*. Medication only cases are exempt from completion of outcome measures.

Billing: Medication-only cases shall be billed using only the range of Medication Support service codes, except in the case of Crisis Intervention. If case management or formal assessment is required in addition to Medication Support, the case no longer meets the criteria of medication-only and routine charting and authorization procedures shall be followed.

Utilization Management: Medication-only cases are not subject to UM, but cases open in this status for twelve (12) months or more shall be reviewed annually by the Medication Monitoring Committee. When reviewed by the Medication Monitoring Committee, the reviewer shall consider:

1. Whether the child's age, health status, and emotional functioning continue to support the need for ongoing medication treatment.

2. Whether a return to active psychotherapy is indicated.

Reinstating medication services: If a member who has been receiving medication-only services should experience an increase in symptoms or impairment, or if the course of the member's development suggests that an interval of active psychotherapy is likely to be helpful, the case shall be reviewed to determine if a current UM authorization is in place. When authorization is in place, therapy may resume, however a new *Client Clinical Problem List* is indicated. When authorization has expired, the UM Committee must first authorize services for billing of therapy to resume. In theEHR the name of the server shall be updated to reflect the name of the current clinician.

Considerations for Children/Youth Members

Children and adolescents, as a result of their rapid development, should receive a thorough assessment as a part of any clinical service, and for most, services should include a full spectrum of treatment services, including psychotherapy, designed to reduce or ameliorate symptoms and functional impairment. However, a small number of youths may have chronic conditions for which periodic breaks in treatment are appropriate. For those that require ongoing medication treatment even during such a hiatus, outpatient providers shall leave the assignment open with the psychiatrist designated as the primary server.

The BHP has delegated the responsibility to outpatient County operated programs and contracted providers to assure proper enrollment, services and monitoring of children

and youth who are receiving only medication support and have no therapist or case manager involved. Such cases are not subject to utilization management but are subject to medication monitoring and additional peer review if the situation is unusually prolonged. Children and adolescents who have completed an assignment of psychotherapy and been retained as a medication only member must have rapid access to a resumption of therapy if a need should arise.

Incident Reporting (IRs)

An incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), member or community shall be reported to the BHS Health Plan Organization Quality Assurance Unit. There are two types of reportable incidents: 1.) Critical Incidents are reported to the BHS QA Unit and 2) Non-Critical Incidents which are reported via an online submission form that report directly to the program's Contracting Officer Representative (COR) and reviewed by the Quality Assurance Unit.

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

QI Matters email: QIMatters.BHS@sdcounty.ca.gov
QA Critical Incident fax number: 619-236-1953

Incident Report Trainings

Webinars are now available on the Optum website > *Incident Reporting* tab for all aspects of the Incident Reporting process. There are two separate, self-paced webinars available: the "CIR and NCIR Webinar" and "ROF and RCA Webinar". All new staff are highly encouraged to view these trainings prior to submitting any incident reports. Tip sheets are also available in the same location for CIRs, NCIRs and ROFs.

Critical Incidents

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

Critical Incidents are categorized as the following:

- Death/Pending (Pending CME investigation): Member death in which the actual reason for death is not yet confirmed. The subsequent 'Confirmed' reasons for member death should only be chosen when the actual reason for death is known by the Program.

- Death (Non- BHS Client)- Please note that a "non-BHS client" is defined as the following: Non-BHS Contracted members are members that do not meet the County target population / are not funded by Contracted programs (i.e. private pay, cash pay, members who do not qualify for Medi-Cal and members with Other Health Coverage (OHC) who do not qualify for Medi-Cal).

- Death/Natural Causes (Confirmed): CIRs are not required for deaths that are a natural occurrence. Instead, the program shall maintain a Natural Death Log that QA will review during the Medi-Cal recertification site visit. **However**, if a death that is a natural occurrence happens on a program's premises an CIR is required. Deaths **must** be reported to both the COSD HIM Department at: HIMDept.HHSA@sdcounty.ca.gov via the BHS 025 Form and the County MEDS Coordinator at: 37Crdnt.HHSA@sdcounty.ca.gov including: Member Name, Social Security Number, Date of Birth and Date of Death.

- Death/Overdose (Confirmed)

- Death/Suicide (Confirmed)

- Death/Homicide (Confirmed)

- Suicide Attempt

- Non-Fatal Overdose: For Critical Incidents related to an overdose by an opioid or alcohol, the member must be provided an opportunity for a referral to Medication Assisted Treatment (MAT) if the member is not already receiving MAT services. Information on MAT programs can be accessed through the Provider Directory on the Optum website or by calling the Access and Crisis Line

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

- Alleged abuse/inappropriate behavior by staff: Serious allegations of or confirmed inappropriate staff (including volunteers, interns) behavior such as sexual relations with a member, client/staff boundary issues, financial exploitation of a member, and/or physical or verbal abuse of a member. Effective 1/1/20, a healthcare facility,

health plan, or other entity that grants privileges or employs a healthcare professional must, **within fifteen (15) days** of receiving a written allegation of sexual abuse or sexual misconduct (inappropriate contact or communication of a sexual nature) against one of its healthcare providers, file a report with that professional's licensing board.

- Injurious assault by a client resulting in hospitalization

- Critical Injury on site (MH/SUD related): Defined as an injury to a member where the injury is directly related to the member's mental health or substance use functioning and/or symptoms. Critical injury means any injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, limb, organ, or of mental faculty (i.e., fracture, loss of consciousness), or requiring medical intervention, including but not limited to hospitalization, surgery, transportation via ambulance, or physical rehabilitation. Any injury not falling in these categories and/or not related to the member's mental health or substance use symptoms would be reported under the *Non-Critical Incident* process.

- 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".* The QA Unit shall monitor critical incidents and issue reports to the Quality Review Committee and other identified stakeholders as indicated. After reviewing the incident, QA may request a corrective action plan. QA is responsible for working with the provider to specify and monitor the recommended corrective action plan.

Critical Incident Reporting

The Critical Incident Report must be submitted to the QA Unit within twenty-four (24) hours of knowledge of the incident completed in full. This can be sent to the QIMatters.BHS@sdcounty.ca.gov inbox via secure email or faxed to the secure QA fax at **619-236-1953**. The *Critical Incident report form* can be found on the Optum website> *Incident Reporting* tab. Additionally, consultation can be requested by contacting QI Matters.

IR Timelines: All providers are required to report critical incidents involving members in active treatment or whose discharge from services has been thirty (30) days or less. A Critical Incident Report must be sent to QA **no later than twenty-four (24) hours** from program notification of the incident.

Confidentiality: In the event of a critical incident, the program manager or designee will immediately safeguard the member's medical record. The program manager shall review the chart as soon as possible. The member's medical record shall not be

accessed by unauthorized staff not involved in the incident. All program staff will maintain confidentiality about member and the critical incident. The critical incident should not be the subject of casual conversation among staff. A CIR is never to be filed in the member's medical record. A Critical Incident Report shall be kept in a separate secured confidential file.

Multiple Program Assignments: 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 program assignments submitting a CIR for the same incident may require an ROF per QA or COR request.

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 the procedure below for reporting a **Critical Incident** on Weekends and Holidays:

1. Submit the notification to QI Matters as soon as possible from awareness of the incident occurrence.

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

LPS & IR Reporting

LPS regulations indicate that certain LPS facilities are required to notify DHCS serious incidents (referred to as "Unusual Occurrences" within regulations) occurring within a CSU or Jail psychiatric units. CIR, NCIR, and ROF submission forms now include a checkbox for LPS-designated facilities. For specific reportable situations, please reference the Inpatient Operations Manual on the Optum website> *Manuals* tab.

Report of Findings

All critical incidents shall be investigated and reviewed by the program. Programs have been informed that they should NOT submit the ROF prior to receiving the CME report. The program shall submit a complete Report of Findings to QA within thirty (30) days of knowledge of the incident. In the case of a member death, there is an exception to the Report of Findings report being due to QA within thirty (30) days of knowledge of the incident when the program is waiting on the CME report. The provider must inform QA that the CME report is pending and request an extension.

CME Reports

The CME report is the County Medical Examiner's Report. It provides the final cause of death determination and is required for serious incidents involving death of a client. In addition to notifying the HIMS department and the County MEDS Coordinator programs should request the CME report from the medical examiner's office. Programs will need a copy to complete the ROF / RCA (if applicable). If the CME report indicates that the manner of death was suicide, programs must complete an RCA. To request the CME report, email the County Medical Examiner's Office at: Records.MX@sdcounty.ca.gov requesting the CME report and provide the following information: Name of Program, Name of client, DOB, Date of Incident. Programs will receive a confirmation email from the CME office that the request has been received.

Root Cause Analysis (RCA)

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

San Diego County Contracted programs may use the *Critical Incident RCA Worksheet* or some other process that is approved by their Legal Entity. It is recommended that programs not choosing to use the Critical Incident RCA Worksheet ensure that the process they do use incorporates best practices for their analysis of findings. Technical

assistance is available by request through QIMatters.BHS@sdcounty.ca.gov. RCA training is offered quarterly.

In instances where the RCA is required for a Critical Incident where a member has multiple program assignments, the RCA will only be required for the primary assignment and/or the program where the critical incident requiring the RCA took place. An RCA for any other 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. The Action Items of the RCA shall be summarized and submitted to the QA unit within thirty (30) days of knowledge of the incident. Do not submit the RCA worksheet, only a summary of action items.

Clinical Case Reviews

Under the direction of the BHS Clinical Director, a clinical case review convenes regularly to review cases involving a completed suicide, homicide, and other complex clinical issues. The purpose of the review is to identify systemic trends in quality and/or operations that affect member care. Identified trends are utilized to provide opportunities for continuous quality improvement. Program shall comply with requests for medical records that are reviewed in clinical case conference.

Stakeholders, including BHS Director, CORs, Deputy Directors, QA Chief, Program Managers, County or Contractor QA staff, or other designated staff may make a request at any time for a clinical case review. Specific requests for case reviews should be coordinated through the QA Unit by contacting QIMatters.BHS@sdcounty.ca.gov. The *Critical Incident RCA Worksheet* is required for San Diego County operated programs per current HHSA/MHS requirements.

Non- Critical Incidents (N-CIRs)

A Non-Critical Incident is reported directly to your COR/Program Manager and to QA via an online submission form within twenty-four (24) hours of knowledge of the incident. A Non-Critical Incident is defined as an adverse incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), member or community that does not meet the criteria of a critical incident. Any incident that represents “adverse deviation from usual program processes for providing behavioral health care” and not falling into the Critical Incident categories will be considered a Non-Critical Incident.

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.

Non-Critical Incidents may include but are not limited to:

- AWOL
- Contract/Policy violations by staff (unethical behavior)
- Loss or theft of medication from the Facility
- Physical Restraints (prone/supine): Reported only during program operating hours (applies only to Children, Youth & Families mental health clients during program operating hours and excludes SUD programs, Hospitals, Long-Term Care Facilities, San Diego County Psychiatric Hospital/EPU, CYCSU and PERT). If use of physical restraints leads to member injury, this would be reported as a Critical Incident
- Tarasoffs: Tarasoff incidents will no longer fall under Critical Incidents and will be reported via the online submission form as a Non-Critical Incident. Tarasoff do not require a ROF unless the Program Manager, after review, has concluded one is indicated due to a systemic or member-related treatment issue.
- Non-Critical Injury onsite- injuries that require medical treatment greater than first aid and which occur on program premises.
- Adverse Police/PERT Involvement onsite: Any incident involving Police/PERT, including but not limited to arrests on program site, use of restraints of members, and any notable "adverse deviations" from program processes related to PERT/police engagement will require an N-CIR report.
- Property destruction onsite
- Other: Epidemic, other infectious disease outbreak, and poisoning will be reported under the Non-Critical Incident Reporting process utilizing the "Other" incident category.

Non-Critical Incident Reporting

- N-CIR Timelines: All providers are required to report non-critical incidents involving members in active treatment or whose discharge from services has been thirty (30) days or less.
- Non-Critical Incidents are reported via and online submission form that can be found and on the Optum Website> "*Incident Reporting*" tab.

1. Complete the submission via the online form within twenty- four (24) hours of program knowledge of the incident and complete the form in its entirety.

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

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

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

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

Safety and Security Notifications to Appropriate Agencies

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

1. Child and Elder Abuse Reporting hotlines.

2. Tarasoff reporting to intended victim and law enforcement

3. Law enforcement (police, sheriff, school police, agency security, military security/Naval Investigative Service, etc.) for crime reporting or requiring security assistance and inquiries.

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

Children, Youth and Family: Additional Reporting

Children, Youth & Families providers shall notify other outside agencies who serve the member upon consideration of clinical, health and safety issues. Notification should be timely and within twenty- four (24) hours of knowledge of the incident. The required agencies include but are not limited to:

- Children Family Well-Being Services (CFWB)
- Probation Officer
- Regional Center
- School District

- Therapeutic Behavioral Services (TBS) –County and Contractor
- Other programs that also serve the member

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