QUALITY REVIEW COMMITTEE (QRC) MANUAL

COUNTY OF SAN DIEGO – HEALTH AND HUMAN SERVICES AGENCY

BEHAVIORAL HEALTH SERVICES

UPDATED 2024

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Quality Improvement Committee

Chair: Dr. Nicole Esposito

Committee Members:

1. Robert Cook, Substance Use Disorder Provider
2. Rick Heller, Contractor/Consumer Representative
3. Judi Holder, Consumer Representative
4. Celeste Hunter, Contractor/Family Member
5. Janet Cacho, Behavioral Health Services Clinical Director's Office
6. Karen Luton, Family Member/Advocacy Contractor
7. Liz Miles, Cultural Competency Resource Team Representative/Quality Improvement
8. Edith Mohler, Behavioral Health Services Children and Youth Representative
9. Julie Ontiveros, Substance Use Disorder Provider
10. Kristie Preston, Administrative Services Organization & Fee for Service Provider Representative
11. Angela Rowe, Substance Use Disorder Provider
12. Francisco Fernandez, Mental Health Provider
13. Melissa Hall, Jewish Family Service Representative
14. Megan Lawson, Mental Health Provider
15. Samantha Manganaro, Patients' Rights Advocate for Non-residential and Outpatient Behavioral Health Services
16. John Sturm, Consumer/Family Representative
17. Jennifer Whelan, Mental Health Provider
18. Stuart Gaiber, Behavioral Health Advisory Board Representative

If more information is desired, please email your request to bhspophealth.hhsa@sdcounty.ca.gov

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Introduction

As required by the California Department of Health Care Services (DHCS), the County of San Diego Behavioral Health Services (CSDBHS) has a Quality Review Committee (QRC) or as the state refers to it, a Quality Improvement Committee (QIC). The QRC is community-based and focuses on the inclusion of the individuals and family members served. The QRC focuses on business principles in which services are delivered in a cost-effective, outcome-driven, and trauma informed fashion. The QRC is consists of the mental health and substance use disorder staff, practitioners, providers, consumers, and family members. The activities of the QRC shall include participating in the planning, design and execution of the QI Program through:

- Reviewing and evaluating the results of QI activities.
- Oversight and involvement in the implementation of QI activities including performance improvement projects and annual QI work plan goals.
- Recommending policy decisions.
- Instituting needed QI actions.
- Ensuring follow-up of QI processes.

The Quality Improvement (QI) Program is designed to provide a formal ongoing process by which the Behavioral Health Services Administration utilizes objective measures to monitor and evaluate the quality of services, clinical and administrative, provided to clients and families. This program, which addresses behavioral health care and services, defines and facilitates a systematic approach to identify and pursue opportunities to improve services and resolve identified problems. The QI Program is updated, reviewed and approved by the SDCBHS Administration on an annual basis. It is also reviewed by applicable regulatory bodies, such as DHCS, as required.

HHSA and BHS' Vision, Mission, and Strategies

SDCBHS Quality Improvement targets measures by which SDCBHS can objectively evaluate the quality of services, both clinical and administrative, provided to the individuals and family members receiving services. The goals are separated into six target areas: Services Are Client Centered; Services are Safe; Services Are Effective; Services Are Efficient and Accessible; Services Are Equitable; and Services Are Timely. The target areas are in line with the priorities outlined by the DHCS. Some of the goals are process goals, while others are measurable objectives. The prime objective is to continuously improve both clinical and administrative service delivery through a systematic process of monitoring critical performance indicators and implementing specific strategies to improve the process, access, safety, and outcomes of all services provided. All goals are in line with the HHSA and Behavioral Health Services' vision, mission, and strategy/guiding principles.

County of San Diego, Health and Human Services Agency

Vision: Healthy, Safe, and Thriving San Diego Communities.
Mission: To make people's lives healthier, safer, and more self-sufficient by delivering essential services.
Strategy:

1. **Building a Better System** focuses on how the County delivers services and how it can further strengthen partnerships to support health. An example is putting physical and mental health together so that they are easier to access.
2. **Supporting Healthy Choices** provides information and educates residents, so they are aware of how the choices they make affect their health. The plan highlights chronic diseases because they are preventable, and we can make a difference through awareness and education.
3. **Pursuing Policy Changes for a Healthy Environment** is about creating policies and community changes to support recommended healthy choices.
4. **Improving the Culture from Within**. As an employer, the County has a responsibility to educate and support its workforce so employees "walk the talk". Simply put, change starts with the County.

Behavioral Health Services

Vision: Safe, mentally healthy, addiction-free communities.
Mission: San Diego County Behavioral Health Services collaborates with local communities to enhance the safety, health, and self-sufficiency of individuals by delivering high-quality behavioral health services.
Guiding Principles:

1. Support activities designed to reduce stigma and raise awareness surrounding mental health, substance use disorders, and problem gambling.
2. Ensure services are outcome driven, culturally competent, recovery- as well as client- and family- centered, innovative and creative.
3. Foster continuous improvement to maximize the efficiency and effectiveness of services.
4. Maintain fiscal integrity.
5. Assist employees to reach their full potential.

Policies

The QRC has been established to fulfill the mandated functions of the QI Committee as delineated above. The QRC shall act as an advisory group to the QI Program to provide oversight and involvement in QI activities. All activities of the QRC shall be confidential and protected from discoverability under Section (§) 1156 and 1157 of the California Evidence Code.

QRC members shall reflect the mental health and the substance use treatment communities. Ethnic and cultural diversity and representation from all age groups as well as all six Health and Human Services (HHSA) regions shall be priorities in the membership selection process. Representatives shall include individuals from the following groups:

- Consumers at large and family members representing children's, adult or older adult mental health and substance use disorder services
- Behavioral Health Clinical Director's Office
- Children and Adult/Older Adult Systems of Care
- Mental Health and Substance Use Disorder service providers
- Fee-for-Service providers, including inpatient providers and outpatient providers
- Administrative Services Organization (ASO)
- Behavioral Health Advisory Board
- Cultural Competency Resource Team

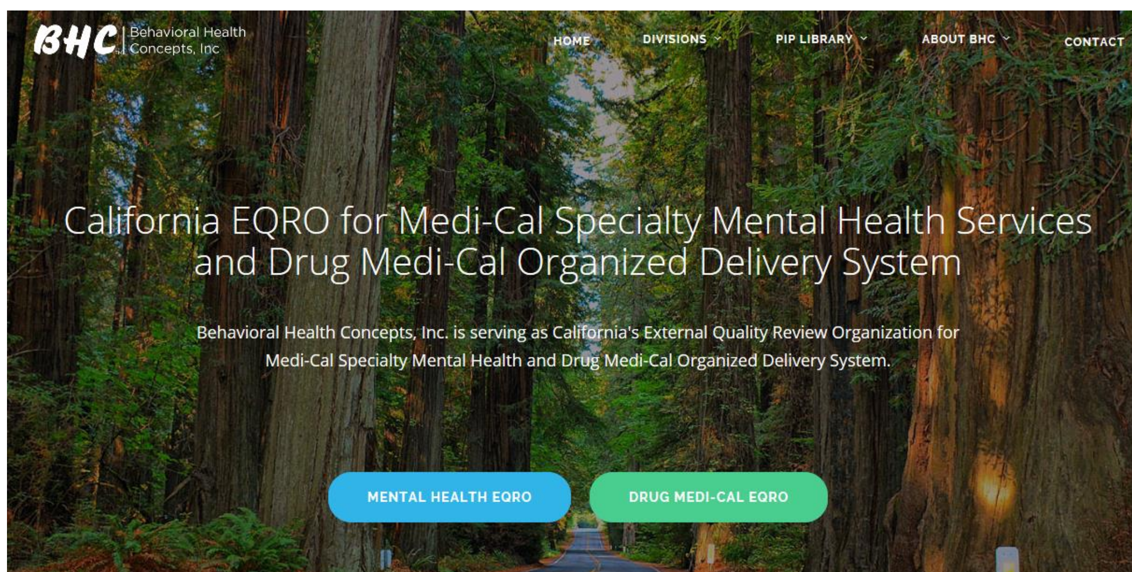
There shall be no alternates or member designees.

The QRC shall meet at least quarterly.

Specific DHCS language mandates:

The Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body. The committee shall meet at least quarterly, but as frequently as necessary, to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS and EQRO upon request. The Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions, as well as avoidance of conflict of interest on the part of committee members.
San Diego County Behavioral Health Services is also monitored by the External Quality Review Organization (EQRO). For more information on the EQRO and access to their reports: https://www.caleqro.com/.



Quality Improvement Process

BHS has adopted a continuous quality improvement model for producing improvement in key service and clinical areas. This model encompasses a systematic series of activities, organization-wide, that focus on improving the quality of identified key treatment, service and administrative functions.

The overall objective of the quality improvement process is to ensure that quality is built into the performance of the BHS functions. This objective is met through a commitment to quality from the administration, QI staff, clients, family members, and providers. The quality improvement process is incorporated internally into all service areas of BHS. It is applied when examining the care and services delivered by the BHS network of fee-for-service providers, County-operated and County-contracted agencies, and the Administrative Services Organization (ASO).

Client and Family Involvement in Quality Improvement

Consistent with our values of involving clients and family members in the quality improvement process, many of the quality improvement activities are based on input from clients and family members.

This goal is to involve clients, family members, providers, and stakeholders in the planning, operations, and monitoring of our quality improvement efforts. Their input comes from a broad variety of sources, including the Behavioral Health Advisory Board (BHAB), community coalitions, planning councils, client and family contracted liaisons, youth and Transition Age Youth (TAY) representatives, Program Advisory Groups, client satisfaction surveys, client advocacy programs, complaints, grievances, and input received on the County BHS website.

Annual Quality Improvement Work Plan

The Quality Improvement Work Plan (QIWP) describes elements by functional area and the aspects of care or service for which the MHP will measure quality. The work plan defines:

1) Indicators – the objective data elements that will be measured to know how well the standard is being met

2) Goals – how this measure is being utilized to assess this aspect of care

3) Data collection method/frequency/source – how necessary data will be collected to measure this indicator and how often this indicator is measured

4) Reporting frequency/responsible party/collaborator(s) – the frequency with which data will be reported, the source of the data and who will be responsible

The QIWP is monitored and updated annually on the previous year's objectives. A formal evaluation is conducted annually. Key findings of the performance goals are presented to the appropriate quality improvement committee(s) and key BHS staff for recommended action, if needed.

Annual Evaluation of Program Effectiveness

BHS shall evaluate the QI Program at least annually to ensure that it is effective and remains current with overall goals and objectives. The assessment will include a summary of completed and in-process quality improvement activities, results and intervention, the impact the process has had, and the need for process revisions and modifications. Evaluation findings are used to develop the following year's QIWP.

Quality Review Council (QRC)

Purpose:

The Quality Review Council (QRC) is a standing, countywide body charged with the responsibility to implement the QI Program and QIWP.

Composition:

The QRC shall include members from across the behavioral health community. Recommendations for the QRC membership are requested from several stakeholder organizations. Ethnicity/culture is considered during selection, whenever possible.

The committee may consist of representation from: clients, family members, veteran representatives, peer support specialists, family support partners, mental health and substance use disorder organizational providers, SDCBHS quality improvement staff, other County representatives, ASO representatives, and advocacy group representatives.

Specific Responsibilities:

1. Recommend quality improvement policies.
2. Review and evaluate results of quality improvement activities.
3. Recommend remedial actions.
4. Monitor follow-up.
5. Provide advice and guidance on the identification of methods for including clients in management of quality improvement activities.
6. Provide advice and guidance on the collection and review of quality measures.
7. Identify any other measures and data that should be collected.
8. Consider options for improvements based upon the data.

9. Make recommendations to the County and provider network for system improvements and change.

10. Participate in preparation of annual quality improvement reports for the County and community.

11. Consider and recommend annual updates of the QIWP.

12. Solicit input from County QI Unit staff, the System of Care Councils, and regional advisory groups.

13. Propose mechanisms for quality improvement feedback to the organization and to service providers.

What does the QRC monitor?

1. Conducts monitoring activities, including but not limited to review of beneficiary complaints and grievances, fair hearings, provider appeals, and clinical records review.
2. Monitoring activities include, but are not limited to, the Service Delivery Capacity of Behavioral Health Services, Accessibility of Services, Beneficiary satisfaction, the service delivery system, continuity and coordination of care with physical health, provider appeals and two (2) Performance Improvement Projects (PIPs) in each of the mental health and substance use disorder Systems of Care.
3. Other areas as identified by staff and/or members.

Procedures:

1. Applications for new members are reviewed by the QRC Membership committee, and recommendations are taken to the QRC. The QRC votes on members presented by the QRC Membership committee.

2. The QRC meets at least once every quarter. There shall be no alternates and members may not designate attendance to any other representative.

Membership

QRC membership shall be chosen to represent the broad spectrum of stakeholders in the MHP. To foster this broad representation, a QRC Membership Committee shall review membership applications and make recommendations for QRC membership to the current QRC.

There shall be a minimum of 15 and a maximum of 21 QRC members. The QRC Membership Committee will review applications and solicit others in order to achieve and maintain the desired broad representation of stakeholders outlined in the policy statement above.

The QRC Membership Committee shall be made up of volunteers from the QRC plus one designated QI staff member and shall meet, in person or telephonically, as necessary, to fill vacancies as they arise. The QRC Membership Committee Chair shall be appointed by the QRC Chair. The QRC Membership Committee will bring recommendations on membership to the QRC for approval.

To encourage consumer and family membership, a meeting stipend will be available for members of the QRC who are not being compensated by any other organization to be at the QRC meeting, unless approved by the director.

The meeting stipend will be available for only the meetings attended and will incorporate an allowance for preparation time and QRC committee work done in conjunction with that meeting.

If a member does not attend two (2) meetings within a one-year period, the QRC Membership Committee may determine that the member be removed from the QRC.

QRC Subcommittees

Subcommittees of the QRC may be formed on a standing or ad hoc basis. Subcommittee members must be members of the QRC or be a designated County staff. Activities of the Subcommittee are also confidential as noted in the section of this policy on confidentiality.

Current QRC Subcommittees include:

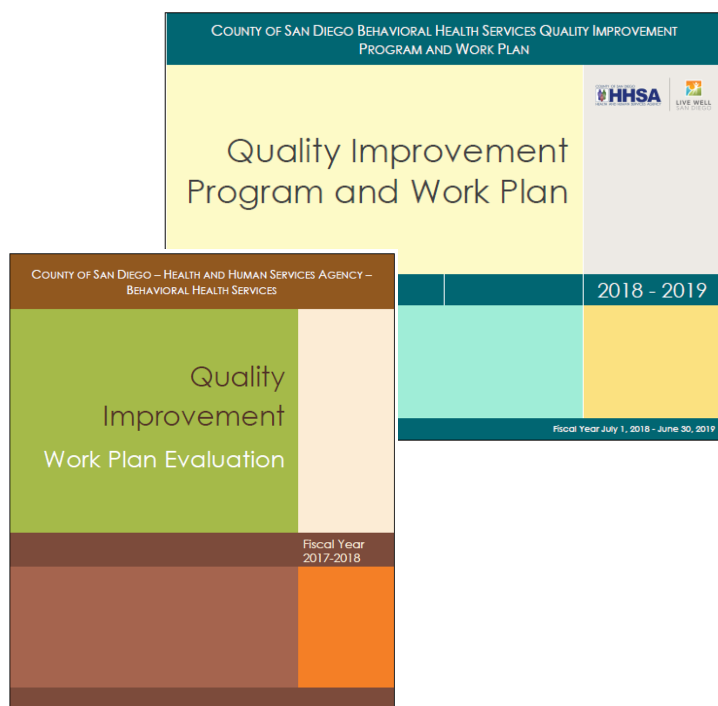
- QRC Membership
- Peer-Family Employment

QI Workplan and Evaluation

The QI Program will/shall have an Annual QI Work Plan, including the following:

- QRC oversees and examines all mandatory components of BHS' QI Work Pan.
- An annual evaluation of the overall effectiveness of the QI program, demonstrating the QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service, and describing completed and in-process QI activities, including performance improvement projects.
- Monitoring of previously identified issues, including tracking of issues over time.
- And, objectives, scope, and planned activities for the coming year, including QI areas and any additional areas as required by the Centers for Medicare and Medicaid (CMS) in an effort to align with HEDIS.
- Monitoring (1) Service Delivery Capacity, (2) Accessibility of Services, (3) Beneficiary satisfaction, (4) Service delivery system, (5) Continuity and coordination of care with physical health, (6) Provider appeals AND two (2) Performance Improvement Projects (PIPs).

The most current BHS QI Workplan and Evaluation can be found on the TRL: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/technical_resource_library.html#7



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TARGET AREA: SERVICES ARE CLIENT CENTERED

Goal 1: Decrease the number of Quality of Care related grievances by 5% 7

Goal 2: Evaluate changes in satisfaction, engagement, and career opportunities among Support Specialists 9

Goal 3: Implement new Outcome Tools in the CYF System of Care 11

TARGET AREA: SERVICES ARE SAFE

Goal 4: Reduce the number of completed suicides in the Behavioral Health System of Care by 5% from the previous Fiscal Year. 13

Goal 5: Ensure programs meet the medication monitoring review requirement 15

Goal 6: Increase Psychiatric Emergency Response Team (PERT) clinicians 17

TARGET AREA: SERVICES ARE EFFECTIVE

Goal 7: Ensure that 60% of Full Service Partnership (FSP) Project One for All (POFA) clients are in permanent housing at the latest assessment 19

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TARGET AREA: SERVICES ARE EFFICIENT AND ACCESSIBLE

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Goal 13: Ensure preferred languages requests meet the systemwide access time standard 31

TARGET AREA: SERVICES ARE TIMELY

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Goal 15: Ensure timely mental health assessments 35

Performance Improvement Projects (PIPs)

The purpose of Performance Improvement Projects (PIPs) is to assess and improve processes, thereby improve outcomes of care. What sets a PIP apart from a regular report is that PIPs must be designed and conducted in a methodologically sound manner. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. These projects are required by the State and can be of the MHP's choosing *or* prescribed by the State.

- ❖ The PIP should target improvement in either a clinical or non-clinical service delivered by the MHP.
- ❖ The PIP process is not used to evaluate the effectiveness of a specific program operated by the MHP. If a specific program is experiencing identified problems, changes and interventions can be studied using the PIP process. This can be done to create improvements in the program and should be included in the narrative.
- ❖ The narrative should explain how addressing the study issue will also address a broad spectrum of consumer care and services over time. If the PIP addresses a high-impact or high-risk condition, it may involve a smaller portion of the MHP consumer population, so the importance of addressing this type of issue must be detailed in the study narrative.
- ❖ Each year a PIP is evaluated as separate and specific. Although topic selection and explanation may cover more than one PIP year, every section should be reviewed and updated, as needed, to ensure continued relevance and to address ongoing and new interventions or changes to the study.

For more information on current PIPs for both mental health and substance use disorder services, please refer to the QI Workplans found on the TRL:
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/technical_resource_library.html#7

Reviewing Reports

Looking at Data – Is there a Concern?

QRC looks at different items mandated by the state and if necessary, plans, designs, and executes a plan to correct and/or improve problem(s).

Additional Data for Indicators:

- Review reports carefully. Look for outliers, increasing/de-creasing trends.
- System utilization of services.
- Types of grievances.

Substance Use Disorders
FY 2018-19 Q2

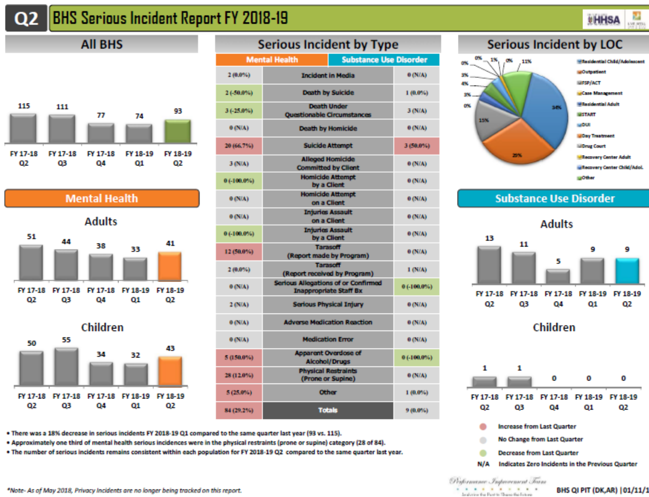
Access Time Report

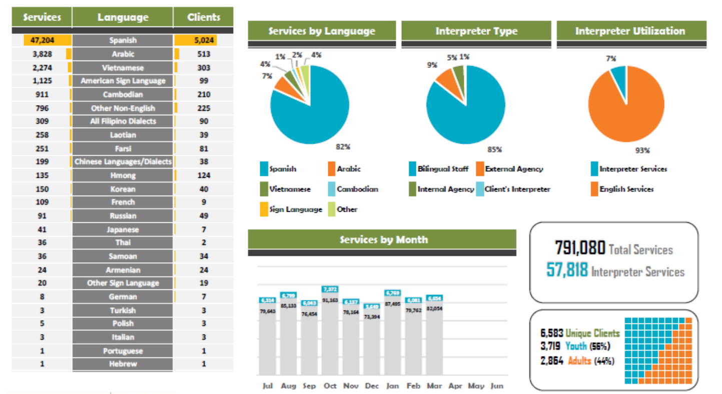
Initial Request to First Offered Appointment	Adult	Children	All Services
Average length of time (days)	3.7	3.3	3.7
Percent of requests that meet access time standards	82.7%	85.7%	82.9%
Range (days)	0 - 59 days	0 - 41 days	0 - 59 days

Initial Request to First Face to Face Appointment	Adult	Children	All Services
Average length of time (days)	3.6	2.9	3.5
Percent of requests that meet access time standards	83.0%	87.8%	83.5%
Range (days)	0 - 59 days	0 - 41 days	0 - 59 days

Initial Request to First MAT Appointment	Adult	Children	All Services
Average length of time (days)	2.5	N/A	2.5
Percent of requests that meet access time standards	88.2%	N/A	88.2%
Range (days)	0 - 53 days	N/A	0 - 53 days

Initial Request to First Methadone Appointment	Adult	Children	All Services
Average length of time (days)	1.2	N/A	1.2
Percent of requests that meet access time standards	95.0%	N/A	95.0%
Range (days)	0 - 56 days	N/A	0 - 56 days





Miscellaneous

Voting

Most QRC voting is done informally, but when there is a formal vote by the QRC, the vote shall be by majority. A quorum is not required.

Minutes

Dated and signed minutes shall reflect all QI Committee decisions and actions. Minutes from the previous meeting will be reviewed and approved by members of the QRC. The minutes of the QRC are confidential and will not be sent out prior to meetings for review.

Guests and Presenters

Guests and presenters may participate in the QRC meetings on a very limited basis due to the confidentiality of the QRC activities. Guests will only be allowed to attend upon invitation and will be required to sign a confidentiality form. Guests will be asked to leave the meeting if any issues related to specific clients or providers are being discussed.

Presenters may be invited but will only be allowed to attend the portion of the meeting relevant to their topic. They will be required to sign a confidentiality form and will be asked to leave the meeting if any issues related to specific clients or providers are being discussed.

Grievances / Appeals / State Fair Hearings

Overview of Grievance and Appeal Procedures

Consistent with the principle of a consumer driven system of care, the grievance process has been developed through a collaborative process with consumers, family members, the contracted patient advocacy programs, and the County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) staff.

Consumers stress that these procedures are as important as all other behavioral health services, and that they deserve equal priority in the health care system. Consequently, the number of grievances received through this consumer-friendly process can be viewed as a reflection of the provider's efficiency and integrity, and a genuine commitment to improve quality services.

The Code of Federal Regulations (42 CFR 438.400 through 42 CFR 438.424) and The California Code of Regulations (Title 9, Section 1850.205) are the basic authorities for the grievance and appeal process. This process covers Medi-Cal beneficiaries and persons without Medi-Cal funds receiving Mental Health Plan (MHP) mental health services. According to the Welfare and Institution Code 10950, the State Fair Hearing process is only available to Medi-Cal beneficiaries.

Objectives of the Grievance and Appeal Policy

- To assist individuals in accessing medically necessary, high quality, trauma informed, consumer-centered mental health and substance use disorder services and education
- To provide a formal process for independent resolution of grievances and appeals
- To respond to consumer concerns in a linguistically appropriate, culturally competent, trauma informed, and timely manner
- To be carried out in the appropriate language, with translators available
- To protect the rights of consumers during grievance and appeal processes
- To provide education regarding, and easy access to, the grievance and appeal process through widely available informational brochures, posters, and self-addressed grievance and appeal forms located at all provider sites
- To educate beneficiaries, consumers, families, and staff about the process

Grievance Policy

The Mental Health Plan (MHP) shall establish a procedure for addressing and resolving grievances regarding specialty mental health services. Grievances registered by the direct recipient of such services and/or persons acting on his/her behalf shall be responded to in accordance with these procedures. Beneficiaries and/or their representatives may submit a grievance, file an appeal, or request a State Fair Hearing (upon the completion of the County grievance and appeal process) at any time.

- Consumer concerns shall be responded to in a linguistically appropriate, culturally competent and timely manner.
- Beneficiaries' rights and confidentiality shall be protected at all stages of the grievance process by all providers, advocates, and MHP representatives involved.
- Beneficiaries of the MHP and persons seeking services shall be informed annually of their rights to contact the patient advocacy programs at any time, for assistance in resolving a grievance at County level, or obtaining a second opinion at no cost or requesting a State Fair Hearing.
- Beneficiaries of the MHP and persons seeking services shall be informed of the procedure for resolution of grievances. All grievance, appeal, and State Fair Hearing brochures are available on www.optumsandiego.com and from all specialty mental health and substance use disorder organizations and fee-for-service providers. This will include information about the availability of patient advocacy programs.
- At the client's request, a support person chosen by the client, such as a family, friend or other advocate may accompany them to any meetings or hearings regarding a grievance.
- Beneficiaries and consumers shall not be subject to any discrimination, penalty, sanction, or restriction for filing a grievance. The consumer shall not be discouraged, hindered, or otherwise interfered with in seeking or attempting to register a grievance.
- The client may authorize another person or persons to act on his/her behalf as an authorized representative. Advocacy programs may request this in writing from the consumer.
- Issues identified because of the unsatisfactory problem resolution with the provider or grievance process shall be reviewed by the MHP for implementation of system changes when appropriate.

Definitions

Adverse Benefit Determination: Any of the following actions taken by a Plan:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner.
5. The failure to act within the required timeframes for standard resolution of grievances and appeals.
6. The denial of a beneficiary's request to dispute financial liability.

ASO: Administrative Services Organization contracted by the Health and Human Services Agency (HHSA) to provide Managed Care Administrative functions.

Beneficiary: A person/individual who is currently requesting or receiving specialty mental health or substance use disorder services paid for under the County's Medi-Cal Managed Care Plan.
Any individual currently receiving mental health or substance use disorder services from County Behavioral Health Services (BHS), regardless of funding source.

Complaint: An oral or written expression of dissatisfaction or concern, from the consumer regarding mental health or substance use disorder services provided to the consumer. All complaints are considered grievances.

Consumer: Any individual who is currently requesting or receiving specialty mental health or substance use disorder services regardless of the individual's funding source and/or has received such services in the past and/or the persons authorized to act on his/her behalf. (This includes family members and any other person(s) designated by the client as his/her authorized representative.)

Grievance: A written or oral expression of dissatisfaction by the beneficiary about any matter (other than an adverse benefit determination) regarding mental health or substance use disorder services. (See Grievance Process below.)

Patients' Rights Advocate: An advocate who is available to help consumers through the grievance process.

Grievance Process: A formal process for the purpose of hearing and attempting to resolve beneficiary concerns regarding specialty mental health or substance use disorder services.

Medical/Clinical Review Panel: A panel of behavioral health professionals qualified to provide second opinions regarding denial, reduction, or termination of services. Said professionals shall not be employed by the same party providing the first opinion or have any financial interest other than for purposes of providing these specific services.

Mental Health Plan (MHP): Entity, usually a County, under contract with the State of California to administer public mental health services. For San Diego, it is the County of San Diego, HHSA, Behavioral Health Services.

Notice of Adverse Benefit Determination (NOABD): Beneficiaries must receive a written NOABD when the MHP takes any of the actions described in the Adverse Benefit Determination. The MHP must give beneficiaries timely and adequate NOABD in writing, consistent with the requirements in 42 CFR 438.10, and must explain all the following:

1. The adverse benefit determination the MHP has made or intends to make.
2. A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. The MHP shall explicitly state why the beneficiary's condition does not meet specialty mental health services.
3. A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations.
4. The beneficiary's right to be provided, upon request and free of charge; reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination.

Patient Advocacy Organizations: Community based programs that provide education, information, outreach, and advocacy services, including investigation of patients' rights complaints, grievances from beneficiaries and consumers receiving outpatient, inpatient, and residential services.

Patients' Rights Advocate: The persons designated under Welfare and Institutions Code, Section 5500 et seq. to protect the rights of all recipients of specialty mental health services. The Patients' Rights Advocate shall have no direct or indirect clinical or administrative responsibility for any recipient of Medi-Cal Managed Care

Services and shall have no other responsibilities that would otherwise compromise his or her ability to advocate on behalf of specialty mental health beneficiaries.

QI Unit: The Quality Improvement (QI) Unit, within County of San Diego Behavioral Health Services that provides monitoring and oversight of the grievance and appeal process.

Second Opinion: A medical clinical individual or panel review providing a re-assessment when other specialty mental health services have been denied, reduced, or terminated.

State Fair Hearing: A formal hearing conducted by the California Department of Social Services as described in Welfare and Institutions Code, Section 10950 and Federal Regulations Subpart E, Section 431.200 et. seq. This process is available to Medi-Cal beneficiaries any time within 120 days of completion of receiving the Notice of Appeal Resolution (NAR) from the MHP (42 CFR 438.408(f)(2); MHSUDS-IN-18-010E; W&IC 10951). Beneficiaries do not need to use the County process to request a State Fair Hearing.

Application for Quality Review Council Membership

Please fill in the information requested below. Write your initials on the line next to items numbered 1 - 10 to indicate that you have read and agree with each condition. Representation of various age groups, as well as a balanced representation of client, family, and provider members are considerations for selection of all members of the Quality Review Council.

The Quality Review Council Membership Committee will review all applications and will contact you to inform you of their decision. Please complete the Application for Stipend if you would like to apply to receive a stipend as reimbursement for participation on the Quality Review Council. Please note that only client or family members; those who are currently receiving services or who have received services in the past, may apply for stipend.

Print Name ____

Address ____

____

Phone______________________ Email_________________________

1) ___ I understand that QRC meetings occurs the fourth Thursday of every two months and that I am to notify the designated County Behavioral Health Staff if I am unable to attend. Please contact Liz Miles at Elizabeth.Miles@sdcounty.ca.gov or 619-584-5015 with this notification.

2) ___ I understand that my membership on the Quality Review Council is an on-going commitment and that non-attendance at meetings, or lack of work on reports or subcommittees, as required, may result in removal from membership on the Quality Review Council.

3) ___ I understand that all materials, reports, and topics of discussion at the Quality Review Council meetings are confidential.

4) ___ I understand that as a member of the Quality Review Council, my responsibilities may include:

a) Recommending quality improvement policies.
b) Reviewing and evaluating results of quality improvement activities.
c) Recommending remedial actions.
d) Monitoring follow-up.
e) Providing advice and guidance on the implementation of the quality improvement training program.
f) Providing advice and guidance on the identification of methods for including clients in management of quality improvement activities.

g) Providing advice and guidance on the collection and review of quality measures.
h) Identifying any other measures and data that should be collected.
i) Considering options for improvements based upon the data.
j) Monitoring client satisfaction and consumer grievances and appeals
k) Making recommendations to the County and provider network for system improvements and change.
l) Participating in preparation of annual quality improvement reports to the County and the community.
m) Considering and recommending annual updates of the Quality Improvement Work Plan.
n) Soliciting input from committee, groups, and other client/consumers and family members
o) Review the contracted Statements of Work of Behavioral Health funded programs as necessary or as requested by the County.
p) Propose mechanisms for quality improvement feedback to the organization and to service providers.

The Quality Review Council is made up of stakeholders in the behavioral health process including consumers of all ages, members, fee-for-service providers, organizational providers, members of the Quality Improvement Unit, client advocates and other service providers. This composition allows the QRC to bring a broad range of expertise to quality improvement issues. Please check the membership category that you represent:

5) The following age group/s is/are the age groups I am representing (check all that apply):

_____ Child or Adolescent (0-18)
_____ Transitional Age Youth (16-24)
_____ Adult (18-59)
_____ Older Adult (60+)

6) I represent the following Racial/Ethnic group(s):

____

7) I speak a language other than English_______________________
(specify)

8) I am a (check all that apply):

___ Client ____Consumer ___ Family Member
___ MH Organizational Provider
___ SUD Organizational Provider ___ FFS Provider
___ Other interested Community Member: _____________________

9) The reason I would like to participate on the Quality Review Council is:

____
____
____
____
____
____
____
____

(Please use additional pages if the above space does not provide enough room to express your reasons for applying for membership on the Quality Review Council.)

Signature______________________________ Date_______________

Applications may be mailed, faxed, or emailed to the following addresses which upon receipt will be distributed to the Membership Committee:

Address: County Behavioral Health Services
QRC Membership (QI Unit)
3255 Camino del Rio South
San Diego, CA 92108

Fax: (619)563-2705

Email: Elizabeth.Miles@sdcounty.ca.gov

QRC Stipend Application

In addition to applying for membership on the Quality Review Council, I am applying for a stipend as reimbursement. My initials on the line next to each item below indicate that I agree with the statement as written. Please note that only a Client/Consumer/Family Member may apply for the stipend.

___ I am a Consumer/Client/Family Member and, as such, have been or am currently involved with accessing specialty mental health and/or substance use disorder services.
___ I understand that attendance at the regular QRC meetings, performance of meeting related work and preparation for regular QRC meetings will be required to receive a stipend payment, and the maximum payment amount will be $100 per meeting including meeting related duties. The QRC meets bimonthly, or six times per year.
___ I understand that meetings and related duties constitute one activity. I will not be paid a stipend for any meeting that I do not attend, nor will I be paid for any work that I have done to prepare for that meeting.
___ I am not being paid to attend the Quality Review Council by any other entity.
___ I agree to furnish my address, phone number, and Social Security Number, and I understand that stipend payment amounts will be reported to the IRS for tax purposes.
___ I understand that non-attendance at meetings, or lack of work on reports or subcommittees, as required, will result in discontinuation of stipend.
___ I understand that the QRC member stipend is based on availability of funding and may be discontinued at any time.
___ I agree to recuse/exempt myself from any discussion, deliberation, process, or recommendation which may, in my opinion or the opinion of the QRC, present a conflict of interest.

Signature____

Social Security Number_____________________________________