COUNTY OF SANTA CLARA

Behavioral Health Services

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TRAINING ON...

Grievances

and

Sentinel, Critical, Quality Incidents

SEPTEMBER 2023

COUNTY OF SANTA CLARA
Behavioral Health Services

AGENDA

I. Goal and Target Audience

II. Grievances

- a. Role and Purpose
- b. Grievance Definition and Types
- c. Process and Timelines
  - I. Availability and Process with beneficiary
  - II. Language Needs
  - III. Internal vs County vs State
  - IV. Communications with Staff Investigating
    1. Appropriate Staff/Manager/QA/QI
    2. Timeliness in Communication
- d. What's Changed and Why
- e. Grievance Form
- f. Grievance Log (MHP's Grievance Dept and CCPs only)

AGENDA CONTINUED

III. Sentinel, Critical, Quality Incidents
   a. Key Changes
   b. Categories
      i. Sentinel Event
      ii. Critical Incident
      iii. Quality of Care Concern
   c. What to Do Now
   d. The Form
   e. Activity
   f. Reminders

IV. What's Next and Questions

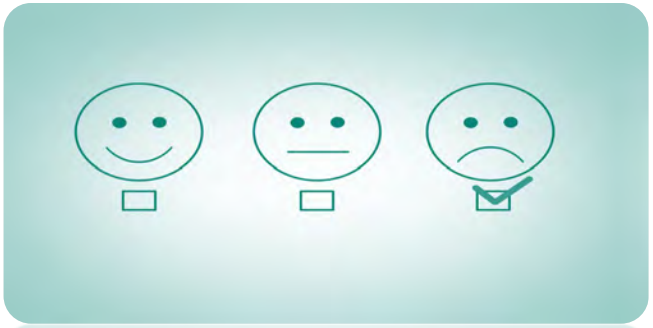
Goal and Target Audience

- Goal:
  - Working Knowledge
    - What to do?
    - When to do it?

- Target Audience:
  - Leadership
  - County Clinics – Managers and Leads
  - CCPs – QA/QI Staff and Designees
  - Beneficiary Facing Staff – Clinicians, Front Desk Staff, Others,...

Grievances: Role and Purpose

- Grievances are a Beneficiary Right per Federal and State standards
- BHSD Required by DHCS (State) to inform them (via annual MCPAR), our system and providers regarding Grievances, the process, standards, etc...
- New Grievance P&P and Provider Manual
- Review definition and types of grievances
- Discuss what's new



Grievances: What is a Grievance and Types per DHCS

*A **grievance** is an **expression of dissatisfaction** about any matter other than an Adverse Benefit Determination. There is no distinction between an informal and formal grievance. A complaint is the same as a formal grievance. (Reference BHIN 22-36 and Federal Title 42, CFR, Section 438.400(b))*

- Related to **Customer Service** - Includes grievances about interactions with the Plan's Member Services department, provider offices or facilities, Plan marketing agents, or any other Plan or provider representatives.

- Related to **Case Management** - Includes grievances about the timeliness of an assessment or complaints about the Plan or provider care or case management process.

- **Access to Care** Grievances - Includes grievances about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.

Continued: What is a Grievance & Types per DHCS

- **Quality of Care** - Includes grievances about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the Plan.

- **County (Plan) Communication** Grievances - Includes grievances related to the clarity or accuracy of enrollee materials or other Plan communications or to an enrollee's access to or the accessibility of enrollee materials or Plan communications.

- **Payment/Billing issues** - Includes reasons related to payment or billing issues.

- **Suspected Fraud** - Includes suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. (Note: grievances reported in this row should only include grievances submitted to the Plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General).

Continued: What is a Grievance & Types per DHCS

- **Abuse, Neglect or Exploitation** - Includes grievances about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the Plan.

- **Lack of Timely Response** to a service authorization or appeal request (including requests to expedite or extend appeals).

- **Denial of Expedited Appeal** - Includes grievances related to the Plan's denial of a beneficiary request for an expedited appeal. (Per MHSUDS Information Notice 18-010E, pg. 12, the Plan must resolve the expedited appeal within 72 hours from receipt of the appeal. If a Plan denies a request for an expedited appeal, the beneficiary or their representative have the right to file a grievance.)

- **Filed for other reasons** - Includes grievances that were filed for a reason other than the reasons listed above.

Grievances: Process and Timelines

Beneficiary can file a Grievance at any time

- Calling 1-800-704-0900, Option #5 (MH and SUTS).
- ...or submits a completed Grievance form to Utilization Management usually by mail or fax 408-288-6113.

QA receives Grievance

- Manager reviews then coordinates with one of the Quality Improvement Coordinators (QICs) to follow up with beneficiary.
- Grievance is logged and log is updated throughout the process.

Grievance follow up

- Acknowledgement letter mailed to beneficiary within 5 calendar days.
- Follow up initiated with provider and relevant stakeholders to bring grievance to a resolution.

Grievance completion

- Send closure and disposition letters.
- **Standard** grievances resolved within 90 calendar days and **Exempt** grievances resolved by close of next business day.
- Follow grievance policy and workflow throughout.
- Log in Grievance Log.
- Data reported to stakeholders.

Grievances: What Changed and Why

- Grievance categories have been revised/simplified by DHCS
- BHSD has a unified intake triage process (with eventual handling of all SUTS and MH grievances done by a single county team under the MHP)
- CCPs under normal circumstances can handle Exempt grievances on their own (but those that take longer would be deferred to the MHP's Grievance Team)
- Grievances handled by CCPs need to be reported to BHSD according to required timeline and intervals specified in the new Provider Manual.
- Discrimination Grievances as its own category
- Grievances Committee being established within BHSD

Grievance Form

Filing a State Fair Hearing You may request a State Fair Hearing by calling (800) 952-5253. Your current services will continue without disruption until a decision is reached. A Client may request a State fair hearing only after receiving notice (letter) that we are upholding the adverse benefit determination or the client has exhausted the appeal process. In the case that we fail to adhere to the notice and timing requirements stated above, you are deemed to have exhausted our appeals process and may initiate a State fair hearing. Clients must request a State fair hearing no later than 120 calendar days from the date you received the notice of resolution.

Medi-Cal Beneficiaries may file a complaint directly with:

Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413
Or call the Office of the Ombudsman at
(916) 896-4042

County of Santa Clara Behavioral Health Services Department
Attn: Quality Assurance
Program
P.O. Box 28504 San Jose, CA 95159-9903

Place Stamp Here. Post of... will not deliver mail without proper...

County of Santa Clara Behavioral Health Services Program
Attn: Quality Assurance
Program
P.O. Box 28504 San Jose, CA 95159-9903

We will provide you reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

We will ensure that individuals who make decisions on grievances and appeals are individuals:

- Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual;
- Who, if deciding on issues related to medical necessity, an expedited grievance or appeal, or a clinical issue are individuals who have the appropriate clinical expertise, as determined by us, in treating the client's condition or disease; and
- Who, take into account all comments, documents, records, and other information submitted by the client or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

We will provide you (and your representative/estate) your case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by us or our subcontractors in connection with the appeal of the adverse benefit determination. This information will be provided free of charge and sufficiently in advance of the resolution timeframe for ap-

Your Grievance and Appeal Rights

COUNTY OF SANTA CLARA
Behavioral Health Services

Grievance Form: Continued

Grievance & Appeal Process Our process for handling your grievance/appeal of adverse benefit determinations includes sending you an acknowledgement receipt of each grievance and appeal and a resolution notice. There will be no retaliation or discrimination for expressing a concern or filing a grievance. We will resolve each grievance and appeal, and provide notice, as expeditiously as your health condition requires within the timelines listed below. You may file a Grievance at any time to express dissatisfaction about any matter other than an adverse benefit determination. Grievance includes your right to dispute an extension of time proposed by us to make an authorization decision. You may share evidence and testimony and make legal and factual arguments in person, on the phone or in writing at any time. Standard resolution of grievances will not exceed 90 calendar days from the day that we receive the grievance.

How to File a Grievance:

- For both Mental Health Services (MHS) and Substance Use Treatment Services (SUTS), call 1-800-704-0900 or (408) 793-5894
- Complete and mail/fax this form or a letter MHS Fax # 408-288-6113

Appeal An appeal is a review by us of an adverse benefit determination. Following receipt of a notification of an adverse benefit determination, you have 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal. We have only one level of appeal for clients. You may request a State fair hearing after receiving notice of an adverse benefit determination is upheld. You may request an appeal either orally or in writing. Further, unless you request an expedited resolution, an oral appeal must be followed by a written, signed appeal. Your benefits will continue pending resolution of the appeal. Oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and will be confirmed in writing, unless you or your provider requests expedited resolution.

Adverse Benefit Determination Means The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. We reduce, suspend, or terminate any previously authorized service. The denial, in whole or in part, of payment for a service. The failure to provide services in a timely manner. Failure to adhere to the timeframes regarding the standard resolution of grievances and appeals. For a resident of a rural area, the denial of an enrollee's request to exercise his or her right, to obtain services outside the network. The denial of a client's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other client's financial liabilities.

Expedited Appeals Standard resolution of appeals will not exceed 30 calendar days from the day we receive the appeal: unless a 14 day extension is granted due to your request to extend. We determine the need for additional information, or if the delay is in your interest.

Expedited resolution of appeals. 72 hours after we receive the appeal. This timeframe may be extended only be extended up to 14 calendar days if you request the extension; or we show (based on the states standards) that there is need for additional information and how the delay is in your interest. If there is a timeframe extension, we *will*: make reasonable efforts to give you prompt oral notice of the delay and within 2 calendar days give you written notice of the reason for the decision to extend the timeframe and inform you of your right to file a grievance if you disagree with that decision. We will resolve appeals as expeditiously as the client's health condition requires and no later than the date the extension expires.

Expedited Resolution of Appeals. When we determine (for a request from the enrollee) or a provider indicates (in making the request on the your behalf or supporting the your request) that taking the time for a standard resolution could seriously jeopardize your life, physical or mental health, or ability to attain, maintain, or regain maximum function the grievance and/or appeal must be expedited. If we deny a request for expedited resolution of an appeal, we must transfer the grievance and/or appeal to the timeframe for standard resolution (as stated above).

Detach, fold, seal and return this

GRIEVANCE FORM

TYPE OF REQUEST (check one)

Grievance ☐ Appeal ☐

Expedited Grievance ☐ Expedited Appeal ☐

Client / Consumer Name	Date of Birth
Address	City/State/Zip
Phone	Program/Staff

Describe the problem or concern:

Signature **Date**

Grievances Log (MHP Grievance Dept and CCPs)

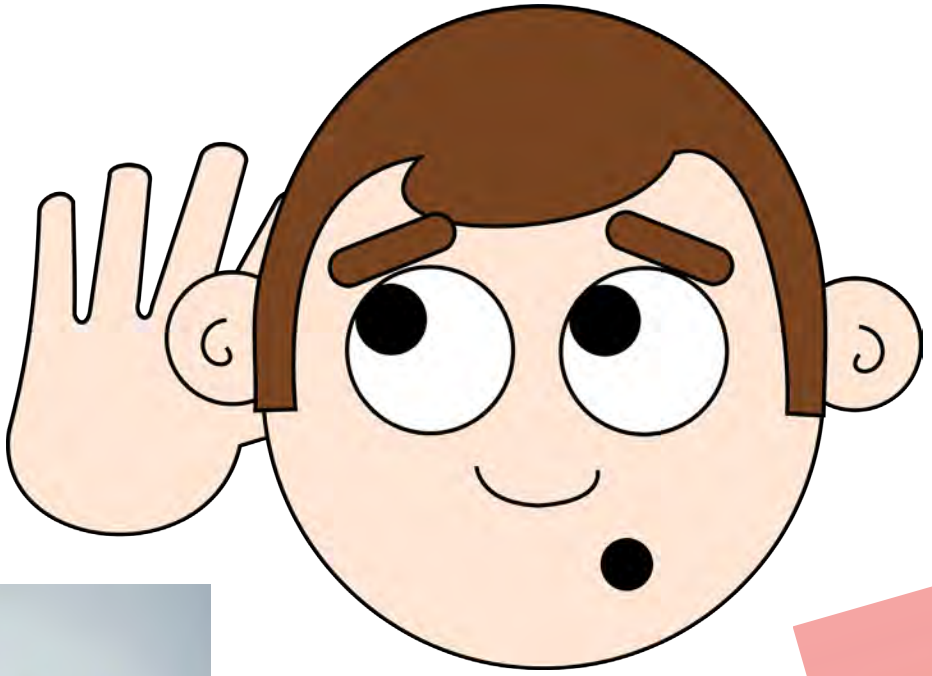
Headers for Excel Log

Beneficiary's Designated Representative (with a valid ROI)
DATE (Date on Grievance or Appeal form)
LOG-IN DATE (Date of contact / received)
DUE DATE
LANGUAGE
EXTENSION
AGENCY
DIVISION
NOABD (select type)
Date of NOABD
Aid Paid Pending (APP)
Non-G, or Pre-G
Grievance (due within 90 days)
Exempt Grievance
Appeal (due within 30 days)
Expedited Appeal-Time Received (due within 72 hours)

State Fair Hearing
Expedited State Fair Hearing
Expedited SFH time received (due within 72 hrs)
2nd Opinion
GRIEVANCE CATEGORIES
GRIEVANCE CATEGORIES for MCPAR (Primary Selection)
GRIEVANCE CATEGORIES for MCPAR (Secondary Selection)
NATURE OF PROBLEM
Disposition
Disposition for MCPAR
DISPOSITION (Client's Response and How Resolved)
DISPO DATE
QI COORDINATOR who Received and Resolved the Grievance, Appeal, or State Fair Hearing
Letter of Acknowledgement
Disposition Letter

Grievances: Remember...

Any expression of dissatisfaction, is an opportunity to listen.



Grievances: Conclusion

Questions??

IIIA. SENTINEL, CRITICAL, QUALITY INCIDENTS: WHY CHANGE

Time for some change in how we use and report incidents that occur within our system.

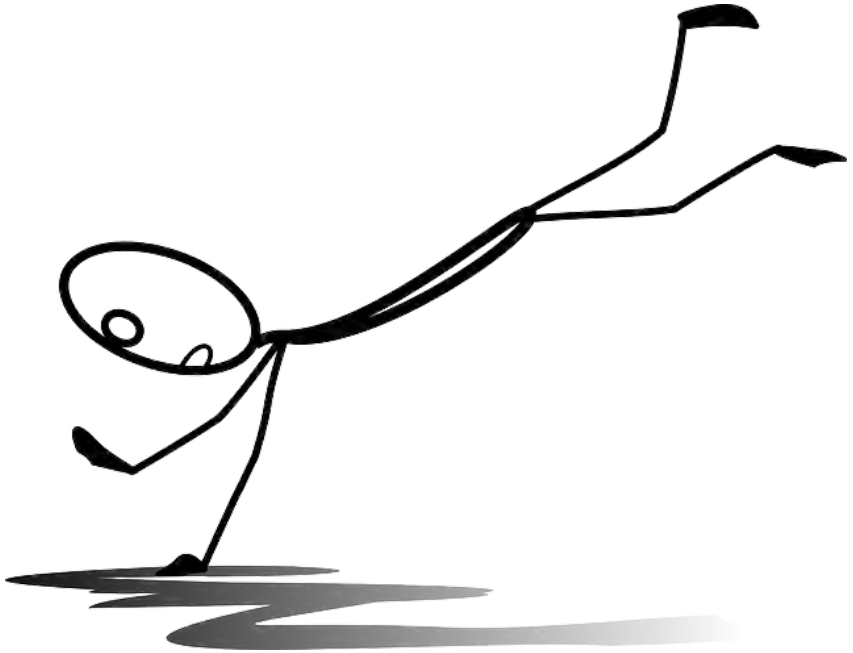
IIIA. INCIDENT REPORTS - WHAT ARE THE KEY CHANGES?

- Sentinel, Critical, Quality Incidents:

1. We have broken the incident reporting to Quality Assurance into three categories.
2. All participating providers (CCP's and County Clinics) must also have an internal policy regarding incidents.
3. We will now have Quality of Care Concern Committee.
4. Critical Incident Review Teams will meet when needed to review and determine any further actions that may be needed currently or for future similar occurrences.
5. The timing for incidents being submitted has changed.
6. Not all incidents are reported through a report, some are logged.

IIIA. QUALITY OF CARE CONCERN

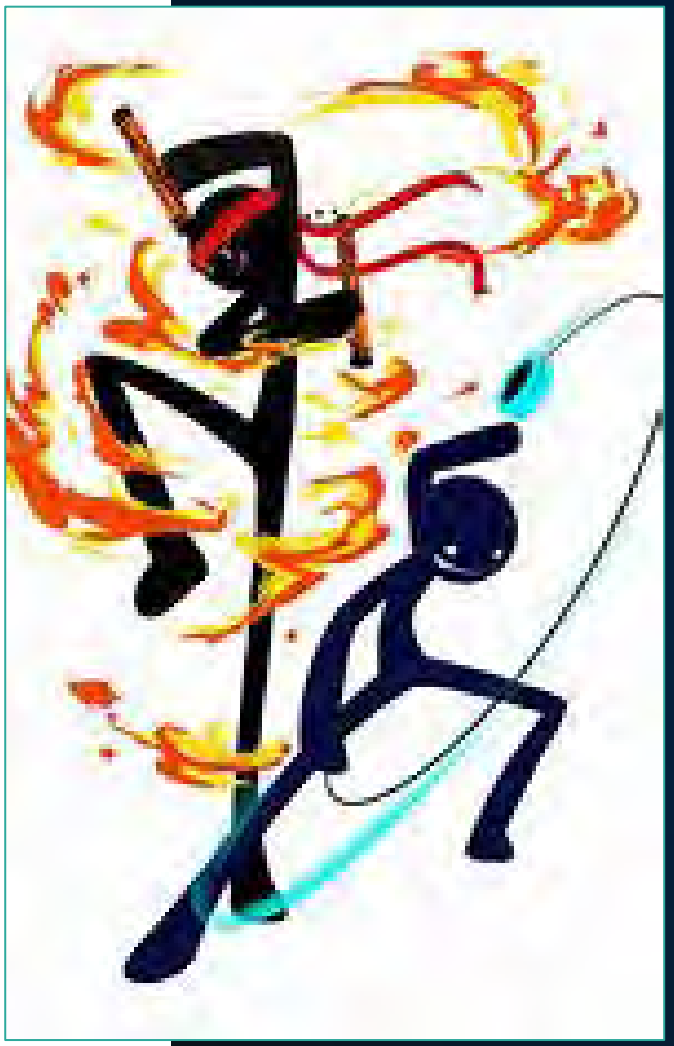
An event or condition that has had or may have an adverse effect on the health or safety of our program beneficiaries, guests, staff, or members of the general public.

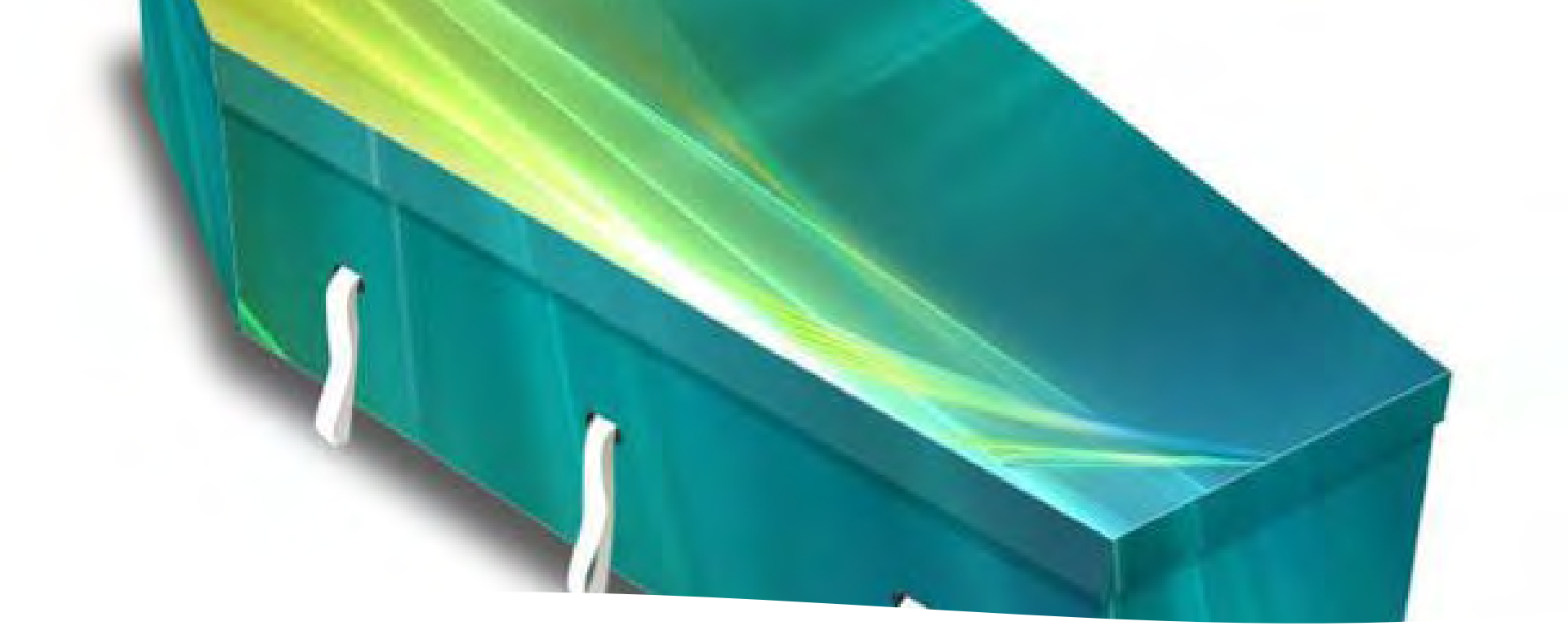


IIIA. CRITICAL INCIDENT

- May pose a threat to life, disrupt essential community routines or vital services, or may require resources to manage the incident.

- Examples of critical incidents include, but are not limited to, situations involving injury, accident, acute medical problem, aggression/violence, suicide attempt, unauthorized absences, natural death, inappropriate treatment, loss of medical record, medication issue, or facility damage.





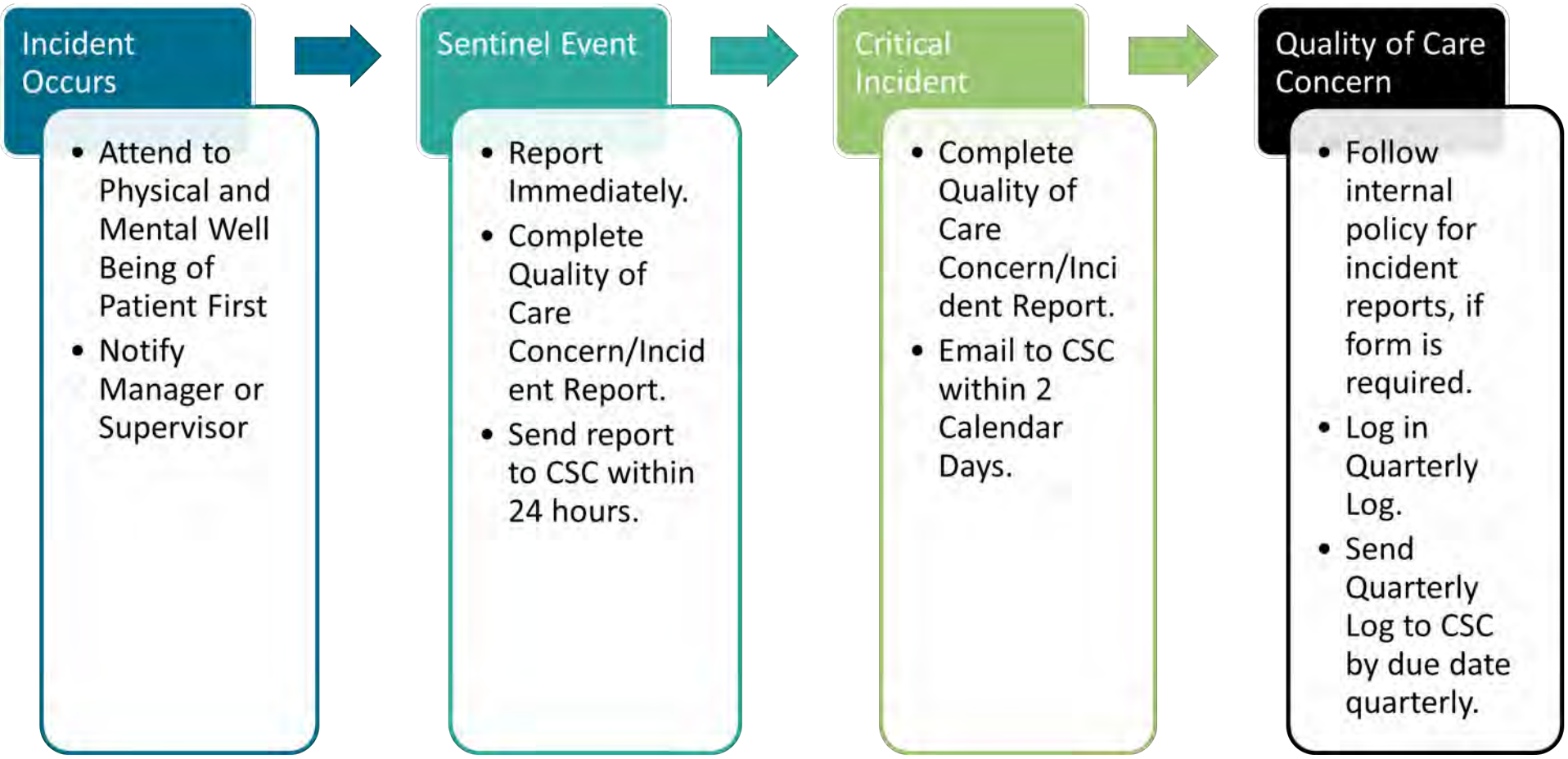
IIIA. SENTINEL EVENT

An unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof including those for which a recurrence would carry a significant risk of an adverse outcome, or which otherwise adversely affects the quality of service or operations of BHSD.

IIIA. INCIDENT REPORTS – WHAT CAN BE INCLUDED IN THE CATEGORIES?

Quality of Care Concern	Critical Incident	Sentinel Event
Mandatory abuse reporting	Violent or Suicidal Behavior Resulting in a psychiatric hold	Physical assault by a client or visitor on staff or other client requiring emergency medical intervention.
Suicidal Ideation	Verbally threatening behavior	Client Death
Pushing and cutting in line, causing yelling due to no security on weekends.	Physical assault on staff or other client no medical intervention	Suicide attempt requiring emergency medical intervention.
Baseline behavior that is repeated without risk.	Injury or accident that is a concern with no medical attention.	Medication issue involving emergency medical intervention.
Not following rules of program.	Unexcused absence from a 24-hour care facility.	Violation of professional code of conduct.
Stubbed toe, cut finger accidentally -band-aide needed.	Property damage by a client.	Sexual assault/misconduct involving client by staff or another client.
	Medication issue: timing, dosage, wrong meds not needing medical intervention.	Accident on site involving emergency intervention.

IIIC. WHAT HAPPENS WHEN AN INCIDENT OCCURS?



IIID. THE NEW FORM: 17E

Initial Update

COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

CONFIDENTIAL REPORT OF CONCERNS REGARDING QUALITY OF CARE (NOT PART OF MEDICAL RECORD)
All sections must be completed – Handwritten versions will not be accepted

Complete this form in full and give to your Manager/Director for review & signature, then fax a copy to the appropriate number below. All sections required to be completed prior to submission, including contacts and signature. ATTN: County of Santa Clara Behavioral Health Services Department

☐ Submit Form with use of Secure Email to QualityofCareConcern@hhs.sccgov.org

1. Client Information

a. Division:

b. ☐ County Clinic ☐ County Contracted Provider

c. Agency & Program Name:

d. Date of Report:

e. Date of Incident:

f. Avatar MRN:

g. Name of beneficiary/or person involved (Last, First MI) involved (Last, First MI):

h. Gender Identity: Choose an item.

b. DOB:

c. Primary Provider:

d. Assigned MD:

2. Account of Incident

a. Where (check all that apply): ☐ Clinic ☐Community/Home ☐ County Owned Property ☐ Residential Facility ☐ Other

b. Address of Incident:

c. Incident Type: *Please check the categories below that best describe the event. **Sentinel Events requiring a** report within 24 **hours are in bold/italic type**. All other reports are required within 7 days. Incident Type (check all that apply):*

Violent Behavior
- ☐ **Physical assault by a client on staff requiring emergency medical intervention**
- ☐ **Physical assault between clients requiring emergency medical intervention**
- ☐ **Homicide**
- ☐ Verbally or physically threatening behavior by a client (includes mandatory reports of threatened violence)
- ☐ Physical assault by a client on staff NOT requiring emergency medical intervention
- ☐ Physical assault between clients NOT requiring emergency medical intervention
- ☐ Damage to program property by client
- ☐ Violent behavior or thoughts resulting in a psychiatric hold
- ☐ Other violent behavior (e.g., visitors, witness community violence)

Sexual Assault/Misconduct (all considered sentinel)
- ☐ **Sexual assault/misconduct involving client by staff**
- ☐ **Sexual assault/misconduct involving client by another client**

Client Suicide Attempt
- ☐ **Requiring emergency medical intervention**
- ☐ NOT requiring emergency medical intervention, and serious

Medication Issue
- ☐ **Client required emergency care, hospitalization, or transfer to medical unit as a result of medication issue.**
- ☐ Client was administered the wrong medication
- ☐ Client was administered the wrong dose, causing problems but not requiring medical intervention
- ☐ Issue with the timeliness of obtaining or the administration of a client's medication

Page 1 SCCBHSD Quality of Care Concern Report 17e BHSD Policy #AGH003A

ACTIVITY: WHICH CATEGORY WOULD THIS LIST FIT IN?

- Verbally or physically threatening behavior by a client (includes mandatory reports of threatened violence)
- Physical assault by a client on staff NOT requiring emergency medical intervention.
- Physical assault between clients NOT requiring emergency medical intervention.
- Damage to program property by client
- Violent behavior or thoughts resulting in a psychiatric hold.
- Other violent behavior (e.g., visitors, witness community violence)
- Suicide Attempt NOT requiring emergency medical intervention.
- Client was administered the wrong medication.
- Client was administered the wrong dose.
- Issue with the timeliness of obtaining or the administration of a client's medication.
- Other medication-related issue
- Staff injury, accident, or acute medical problem NOT requiring emergency medical intervention.
- Client injury, accident, or acute medical problem NOT requiring emergency medical intervention.
- Unauthorized/Unexcused Client Absence from 24-hour Care Settings (AKA AWOL)
- Other

ACTIVITY: WHICH CATEGORY WOULD THIS LIST FIT IN?

- Physical assault by a client/visitor on staff requiring emergency medical intervention.
- Physical assault between clients/visitors requiring emergency medical intervention.
- Homicide
- Sexual assault/misconduct involving client by staff.
- Sexual assault/misconduct involving client by another client.
- Suicide Attempt: Requiring emergency medical intervention.
- Medication Issue: Client required emergency care, hospitalization, or transfer to medical unit because of medication issue.
- Violation of professional code of ethics or of any County of Santa Clara policy governing professional conduct
- Client Death: Expected medical problem, unexpected problem, accident/injury, overdose, suicide.
- Service Disruption: Damage to a facility resulting in service disruption or injury requiring emergency medical intervention.
- Service Disruption: An unusual occurrence such as human or natural phenomena and requires response actions to prevent or minimize loss of live, or damage to property and/or the environment.
- Accidents on-site requiring emergency medical intervention.
- Needlestick

QUARTERLY QUALITY OF CARE LOG

Headers for Excel Log
Date of Incident
Date Logged
Agency
Client First Name
Client Last Name
Avatar Number
Level of Care
Primary Provider
Location of Incident
Address of Incident
Incident Type
Issue
Specifics
Brief Description
Outcome
Manager Signature

Participating Providers will maintain and send a Quarterly **Quality of Care Log** that outlines information about all QOC events that happened during the quarter and will be sent by the 5th day of the month after the prior quarter to QualityofCareConcern@hhs.sccgov.org in a secure email

REMINDER: WHAT IS REPORTED TO THE COUNTY?

2. SENTINEL EVENT (24 HOURS):

Complete Critical Incident/Sentinel Event Report

- QualityofCareConcern@hhs.sccgov.org

2. CRITICAL INCIDENT (48 HOURS)

Complete Critical Incident/Sentinel Event Report

- QualityofCareConcern@hhs.sccgov.org

3. Quality of Care Concern:

Complete Quality of Care Log and email Quarterly

- QualityofCareConcern@hhs.sccgov.org

1. SECURITY BREACH:

HIPAA Breach, Notify Compliance Office

- Compliance_Officer@hhs.sccgov.org

2. COUNTY STAFF AND PROGRAMS

All major and/or media-sensitive events must be reported to County Counsel

- connect.sccgov.org/sites/policies/policypages/Pages/Incident-Notification.aspx
- https://connect.sccgov.org/sites/policies/FormsrelatedtoPolicies/Incident-Notification-Form.docx

BEGINNING OF FAQ:

1. Can we use our own form for incident reporting?:
    1. For Quality of Care reporting all providers will need to turn in the same log; however, if another form is required by your agency, then you may use that since those are not turned in. For all Critical Incidents and Sentinel Events it is expected you will use the County of Santa Clara form.

2. What if there is an overlap in which area the incident fits in?
    2. If there is an overlap, then the highest level of reporting would be the expected report. So if, for instance, there was an incident that fit into both Quality of Care and the Critical Incident category it would be reported as a Critical Incident.

3. Can we log all our reports in the Quality-of-Care Log, even if we have sent them into the county?
    3. The Quality-of-Care log is to track the incidents that are lower level and have not yet been reported If the provider wishes to also track the incidents reported than that would need to be done separately or on a separate tab.

4. Where can I direct my staff to find the form?
    4. Our website is in the process of being updated. For now, the forms can be found under our training handouts Handouts - Behavioral Health Services - County of Santa Clara (sccgov.org)

5. What if I fill out the form and send it in but it was really a Quality-of-Care Concern?
    5. You may get it sent back with a request to log in your Quality-of-Care Log.

6. Who can I email or call if I have more questions regarding the new process?
    6. Please email QualityofCareConcern@hhs.sccgov.org or call Quality Assurance at 408-793-5894.

7. When does this start?
    7. August 1.


Comments & Questions