Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Problem Resolution 02.02.02 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	9/8/17

SUBJECT: Beneficiary Problem Resolution and Grievance Process and Log Procedures in Outpatient County and Contracted Clinics and Inpatient Treatment Programs

PURPOSE:

To outline the process for responding to and resolving concerns and grievances of all consumers (and parent/guardian/conservator as appropriate) receiving services through Orange County's Behavioral Health Services (BHS) County operated and County Contracted clinics and Inpatient Treatment Programs.

POLICY:

It is the policy of BHS that at every step of these procedures, staff shall maintain the confidentiality of consumers, consistent with other policies related to State and Federal confidentiality and privacy regulations.

BHS County and County Contracted clinic and Inpatient Treatment Program staff shall strive for the resolution of concerns at the point of service whenever possible. A uniform documentation process shall be followed to track the number, type, and resolution of all grievances.

SCOPE:

These procedures apply to all consumers and parent/guardian/conservator receiving services within BHS County and County contracted clinics. This includes mental health and substance use treatment services and Inpatient mental health treatment programs, including but not limited to services funded by Drug Medi-Cal Organized Delivery System (DMC-ODS), Mental Health Plan, Substance Abuse and Mental Health Services Administration (SAMHSA), Tobacco Settlement Revenue (TSR) and county block grants. Students receiving educationally related services through an IEP shall route grievances through the IEP process. If the grievance is filed using the BHS grievance process, BHS staff will coordinate with Children, Youth Prevention Behavioral Health (CYPBH) Administration.

REFERENCES:

BHS P&P 02.02.03 Beneficiary Appeal of Actions Process

BHS P&P 02.06.02 Informing Materials for Behavioral Health Services Consumers and Intake/Advisement Checklist

FORMS:

Grievance and Appeal Form F346-706 DTP318

State Fair Hearing Request Form F346-742 DTP1115

Notification of Adverse Benefit Determination (NOA) Delay in Grievance/Appeal Processing

DEFINITIONS:

Adverse benefit determination:

(1) 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.

(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, as defined by the State.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Appeals - Appeals are defined as a request for a review of an "adverse benefit determination" (see above for definition of action). Appeals processes are outlined in the BHS Policy and Procedure 02.02.03 Beneficiary Appeal of Action Process.

Authority and Quality Improvement Services (AQIS) – Is an administrative unit providing oversight and coordination of quality improvement and compliance activities across the Divisions of BHS.

Days - Defined as calendar days unless otherwise specified.

Grievance - A consumer's expressed dissatisfaction about any matter, other than a matter covered by an Appeal, that is being dealt with within the procedures outlined herein. A consumer concern that the consumer wishes to deal with within the formal procedures is considered a grievance.

Notice of Adverse Benefit Determination (NOA)- Each contract must provide for the Plan to notify the requesting provider, and give the enrollee written notice of any decision by the Plan to deny or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

Patients' Rights Advocacy Services (PRAS) – A department within BHS with multiple responsibilities, including providing assistance, advice and advocacy services to consumers and their family members who have filed a grievance or requested a State Fair Hearing.

Participating Inpatient Health Plan (PIHP) – The State Department of Health Care Services (DHCS) has notified counties that the county MHPs and DMC-ODS are considered PIHPs for purposes of CFR, Title 42, Chapter IV, Section 438.

Provider Representative – The individual assigned at each clinic and treatment site to educate and assist consumers and family members with grievances. The Provider Representative is the person designated to provide information to the beneficiary about the status of a grievance upon request.

Working Day – A working day is defined as Monday through Friday, 8:00am-5:00pm, excluding County holidays.

PROCEDURES:

I. All BHS County-operated and County-contracted clinics and inpatient treatment programs shall have a mechanism for consumers and/or the parent/guardian/conservator to resolve grievances. Clinic staff shall inform consumers and/or the parent/guardian/conservator of their rights and assist them in problem resolution through the grievance process. A grievance may be filed at any time.

   A. Staff at all levels shall assist the beneficiaries in completing the forms and other procedural steps related to a grievance. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

   B. Grievance information shall be made available to consumers and/or parent/guardian/conservator without having to request it verbally or in writing, in all clinics and inpatient treatment programs, and placed in a conspicuous location for consumers.

   C. The consumer and/or parent/guardian/conservator shall be informed of their right to access PRAS at any time before, during or after the Grievance Process for information, assistance and representation.

   D. The consumer and/or parent/guardian/conservator may choose an authorized Representative to act on his/her behalf. This person can be a family member, significant other or other person of his/her choice. The consumer's legal Representative may use the grievance process on the beneficiary's behalf. The

consumer and/or parent/guardian/conservator shall provide written confirmation of the authorization of a representative by completion of an Authorization to Use and Disclose Protected Health Information to that representative which documents that it is for the purpose of acting as the representative for the grievance process.

E. No consumer or parent/guardian/conservator shall be subject to discrimination or any other penalty for filing a grievance.

II. A consumer or parent/guardian/conservator may request assistance with a grievance from PRAS at any point in the process. The Patients' Rights Advocate, upon the consumer's or parent/guardian/conservator's request, shall provide information and assistance regarding legal rights and may represent the consumer through the grievance process.

III. Grievance Process–Outpatient Clinic and Inpatient Treatment Program Responsibilities:

A. Consumer concerns may be brought to the attention of BHS in several different ways, in accord with current regulations. A consumer or parent/guardian/ conservator is encouraged to first direct concerns to the appropriate Plan Coordinator, therapist, outpatient clinic Service Chief, Program Director, Inpatient Program Director or Provider Representative, but may use the grievance process whether or not these steps have been taken.

B. Staff are to make all reasonable efforts to address the concerns at the local level to the satisfaction of the consumer.

1. Regardless of the outcome of the attempts to resolve the concern, the treatment staff shall ask the consumer if he/she wishes to have the concern addressed as a grievance and shall inform the consumer of the process for filing a grievance, including the location of grievance materials that are available in each service site without verbal or written request to anyone. The staff shall also offer the consumer assistance in filing the grievance if the consumer so desires. If the consumer indicates a desire to file a grievance without completing any paperwork, the staff shall complete the Grievance or Appeal form, putting that staff person's identifying information on the form in the section asking for identification of those filling out the form if they are not the consumer. The treating clinician shall not be the staff person who assists with completion of the grievance form, unless requested by the consumer. The staff person completing the form shall send it to AQIS on day of the consumer's indication that he/she wishes to file a grievance.

IV. The Service Chief, Program Director or Inpatient Program Director shall ensure that the following materials are located in a conspicuous location in the clinic or inpatient unit. Materials shall be in English and in all of the threshold languages. The location of the materials shall be such that the consumer does not have to make a verbal or written request to anyone for the materials:

A. Grievance or Appeal form (which includes the phone number for filing a grievance verbally).

B. Pre-addressed envelopes for submitting the form.

C. Consumer Grievance and Appeal Process poster.

V. Grievance Process – Authority and Quality Improvement Services (AQIS) Responsibilities when received by phone, mail, or fax:

A. Grievances may reach AQIS in any of 3 primary ways:

1. A consumer may mail in a Grievance or Appeal Form.

2. A consumer may phone in a grievance.

3. A clinic may send in a Grievance or Appeal Form.

B. AQIS Grievance Representative shall complete and mail a Grievance Acknowledgement Letter to the consumer within 24 hours from the time the grievance is received.

C. The consumer shall be notified of the opportunity to provide, in person or in writing, evidence and testimony and to make legal and factual arguments and of the limited time available to do this.

D. AQIS Grievance Representative shall log receipt of the grievance on the day it is received. All sections of the grievance log shall be completed with the exception of the resolution section.

E. AQIS Grievance Representative will give the form and/or letter along with the acknowledgment letter to the designated AQIS Office Support staff.

F. Designated AQIS Office Support staff will scan the grievance form and/or letter along with the acknowledgment letter into the appropriate folder.

G. Designated AQIS Office Support will notify the designated investigating Representative by emailing the link where the grievance is located and placing a copy of the email in the consumer's electronic grievance file.

H. Grievances will be investigated by either the AQIS Adult and Older Adult Behavioral Health (AOABH) Representative, AQIS Children, Youth, and Prevention Behavioral Health (CYPBH) Representative, AQIS Substance Use Disorder (SUD) Representative or AQIS Patients' Rights Advocacy Services (PRAS) Advocate. The AQIS Representative and AQIS PRAS Advocate will have the appropriate and clinical expertise to treat the consumer's condition and in addition shall not have been involved in any previous level of review or decision-

making, and shall not be the subordinate of any individual who was involved in a previous level of review or decision making.

VI. AQIS AOABH/CYPBH/SUD Representative or AQIS PRAS Advocate will research the grievance and prepare the decision and/or action on the grievance. Within the parameters of confidentiality, all relevant information, resources and involvement of others shall be utilized to resolve the grievance within 90 days, unless the consumer or parent/guardian/conservator requests additional time or agrees to a continuance. Decision makers on grievances shall take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. If the consumer requests an extension, or if the AQIS AOABH/CYPBH/SUD Representative or AQIS PRAS Advocate determine that there is a need for additional information and that the delay is in the consumer's interest, this timeframe may be extended by up to 14 calendar days.

A. If the AQIS Representative or PRAS Advocate extends the timeframe, the beneficiary shall be given prompt oral notice and written notice of the extension and the reasons for the extension within 2 calendar days of the decision to extend.

VII. AQIS AOABH/CYPBH/SUD Representative or AQIS PRAS Advocate shall create a resolution letter for the client within 90 days of receiving the grievance information from AQIS Grievance Representative (or within 104 days if an extension has been invoked as described above). If the grievance has not been resolved within the specified timeframe, and if the consumer is a Medi-Cal beneficiary, then AQIS AOABH/CYPBH/SUD Representative or AQIS PRAS Advocate shall provide a Notice of Adverse Benefit Determination-Delay (NOA-D) to the consumer and shall make reasonable efforts to give the beneficiary prompt oral notice of the delay. This will advise the consumer of the right to request a fair hearing. The NOA-D shall be provided on the date that the timeframe expires.

VIII. A signed resolution letter will be hand carried by AQIS AOABH/CYPBH/SUD Representative or AQIS PRAS Office Support to the designated AQIS Office Support.

IX. Upon receipt of resolution letter from the AQIS AOABH/CYPBH/SUD Representative or AQIS PRAS Office Support, the designated AQIS Office Support will scan and e-file letter into grievance folder.

X. Original resolution letter will be mailed via Delivery Confirmation to the consumer and designated parties, including any provider identified by the beneficiary in the grievance, by the designated AQIS Office Support. The designated AQIS Office Support staff will:

A. Scan and e-file a copy of the Delivery Confirmation into the designated grievance folder.

B. Upon verification of delivery, e-file a copy of the Delivery Confirmation status into the designated grievance folder.

C. If there is no address for the consumer, the e-filed letter will remain stored in the designated grievance folder.