Kern County Mental Health Plan (MHP)
Plan of Correction

Department of Health Care Services (DHCS) Onsite Review 2016

ITEM NO. 1b:

1. Regarding the Treatment Authorization Requests (TARS) for hospital services:

   1b. Are all adverse decisions regarding hospital requests for payment authorization that were based on criteria for medical necessity or emergency admission being reviewed and approved in accordance with title 9 regulations by:

   1) a physician, or
   2) at the discretion of the Mental Health Plan (MHP), by a psychologist for patients admitted by a psychologist and who received services under the psychologists scope of practice?

FINDING:

The TAR sample included 17 TARs which were denied based on criteria for medical necessity or emergency admission. Two of the TARS reviewed by DHCS did not include evidence that adverse decisions based on criteria for medical necessity or emergency admission were reviewed and approved by a physician (or by a psychologist, per regulations). Protocol question 81b is deemed in partial compliance.

	PROTOCOL REQUIREMENT	# TARS IN COMPLIANCE	# TARS OCC	COMPLIANCE PERCENTAGE
1b	Adverse decisions based on criteria for medical necessity or emergency admission approved by a physician (or psychologist, per regulations)	15	2	88%

PLAN OF CORRECTION:

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services.

PLAN OF ACTION:

Authorizations team was not sending TARs denied due to excluded diagnosis for Physician Advisor (PA) Review, resulting in two TARs reviewed being in non-compliance with DHCS standards. Upon feedback provided, the Authorizations team will immediately correct use of PA review, ensuring all TARs suspected of not meeting requirements for medical necessity are reviewed by the Physician Advisor.

Training:

1) Enhanced training is provided to all LPHA's completing PA review to educate LPHAs on documentation requirements for medical necessity at the time of initiating TAR review. Training will include reference that any and all TARs suspected of not meeting documentation criteria for medical necessity, for any reason, will be subject to review, and potential denial by PA review.

Procedure:

All TARs suspected of not meeting documentation criteria will be reviewed and denied by a PA.

UR / Ongoing Monitoring:

1) Internal monitoring is completed 100% by the Authorizations supervisor and Authorizations support staff to ensure all TARS meet compliance criteria prior to being sent to Medi-Cal. UR of this process is completed through the TAR tracking log which records all TARS that have denials have been reviewed by the PA.
2) External oversight and monitoring is provided to the Authorizations Team by the Quality Improvement Compliance Team annually. QID compliance team will review both TARs approved and TARs denied to ensure all TARs denied are being completed by a Physician Advisor.

Training:

1) Revised training for LPHA and PA that addresses and emphasizes that all denials based on DHCS regulations must be reviewed by PA.

Timeline for Action:

1) Upon feedback from DHCS, the Authorizations team immediately proceeded with ensuring all TARs denied are reviewed and denied by the PA.
2) Training regarding PA review was completed in November 2016.

Documentation to be submitted:

1) TAR database demonstrating denials going through PA review.
2) Example TARs denied via PA corresponding to TARS documented on the database.
3) Training sign off sheet from PA review requirements.

Progress on actions (if any) implemented to date:

Training has been completed. Full documentation demonstrating all denied TARS are reviewed by PA will be provided at the end of January 2017.

ITEM NO.3A:

3. Regarding payment authorization for Day Treatment Intensive and Day Rehabilitation Services:

3a. The MHP requires providers to request advance payment authorization for Day Treatment Authorization and Day Rehabilitation in accordance with MHP Contract.

1) In advance of service delivery when services will be provided for more than 5 days per week.
2) At least every 3 months for continuation of Day Treatment Intensive.
3) At least every 6 months for continuation of Day Rehabilitation.
4) The MHP requires providers to request authorization for mental health services provided concurrently with day treatment intensive and day rehabilitation, excluding services to treat emergency and urgent conditions.

FINDING:

The MHP did not furnish evidence it requires providers to request advance payment authorization for Day Treatment Authorization (DTI) and Day Rehabilitation (DR). DHCS reviewed the MHP's authorization policy and procedure: 5.1.19 Treatment Authorization Requests. In addition, DHCS inspected a sample of 15 authorizations for DTI and DR to verify compliance with regulatory requirements.

PROTOCOL REQUIREMENT		# IN COMPLIANCE	# OCC	COMPLIANCE PERCENTAGE
3a	1) Approved in advance of service delivery when services will be provided for more than 5 days per week.	15	3	80%
	2) Approved at least every 3 months for continuation of Day Treatment Intensive	15	0	100%
	3) Approved at least every 6 months for continuation of Day Rehabilitation	15	0	100%

Protocol question 3a1 is deemed in partial compliance.

PLAN OF CORRECTION:

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it requires providers to request advance payment authorization for DTI and DR.

PLAN OF ACTION:

The department will provide enhanced monitoring to ensure staff and contractors follow the department standard for approving Day Treatment Intensive/Day Rehabilitation Service Authorization Requests in advance when services will be provided for more than 5 days per week as outlined in policy 5.4.4 *"EPSDT Supplemental Specialty Mental Health Services-Day Rehabilitation/Day Treatment Intensive."* Additionally, the inclusion of specific language in any future contracts for Day Treatment Intensive/Day Rehabilitation services will outline obtaining advance approval for services when being provided more than 5 days per week.

Training:

Children's System of Care (CSOC) staff will review policy 5.4.4 *"EPSDT Supplemental Specialty Mental Health Services-Day Rehabilitation/Day Treatment Intensive."* when a SAR is received for any Day Treatment Intensive/Day Rehabilitation service being requested.

Procedure:

When the department receives a Service Authorization Request for Day Treatment Intensive/Day Rehabilitation services verification of amount of days to be provided will be reviewed. This process was a specific concern for one day-treatment provider and now that the requirement has been identified, ensuring this process is followed as required is being enacted by staff providing the authorization. If more than 5 days of service is requested the CSOC Administrator will ensure that the signature date and the SAR start date are the same.

UR / Ongoing Monitoring:

Children's System of Care Administration will monitor that each SAR received is approved according to department policy 5.4.4 *"EPSDT Supplemental Specialty Mental Health Services-Day Rehabilitation/Day Treatment Intensive."* Service Authorization Requests will be reviewed on an annual basis when the Quality Improvement Division completes their annual chart reviews. Ongoing quality assurance review of SARS has not been implemented previously and will be incorporated into quality assurance reviews completed by the QID team. If any services are found that have not received prior authorization, a Plan of Correction will be required.

Timeline for Action:

We are no longer in contract with the provider that was reviewed during this annual review and they are also no longer providing Day Treatment Intensive services. When a child is approved for placement at a level 13/14 group home the department will ensure that the SAR is approved according to department policy 5.4.4 at that time.

A review of the current policy 5.4.4 "*EPSDT Supplemental Specialty Mental Health Services-Day Rehabilitation/Day Treatment Intensive"* has been completed by all staff who review SARS.

Documentation to be submitted:

Policy 5.4.4 Policy 5.4.4 *"EPSDT Supplemental Specialty Mental Health Services-Day Rehabilitation/Day Treatment Intensive."*

Progress on actions (if any) implemented to date:

Children's System of Care Administration has reviewed the department policy on Day Treatment Intensive/Day Rehabilitation services and QID will review Day Treatment Intensive/Day Rehabilitation providers in the Spring of 2017. If new providers are implemented, they will be provided information regarding the requirements of SARS submission and the authorization of these services.

ITEM NO.5a:
5a. Regarding Notices of Action (NOAs):

1) NOA-A: Is the MHP providing a written NOA-A to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible to any SMHS?

FINDING:
The MHP did not furnish evidence it provides a written NOA-A to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible ~~to~~ for any SMHS. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: A sample of NOA-As sent to beneficiaries in January 2016 and the MHP's tracking mechanism. It was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements.

Specifically, DHCS identified one beneficiary on the MHP's list who received an assessment in January 2016, which resulted in a determination that the beneficiary did not meet medical necessity criteria. However, there was no record the MHP sent the beneficiary the required NOA-A.

PLAN OF CORRECTION:
The MHP must submit a POC addressing the POC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a written NOA-A to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible to any SMHS.

PLAN OF ACTION:
The department will provide enhanced training and monitoring to ensure staff follow documentation requirements as outlined in policy 10.1.9 *"Notice of Action."* Additional review will be conducted by individual teams, through the Care Coordination Unit and via QID to ensure all beneficiaries who do not meet requirements for specialty mental health services are provided a NOA-A at the conclusion of their encounter.

An additional element will be added to the existing screening, assessment and re-assessment documents that require staff to document if the client served was provided with an NOA-A. This will allow ongoing reporting of the NOA-As completed by all teams at the conclusion of an assessment.

Training:

1) Annual review of Notice of Action Policy is provided throughout the department to all intake teams completing initial mental health assessments.
2) A Documentation Update Training curriculum will be developed to include the requirements for NOA-As, outlining circumstances in which NOA-As are to be provided.
3) Additional training will be asked from all intake service teams to ensure they review policy 10.1.9 to ensure all staff are currently informed of NOA-A requirements.
4) Integration of the new element documenting the provision of a NOA-A on the screening, assessment and re-assessment forms will be integrated into the annual Assessment / Re-assessment training.

UR / Ongoing Monitoring:

1) NOA-As are tracked individually on a team basis through the chart audit review completed by every team supervisor.
2) Additional monitoring and oversight is completed by the Care Coordination Unit. CCU staff review all cases closed throughout intake teams on a monthly basis and review the electronic medical record to ensure NOA-As were provided to all beneficiaries who do not meet criteria for specialty mental health services. CCU staff prompt team supervisors to complete missing NOA-As when it is identified that they were required and not completed.
3) QID will monitor for NOA-A completion by submitting a quarterly report to the QIC and team Administrators regarding the percentage of NOA-As given when a mental health assessment determines that the client no longer meets medical necessity. Information regarding the necessity of the NOA-As provided at screening, assessment and re-assessment would be obtained by running reports in the electronic medical record based on the check box that will be integrated into these forms.

Timeline for Action:

1) The curriculum for the Documentation Update Training will be developed and ready to present to staff in February 2017.
2) Document review tools will undergo review and revision by the end of January 2017.
3) Updates to the screening, assessment and re-assessment forms will be completed by January 2017.

Documentation to be submitted:

1) NOA-A tracking log will be submitted to outline all beneficiaries who did not meet criteria but who required NOA-A.
2) Documentation Update Training sign-in sheet will be provided at the conclusion of this training.

Progress on actions (if any) implemented to date:

None to date.

Section K. "Chart Review – Non-Hospital Services"

ITEM NO. 1c-2:
Medical Necessity
1c-2. Do the proposed and actual intervention(s) meet the intervention criteria listed below:

2) The expectation that the proposed intervention(s) will do at least one (1) of the following (A, B, C, D):
   A. Significantly diminish the impairment
   B. Prevent significant deterioration in an important area of life functioning
   C. Allow the child to progress developmentally as individually appropriate
   D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition

FINDING:
The medical record associated with the following Line numbers did not meet the medical necessity criteria since there was no expectation that the documented intervention would meet the intervention criteria as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(B)(1-4).

- [1], refer to Recoupment Summary for details

PLAN OF CORRECTION:
The MHP shall submit a POC that indicates how the MHP will ensure that the interventions provided meet the intervention criteria specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(8)(1-4).

PLAN OF ACTION:
The department will provide enhanced training and monitoring to ensure staff follow documentation requirements as outlined in policy 5.1.21 *"Progress Note Documentation Standards"* will be covered by the QID department.

Progress notes that fail to establish how the intervention clearly addresses the expectation that symptoms/impairments will be improved by the intervention will be disallowed.

Training:

1) Updates will be made to the existing progress note documentation training that is offered to all staff that will emphasize the medical necessity requirements for an intervention.
2) A Documentation Update Training curriculum will be developed to include the medical necessity requirement for a service intervention and presented to all teams that provide specialty mental health services.

UR / Ongoing Monitoring:

1) Progress note interventions will be reviewed on a monthly basis through the team-based Quality Assurance (QA) Reviews completed by team supervisors or designee.
2) Quarterly reports of team compliance with these monthly reviews will be provided to the Management Team to assure 100% compliance with conducting these reviews.

[1] Line number(s) removed for confidentiality

3) Progress note interventions are also reviewed in the annual chart reviews of all performed by the Quality Improvement Division. When a progress note does not demonstrate that the proposed intervention fulfills the above requirements, the service will be disallowed and a POC will be required if that team obtains a disallowance rate above 5%.

Timeline for Action:

1) The curriculum for the Documentation Update Training will be developed and ready to present to staff in February 2017.
2) Document review tools will undergo review and revision by the end of January 2017.

Documentation to be submitted:

1) Kern County Policy 11.1.4 *"Quality Assurance Team Reviews"*
2) Quality Assurance (QA) Review Tools
3) Progress Note Audit Tool
4) Documentation Update Training curriculum
5) Training Sign-in Sheets for item 3 above
6) Curriculum from progress note documentation training that emphasizes the medical necessity requirements
7) Revised Policy 5.1.21 "Progress Note Documentation Standards" which will be updated to include medical necessity requirements.

Progress on actions (if any) implemented to date:

None to date.

ITEM NO. 2a:
Assessment
2a. Regarding the Assessment, are the following conditions met:

1) Has the Assessment been completed in accordance with the MHP's established written documentation standards for timeliness?
2) Has the Assessment been completed in accordance with the MHP's established written documentation standards for frequency?

FINDING:
Assessments were not completed in accordance with regulatory and contractual requirements, specifically:

1) One or more assessments were not completed within the timeliness and frequency requirements specified in the MHP's written documentation standards. The following are specific findings from the chart sample:
    - [2]: There was no updated assessment found in the medical record. *During the review, MHP staff were given the opportunity to locate the missing assessment but could not locate the document in the medical record.*
    - [3]: The updated assessment was completed late.

PLAN OF CORRECTION:
The MHP shall submit a POC that:

1) Indicates how the MHP will ensure that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.

PLAN OF ACTION:
The department will provide training and monitoring via the monthly supervisory audit review and by ongoing QID reviews to ensure staff follow the timeliness standard for completing annual reassessments as outlined in policy 5.1.15 *"Mental Health Assessment and Re-Assessment: Determination of Medical Necessity and Treatment Needs for Recovery"*. A mental health reassessment is required within 365 days of the date the LPHA signed the prior assessment/reassessment.

Training:

1) The department will implement an annual assessment / reassessment training for staff. Training will be offered to all staff on an ongoing basis, a minimum of once per year.
2) Reassessment documentation requirements will be added to the ongoing monthly Treatment Plan training curriculum.
    - The curriculum will emphasize timeliness requirements as well as the expectation that the Treatment Plan will be developed based on the ongoing medical necessity from the annual reassessment.

[2] Line number(s) removed for confidentiality
[3] Line number(s) removed for confidentiality

- Expectations will be set forth via training to staff outlining the timeframes for treatment plans to be completed at the conclusion of the initial assessment or annually with the completion of the annual re-assessment. Dates for treatment plans are monitored by supervisors and reported on regularly to staff, including the expectation that the re-assessments are completed at the same time as the treatment plan update. This will ensure that the assessment is updated a minimum of annually.

3) A Documentation Update Training curriculum will be developed to include reassessment timeliness standards and presented to all teams that provide specialty mental health services.

UR / Ongoing Monitoring:

1) Timeliness will be monitored on a monthly basis through the team-based Quality Assurance (QA) Reviews.
2) Quarterly reports of team compliance with these monthly reviews will be provided to the Management Team.
3) Timeliness is also monitored in the annual chart reviews of all performed by the Quality Improvement Division.

Timeline for Action:

1) The annual assessment / reassessment training for staff will be ready to implement in February 2017.
2) The reassessment documentation requirements will be added to the Treatment Plan training curriculum by the end of December 2016.
3) The curriculum for the Documentation Update Training will be developed and ready to present to staff in February 2017.
4) Document review tools will undergo review and revision by the end of January 2017.

Documentation to be submitted:

1) Kern County Policy 11.1. 4 *"Quality Assurance Team Reviews"*
2) Quality Assurance (QA) Review Tools
3) Electronic Health Record Review Tool
4) Treatment Plan training curriculum that includes the addition of reassessment standards
5) Assessment/Reassessment training curriculum
6) Documentation Update Training curriculum
7) Training Sign-in Sheets for items 4 and 5 above

Progress on actions (if any) implemented to date:

None to date.

ITEM NO.2b:
Assessment
2b: Do the Assessments include the areas specified in the MHP Contract with the Department?

1) Presenting Problem. The beneficiary's chief complaint, history of presenting problem(s) including current level of functioning, relevant family history and current family information;
2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health including, as applicable; living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
3) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data such as previous mental health records and relevant psychological testing or consultation reports;
4) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports
5) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment must include documentation of the absence or presence of allergies or adverse reactions to medications and documentation of an informed consent for medications;
6) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs;
7) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
8) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;
9) A mental status examination;
10) A Complete Diagnosis; A diagnosis from the current ICD-code must be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; including any current medical diagnoses.

FINDING:
One or more of the assessments reviewed did not include all of the elements specified in the MHP Contract with the Department. The following required elements were incomplete or missing:

1) Relevant conditions and psychosocial factors affecting the beneficiary's physical health and mental health: [4].
2) Mental Health History:[5].
3) Medical History: [6].
4) Medications: [7].

[4] Line number(s) removed for confidentiality
[5] Line number(s) removed for confidentiality
[6] Line number(s) removed for confidentiality
[7] Line number(s) removed for confidentiality

5) Substance Exposure/Substance Use: [8].
6) Client Strengths: [9].
7) Risks: [10].
8) A mental status examination: [11].

PLAN OF CORRECTION:
The MHP shall submit a POC that indicates how the MHP will ensure that every assessment contains all of the required elements specified in the MHP Contract with the Department.

PLAN OF ACTION:
Previous (current) version of the re-assessment document does not explicitly prompt staff to complete all required documentation requirements. The department will review and update the re-assessment form to ensure that all required elements are prompted for documentation. Training regarding the new documentation standards will be provided to staff to increase understanding of the requirements and compliance with documentation standards.

Training:

1) The department will implement an annual assessment / reassessment training for staff.
2) Reassessment documentation requirements will be added to the ongoing monthly Treatment Plan training curriculum. The curriculum will emphasize that all areas of the form must be addressed.
3) A Documentation Update Training curriculum will be developed to include reassessment documentation requirements and presented to all teams that provide specialty mental health services.

UR / Ongoing Monitoring:

1) Reassessments will be monitored on a monthly basis through the team-based Quality Assurance (QA) Reviews.
2) Quarterly reports of team compliance with these monthly reviews will be provided to the Management Team.
3) Reassessments are also monitored in the annual chart reviews of all performed by the Quality Improvement Division.

Timeline for Action:

1) The reassessment form will undergo review and revision by the end of January 2017.
2) The annual assessment / reassessment training for staff will be ready to implement in February 2017.
3) The reassessment documentation requirements will be added to the Treatment Plan training curriculum by the end of January 2017.
4) The curriculum for the Documentation Update Training will be developed and ready to present to staff in February 2017.

[8] Line number(s) removed for confidentiality
[9] Line number(s) removed for confidentiality
[10] Line number(s) removed for confidentiality
[11] Line number(s) removed for confidentiality

5) Document review tools will undergo review and revision by the end of January 2017.

Documentation to be submitted:

1) Kern County Policy 11.1. 4 *"Quality Assurance Team Reviews"*
2) Quality Assurance (QA) Review Tools
3) Electronic Health Record Review Tool
4) Updated version of Re-Assessment template that includes or prompts required elements.
5) Treatment Plan training curriculum that includes the addition of reassessment standards
6) Assessment/Reassessment training curriculum
7) Documentation Update Training curriculum
8) Training Sign-in Sheets for items 4 and 5 above

Progress on actions (if any) implemented to date:

None to date

ITEM NO.3b:

Medication Consent

3b: Does the medication consent for psychiatric medications include he following required elements:

1) The reasons for taking such medications?
2) Reasonable alternative treatments available, if any?
3) Type of medication?
4) Range of frequency (of administration)?
5) Dosage?
6) Method of administration?
7) Duration of taking the medication?
8) Probable side effects?
9) Possible side effects if taken longer than 3 months?
10) Consent once given may be withdrawn at any time?

FINDING:

Written medication consents did not contain all of the required elements specified in the MHP Contract with the Department. The following required elements were not documented on the medication consent forms found in the beneficiary's medical record:

1) Reasonable alternative treatments available, if any:[12].
2) Range of frequency:[13].
3) Dosage:[14].
4) Method of administration (oral or injection):[15].
5) Duration of taking each medication:[16].
6) Possible side effects if taken longer than 3 months:[17].
7) Consent once given may be withdrawn at any time:[18].

PLAN OF CORRECTION:

The MHP shall submit a POC that indicates how the MHP will ensure every medication consent includes documentation of all of the required elements specified in the MHP Contract with the Department.

PLAN OF ACTION:

The department had already updated and implemented all medication consent forms in August 2015, which occurred after the DHCS chart review period of January – March 2015. After thorough review of the consent forms, there are two required elements that still need to be addressed. The two elements are:

1) The “duration of taking the medication”
2) “Possible side effects if taken longer than 3 months”.

[12] Line number(s) removed for confidentiality
[13] Line number(s) removed for confidentiality
[14] Line number(s) removed for confidentiality
[15] Line number(s) removed for confidentiality
[16] Line number(s) removed for confidentiality
[17] Line number(s) removed for confidentiality
[18] Line number(s) removed for confidentiality

QID will work collaboratively with Medical Services and Cerner support to bring all consents into compliance.

Training:

1) Medical Services will review the updated medication consent forms with medical staff to emphasize that all items on the forms must be completed.
2) Medical staff will also be trained that they must complete updated consent forms and obtain new physician and client/guardian signatures at the frequency specified for the “duration of taking the medication” on each consent.

Procedure:

1) Medication consent forms will be filled out completely and signed by the physician and client/guardian for all medications being prescribed.
2) Consent forms will be updated with new physician and client/guardian signatures at the frequency specified for the “duration of taking the medication” on every document.

UR / Ongoing Monitoring:

1) Medication consent forms will be reviewed on a monthly basis through the team-based Quality Assurance (QA) Reviews. Quarterly reports of team compliance with these monthly reviews will be provided to the Management Team.
2) Medication consent forms are also reviewed in the annual chart reviews of all performed by the Quality Improvement Division. The review will include making sure there is a consent present for all medications being prescribed and that they are being updated based on the frequency specified for the “duration of taking the medication” on each consent.

Timeline for Action:

1) Medication consent forms will be brought into compliance by February-March 2017.
2) Document review tools will undergo review and revision by the end of January 2017.

Documentation to be submitted:

1) Updated medication consent forms
2) Kern County Policy 11.1. 4 “Quality Assurance Team Reviews”
3) Quality Assurance (QA) Review Tools
4) Electronic Health Record Review Tool

Progress on actions (if any) implemented to date:

None to date.

ITEM NO.4a-2:
Client Plans
4a-2: Has the client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition?

FINDING:
The client plan was not updated at least annually or when there was a significant change in the beneficiary's condition (as required in the MHP Contract with the Department and/or as specified in the MHP's documentation standards):

- [19]: There was a lapse between the prior and current client plans. However, this occurred outside of the audit review period.
  The MHP should review all services identified during the audit that were claimed outside of the audit review period for which no client plan was in effect and disallow those claims as required.

PLAN OF CORRECTION:
The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that client plans are completed at least on an annual basis as required in the MHP Contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards.
2) Provide evidence that all services identified during the audit that were claimed outside of the audit review period for which no client plan was in effect are disallowed.

PLAN OF ACTION:
The department will provide enhanced training and monitoring to ensure staff follow the timeliness standard for completing annual client plans as outlined in policy 5.1.0 *"Treatment Planning for Mental Health Services."* A treatment plan is required within 365 days of the date the LPHA signed the prior plan. QID will review services to determine if services were claimed during the time there was no plan in effect.

Training:

1) Treatment Plan training will emphasize the timeliness standards for completion of annual treatment plans.
2) A Documentation Update Training curriculum will be developed to include treatment plan timeliness standards and presented to all teams that provide specialty mental health services.

UR / Ongoing Monitoring:

1) Treatment Plans will be monitored on a monthly basis through the team-based Quality Assurance (QA) Reviews.
2) Quarterly reports of team compliance with these monthly reviews will be provided to the Management Team.

[19] Line number(s) removed for confidentiality

3) Treatment Plans are also monitored in the annual chart reviews of all performed by the Quality Improvement Division.

Timeline for Action:

1) The curriculum for the Documentation Update Training will be developed and ready to present to staff in February 2017.
2) Document review tools will undergo review and revision by the end of January 2017.
3) QID to review services provided during the time there was no plan in effect and submit disallowances for services that were claimed to Medi-Cal. This review will be completed by the end of January 2017.

Documentation to be submitted:

1) Kern County Policy 11.1. 4 “Quality Assurance Team Reviews”
2) Quality Assurance (QA) Review Tools
3) Electronic Health Record Review Tool
4) Evidence that services were reviewed and disallowed (if necessary)
5) Treatment Plan training curriculum that emphasizes the timeliness standards for annual plans
6) Documentation Update Training curriculum
7) Training Sign-in Sheets for item 4 above

Progress on actions (if any) implemented to date:

None to date.

ITEM NO.4b:
Client Plans
4b. Does the client plan include the items specified in the MHP Contract with the Department?

1) Specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.
2) The proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.
3) The proposed frequency of intervention(s)
4) The proposed duration of intervention(s).
5) Interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance.
6) Interventions are consistent with client plan goal(s)/treatment objective(s).
7) Be consistent with the qualifying diagnosis.

FINDING:
The following Line numbers had client plans that did not include all of the items specified in the MHP Contract with the Department:

1) 4b-1. One or more of the goals/treatment objectives were not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments as a result of the mental health diagnosis.[20].
2) 4b-2. One or more of the propose interventions did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded on the client plan (e.g. "Medication Support Services", "Targeted Case Management", "Mental Health Services", etc). [21]
3) 4b-3. One or more of the propose interventions did not indicate an expected frequency.[22].
4) 4b-6. One or more of the propose interventions were not consistent with client plan goals/treatment objectives. [23].

PLAN OF CORRECTION:

The MHP shall submit a POC that indicates how the MHP will ensure that:

1) All client plan goals/treatment objectives are specific, observable and/or quantifiable and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis.
2) All mental health interventions/modalities proposed on client plans include a detailed description of the interventions to be provided and do not just identify a type or modality of service (e.g. "therapy", "medication", "case management", etc.).
3) All mental health interventions proposed on client plans indicate both an expected frequency and duration for eachintervention.
4) All mental health interventions proposed on client plans are consistent with client plan

[20] Line number(s) removed for confidentiality
[21] Line number(s) removed for confidentiality
[22] Line number(s) removed for confidentiality
[23] Line number(s) removed for confidentiality

goals/treatment objectives.

PLAN OF ACTION:

The department will provide training and monitoring to ensure staff develop goals/treatment objectives that are specific, measurable, have individualized frequencies/durations, and interventions, with details and purpose, that are consistent with goals/treatment objectives identified on the plan in addition to identifying the type.

Training:

1) Treatment Plan training will continue to emphasize the requirement for goals/objectives to be specific, measurable, and have individualized frequencies/durations.
2) Treatment Plan training curriculum will include the requirement for interventions to have detailed descriptions that are consistent with the goals/objectives.
3) A Documentation Update Training curriculum will be developed to include the requirement for goals/objectives to be specific, measurable, have individualized frequencies/durations, and that interventions must have detailed descriptions that are consistent with the goals/objectives. The update training will be presented to all teams that provide specialty mental health services.

UR / Ongoing Monitoring:

1) Treatment Plans will be monitored on a monthly basis through the team-based Quality Assurance (QA) Reviews.
2) Quarterly reports of team compliance with these monthly reviews will be provided to the Management Team.
3) Treatment Plans are also monitored in the annual chart reviews of all performed by the Quality Improvement Division.

Timeline for Action:

1) The curriculum for the Documentation Update Training will be developed and ready to present to staff in February 2017.
2) Document review tools will undergo review and revision by the end of January 2017.

Documentation to be submitted:

1) Quality Assurance (QA) Review Tools
2) Electronic Health Record Review Tool
3) Treatment Plan training curriculum
4) Documentation Update Training curriculum
5) Training Sign-in Sheets for items 4 above

Progress on actions (if any) implemented to date:

None to date.

ITEM NO. 4d-1:
Client Plans
4d. Regarding the beneficiary's participation and agreement with the client plan:

1) Is there documentation of the beneficiary's degree of participation and agreement with the client plan as evidenced by, but not limited to:
    a. Reference to the beneficiary's participation in and agreement in the body of the client plan; or
    b. The beneficiary signature on the client plan; or
    c. A description of the beneficiary's participation and agreement in the medical record.
2) Does the client plan include the beneficiary's signature or the signature of the beneficiary's legal representative when:
    a. The beneficiary is expected to be in long-term treatment, as determined by the MHP, and,
    b. The client plan provides that the beneficiary will be receiving more than one (1) type of SMHS?
3) When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan and the beneficiary refuses or is unavailable for signature, does the client plan include a written explanation of the refusal or unavailability of the signature?

FINDING:
The MHP did not have written documentation standards for the beneficiary's participation in and agreement with the client plan, and for the beneficiary's signature on the client plan. There was no documentation of the beneficiary's or legal representative's degree of participation in and agreement with the plan, and there was no written explanation of the beneficiary's refusal or unavailability to sign the plan, as required in the MHP Contract with the Department:

- [24]: The beneficiary or legal representative was required to sign the client plan per the MHP Contract with the Department (i.e., long-term treatment and receiving more than one type of SMHS) / per the MHP's written documentation standards (select one). However, the signature was missing.
  RR7, refer to Recoupment Summary for details

Plan of Correction 4b:
The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that each beneficiary's participation and agreement is obtained and documented in a timely manner as specified in the MHP Contract with the Department and CCR, title 9, chapter 11, section 1810.440(c)(2).
2) Ensure that the beneficiary's signature is obtained in a timely manner on the client plan as specified in the MHP Contract with the Department and CCR, title 9, chapter 11, section 1810.440(c)(2)(A)(B).
3) Ensure that services are not claimed when the beneficiary's:
    a) Participation in and agreement with the client plan is not obtained or not obtained in a timely manner and the reason for refusal is not documented.
    b) Signature is not obtained when required or not obtained in a timely manner and the reason for refusal is not documented.

[24] Line number(s) removed for confidentiality

PLAN OF ACTION:

Department quality review audits demonstrated that of the 1228 charts and notes reviewed by the QID team, 3 were found without the client signature or adequate documentation to support why the signature was not obtained.

The department will continue to provide training and monitoring to ensure staff understand and are in compliance with the requirement to obtain a client/guardian signature on all treatment plans in a timely manner. Training will also emphasize the requirement for staff to document the reason the signature could not be obtained, the plan for future attempts, and the attempts to get the signature at every subsequent service provided.

Monthly team-based quality assurance reviews will be required of all teams. Monitoring tools for this review will be revised to prompt staff to report when treatment plans do not have client signatures and when this omission is present, will prompt a review of the documentation to ensure there is documentation to justify why the client signature is missing. As these reviews will occur on a monthly basis, teams will get feedback about ongoing needs to maintain justification or obtain the client signature.

Training:

1) Treatment Plan training will continue to emphasize the requirement for client/guardian signatures and documentation when staff are unable to get the signature.
2) A Documentation Update Training curriculum will be developed that will include the requirement for client/guardian signatures on all treatment plans as well as to document when staff are unable to obtain the signature. The update training will be presented to all teams that provide specialty mental health services.

UR / Ongoing Monitoring:

1) Treatment Plans will be monitored on a monthly basis through the team-based Quality Assurance (QA) reviews. The review tool will be updated to include identification of treatment plans missing client signatures and prompting the reviewer to review documentation for justification.
2) Quarterly reports of team compliance with these monthly reviews will be provided to the Management Team.
3) Treatment Plans are also monitored in the annual chart reviews of all performed by the Quality Improvement Division.

Timeline for Action:

1) The curriculum for the Documentation Update Training will be developed and ready to present to staff in February 2017.
2) Document review tools will undergo review and revision by the end of January 2017.

Documentation to be submitted:

1) Updated Quality Assurance (QA) Review Tools
2) Electronic Health Record Review Tool

3) Treatment Plan training curriculum
4) Documentation Update Training curriculum
5) Training Sign-in Sheets for item 4 above

Progress on actions (if any) implemented to date:

None to date

ITEM NO.5a:
Progress Notes
5a. Do the progress notes document the following:

1) Timely documentation (as determined by the MHP) of relevant aspects of client care, including documentation of medical necessity?
2) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions?
3) Interventions applied, beneficiary's response to the interventions, and the location of the interventions?
4) The date the services were provided?
5) Documentation of referrals to community resources and other agencies, when appropriate?
6) The amount of time taken to provide services?
7) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?

FINDING:
Progress notes were not completed in accordance with regulatory and contractual requirements and/or with the MHP's own written documentation standards:

- One or more progress note was not completed within the timeliness and frequency standards in accordance with regulatory and contractual requirements.
- The MHP was not following its own written documentation standards for timeliness of staff signatures on progress notes.
- Progress notes did not document the following:
  5a-1) [25]: Timely documentation of relevant aspects of beneficiary care as specified by the MHP's documentation standards (i.e., progress notes completed late based on the MHP's written documentation standards in effect during the audit period).
  Appointment was missed or cancelled: [26], refer to Recoupment Summary for details.

PLEASE NOTE: The exact same verbiage was recorded on multiple progress notes, and therefore those progress notes were not individualized, did not accurately document the beneficiary's response and the specific interventions applied, as specified in the MHP Contract with the Department for: [27].

PLAN OF CORRECTION:
The MHP shall submit a POC that indicates how the MHP will:

1) Describe how the MHP will ensure that progress notes are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.
2) The MHP shall submit a POC that indicates how the MHP will ensure that progress

[25] Line number(s) removed for confidentiality
[26] Line number(s) removed for confidentiality
[27] Line number(s) removed for confidentiality

notes document:

5a-1) Timely completion by the person providing the service and relevant aspects of client care, as specified in the MHP Contract with the Department and the MHP's written documentation standards.

3) The documentation is individualized for each service provided.

PLAN OF ACTION:

The department's policy on progress note documentation standards currently identifies the standard of completing progress notes within 30 days of the service provided. Progress notes entered after 48 hours of the service require the additional documentation to identify this is a "Late Entry." The policy encourages staff to enter their notes within 48 hours but ultimately has a deadline for entry of 30 days. Department Policy 5.1.21 *"Progress Note Documentation Standards"* will be updated to make these timeframes explicit via the following standards:

1. The standard for excellence will require 100% progress notes submitted within 48 hours.
2. The standard for late entry will be to ensure all notes entered after 48 hours are identified as "Late Entry" on the progress note.
3. The standard for billing will be notes entered and final approved in less than 30 days of the service provided."

These standards are monitored and reported on currently via the "Timeliness of Entry" reporting that is reviewed and distributed on a monthly basis. This standard is also embedded within our employee performance expectations with a table that utilizes the Timeliness of Entry report and a standardized rating for performance. Employees who are not meeting these standards are flagged as requiring a corrective action plan.

Additionally, staff will continue to be trained in the requirement that all progress notes must be individualized and never "canned" or copied and pasted.

Training:

1) Progress note training will continue to emphasize the timeliness standard for progress notes to be written within 48 hours of the service and be individualized to the client and the services provided in that contact.
2) A Documentation Update Training curriculum will be developed to include the requirement for progress notes to be written in a timely manner, following standards described in policy 5.1.21.

UR / Ongoing Monitoring:

1) Progress notes will be monitored on a monthly basis through the team-based Quality Assurance (QA) Reviews.
2) Quarterly reports of team compliance with these monthly reviews will be provided to the Management Team.
3) Progress note timeliness will be monitored in the annual chart reviews of all performed by the Quality Improvement Division.

Timeline for Action:

1) The curriculum for the Documentation Update Training will be developed and ready to present to staff in February 2017.
2) Document review tools will undergo review and revision by the end of January 2017.
3) Policy 5.1.21 *"Progress Note Documentation Standards"* will be updated by the end of January 2017.

Documentation to be submitted:

1) Quality Assurance (QA) Review Tools
2) Progress Note Audit Tool
3) Progress note training curriculum
4) Documentation Update Training curriculum
5) Training Sign-in Sheets for item 4 above
4) Updated policy 5.1.21 *"Progress Note Documentation Standards"* will be updated by the end of January 2017.

Progress on actions (if any) implemented to date:

None to date.

ITEM NO.5b:
Progress Notes
5b. When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes include:

1) Documentation of each person's involvement in the context of the mental health needs of the beneficiary?
2) The exact number of minutes used by persons providing the service?
3) Signature(s) of person(s) providing the services?

FINDING:
The following Line numbers had claims for which the time claimed was greater than the time documented on the corresponding progress notes: [28], refer to Recoupment Summary for details.

PLEASE NOTE: The exact same verbiage was recorded on multiple progress notes, and therefore those progress notes were not individualized, did not accurately document the beneficiary's response and the specific interventions applied, as specified in the MHP Contract with the Department for: [29].

PLAN OF CORRECTION:
The MHP shall submit a POC that indicates how the MHP will ensure that the type of service, units of time and dates of service (DOS) claimed are accurate and consistent with the documentation in the medical record and that services are not claimed when billing criteria are not met.

PLAN OF ACTION:
The ITS Administrator will adjust the billing algorithm for group service calculations in the Electronic Health Record (EHR) to avoid the claims billing a greater amount of time than is documented on the progress notes.

UR / Ongoing Monitoring:
As part of the annual QID audits, monitoring the effectiveness of the updated algorithm will be completed by reviewing the group services to ensure service time identified on the note is the actual time claimed.

Timeline for Action:

1) The adjustments to the algorithm will be completed by the end of December 2016.
2) Follow up to match a group service note and the claim submitted will occur within 1-2 months (January-February 2017) following the adjustment of the algorithm.

Documentation to be submitted:

1) A random sample of services will be chosen and a comparison will be done between the claimed dollar amounts to the minutes of service multiplied times the rate.

Progress on actions (if any) implemented to date:

[28] Line number(s) removed for confidentiality
[29] Line number(s) removed for confidentiality

None to date.

ITEM NO.5c:
Progress Notes
5c. Timeliness/frequency as follows:

1) Every service contact for:
    a. Mental health services
    b. Medication support services
    c. Crisis intervention
    d. Targeted Case Management
2) Daily for:
    a. Crisis residential
    b. Crisis stabilization (one per 23/hour period)
    c. Day treatment intensive
3) Weekly for:
    a. Day treatment intensive (clinical summary)
    b. Day rehabilitation
    c. Adult residential

FINDING:
Documentation in the medical record did not meeting the following requirements:

- [30]: There was no progress note in the medical record for the services claimed. RR9, refer to Recoupment Summary for details.
  During the review, the MHP staff was given the opportunity to locate the documents in question but could not find written evidence of them in the medical record.
- [31]: The type of specialty mental health service (SMHS) documented on the progress note was not the same type of SMHS claimed. RR9, refer to Recoupment Summary for details.

PLAN OF CORRECTION:
The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that all SMHS claimed are:
    a. Documented in the medical record.
    b. Claimed for the correct service modality and billing code.
2) Ensure that all progress notes are:
    a. Indicate the type of service, the date the service was provided and the amount of time taken to provide the service as specified in the MHP Contract with the Department.

PLAN OF ACTION:
QID will develop a process to monitor service documentation for Psychiatric Health Facilities (PHF) and Crisis Residential Treatment Programs and conduct reviews at a minimum of an annual basis (the missing notes were from these types of contract providers). The department will also enhance training of the mental health service code descriptions to ensure staff have a clear understanding of the definitions and documentation requirements for each type of service provided as outlined in policy 5.1.14 Service Code Descriptions.

[30] Line number(s) removed for confidentiality
[31] Line number(s) removed for confidentiality

Training:

1) A training will be developed and provided to all clinical staff on the proper use and documentation of the service codes as described in the Service Code Policy 5.1.14 Attachment A.
2) A Documentation Update Training curriculum will be developed and will include service code descriptions and progress note standards.

UR / Ongoing Monitoring:

1) Progress notes will be monitored on a monthly basis through the team-based Quality Assurance (QA) Reviews.
2) Quarterly reports of team compliance with these monthly reviews will be provided to the Management Team.
3) Progress notes will be monitored in the annual chart reviews of all performed by the Quality Improvement Division.

Timeline for Action:

1) The curriculum for the Documentation Update Training will be developed and ready to present to staff in February 2017.
2) Document review tools will undergo review and revision by the end of January 2017.

Documentation to be submitted:

1) Quality Assurance (QA) Review Tools
2) Progress Note Audit Tool
3) Progress note training curriculum
4) Documentation Update Training curriculum
5) Training Sign-in Sheets for item 4 above

Progress on actions (if any) implemented to date:

None to date.

ITEM NO.6a:

Documentation of Cultural and Linguistic Services

6. Regarding cultural/linguistic services and availability in alternative formats:

6a: Is there any evidence that mental health interpreter services are offered and provided, when applicable?

FINDING:

There was no evidence that mental health interpreter services were offered and provided on every occasion to the following Line number/parent/legal guardian of the following: [32].

PLAN OF CORRECTION:

The MHP shall submit a POC that indicates how the MHP will ensure that:

1) All beneficiaries and their parents/legal guardians are offered mental health interpreter services, when applicable.
2) There is documentation substantiating that beneficiaries and their parents/legal guardians are offered mental health interpreter services, when applicable.

PLAN OF ACTION:

The department will provide enhanced training and monitoring to ensure staff follow the standard for documenting whether interpreter services were offered on all progress notes as outlined in policy 5.1.21 *"Progress Note Documentation Standards."* Progress note templates include a prompt for the staff to identify whether or not interpreter services were offered and/or provided.

QID will continue reviewing a sample of up to 5 Spanish charts from every team on an annual basis to ensure all required documentation is present and signed if the client's preferred language has been identified and documented as Spanish.

Training:

1) Progress note training that is offered to all staff will emphasize that staff must document whether or not interpreter services were offered and/or provided on all notes.
2) The Documentation Update Training curriculum will include discussion of the requirement for documentation of interpreter services.

UR / Ongoing Monitoring:

1) Progress notes will be monitored on a monthly basis through the team-based Quality Assurance (QA) Reviews.
2) Quarterly reports of team compliance with these monthly reviews will be provided to the Management Team.
3) Progress notes will be monitored in the QID annual review of Spanish charts to ensure compliance.

Timeline for Action:

[32] Line number(s) removed for confidentiality

1) The curriculum for the Documentation Update Training will be developed and ready to present to staff in February 2017.
2) Document review tools will undergo review and revision by the end of January 2017.

Documentation to be submitted:

1) Quality Assurance (QA) Review Tools
2) Progress note training curriculum
3) Documentation Update Training curriculum
4) Progress note templates
5) Spanish chart review tool
6) Training Sign-in Sheets for item 4 above

Progress on actions (if any) implemented to date:

None to date.

ITEM NO.7a:
Service Components for Day Treatment Intensive and Day Rehabilitation Programs
7a. Regarding Service Components for Day Treatment Intensive and Day Rehabilitation programs:

1) Do Day Treatment Intensive and Day Rehabilitation programs include all the following required service components:
   a. Daily Community Meetings;*
   b. Process Groups;
   c. Skill-building Groups; and
   d. Adjunctive Therapies?

FINDING:
Documentation for the following Line numbers indicated the required service components for a Day Treatment Intensive program were not included, as specified by the MHP Contract with the Department:

- [33]: Community meetings for Day Treatment Intensive/Day Rehabilitation did not occur at least once a day. RR9, refer to Recoupment Summary for details.

PLAN OF CORRECTION:
The MHP shall submit a POC that indicates how the MHP will ensure that all program requirements for Day Treatment Intensive are provided in accordance with regulatory and contractual requirements. For example:

1) Ensure that all the required service components including daily community meetings are met.

PLAN OF ACTION:
QID and Children's System of Care (CSOC) Administration will work collaboratively to ensure that all Day Treatment Intensive/Day Rehabilitation providers submit weekly schedules and attendance sheets that demonstrate evidence of community meetings being provided.

The department will provide enhanced monitoring to ensure staff and contractor follow the department standard for documenting and ensuring Daily Community Meetings are provided as part of the Day Treatment Intensive program as outlined in policy 5.4.4 *"EPSDT Supplemental Specialty Mental Health Services-Day Rehabilitation/Day Treatment Intensive."*

Additionally, specific language in any future contracts for Day Treatment Intensive/Day Rehabilitation services will include Daily Community Meetings being provided as part of the required service components for Day Treatment Intensive/Day Rehabilitation.

Client progress note documentation must also document the clients' participation in the required daily community meetings. Service dates that do not document a community meeting provided will be disallowed.

[33] Line number(s) removed for confidentiality

Training:

1) Children's System of Care staff will review policy 5.4.4 when a SAR is received for any Day Treatment Intensive/Day Rehabilitation service is being requested. Staff will also use the Day Treatment/Rehabilitation service is being requested.
2) Staff will also use the Day Treatment/Rehabilitation Technical and Clinical Audit checklist to ensure all provider documentation support community meetings being participated in.

Procedure:

When the Children's System of Care complete their monthly Day Treatment/Day Rehabilitation Technical and Clinical Audit of documentation received from the contracted providers they will ensure that the documentation includes proof of participation in Daily Community Meetings in their daily notes and on their attendance records.

UR / Ongoing Monitoring:

1) Day Treatment Intensive/Day Rehabilitation documentation will be reviewed on a monthly basis by the CSOC to ensure daily notes, weekly schedules and attendance records provide proof of participation in Daily Community Meetings.
2) This same documentation will be reviewed on an annual basis when the Quality Improvement Division completes their annual chart reviews.

Timeline for Action:

1) We are no longer in contract with the provider that was reviewed during this annual review and they are also no longer providing Day Treatment Intensive services.
2) When a child is approved for placement at a level 13/14 group home the department will ensure that the provider documentation supports participation in daily community meetings.

Documentation to be submitted:

1) Policy 5.4.4 EPSDT Supplemental Specialty Mental Health Services-Day Rehabilitation/Day Treatment Intensive
2) Day Treatment/Rehabilitation Technical and Clinical Audit checklist

Progress on actions (if any) implemented to date:

Children's System of Care Administration has reviewed the department policy on Day Treatment Intensive/Day Rehabilitation services and QID will review Day Treatment Intensive/Day Rehabilitation providers in the spring of 2017.