Glenn County

FY 18-19 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

Requirement

The MHP shall meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services. (42 C.F.R. § 438.206(C)(1)(i).)

DHCS Finding ITEM #1, Section A, I., E:

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. §438.206(c)(1)(i}. The MHP must meet, and require its network providers to meet State standards for timely access to care and services, taking into account the urgency for the need of SMHS.

The MHP submitted the following documentation as evidence of its compliance with this requirement:

- Service request log;
- Policies and procedure BH130 Network Adequacy;
- Provider contract boilerplate; and,
- Timeliness data reports.

The Service request log and the self-reported timeliness data report both indicated concerns with meeting timeliness standard. Further, the MHP indicated timeliness data collection concerns stating the MS Access log (Contact log} was modified to include the Date of First Offered Appointment and started capturing the appointment data only after January 1st, 2019.

The MHP stated that timeliness data for 2019 was calculated using the date of referral and Mental Health or Meds Appointment date, but not the first offered appointment date. In the on-site discussion and in the updated timeliness data reports, the MHP demonstrated improved timely access results after January 2019. The MHP shall continue with current efforts to improve data accuracy to ensure the timely access to care and services are continuously monitored and maintained. DHCS deems the MHP out-of-compliance with 42 C.F.R. §438.206(c}(1}(i). The MHP must complete at POC addressing this finding of non-compliance.

Corrective Action Description

The MHP modified the Access Log to include "First Appointment Offered" in October 2018 and a review of the data shows the MHP was collecting this information consistently from the end of October 2018 on. When DHCS issued MHSUDS Information Notice No.: 19-020 on 3/22/19 which provided detailed guidance on these requirements, the MHP modified the Access Log again to include additional information to ensure timely access to care and services.

The MHP has continued tracking timeliness accurately and consistently with quarterly timeliness self-assessments and NACT data.

The MHP was found in compliance for the NACT timeliness standard during the 18-19 annual certification.

Proposed Evidence/Documentation of Correction

See attached DHCS NACT Certification Pass

Requirement

The MHP shall certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810.435. (MHP Contract, Ex. A, Att. 8)

DHCS Finding ITEM #2, A, VI, E:

The MHP did not furnish evidence to demonstrate it complies with MHP Contract, Ex. A, Att. 8. The MHP must certify, or use another's MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810.435.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and Procedures MH126 Recertification of County Owned Sites;
- MH 150 Medi-Cal Certification;
- MHP's Certification and Re-certification protocol;

- Evidence of on-site certification/recertification of contracted organizational providers and county owned and operated self- certified providers;
- Sample of completed certification documentation;
- Tracking log of certification and re-certification status of providers
- Follow up transmittals from 3/12/2019

Specifically, DHCS overdue provider certification report indicated two overdue providers, Youth for Change in Paradise, CA, and Restpadd Inc. in Redding, CA. At the on-site discussion, the MHP confirmed that Youth for Change in Paradise, CA, was damaged during the Camp Fire and not operable at this time. The MHP stated that the transmittal to terminate the service of the Youth for Change in Paradise, CA, had not been submitted to DHCS at the time of the on-site review. The MHP also confirmed that the MHP continues to maintain the service contract with Restpadd Inc. After the technical assistance provided at the on-site review, the MHP submitted completed transmittals for both overview providers and came into compliance on 3/12/2019.

Prior to the on-site review, DHCS reviewed its Online Provider System (OPS) and generated an Overdue Provider Report which indicated the MHP has providers overdue for certification and/or re- certification. The table below summarizes the report findings:

Although, the MHP reconciled two identified overdue providers after the on-site review, the MHP shall ensure monitoring and tracking of the timely certification/re-certification of the organizational providers.

TOTAL ACTIVE PROVIDERS COMPLIANCE {Per OPS)	NUMBER OF OVERDUE PROVIDERS {At the time of the Review)	PERCENTAGE
15	2	87%

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).

Corrective Action Description

The MHP now keeps an internal log of when certifications are due.

The MHP now has an analyst assigned to this task as a single point of contact for certifications and re-certifications.

Proposed Evidence/Documentation of Correction

See attached Provider Master Certification Log.

Requirement

The MHP shall operate a website that provides beneficiaries with the information required in Title 42 of the Code of Federal Regulations part 438.10. (42 C.F.R. § 438.10.)

DHCS Finding ITEM #3, Section D, A5:

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. § 438.10. The MHP must meet, and require its network providers to meet State standards for timely access to care and services, taking into account the urgency for the need of SMHS. The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policy and procedure BH1023 Information for Clients who are visually and/or Hearing Impaired;
- MH106 Written Informing Materials in English and Spanish;
- MHP website;
- Written informing materials in alternative formats and threshold languages; and,
- Beneficiary handbook.

However, the MHP's current website only lists the provider directory in English and no other alternative format or threshold languages. At the on-site discussion, MHP expressed their awareness about the shortcomings of the current website. The MHP reported that the website is a county owned website created and modified by the county contractor.

The MHP stated that the MHP reported to the county regarding issues with website not meeting format requirement. Per the MHP, the county IT is bringing consultants to address MHP and CWS information requirements. The MHP reported that the Grievance forms are not on there because of IT issues (firewall, secure forms, etc.), and opted to have a secure E-mail address on the website for problem resolution communication. The MHP currently have access to update the existing provider list on the website and will update as required. The MHP is aware of the problem with the provider directory and working with IT to get a PDF alternative format published.

DHCS deems the MHP out-of-compliance with 42 C.F.R. § 438.10. The MHP must complete a POC addressing this finding of non- compliance.

Corrective Action Description

The MHP has made the needed corrections to its website, which can be viewed at https://www.countyofglenn.net/dept/health-human-services/behavioral-health/welcome

Proposed Evidence/Documentation of Correction

Website: https://www.countyofglenn.net/dept/health-human-services/behavioral-health/welcome

Requirement

Beneficiary Information required in Title 42 of the Code of 1 Federal Regulations part 438.10 (e.g., information about managed care, beneficiary handbook, provider directory) may only be provided electronically by the MHP if all of the following conditions are met (42 C.F.R. 438.10(c)(6).)

DHCS Finding ITEM #4, Section K, B 3 and 4:

The MHP did not furnish evidence to demonstrate it complies with 42 C.F.R. 438.10(c)(6). The MHP must maintain electronically provided information in following condition: 1) can be electronically retained and printed, and 2) consistent with the content and language requirements of the MHP Contract.

The MHP submitted the following documentation as evidence of compliance with this requirement:

- Policies and procedure BH1023 Alternate Formats: Information for clients who are visually and/or hearing impaired;
- MH106 Written informing materials in English and Spanish;
- MHP website; and,
- Beneficiary Handbook.

However, the provider directory on the MHP's website does not print in its entirety (Search engine format), the on-line directory is not updated to reflect ADA compliance and cultural competency training, and the website does not offer forms of alternate format (large print, threshold language) or information on how to access alternate format.

At the on-site, MHP expressed their awareness about the shortcomings of the current website. The MHP reported that the website is a county owned website created and modified by the county contractor. The MHP stated that the MHP reported to the county regarding issues with website not meeting format requirements. Per the MHP, the county IT is bringing consultants to address MHP and CWS information requirements. The MHP reported that the Grievance forms are not on the website because of IT issues (firewall, secure forms, etc.), and opted to have a secure E-mail address on the

website for problem resolution communication. The MHP currently have access to update the existing provider list on the website and will update as required. The MHP is aware of the problem with provider directory and is working with IT to get a PDF alternative format published. The MHP stated that PDF format will address all above mentioned problems. DHCS deems the MHP out-of-compliance with 42 C.F.R. 438.10(c)(6). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

The MHP has made the needed corrections to its website, which can be viewed at https://www.countyofglenn.net/dept/health-human-services/behavioral-health/welcome

The MHP website has been modified to include (in addition to the Provider Directory) the following Informing Materials: Advanced Health Care Directives, Beneficiary Handbook, Client Problem Resolution Guide, Continuity of Care, EPSDT Services, Guide to County Mental Health Services, Notice of Privacy Practices, Patients' Rights, and Therapeutic Behavioral Services, all available in English and Spanish.

The MHP website also contains a "Resources" tab which includes additional materials.

Proposed Evidence/Documentation of Correction

Website: https://www.countyofglenn.net/dept/health-human-services/behavioral-health/welcome

Requirement

Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll- free telephone number:

1) The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county.

2) The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.

3) The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.

4) The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes. (CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).)

DHCS Finding ITEM #5, Section D, VI, 82:

DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number. The seven (7) test calls must demonstrate it complies with California Code of Regulations, title 9, chapter 11, §§ 1810.405(d) and 1810.410(e)(1). Each MHP must provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county, that will provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.

TEST CALL #1

Test call #1 was placed on Monday, November 26, 2018, at 5:43pm. The call was initially answered after three (3) rings via a live operator identifying himself as a MHP crisis worker. The caller requested information about accessing mental health services in the county for her child. The operator asked questions to determine urgency of the call. Once the operator determined that the caller was not in an emergent or urgent situation, the operator asked the caller to provide her name and contact information. The caller provided her name, son's name, son's age, but declined to give a call back number. The operator further asked questions to determine urgency of the child's need. Once the operator determined that the child was not in an emergent or urgent situation, the operator advised the caller that someone from the county would contact the caller during the business hour for more information. The caller declined to provide call back number and requested who to call during the business hours. The operator provider phone number of the MHP office to call during the business hours. No additional information about SMHS was provided to the caller. The operator also provided that if the caller needs help immediately to call the toll free number again to access crisis services. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.

DHCS deems the MHP out-of-compliance with specific requirements in California Code of Regulations, title 9, chapter 11, § 1810.405(d) and 1810.410(e)(1).

Based on the test calls, DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, chapter 11, § 1810.405(d) and 1810.410(e)(1). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

There will be quarterly re-training on all access log requirements. Training will include review of services and information required for non-crisis calls on the 24-hour crisis line as well as re- dissemination of an information "cheat sheet" with addresses and phone numbers for Glenn County Behavioral Health offices, other Glenn County agencies, and external resources such as local AMPLA offices, Northern Valley Indian Health, and Substance Abuse treatment centers.

Individual counseling will be provided for 24/7 access line staff who do not meet information dissemination standards in order to re-educate staff and identify barriers to staff providing services on the 24-hour access line.

The 24/7 Access line supervisor and manager plan to implement use of incentives and recognition for staff who successfully manage non-crisis informational calls on the 24/7 Access Line based on test calls and supervisor review of services (positive reinforcement).

The 24/7 Access Line supervisor will conduct weekly review of emergency service notes submitted by staff to identify and remediate issues related to the failure to provide necessary and complete information to consumers who call the 24/7 Access Line seeking information.

Proposed Evidence/Documentation of Correction

- See attached Answering the 24/7 Access Line, "cheat sheet.
- See attached training materials: 24/7 Access Line PPT.

Chart Review

Requirement

The MHP shall ensure the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed (MHP Contract, Ex. A. Att. 9; CCR, title 9, §§ 1810.204 and 1840.112):

1) Presenting Problem. The beneficiary's chief complaint, history of the 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 including, as applicable; living situation, daily activities, social support, and cultural and linguistic factors.

3) History of trauma or exposure to trauma.

4) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions.

5) Medical History, including:

   a) Relevant physical health conditions reported by the beneficiary or a significant support person.

   b) Name and address of current source of medical treatment.

   c) For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history.

6) Medications, including:

   a) Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration and medical treatment.

   b) Documentation of the absence or presence of allergies or adverse reactions to medications.

   c) Documentation of informed consent for medications.

7) 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.

8) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to their mental health needs and functional impairment(s).

9) Risks. Situations that present a risk to the beneficiary and others, including past or current trauma.

10) Mental Status Examination

11) A Complete Diagnosis. A diagnosis from the current ICD-code that is consistent with the presenting problems, history, mental status exam and/or other clinical data; including any current medical diagnosis.

DHCS Finding ITEM #6, Section I, 11, B1-11:

One or more of the Assessments submitted to DHCS did not address all of the elements as required in the MHP Contract. Below are the specific findings pertaining to the chart review sample:

- **Line number 6:** Assessment (annual) completed on 4/21/16 did not address medications. The Assessment did not include an update regarding the beneficiary's current medications, nor did the assessment indicate "no change" or refer to prior documentation in the medical record.
- **Line number 6.** Assessment (annual) completed on 4/21/16 did not address substance exposure/substance use. The Assessment did not include an update about the beneficiary's current substance exposure/substance use status.
- **Line numbers 1, 3, 5, 6, and 9:** Assessments did not include a complete diagnosis from the current ICD code. The MHP's practice is to require completion of separate assessment and diagnosis forms. In the noted line numbers, if a diagnosis form was not completed at the time of Assessment, the MHP practice, per its policy, is to document in the beneficiary's Assessment the link to a prior diagnoses. The MHP's assessment forms include a signed attestation statement, "By signing this assessment, I acknowledge that I have reviewed the most recent diagnosis review form and, if needed, I have completed an updated diagnosis review form." For these line numbers, the completed assessment forms indicated that updates to the diagnosis form were needed; however, the MHP was unable to locate, and did not submit, the corresponding diagnosis forms.

The MHP should review all services and claims during which there was *no client plan in effect and disallow those claims* as *required.*

- The MHP shall submit a POC that describes how the MHP will ensure that every assessment contains all of the required elements specified in the MHP Contract with the Department. The

- MHP shall submit a POC that describes how the MHP will ensure that a full diagnosis from the current ICD code is included with all assessments.

Corrective Action Description

- The MHP has made changes to the assessment in the electronic health record (EHR), to require information to be typed into all the areas of an assessment (listed to the left as areas 1-11).
- In the case of reassessments (the MHP uses the same assessment annually), staff will be trained on the need document something in all the required areas, or to write “no change", or "refer to prior documentation in the EHR.

- This training will occur at the next regularly scheduled QI training to all staff on 2/5/20.
- The MHP has placed a required checkbox in the assessment, which will require the clinician to check the box next to the text which states, "*I certify that I have completed an annual Diagnosis Review Form with this Assessment,"* in the EHR. As a safeguard, the assessment cannot be final approved (completed) if this checkbox is not acknowledged and checked by staff completing the assessment.
- The MHP QI staff will also run a monthly diagnosis report, sending staff a list of their clients who have a diagnosis over a year old. This report will prompt staff to determine if a reassessment is necessary or if a new diagnosis review form is needed.

Proposed Evidence/Documentation of Correction

See attached updated Mental Health Assessment.

Implementation Timeline: February 5, 2020

Requirement

The provider must obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication. (MHP Contract, Ex. A., Att.9)

DHCS Finding ITEM #7, Section I, III, A:

The provider did not obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication. The MHP did not submit documentation that the medical recorded contained a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent. Below are the specific findings pertaining to the chart review:

- **Line number 4:** The MHP did not submit a completed written medication consent form for each of the medications prescribed to the beneficiary. Medication consent form(s) did not address consent for the following: Ability, Prazosin, Hydroxyzine, and Buspirone.
- **Line number 6:** Written medication consent form(s) signed by the beneficiary included consent for medications no longer prescribed to the beneficiary.

Specifically, medication consent forms included the prescription drug Focalin, but progress notes from the associated time period indicated that the beneficiary was no longer being prescribed Focalin.

Please note: During the pre-review and on-site, the MHP was given the opportunity to locate the medication consents in question but were unable to locate them in the medical record.

The MHP shall submit a POC to address actions it will implement to ensure the following:

1) A written medication consent form is obtained and retained for each medication prescribed and administered under the direction of the MHP.
2) Written medication consent forms are completed in accordance with the MHP's written documentation standards.

Corrective Action Description

The MHP continues to meet monthly for the Telepsychiatry Program, and information regarding this Plan of Correction will be shared at the next meeting on Wednesday, January 15, 2020. Additional training will occur during this meeting for case managers who complete the medication consent form is with the clients and as directed by the doctors, and will include the need to complete medication consent forms when medications are prescribed and to update medication consent forms when a medication is no longer prescribed.

Proposed Evidence/Documentation of Correction

See attached 3/20/19 Telepsychiatry Program Meeting minutes of training provided about medication consent forms after our 3/6 & 3/7 review.

Implementation Timeline: January 15, 2020

Requirement

Medication consent for psychiatric medications shall include the 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.

(MHP Contract, Ex. A, Attachment 9)

DHCS Finding ITEM #8, Section I, III, B9:

Medication consents did not address all elements required in the MHP Contract. In addition, the MHP did not submit evidence that these required elements were discussed with the beneficiary or that the MHP provided the beneficiary with required written information about the medications which address the requirement. Below are the specific findings pertaining to the chart review:

- **Line numbers 1, 3, 4, 5, 6, and** 7: Possible side effects if taken longer than 3 months. A review of the medication consent forms utilized by the MHP revealed that there was insufficient information being provided to beneficiaries regarding possible side-effects of medications if taken longer than 3 months. Further, there was no additional information provided by the MHP to corroborate that additional side-effect information was provided to the beneficiary either in oral or written form.

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

Corrective Action Description

The MHP has reviewed its medication consent form and determined that a wording change is needed, changing "psychotropic medications" to "psychiatric medications".

The MHP has updated its medication consent form to change this wording.

The MHP will meet for the Telepsychiatry Program on Wednesday, January 15, 2020 and this information will be shared with the case managers who complete the medication consent forms with the clients and at the direction of the doctors.

Proposed Evidence/Documentation of Correction

See attached updated Medication Consent Form.

Implementation Timeline: January 15, 2020

Requirement

Services shall be provided, in accordance with the State Plan, based on the beneficiary's need for services established by an Assessment and documented in the Client Plan. Services were claimed:

A) Prior to the initial Client Plan being in place; or

B) During the period where there was a gap or lapse between client plans; or,

C) When the planned service intervention was not on the current client plan. (MHP Contract; State Plan, Section 3, Supp. 3 to Att. 3.1-A (SPA 12-025) page 2c; MHSUDS Information Notice 17-040)

The client plan shall be updated at least annually, or when there are significant changes in the beneficiary's condition. (MHP Contract, Ex. A, Attachment 9)

DHCS Finding ITEM #9, Section I, IV, A1 and B:

Client Plans were not completed prior to the delivery of planned services and/or were not updated at least annually or reviewed and updated 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). Below are the specific findings pertaining to the chart review sample:

- **Line number 9:** There was a lapse between the prior and current client plans and, therefore, there was no client plan in effect during a portion or all of the audit review period. Per its policy, the MHP requires a client plan to be updated annually or as needed. Based on completion/signature date of 1/18/17, the Client Plan expired on 1/17/18 and interventions performed after this date were done

when no client plan was in effect. Refer to Recoupment Summary for additional details.

The MHP shall submit a POC that describes how the MHP will:

1)Ensure that client plans are updated 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)Ensure that client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition.

3)Ensure that client plans address all elements relevant to the beneficiary's condition or diagnosis.

Corrective Action Description

MHP policy, MH112 on Client Treatment Plans requires plans to be completed within 60 calendar days of the intake assessment appointment and updated annually, and/or when there are significant changes in the client's condition.

In Line #9, the MHP's electronic health record (EHR) allowed for a staff to "review" the treatment plan for 12/27/16-12/26/17, when the staff intended to "revise" this plan. What this means is that plan was pulled forward for another year (12/27/17-12/26/18), even though this plan was signed on 1/18/17. At a result, it looks as if this client had treatment plans completed annually, but a closer review indicates this was a matter of a treatment plan that was meant to be "revised" and instead was "reviewed."

The MHP will provide additional training to all staff at the monthly QI trainings, to remind staff that:

- client treatment plans are due within 60 days;
- updated annually;
- and/or when there is a significant change; and
- the differences between "review" and “revise."

Requirement

The MHP shall ensure that Client Plans:

1) Have 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) Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.
3) Have a proposed frequency of intervention(s).
4) Have a proposed duration of intervention(s).
5) Have interventions that focus and address the identified functional impairments as a result of the mental disorder (from Cal. Code Regs., tit. 9, § 1830.205(b).
6) Have interventions that are consistent with the client plan goals.
7) Be consistent with the qualifying diagnoses. (MHP Contract, Ex. A, Attachment 9)

DHCS Finding ITEM #10, Section I, IV, C1-7:

Client Plans did not include all of the required elements specified in the MHP Contract. Below are the specific findings pertaining to the chart **review** sample:

- **Line numbers 1 and 7:** 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.
- **Line numbers 1, 2, 3, 4, 6, and 7:** One or more of the proposed interventions did not include a detailed description. Instead, only a generic description of the intervention was recorded on the client plan.
- Line numbers **1, 2, 3, 4, 5, 6,** 7, **8, 9,** and 10: One or more of the proposed interventions did not indicate an expected duration.
- **Line numbers 1 and 3:** One or more client plans did not address the mental health needs and functional impairments identified as a result of the mental disorder.
    - Line 1: The beneficiary was diagnosed with Major Depressive Disorder and Posttraumatic Stress Disorder (PTSD), but the client plan only notes interventions addressing depression and anxiety, not PTSD specifically.
    - Line 3: The beneficiary was diagnosed with PTSD and Major Depressive Disorder, but the client plan appears primarily focused on addressing depression symptoms, without a specific focus on addressing PTSD symptoms.

The MHP shall submit a POC that describes 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 each intervention.
4) Alt mental health interventions/modalities proposed on client plans address the mental health needs and identified functional impairments of the beneficiary as a result of the mental disorder.

Corrective Action Description

The MHP will provide additional training to all staff at the monthly QI trainings, to remind staff that client treatment plans must have

- specific observable and/or quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
- identify the proposed types of interventions/modalities including a detailed description of the intervention to be provided;
- have a proposed frequency of interventions;
- have a proposed duration of interventions;
- have interventions that focus and address the identified functional impairments as a result of the mental disorder;
- have interventions that are consistent with the client plan goals; and
- be consistent with the qualifying diagnosis.
- staff will be trained to write an intervention duration in the text area of the Planning Tier Narrative.

The QI Team is also creating a brief chart review in Survey Monkey that will be completed by supervisors with their staff (at least one brief chart review per staff per month) that can provide real-time data to supervisor and staff while in supervision.

In addition, the QI Team will continue to aggregate data on common chart review findings and provide the results to staff and supervisors monthly.

Supervisors have requested to use one unit meeting per month (both adult and children/youth programs) to provide additional training and chart review feedback to their staff on common findings.

Proposed Evidence/Documentation of Correction

See attached Supervisor Mental Health Chart Review survey sample.

Implementation Timeline: Implementation Date: 2/21/2020

Requirement

The MHP shall ensure that progress notes describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. Items that shall be contained in the client record related to the beneficiary's progress in treatment include:

a) Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;

b) Documentation of beneficiary encounters, including relevant clinical decisions , when decisions are made, alternative approaches for future interventions;

c) Interventions applied, beneficiary's response to the interventions and the location of the interventions;

d) The date the services were provided;

e) Documentation of referrals to community resources and other agencies, when appropriate;

f) Documentation of follow-up care, or as appropriate, a discharge summary; and

g) The amount of time taken to provide services; and

h) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure, or job title. (MHP Contract, Ex. A, Attachment 9)

DHCS Finding ITEM #11, Section I, V, A and B1-8:

Progress notes did not include timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity, as required in the MHP Contract. One or more progress notes was not completed within the timeliness and/or frequency standards in accordance with the MHP Contract and the MHP's written documentation standards. Below are the specific findings pertaining to the chart review sample:

- **Line numbers 5, 6, and 8**: Progress notes associated with the following line number(s) did not include 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).

- MHP's policy statement (Glenn County Health and Human Services Agency, BH 1011, Progress Notes and Late Entry Documentation) indicates for documentation to be completed "... by the end of the next business day. With supervisor approval, progress notes may be completed up to a maximum of three (3) business days from the date of service."
    - Line 5: One note signed 3n/18 for service claimed on 3/1/18, exceeded the 3 business day discretionary period.
    - Line 6: One note signed 2/20/18 for service claimed on 2/14/18, exceeded the 3 business day discretionary period.
    - Line 8: Two notes signed 2/20/18 for services claimed on 2/16/18, exceeded the 3 business day discretionary period.
- **Line number 7**: Timeliness of the progress note could not be determined because the note was signed but not dated by the person providing the service. Therefore, the date the progress note was entered into the medical record could not be determined, and the note was considered to be late.

The MHP submitted a contracted TBS provider's notes in which provider signs, but does not separately date progress notes. This practice does not adequately confirm the date the progress note was completed and entered into the medical record.

- **Line numbers 2, 3, and 5**: The provider's professional degree, licensure or job title was missing from progress notes.

Please note: The MHP informed reviewers that the Electronic Health Record (EHR) had a technical problem during a period of time in which the professional degree, licensure, or job title was not embedded with some electronic signatures. However, the MHP was able to confirm that the associated providers had active licenses or degrees during the noted time-periods.

The MHP shall submit a POC that describes how the MHP will ensure that progress notes document:

- Timely completion by the person providing the service and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.
- The date the progress note was completed and entered into the medical record by the person(s) providing the service in order to determine the timeliness of completion, as specified in the MHP Contract with the Department.
- The provider's/providers' professional degree, licensure or job title.

Corrective Action Description

The MHP will provide additional training to all staff at the monthly QI trainings, to remind staff that progress notes must be:

- In accordance with MHP Policy BH1011, which states, "it is expected that each service will be completed, entered, and final approved in the electronic health record (EHR) by the end of the next business day. With supervisor approval, progress notes may be completed up to a maximum of three (3) business days from the date of service.
- Of the 3 services that DHCS identified as late documentation, 2 of the 3 services occurred within the MHP's 3 business day maximum timeframe.
    - Line #6 service occurred on 2/14/18 and was entered on 2/20/18. Monday 2/19/18 was a holiday.
    - Line #8 service occurred on 2/16/19 and was entered on 2/20/18. Monday 2/19/18 was a holiday.

The MHP has created a new process to ensure that the signature of the person providing the services includes the person's type of professional degree, licensure, or job title.

The MHP Analyst maintaining the records in the electronic health record (EHR) will work only with a specific person at our vendor's (Kings View) headquarters. This person is assigned to the MHP as the main contact for any credentialing updates in our EHR platform. After an update is made by our main contact at Anasazi, the MHP Analyst will review to ensure the change is permanent in the EHR until the next update.

The MHP's contractor that provides TBS services, Youth for Change, was responsible for notes associated with Line #7 in which timeliness of documentation could not be verified due to no date stamp. This has been discussed with the provider and has since been resolved, as the provider now uses an EHR with progress notes date stamped on the date they were written.

Requirement

When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, the progress notes must 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. (CCR, title 9, § 1840.314(c).

DHCS Finding ITEM #12, I, V, C:

Documentation of services being provided to, or on behalf of, a beneficiary by two or more persons at one point in time did not include all required components. Below are the specific findings pertaining to the chart review sample:

- Line number 4: Progress note(s) did not accurately document the number of group participants. The progress notes for groups held on 1/2/18 and 2/7/18 did not display the correct number of group participants. The MHP indicated that there are limitations on what their EHR can display regarding the number of participants on their group notes.

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

1) All group progress notes document the number of clients in the group, number of staff, units of time, type of service and dates of service (DOS).
2) The number of clients in the group, number of staff, units of time, type of service and dates of service (DOS) documented on the group progress notes are accurate and consistent with the documentation in the medical record and that services are not claimed when billing criteria are not met.

Group progress notes clearly document the beneficiary's response, the beneficiary encounters and interventions applied, as specified in the MHP Contract with the Department.

Corrective Action Description

The MHP has determined that the group progress note for Line #4 item was billed properly, however a system limitation causes our group progress notes to print without the number of group attendees.

Group progress notes print the number of staff, units of time, type of service, and dates of service.

The MHP plans to migrate to Millennium software in late Winter or early Spring of 2020, and expect this issue will be resolved with the new software.

The MHP will provide additional training to all staff at the monthly QI trainings, to remind staff that group progress notes must:

- clearly document the beneficiary's response;
- the beneficiary encounters; and
- interventions applied, as specified in the MHP contract with the Department.

The MHP is also creating a brief chart review in Survey Monkey that will be completed by supervisors with their staff *(at least one brief chart review per staff per month)* that can provide real-time data to supervisor and staff while in supervision.

In addition, the QI Team will continue to aggregate data on common chart review findings and provide the results to staff and supervisors monthly.

Supervisors have requested to use one unit meeting per month (both adult and children/youth programs) to provide additional training and chart review feedback to their staff on common findings.

Requirement

Progress notes shall be documented at the frequency by type of service indicated below:

- Every Service Contact:
  A. Mental Health Services;
  B. Medication Support Services;
  C. Crisis Intervention;
  D. Targeted Case Management;

- Daily:
  A. Crisis Residential;
  B. Crisis Stabilization (1x/23hr);
  C. Day Treatment Intensive;

- Weekly:
  A. Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service;
  B. Day Rehabilitation;
  C. Adult Residential.

(MHP Contract, Ex. A, Attachment 9)

DHCS Finding ITEM #13, I, V, D1A and D1D:

Progress notes were not documented according to the frequency requirements specified in the MHP contract. Below are the specific findings pertaining to the chart review sample:

- **Line numbers 5, and 8:** For Mental Health Services claimed, the service activity (e.g., Assessment, Plan Development, Rehab) identified on the progress note was

not consistent with the specific service activity actually documented in the body of the progress note.

- Line 5: Services provided on 1/30/18 and 3/13/18 were claimed as Collateral service, but documentation describes services more consistent with Mental Health Rehabilitation.
- **Line 8:**
  - Services provided on 1/9/18, 1/23/18, 2/9/18, 2/13/18, 3/8/18, 3/15/18, 3/22/18, 3/29/18 were claimed as Individual Rehabilitation Service, but the documentation describes services more consistent with Family Therapy.
  - Services provided on 2/5/18, 2/12/18, 2/26/18 were claimed as an Individual Rehabilitation Service, but the documentation describes services more consistent with Collateral services.
  - Services provided on 2/9/18, 2/13/18, 3/19/18, 3/22/18 were claimed as Targeted Case Management. Progress notes for these services described Collateral services in which the case manager provided consultation to the parent or guardian regarding their interaction with the child beneficiary.

The MHP shall submit a POC that describes how the MHP will:

1) Ensure that all progress notes:
   - Are accurate, complete and meet the documentation requirements described in the MHP Contract with the Department.
   - Describe the type of service or service activity, 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.
   - Are completed within the timeline and frequency specified in the MHP Contract with the Department.

Corrective Action Description

Using the MHP Code Sheet, the MHP will provide additional training to all staff at the monthly QI trainings, to remind staff that progress notes must be:

- accurate, complete, and meet documentation requirements described in the MHP Contract with the Department; and
- describe the type of service or service activity, 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; and
- written in accordance with MHP Policy BH1011 which states, “it is expected that each service will be completed, entered, and final approved in the electronic health record (EHR) by the end of the next business day. With supervisor

approval, progress notes may be completed up to a maximum of three (3) business days from the date of service."

The MHP is also creating a brief chart review in Survey Monkey that will be completed by supervisors with their staff (at least one brief chart review per staff per month} that can provide real-time data to supervisor and staff while in supervision.

In addition, the QI Team will continue to aggregate data on common chart review findings and provide the results to staff and supervisors monthly.

Supervisors have requested to use one unit meeting per month (both adult and children/youth programs) to provide additional training and chart review feedback to their staff on common findings.

Requirement

The ICC Coordinator and the CFT should reassess the strengths and needs of children and youth, and their families, at least every 90 days, and as needed. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

DHCS Finding ITEM #14, I, VI, B:

The medical record for the following Line number(s) did not contain evidence that the ICC Coordinator and the CFT had regularly met to reassess the strengths and needs of the beneficiary, at least every 90 days, for the purpose of determining if ICC and/or IHBS should be added or modified. Below are the specific findings pertaining to the chart review sample:

- **Line numbers 6, 7 and 8.**
    - **Line number 6:** Progress notes indicate that the beneficiary is receiving ICC services. Although there is mention of a plan to convene a CFT meeting, it is unclear from documentation if CFT meetings are being held, the frequency of meetings, the roles of participants in CFT meetings, etc.
    - **Line number 7:** Progress notes included examples in which providers would meet with the caregiver, and/or other coordinating services. However, it is unclear if providers were conducting CFT meetings at least every 90 days. Meetings did not appear to include the beneficiary, which is a standard of CFT meetings.
    - **Line number 8:** Progress notes included examples in which providers would meet with the caregiver and other coordinating services, but the

child was not present for these meetings. CFT meetings, which include the beneficiary and family, should occur at least every 90 days as required

The MHP shall submit a POC that describes how it will ensure that:

1) Written documentation is in place describing the policy and process for convening and conducting CFT meetings at least every 90-days for all beneficiaries receiving ICC and IHBS under the age of 21.
2) Training is provided to all staff and contracted providers who have the responsibility for determining eligibility and need for the provision of ICC and IBHS.
3) Each beneficiary receiving ICC and IHBS should be regularly reassessed to determine their continuing need and appropriate level of services.

Corrective Action Description

The ICC Coordinator is updating the MHP's policy, MH127, Intensive Services for Medi-Cal Youth/Pathways to Well-Being (Formerly Katie A. Services), to include role definitions and a flow chart.

Additional training was provided to the core CFT Team on 12/11/19, and additional training will be provided again on 12/17/19. Follow up trainings will occur in January or February 2020 to all MHP staff on this process.

The Reassessment process will be monitored by the ICC Coordinator by collaborating with the clinician, and discussed and documented during the CFT. This documentation will be in the CFT notes that will be uploaded in "Client Attachments" in the client's electronic chart and also documented in the client's ICC progress notes.

There is a standardized process to screen for IHBS/ICC services built into the mental health assessment medical necessity determination. This screening allows for the Children's Program Manager to authorize and monitor the delivery of ICC/IHBS services, and to arrange for the ICC coordinator to be assigned.

Proposed Evidence/Documentation of Correction

See attached example medical necessity form.

There is also a new log for the ICC coordinator to track CFT timeliness. See the CFT tracking log.

Implementation Timeline: December 17, 2019