Placer/Sierra County Mental Health Plan

FY 18/19 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

Requirement

Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: (Cal. Code Regs., tit. 9, §§ 1810.405(d) and 1810.410(e)(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.

The toll-free telephone number provides information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met.

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

The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

DHCS Finding: Protocol Section D. VI. B

TEST CALL#1

Test Call #1 was placed on Thursday, October 4, 2018, at 7:46 a.m. The call was initially answered after two rings via a live operator. The caller requested information about accessing mental health services in the county. The operator asked, the caller to spell their full name and to provide their county of residence. The caller provided the requested information. The operator provided two methods to receive services: 1) to receive a referral, or 2) use the walk- in services located in Roseville, CA from 9:00 a.m. to 10:00 a.m. The operator also informed the caller that the wait may be long and it is the first step in receiving mental health services in the county, but they would be seen the same day. The caller was provided information 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.

FINDING

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

TEST CALL#2

Test Call #2 was placed on Monday, September 24, 2018, at 9:54 a.m. The call was initially answered after two rings via a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller about residency and insurance (i.e., Medi-Cal). The called provided the requested information and confirmed they are a Medi-Cal beneficiary. The operator informed the caller that Placer MHP offers walk-in services or the operator could set-up an appointment for the caller. The operator provided the location and hours for the walk-in clinic in Auburn, CA (closest to the caller's home). The caller was provided information 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.

FINDING

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

TEST CALL #3

Test Call #3 was placed on Monday, October 1, 2018, at 12:20 p.m. The call was initially answered after two rings via a live operator. The caller requested information about accessing mental health services in the county. The operator provided several options to the caller with two locations and times for walk-in services. The caller was provide information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met and services necessary to treat a beneficiary's urgent condition.

FINDING

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

TEST CALL#4

Test Call #4 was placed on Thursday, September 27, 2018, at 7:26 a.m. The call was initially answered after one ring via a live operator. The caller requested information about filing a grievance in the county. The operator provided the phone number for the County's Patient Rights Advocate. The caller was not provided with sufficient information about how to use the beneficiary problem resolution and fair hearing processes. The MHP must make available forms that may be used to file grievances, appeals, and expedited appeals and self- addressed envelopes that beneficiaries can access at all provider sites without the beneficiary having to make a verbal or written request to anyone. (Cal. Code Regs., tit. 9, § 1850.205(c)(1)(C).) At a minimum, the operator should provide this information to beneficiaries requesting information about how to use the beneficiary problem resolution process.

FINDING

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

TEST CALL#5

Test Call #5 was placed on Tuesday, October 16, 2018, at 11:53 a.m. The call was initially answered after two rings via a live operator. The caller requested information about filing a grievance in the county. The operator provided the contact information for the County's Patient Rights Advocate. The caller asked if there were any other way to file a complaint. The operator then asked for the caller's name. The caller stated they did not want to give their name. The operator stated they would document the call and that the caller should ask the Patients' Rights Advocate for assistance. The caller was not provided with sufficient information about how to use the beneficiary problem resolution and fair hearing processes. The MHP must make available forms that may be used to file grievances, appeals, and expedited appeals and self-addressed envelopes that beneficiaries can access at all provider sites without the beneficiary having to make a verbal or written request to anyone. (Cal. Code Regs., tit. 9, § 1850.205(c)(1)(C).) At a minimum, the operator should provide this information to beneficiaries requesting information about how to use the beneficiary problem resolution process.

FINDING

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

TEST CALL #6 ·

Test Call #6 was placed on Tuesday, October 16, 2018, at 12:31 p.m. The call was initially answered after one ring via a live operator. The caller requested information about accessing mental health services in the county. The operator informed the caller about counseling, therapy services and county-paid services would depend on insurance, and then asked the caller for their type of insurance. The caller stated Medi-Cal. The operator provided instruction to the caller and a telephone number (916) 872-6549; and, to choose option 3 for Children's System of Care. The phone tree answered after one ring. The caller heard instructions for 911, child protective services, and mental health services in Spanish, and then a live operator greeted the caller. The caller requested information about accessing mental health services in the county and that they would be using Medi-Cal. The-operator informed the caller the county provided all-inclusive team of services, which included a case manager, facilitator, specialist, a parent-focused partner and a fast-track family service program offered through the county contractor. The operator then asked the caller if they would like to be transferred to another person who could immediately conduct an assessment and provide a referral over the phone this would take.5-10 minutes. The caller declined and stated they would call back. The caller was provided information 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.

FINDING

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

TEST CALL #7

Test Call #7 was placed on Wednesday, November 7, 2018, at 1:28 p.m. The call was initially answered after two rings via a live operator. The caller requested information about accessing mental health services in the county. The operator asked the caller if they knew who their insurance provider was and listed several. The caller informed the operator that they knew they had Medi-Cal, but was not sure about a specific type. The operator instructed the caller to retrieve their insurance information and call back for assistance. The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, nor was the caller provided information about services needed to treat a beneficiary's urgent condition.

FINDING

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

The MHP submitted evidence that demonstrates that it is in partial compliance with California Code of Regulations, title 9, §§ 1810.405(d) and 1810.410(e)(1). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

The MHP has updated its training materials and schedule of trainings for the call center access points, with an emphasis on the beneficiary problem resolution process.

The Adult Intake Services (AIS) call center and Family and Children’s Services (FACS) call center received training post triennial on April 22nd and 24th. After receiving the response from DHCS, additional language and training was provided to the Adult Intake Services call center (AIS on August 6, 2019) with additional training to be scheduled for the Family and Children’s Services call center.

The number of overall trainings has increased from 1-2 annually, to 3-4 annually per call center, with ad-hoc trainings added as the need arises.

The Placer County Systems of Care Problem Resolution Guide and Placer County Systems of Care Appeal/Grievance Form was provided to call AIS center staff on August 6, 2019, along with a question and answer session regarding how to respond to callers who ask about or want to file a grievance, appeal, or expedited appeal.

Post-training, it was decided to prepare a short desk reference for the call center staff.

Placer County Quality Management will administer the Placer County Beneficiary Protection Training annually to the contracted staff at Adult Intake Services (AIS). This will align with current practice which requires Placer County Health and Human Services staff to complete this training annually.

In addition, the test call training materials and the associated Survey Monkey has been updated and refined. The Test Call Training Manual has been updated to current expectations and will be distributed as Test Callers complete training. The test call training will be administered as individuals are identified to be assigned test callers and annually thereafter, as long as they continue to be identified assigned test callers. All assigned test callers will complete training prior to completing test calls on behalf of Placer County Systems of Care. Volunteers (unassigned individuals) who are not contracted or employed by Placer County, but complete a test call in a language other than English on behalf of an assigned individual, will fall under the responsibility of the assigned individual for training materials and survey completion.

A schedule is being completed and staff will be assigned to complete three (3) calls per month.

Placer County continues to complete a minimum of 36 test calls per year on the Behavioral Health call centers and has updated the 2019/2020 Quality Improvement Workplan to include a minimum of 12 calls annually be designated as grievance calls.

Proposed Evidence/Documentation of Correction

Placer County Call Center Access Team Training PowerPoint

AIS Training and Sign-in sheet

Systems of Care Problem Resolution Guide

Grievance Appeal Form in English large print

Problem Resolution Process Guide for call centers

Beneficiary Protection Training

24-7 Test Call Training

Survey Monkey Test Calls

Test Call schedule for FY 19-20

Placer County 24-7 Test Call Manual

Implementation Timeline:

April 22nd and 24th, 2019

Ongoing test call schedule for 2019/2020

Requirement

The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. (CCR, title 9, chapter 11, section 1810.405(f))

The written log(s) contain the following required elements:

a) Name of the beneficiary.

b) Date of the request.

c) Initial disposition of the request.

DHCS Finding: Protocol Section D. VI. C

The MHP did not furnish evidence to demonstrate it complies with California Code of Regulations, title 9, § 1810.405(f). The MHP must maintain a written log of the initial requests for SMHS from beneficiaries of the MHP. The requests must be recorded whether they are made via telephone, in writing, or in person. The log must contain the name of the beneficiary, the date of the request, and the initial disposition of the request.

Corrective Action Description

Placer County records and maintains a written log on the initial requests for SMHS from beneficiaries of the MHP. The log for Placer and Sierra counties were submitted as evidence of compliance for this metric. Placer County logs an average of 25,000 calls per year, including SMHS, Substance Use Services, IHSS, and APS. The following actions have been completed or are in queue to implement in the next 30 days:

The MHP has updated its training materials and schedule of trainings for the call center access points, with an emphasis on the beneficiary problem resolution process.

The Adult Intake Services (AIS) call center and Family and Children's Services (FACS) call center received training post triennial on April 22nd and 24th.

The number of overall trainings has increased from 1-2 annually, to 3-4 annually per center, with ad-hoc trainings added as the need arises.

In addition, the test call training materials and the associated Survey Monkey has been updated and refined. The Test Call Training Manual has been updated to current expectations and will be distributed as Test Callers complete training. The test call training will be administered as individuals are identified to be assigned test callers and annually thereafter, as long as they continue to be identified assigned test callers. All assigned test callers will complete training prior to completing test calls on behalf of

Placer County Systems of Care. Volunteers (unassigned individuals) who are not contracted or employed by Placer County, but complete a test call in a language other than English on behalf of an assigned individual, will fall under the responsibility of the assigned individual for training materials and survey completion.

A schedule is being completed and staff will be assigned to complete three (3) calls per month.

Placer County continues to complete a minimum of 36 test calls per year on the Behavioral Health call centers.

Proposed Evidence/Documentation of Correction

AIS Training

24-7 Test Call Training

Survey Monkey Test Calls

Placer County 24-7 Test Call Manual

Test Call schedule for FY 19-20

Implementation Timeline: September 30, 2019

Requirement

For standard authorization decisions, the MHP shall provide notice as expeditiously as the beneficiary's condition requires not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days when:

a) The beneficiary, or the provider, requests extension; or

b) The MHP justifies (to DHCS upon request) a need for additional information and how the extension is in the beneficiary's interest. (MHP Contract, Ex. A, Att 6; 42 C.F.R. § 438.210(d)(1).)

DHCS Finding: Protocol Section E. I. H

The MHP did not furnish evidence to demonstrate it complies with 42 CFR § 438.210(d)(1). For standard authorization decisions, MHPs must provide notice as expeditiously as the beneficiary's condition requires and within DHCS established timeframes that may not exceed 14-calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days.

In addition, DHCS reviewed a sample of 37 service authorizations as evidence of compliance with this requirements. The service authorization decision sample review findings are detailed below:

- One of 37 standard authorization requests did not have a signature for approval;
- Two of 37 standard authorization requests were outside of the 14-calendar days; and,
- One of 37 standard authorization request had no date-of-receipt for validation.

Corrective Action Description

The MHP has revised the policy for Authorization for Medi-Cal Specialty Mental Health Services (EA 420) which details timelines in section D of the policy. This policy was submitted to DHCS on 8/1/2019 per Information Notice 19-026 and has subsequently been revised on 8/28/2019. An updated copy is being submitted as part of this POC. The MHP has also revised the Day Rehabilitation and Day Treatment Intensive Payment and Services Authorization Process EA 545 on 8/28/2019. The MHP will complete training on the revised policy including timelines for completing authorizations and required elements by the next monthly QM chart review meeting scheduled for September 17, 2019.

Proposed Evidence/Documentation of Correction

Policy EA 420

Email confirmation to DHCS for Policy EA 420 submission

Policy EA 545

Implementation Timeline: September 17, 2019

Chart Review

Requirement

The beneficiary must meet medical necessity criteria outlined in subsections (1-3) to be eligible for services. (CCR, title 9, § 1830.205(b).)

1) The beneficiary meets DSM criteria for an included ICD diagnosis for outpatient SMHS in accordance with the MHP contract. (MHSUDS IN Nos., 15-030, 16-016, 16- 051, and 17-004E)
2) The beneficiary must have at least one of the following impairments as a result of the mental disorder or emotional disturbance (listed above in A1):
   1. A significant impairment in an important area of functioning.
   2. A probability of significant deterioration in an important area of life functioning.
   3. A probability that the child will not progress developmentally as individually appropriate
   4. For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate. (CCR, title 9, § 1830.205 (b)(2)(A-C).)
3) The proposed and actual intervention(s) meet the intervention criteria listed below:
   a) The focus of the proposed and actual intervention(s) addresses the condition identified in No. 1b (1-3) above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that the SMHS can correct or ameliorate per No. 1 (b)(4).
   b) The expectation is that the proposed and actual intervention(s) will do at least one (1) of the following (A, B, C, or 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.
      (CCR, title 9, § 1830.205 (b)(3)(B)(1-4).)
4) The condition would not be responsive to physical health care based treatment. (CCR, title 9, § 1830.205(b)(3)(C).)

DHCS Finding: Medical Necessity 3A

The medical record associated with the following Line number(s) did not meet medical necessity criteria since the focus of the intervention(s) did not address the mental health condition, as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A):

- **Line number(s) 10, 16 and 18. RR15b refer to Recoupment Summary for details.**

Corrective Action Description

The MHP has provided yearly required training to staff and Network and Organizational Providers which directs them to ensure that the interventions they provide to their clients are focused solely on functional impairments as they relate to the client's mental health condition. In turn, a percentage (at least 5%) of these records have been reviewed on a yearly basis to ensure that documentation meets these standards, and staff were followed up with by their supervisor when found not to be in compliance. As it is the goal for the MHP to be 100% in compliance with this standard, the following has occurred in response to this plan of correction: To make the standard more clear, the mental health chart audit tool used to review documentation completed by MHP staff was revised on 8-7-19. On 9-17-19, the supervisory staff responsible for reviewing this documentation will be re-trained on the use of this tool, and on this requirement during the monthly QM Skype meeting. The monthly QM Skype meeting was created in February 2019 following the 2018 Triennial audit to create a forum for QM to meet with mental health Supervisors and Managers on a Monthly basis and have a set agenda of topics which is managed by QM. QM had always had a meeting with mental health Supervisors and Managers on an on-going basis in a lab, and the focus was primarily on various chart documentation issues. The new QM Skype meeting structure and agenda, which QM hosts, allows staff to join from their desks from various MHP locations across the county. This has allowed QM to review a broader range of topics with affected staff, and has enabled QM to keep staff educated and aware of important changes that may be occurring, or of important requirements, they should be made aware of.

To make the standard more clear the mental health chart audit tool used to review documentation completed by Network and Organizational Providers was also revised on 8-7-19, and the staff that review these providers will be trained by October 1st, 2019 on the use of this tool, and this requirement. In addition, updated information was added to the yearly required documentation training required for all MHP staff and Network and Organizational providers regarding this requirement, and this training will be re-sent by 12-1-19.

Proposed Evidence/Documentation of Correction

Revised mental health chart audit tool

Agenda and Minutes from February 2019 meeting

Documentation Training

Implementation Timeline:

Mental health chart audit tool revised on August 7, 2019 and will train providers by October 1, 2019

QM Skype Meeting initiated February 2019

Yearly updated documentation training will be re-sent by December 1, 2019

Requirement

The MHP must establish written standards for (1) timeliness and (2) frequency of the Assessment documentation. (MHP Contract, Ex. A, Att.9)

DHCS Finding: Assessment 2A

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

One or more assessments were not completed within the timeliness and/or frequency requirements specified in the MHP's written documentation standards, which requires assessments to be performed within 60 days from the date of admission. The following specific findings from the chart sample:

Line numbers: 6,8,9,17 and 19 The assessment was completed late
Line number 6: The assessment was due on 6/11/17, based on MHP 60 day policy for initial Assessments, The Assessment was completed 7/28/17.
Line number 8: The MHP documented that the beneficiary's last episode of treatment was closed on 6/30/15. The MHP provided evidence of a Discharge Summary dated 6/11/15, including the reason for discharge, "Client has completed treatment." The MHP documented that the beneficiary returned to services with a new admission date of 7/14/16; however, the assessment was completed beyond the MHP's standard of 60 days on 3/1/17.
Line number 9: The MHP documented that the beneficiary's admission to be 5/10/16; however, the current assessment is dated prior to admission on 12/30/15. The MHP provided a progress note for a Targeted Case management service dated 5/3/16, which documented the reasons the beneficiary requested to return to care.
Line number 17: The admission date was 10/5/17. The assessment was documented to have started on 12/13/17 and completed 1/8/18, more than 60 days from the admission date.
Line number 19: The admission date was 8/28/17. The assessment was completed 11/1/17 with diagnosis date of 11/15/17.
Line numbers 2,10,11 and 16: The updated assessment was completed late
Line number 2: See above, item **1)**.
Line number 10: The updated assessment was completed 3 days late.
Line number 11: See above, item **1)**.
Line number 16: The updated assessment was completed 11 days late.

Corrective Action Description

According to MHP standards, an initial client assessment is to be completed within two months of the date open to the Provider/Agency. This policy has now been amended to include the statement, "unless a documented reason has been provided otherwise." While it is always the goal of the MHP to enter a client into services as quickly as possible, the MHP will often have circumstance where it is at the client's request to not

receive the appointment time that is the most expeditious. When this has occurred, the MHP has on occasion found itself up against required timelines. In order to meet this client request, and to ensure the MHP is still adhering to state required timelines, the MHP will now require its caseworkers to clearly document within the client record as a client request to allow time to complete the assessment and service plan.

Lastly, there have been occasions where assessments have not been completed timely due to a number of factors. In order to address this, the MHP has worked with its IT depart to create a report called Client Services Timeline report (see sample attached). While this report has been in existence for a while, the QM team has recently met with MH leadership regarding this report to discuss enhancements and it was re-launched to staff on 7-22-19. This report is automatically sent out to all MH supervisors on a weekly basis and it includes all of their staff. This report will show a list of all of their clients, the assessment due date, and when the service plan is due. It is color coded so when a client's assessment is becoming due, is will be shaded a different color, including becoming red if it is past-due. All Supervisors are required to use this report with their staff in supervision with their staff and ensure their staff have a plan to complete their required work.

To address the MHP policy (see attached) regarding clients who are closed and have returned to services, the following guidance will be used by staff to determine if a new assessment should be completed:

A. Under all circumstances, if a client is discharged from services and requests to return to services 6 months or later from the date of discharge, a new assessment shall be completed.
B. If a client is discharged from services and requests to return to services within 6 months from the date of discharge, the following shall occur:

    1. The Supervisor (or LPHA/LPHA waived staff if the Supervisor is not LPHA/LPHA waived) will review the client's case, previous assessment, reason for discharge, reason for requesting service, any new information including recent hospitalizations, current mental status, presenting problem, etc.

    2. If the Supervisor believes that due to the information reviewed/received that the client should receive a new assessment, then a new assessment shall occur.

    3. If the client had an assessment that is less than one year old, and it is not clinically indicated by the information reviewed/received by the Supervisor, then the client may be opened with the previously completed assessment from the previous episode of treatment.

    4. If the client is opened using the previously completed assessment, then the Supervisor/LPHA shall complete as soon as possible a progress note which explains how the client returned to services; the presenting problem/reason for returning to services, current mental status examination; and any other updates

to ensure that the client's recommended course of treatment is based on a current assessment; and refer to the date of the client's current assessment in the electronic medical record so it is clear what the client's current assessment is and what the client's service plan should refer to.

Proposed Evidence/Documentation of Correction

Client Services Timeline Report

SP 510 Policy

Implementation Timeline: July 22, 2019

Requirement

The MHP shall ensure that the following areas are included, as appropriate, as part of a comprehensive beneficiary record when an assessment has been performed:

a) 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;

b) 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;

c) 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;

d) 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;

e) Medications. Information about medications the beneficiary has received, or is receiving, to treat health and mental health conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medication;

f) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;

g) 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;

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

i) A mental status examination;

j) A complete diagnosis from the most current DSM, or a diagnosis from the most current ICD-cods shall be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; and,

k) Additional clarifying formulation information, as needed.

(MHP Contract, Ex, A, Att. 9)

DHCS Finding: Assessment 2B

One or more of the assessments reviewed did not address all of the elements specified in the MHP Contract. Below are the specific findings pertaining to the charts in the review sample:

Mental Health History**: Line number 17**

Medical History: **Line numbers 4, 6, 8 and 12**

Line number 4: The beneficiary is documented as having sustained multiple head injuries. The documentation stops short of providing detail with regard to the recentness of these events, whether or not these events have impact on the beneficiary's current mental health condition, and recommendations for their course of treatment.

Line number 6: The beneficiary is documented as having a history of stroke, seizures/epilepsy and head injury; however, there is not clear documentation regarding the recentness of these events, the severity and current medical stability of the beneficiary and whether or not the beneficiary is receiving medications pertaining to the injury. These physical health considerations are relevant to the mental health diagnostic considerations and for appropriate recommendations for course of treatment.

Line number 8: The beneficiary is documented as having physical conditions, including: Back injury, migraines, nerve damage and neuropathy in legs, pancreatic disease, joint injuries, sleep disturbance, sugar levels (diabetes), etc. These conditions are not documented on the current Diagnosis Form. The documentation in the assessment does not provide detail with regard to consideration of the beneficiary's physical health as it relates to their mental health condition. These physical health considerations are relevant to mental health diagnostic considerations and for appropriate recommendations for course of treatment

Line number 12: The beneficiary is documented as having enuresis, with episodes present during the day and night. The documentation does not provide detail about whether or not these events are attributed to a medical condition, if the beneficiary is receiving treatment, and what impact (if any) these episodes have on the beneficiary's current mental health condition. Specifically, section "4. Medical: What health care visits has child/youth had in past 6 months?" there is a check "x" in the "Other" category, without further detail.

Substance Exposure/Substance Use: **Line number 16**

A mental status examination: **Line number 9**

A full diagnosis from the current ICD code: **Line numbers 18, 19 and 20**

Line number 18: The diagnosis on the 10/28/14 Diagnosis Form included a rule out for Posttraumatic Stress Disorder. This rule out is maintained on the 10/14/17 Diagnosis Form; however, the assessment documentation does not provide a clear rationale.

Line number 19: The assessment start date and diagnosis form are both dated 11/1/17; however, the assessment was not completed until 11/15/17. It is not clear what factors/elements of the assessment the clinician took into consideration to make a diagnostic determination, before completing the assessment

Line number 20: The current assessment is dated 6/1/17 with the diagnosis section dated 5/24/16 (prior to the last assessment date of 6/1/16). There is a note within the diagnosis section "Updated per [sic] on 7/25/17. See chart for updated ICD-10." The MHP provided the progress note referenced in this section, for the updated diagnosis information. Notably, the diagnosis in the assessment for 6/1/16 is dated 6/23/15. The way these details are being documented in the record is confusing. It is not clear how the diagnosis section of the assessment is linked to the other elements of the assessment document. Refer to Information Notice 17-040, Section B, Item 3.

Corrective Action Description

1) It is the policy of the MHP that all assessments contain all of the required elements. The required elements are listed in the required training that all MHP staff and Individual Network/Organizational Provider staff take on a yearly basis. This training will be re-sent by 12-1-19. To continue to monitor compliance to this standard, a minimum of 5% of all mental health charts will continue to be audited on a yearly basis and corrections will be made to those chart that are audited.

2) In order to address how the MHP will ensure that every assessment element is sufficiently addressed, specifically the medical history element of the assessment, an update was made to the required annual training that will be re-sent to all MHP staff and providers by 12-1-19. The update specifically reads, *"When documenting medical history reported by the client, it is important to include the recentness of those events, as appropriate (e.g. dates of head injuries). The documentation in the assessment must*

provide detail with regard to consideration of the client's physical health as it relates to their mental health condition. These physical health considerations are relevant to mental health diagnostic considerations and for appropriate recommendations for course of treatment. In addition, referrals should be made as appropriate to physical health care providers for physical health care conditions that are made aware to the clinician during the assessment process and during the course of treatment."

3) The MHP recognizes that the way the dates and forms were aligned within the assessment documents made it difficult for the reader to follow and understand how everything was interrelated within the client record. To remedy this, several changes were made to the assessment document. The paper assessment document is only used by select Organizational Providers who do not have their own electronic medical record, and by all Individual Network Providers. No other providers, including all MHP staff and most Organizational Providers, use these forms, since all of these documents are completed within the electronic medical record and are completely different processes. These paper forms do represent a small overall percentage of the documentation, but these forms are being amended and rolled-out for those providers who use them. The following changes were made to make the assessment documents more clear:

a) On the front page of both the Child and Adult assessment documents, the name of the field "Date of Assessment" was changed to "Date assessment began." The reason for this is due to, especially in the children's system, assessments not being completed during a single session. Rather, multiple sessions are required due to needing to talk with different collateral contacts in order to complete the assessment.

b) On the signature page of both the Child and Adult assessment documents, next to the LPHA/LPHA waived signature line, the name of the field "Date" was changed to "Date of assessment." This change was made to make it very clear that this is the official date of the finalized assessment. When an auditor subsequently comes to audit client records and asks for the date of a client assessment, this is the date that would be clearly marked as the date of the assessment as it is the date that the LPHA/LPHA waived staff signed off on the assessment.

c) On the last page of both the Child and the Adult assessment, which is the Diagnosis page, a sentence was added to the bottom of the page below the signature line which reads: *"Please Note: The signature date of the diagnosis must match the signature date above of this assessment."*. This is to help ensure that the diagnosis is linked to the rest of the assessment.

d) Both assessment documents will be posted to the Placer County MHP website here: https://www.placer.ca.gov/1981/Provider-Forms by October 1st, 2019.

Proposed Evidence/Documentation of Correction

Child Biopsychosocial Assessment CARE141e

Biopsychosocial Assessment Form CARE015

SP 510 Policy

Implementation Timeline:

Policy Training by December 1, 2019

Assessment documents posted by October 1, 2019

Requirement

The provider obtains and retains a current written medication consent form signed by the beneficiary agreeing to the admission of each prescribed psychiatric medication.

(MHP Contract, Ex. A. Att.9)

DHCS Finding: Medication Consent 3A

The provider did not obtain and retain a current written consent form signed by the beneficiary agreeing to the admission of each prescribed psychiatric medication, and there was no documentation in the medical record of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent:

1) **Line numbers 1, 6, 8, 10 and 20**: There was no written medication consent form found in the medical record. The MHP did not submit all required medication consent documentation, as requested.

> **Line number 1**: The documentation in the beneficiary's record identified Cogentin as a current prescription (reference progress note 11/20/17).
>
> **Line number 6**: The documentation in the beneficiary's record identified Zoloft as a current prescription (reference progress note 11/16/17).
>
> **Line number 8**: The documentation in the beneficiary's record identified Lamotrigine as a current prescription (reference progress note 10/5/17).
>
> **Line number 10**: The documentation in the beneficiary's record identified Depakote as a current prescription (reference progress note 11/14/17).
>
> **Line number 20**: The documentation in the beneficiary's record identified Invega Sustenna as a current prescription (reference progress note 10/11/17).

Corrective Action Description

It is the policy of the MHP that medication consents are obtained prior to the administration of medication, with the exception of STAT/emergency medication, in compliance with state consent requirements. To ensure adherence to medication

prescribing standards, a minimum of 10% of all clients who are provided medication support services or prescription are audited on a yearly basis by medication support staff. As well, the MHP requires its Organizational Providers that offer medication support services to monitor their medication services on a monthly basis and provide the MHP with a quarterly report to the Quality Improvement Committee for follow-up where deficiencies and trends are discussed and any follow-up plans are discussed as well as appropriate. On 8-21-19, the requirement was reviewed with all Placer MHP prescribers to obtain medication consents, as well as a review of the required elements of a medication consent, and the updated medication consent was distributed. In addition, all contract monitors for Organizational Providers that offer medication support services will review this requirement, as well as a review of the requirements for a medication consent, for these providers no later than 8-30-19.

Proposed Evidence/Documentation of Correction

Medication Consent Policy RE 401

Medication Monitoring Policy SP 770

Implementation Timeline: August 21, 2019

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: Medication Consent 3B

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 form, and/or documented to have been reviewed with the beneficiary, and/or provided in accompanying written materials to the beneficiary:

Range of Frequency: **Line number 10**

Dosage: **Line number 10**

Method of administration (oral or injection): **Line number 10**

Duration of taking each medication: Line number 10

Possible side effects if taken longer than 3 months: **Line numbers 1, 2, 3, 4, 6, 7, 8, 9, 10, 14, 16, 18 and 20**

Corrective Action Description

It is the policy of the MHP that medication consents are obtained prior to the administration of psychotropic medications, and that these consents contain all of the areas required by the MHP Contract. To ensure compliance with this requirement, a minimum of 10% of files are reviewed on a yearly basis. However, from a review of the current medication monitoring form that was being used for these reviews, it was noticed that one of the required elements was lacking – Possible side effects if taken longer than 3 months. This element has now been added to the form and will be reviewed with all prescribers, both MHP prescribers and contracted providers, no later than 8-30-19. In addition, the form used to audit the medication charts lacked the specificity in order to review for all of the required elements, and they have now been added to the form. This form will be reviewed with all MHP medication staff who perform these reviews as well as Organizational Provider medication staff no later than 8-30-19.

Proposed Evidence/Documentation of Correction

Medication Consent Policy RE 401

Medication Monitoring Form

Consent for Medication Form

Implementation Timeline: August 30, 2019

Requirement

All entries in the beneficiary record shall include:

1) The date of service

2) The signature of the person providing the service (or electronic equivalent).

3) The type of professional degree, licensure, or job title of the person providing the service.

4) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Attachment 9)

DHCS Finding: Medication Consent 3C

Medication Consents in the chart sample did not include the signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, job title, or the date the documentation was entered in to the medical record. Below are the specific findings pertaining to the charts in the review sample.

Signature of the person providing the service (or electronic equivalent):

Line number 18

The type of professional degree, licensure, or job title of person providing the service:

Line numbers 4, 10

The date the documentation was entered in the medical record:

Line number 2

Corrective Action Description

As stated previously, it is the policy of the MHP that all medication consents contain all of the areas required of the MHP Contract, and this is monitored by auditing a minimum of 10% of the charts that receive a medication support service on an annual basis. In addition, the MHP requires all Organizational Providers to also audit a minimum of 10% of their charts on an annual basis, and report this information to the MHP on a quarterly basis to the Quarterly Improvement Committee for trend analysis and discussion. All required elements of the medication consent form will be reviewed with all MHP and contracted prescribers no later than 8-30-19.

Proposed Evidence/Documentation of Correction

Medication Consent Policy RE 401

Implementation Timeline: August 30, 2019

Requirement

Services shall be provided, in accordance with the State Plan, to beneficiaries, who meet medical necessity criteria, based on the beneficiary's need for services established by an assessment and documented in the client plan. Services shall be

provided in an amount, duration, and scope as specified in the individualized client plan for each beneficiary.

(MHP Contract, Ex. A, Attachment 2)

The client plan shall be update at least annually, or when there are significant changes in the beneficiary's condition.

(MHP Contract, Ex. A, Attachment 9)

DHCS Finding: Client Plans 4A

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 charts in the review sample:

Line number 19: The initial client plan was not completed until after treatment services were claimed. **RR4a, refer to Recoupment Summary for details.**

Line number 6: The initial client plan was completed late, according to the MHP standards; however, this occurred outside of the review period.

Line numbers 2, 3 and 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. **RR4b, refer to Recoupment Summary for details**

Line numbers 4, 9, 10, 11 and 14: There was a lapse between the prior and current client plans. However, this occurred outside of the audit review period.

Line number 12: There was a lapse between the prior and current client plans. However, no services were claimed.

Line number 8: The client plan dated 3/20/17 is identical to the current client plan dated 9/18/17. It is clear that the current client plan has not been updated based on the beneficiary's need for services, established by an assessment.

Corrective Action Description

The MHP created a new training for staff to improve their understanding of the requirements of the timelines regarding the service plan, including services that can be billed prior to the completion of a service plan; services that can be billed in the gap between service plans; and the lockouts for service plans. These in-person trainings occurred on July 16th and 23rd, 2019. In addition, the yearly required documentation training was updated and will be re-sent to all staff by 12-1-19. These trainings highlights the areas required in the MHP Contract and other documentation requirements. These trainings are required yearly for all MHP and Individual and Organizational Provider staff that provide and document mental health services.

In addition to the required trainings, the MHP continues to have a report that are sent to MHP supervisory staff on a weekly basis to assist staff with a number of different variables regarding their cases, including when their service plans are due. Supervisors send and review these reports with their staff on a weekly basis to ensure timely completion of required mental health documentation.

To ensure that planned services are not claimed when the service provided is not included in the client's current service plan, QM has discussed possible technological solutions for this with IT within the EHR. Without a technological solution within the EHR to prevent this from occurring, the only other way to accomplish this is through a variety of monitoring post-service delivery. QM's discussions with IT have been fruitful and a possible solution has been identified. However, in order to accomplish this there are several steps that must first take place within Placer's EHR due to how it is set up, and this process is anticipated will take some time (longer now due to COVID as timelines on some projects are now off.)

Currently, Placer requires both leadership staff, including mental health Managers and Supervisors, as well as clinical case managers to review on a routine basis a number of reports that will assist them in monitoring the documentation of services provided to their clients within the EHR. The list of these reports are included in the attached P&P Electronic Health Record Monitoring. These reports include the Timeliness and Units of Service report, which shows all client services billed for a specified time range. The Client Services Timeline Report shows when the client's assessment and treatment plan are due. These two reports in particular, when used in conjunction, can assist staff to monitor the services that are being provided and if the client has a current plan. This is also an opportunity for staff to catch whether or not there are services that have been billed that are not on the client's plan as they are the ones who completed the plan with the client. Lastly, monthly peer chart audits monitor for services that were not included in the current plan. For all such instances that are found, Supervisors are instructed to notify Fiscal so they can begin a process to delete the billing if this has already occurred.

Proposed Evidence/Documentation of Correction

Service Code Training Slides and rosters

Sample Client Services Timeline Report

Implementation Timeline:

Service Code Training occurred on July 16 and 23, 2019

Yearly documentation training by December 1, 2019

Requirement

The MHP shall ensure that client plans:

a) 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.

b) Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.

c) Have a proposed frequency of the intervention(s).

d) Have a proposed duration of the intervention(s).

e) Have interventions that focus and address the identified functional impairments as a result of the mental disorder (from Cal. Code Regs. title 9, § 1830.205(b).

f) Have interventions that are consistent with the client plan goals.

g) Be consistent with the qualifying diagnosis.

(MHP Contract, Ex. A, Attachment 9)

DHCS Finding: Client Plans 4C

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

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 a mental health diagnosis.

Line number 17: The treatment goal did not appear to correspond to the beneficiary's mental health condition ADHD, Unspecified. The goal, included "taking a nap and/or getting good sleep; getting on social media to occupy his mind; and talking to positive, healthy friends/people online from 1 time per day to 3 times per day as measured by self-report, the caretakers and/to the Wraparound team.

One or more of the proposed interventions did not include a detailed description.

Line numbers: 1, 2, 3, 4, 6, 7, 8, 9, 10, 12, 14, 17, 18, 19 and 20

> **For example, Line number 1**: Interventions are generically written and repeated across goals. Specificity is lacking with regard to which of the beneficiary's needs is being addressed and how the interventions will be applied to meet that need. For example, the Targeted Case Management intervention is written, "…Individual Therapy (if deemed clinically appropriate, minimum 10-12 sessions)…TCM to include linkage to appropriate community resources such as Health 360, PCP, dentist, Medi-Cal, SSI, etc."

One or more of the proposed interventions did not indicate an expected frequency.

Line numbers 3, 4, 6, 8, 9, 12, 18 and 20

One or more of the proposed interventions did not indicate an expected duration.

Line numbers 9, 12, 18 and 20

One or more of the proposed interventions did not address the mental health needs and functional impairments identified as a result of the mental disorder.

Line numbers 17 and 20

> **Line number 17**: The interventions do not note which functional impairments are being addressed and by which service activity.
>
> **Line number 20**: The client plan includes the statement, “Services include but [may not be limited to]: individual/group therapy, housing support, independent living skills, connection to community resources, crisis support, team meetings, and prosocial skill development.” It is not clear what services the beneficiary requires to meet their needs. For example, the current assessment documentation indicates that the beneficiary’s housing situation has been stable over the last year.

Corrective Action Description

The MHP provides annual required training for all MHP and Individual/Organizational Provider staff on Medi-Cal documentation standards which will be re-sent by 12-1-19. This training provides important state and federal updates as they apply to providing specialty mental health services, and also important documentation policies and policy updates as they pertain to MHP mental health documentation practices. To ensure that MHP staff are adhering to these standards, a minimum of 5% of all charts are audited on a yearly basis. Organizational providers also audit a minimum of 5% of their charts on an annual basis, and report on a quarterly basis to the Quality Improvement Committee for trend analysis.

In addition to the activities noted above, the MHP will continue to use dedicate time during the monthly scheduled QM Skype meeting to review any deficiency trends noticed by either QM or supervisory staff during the chart audit review process, and appropriate course of action is discussed at that time.

Proposed Evidence/Documentation of Correction

Sample QM Skype Meeting Agenda

Implementation Timeline:

Documentation Training by December 1, 2019

QM Skype Meeting initiated February 2019

Requirement

The MHP shall ensure that client plans include documentation of the beneficiary's participation in and agreement with the client plan.

(MHP Contract, Ex. A, Att. 9; CCR, title 9, § 1810(c)(2).)

The MHP shall ensure that client plans 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.

(CCR, title 9, § 1810.440(c)(2)(A).)

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, the client plan includes a written explanation of the refusal or unavailability of the signature.

(CCR, title 9, § 1810.440(c)(2)(B).)

DHCS Finding: Client Plans 4E

There was no documentation of the beneficiary's or legal representative's degree of participation in and agreement with the client plan, and there was no written explanation of the beneficiary's refusal or unavailability to sign the plan, if the signature was required by the MHP Contract with the Department and/or by the MHP's written documentation standards:

Line numbers 3, 4, 9, 11, 12, 13, 14, 15, 16, 17, 18 and 19

Corrective Action Description

It is county policy for staff to complete the client plan with the client/family, and obtain their signature and this is included in the yearly required training to be re-sent to all staff by 12-1-19. When it is not possible to obtain the signature, it is policy to document their participation in the development of the plan, and their agreement with the plan. All staff within the ASOC and CSOC as well as Network and Individual Providers will be reminded of the importance of developing the plan with the client/family and obtaining their signature on the plan in this yearly required training. All Individual Network and Organizational Provider staff are able to access MHP training materials on the MHP website here https://www.placer.ca.gov/2006/Provider-Training-Materials. Client plans have always been completed with client/family input, be it on the phone, in the field, or in the office. Depending on the situation, client signatures are sometimes captured at the time the plan is completed and sometimes they are obtained at a later date and

scanned into the client record. This is due to the fact that sometimes, due to a number of factors, a service plan may be completed over the phone where capturing a signature is not possible. Or an electronic signature pad was not available for whatever reason, or malfunctioning, etc. These are one of many reasons for the client being unavailable to sign their client plan when it was initially created, but they assisted in the development of the plan and agree with the plan, and they later sign a copy of that plan that is then scanned into their record. In addition, the on-going MH chart monitoring tool will be amended to be more clear for the reviewers to ensure that the requirement for client signature and/or reason why the signature was not obtained. QM shares the results of the on-going mental health chart audits with clinical leadership including Managers, Supervisors, and Seniors during the monthly QM Skype meeting to ensure follow-up is occurring with clinical staff as needed.

Proposed Evidence/Documentation of Correction

Documentation Training Slides (slides 88 and 89)

MHP website for training materials

Mental Health Chart Monitoring Tool

Implementation Timeline:

Documentation Training by December 1, 2019

Requirement

There is documentation in the client plan that a copy of the client plan was offered to the beneficiary.

DHCS Finding: Client Plans 4G

There was no documentation that the beneficiary or legal guardian was offered a copy of the client plan for the following:

Line numbers 3, 4, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18 and 19

Corrective Action Description

It is the understanding of the MHP that since the non-signature explanations were not seen as a valid representation of the client/family participation and agreement with the plan, that then there was no subsequent valid offer of a copy of the plan to the client/family. To address this issue, in addition to addressing the signature/non-signature explanation as already mentioned above, the MHP will again address the importance with staff of creating the client plan with the family and offering them a copy of the plan. In addition to requiring the client signature on the plan, Placer would like to reiterate that it is printed on the treatment plan itself that by signing the plan that the client is acknowledging that they have received a copy of the plan. This requirement is

also included in the yearly required training. In addition to this, a new element to the on-going MH chart-monitoring tool will be added and this will now be a regularly reviewed item for quality assurance purposes. The results of these on-going chart audits are shared by QM with clinical leadership including Managers, Supervisors, and Seniors during the monthly QM Skype meeting to ensure follow-up is occurring with clinical staff as needed.

Proposed Evidence/Documentation of Correction

Billable Service Codes Training Slides (slide 80)

Copy of the treatment plan

Mental Health Chart Monitoring Tool

Implementation Timeline: December 1, 2019

Requirement

All entries in the beneficiary record (i.e. client plans) include:

1) Date of service.

2) The signature of the person providing the service (or electronic equivalent);

3) The person's type of professional degree, licensure or job title.

4) Relevant identification number (e.g., NPI number), if applicable.

5) The date the documentation was entered in the medical record

(MHP Contract, Ex. A. Att. 9)

DHCS Finding: Client Plans 4H

One of the client plans in the chart sample, **Line number 8**, did not include the signature of the person providing the service (or electronic equivalent) with the person's professional degree, licensure, or job title.

Corrective Action Description

It is the policy of the MHP to have the staff sign all MH progress notes, along with their signature and licensure/job title. In the age of electronic health records, this is completed instantaneously without staff requiring to complete anything additional. All of the MHP's large contracted providers have electronic health records as well, and this is not an issue. There was one note in the sample where this did occur, and it was for a provider with paper records. While the MHP does audit this particular provider on a yearly basis, it is not possible to audit 100% of all client records, the goal is to audit 5% of client records. The MHP does require the provider to conduct an internal audit of an

additional 5% their charts and report to the MHP on a quarterly basis, which is reported at the Quality Improvement Committee. This is an element that is already included in the yearly-required training for all staff who bill for mental health services, and it is also an element that is on the MH chart-monitoring tool that is tracked by QM. All staff will continue to be reminded and trained of this required element of MH chart documentation.

Proposed Evidence/Documentation of Correction

Mental Health Chart Monitoring Tool

Billable Service Codes Training Slides

Implementation Timeline: December 1, 2019

Requirement

The MHP shall ensure that progress notes describe how services provided reduced impairment, restored functioning, or prevented 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:

i. Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;
ii. Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
iii. Interventions applied, beneficiary's response to the intervention and the location of the interventions;
iv. The date the services were provided;
v. Documentation of referrals to community resources and other agencies, when appropriate;
vi. Documentation of follow-up care, or as appropriate, a discharge summary; and
vii. The amount of time taken to provide services; and
viii. 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: Progress Notes 5A

The progress note does not describe how services provided to the beneficiary reduced impairment, restored functioning, prevented significant deterioration in an important area of life functioning, or how services were necessary to correct or ameliorate a beneficiary's (under the age of 21) mental health condition. (MHP Condition, Exhibit A, Attachment 9) Below are the specific findings pertaining to the charts in the review sample:

Line number 1: Although group rehabilitative services were a planned service on the beneficiary's client plan, the nutrition group was not found to be medically necessary, as the focus of the group did not correspond to the beneficiary's functional impairments as described in the current assessment. **RR 6**

Line number 11: There is no description of the service intervention provided to the beneficiary. Specifically, there was no documentation noting the intervention applied on the part of the therapist during the Individual Therapy service dated 10/9/17. **RR 7**

Corrective Action Description

The MHP provides yearly training to its staff and to Individual/Organizational providers on documentation standards and requirements, including documentation standards for writing progress notes. When these standards are not met in certain circumstances, such as when the writer did not document an intervention that reduced the client's impairment, restored functioning, or prevented deterioration, then this service is reported to the county Fiscal department to be backed-out from the county claim from DHCS. This will continue to be the county standard, and the annual required training was updated to highlight this requirement and all staff will be re-retrained by 12-1-19. In order to prevent this from occurring, the MHP reviews a minimum of 5% of county charts, and on the review tool the reviewer is required to document a description of the intervention, which must match the intervention billed. This tool was updated to also include the information that the intervention must either reduce the identified impairment, restore functioning, or prevent deterioration. Supervisory staff will be trained on this tool at the September QM Skype meeting on 9-17-19. When an audit exception is found, it is first sent to the Supervisor to address with their staff, and to Fiscal for recoupment if required. Management and QM staff are also available for consult.

Proposed Evidence/Documentation of Correction

Billable Service Codes Training Slides

Mental Health Chart Review Tool

Implementation Timeline:

Training done by December 1, 2019

Supervisory staff will be trained on chart review tool on September 17, 2019

Requirement

The MHP shall ensure that progress notes describe how services provided reduced impairment, restored functioning, or prevented 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:

i. Timely documentation of relevant aspects of beneficiary care, including documentation of medical necessity;
ii. Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
iii. Interventions applied, beneficiary's response to the intervention and the location of the interventions;
iv. The date the services were provided;
v. Documentation of referrals to community resources and other agencies, when appropriate;
vi. Documentation of follow-up care, or as appropriate, a discharge summary; and
vii. The amount of time taken to provide services; and
viii. 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: Progress Notes 5B

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 charts in the review sample:

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).

Line numbers 4, 6, 7, 8, 9, 12, 14, 15, 16, 17 and 18.

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**.**

Line numbers 1, 2, 10 and 20.

Progress notes did not document the interventions applied, beneficiary's response to the interventions and the location of the interventions.

Line number 11.

Corrective Action Description

The MHP policy for timely completion of documentation is within 5 days of providing the service. This information is provided in the yearly required training for all MHP and Individual/Organizational provider staff which will be re-sent by 12-1-19.

Regarding the four client records where timeliness of the documentation could not be determined, these were all from a single Organizational provider. It was explained to the DHCS review team that this was a technical issue with the provider's electronic medical record that has since been resolved. The MHP has since returned to the provider to review their records and they are in compliance with this requirement, and the MHP has not encountered any additional records from any other provider with this issue at this time. This requirement remains in the yearly annual training for all providers as a reminder of this requirement.

There was one progress note in the sample, as stated above, where the clinician did not describe how the service provided reduced impairment, restored functioning, or prevented deterioration. It was a note in which a therapist was meeting with a young child who was unable to identify and verbalize his feelings, per the treatment plan, and the documented intervention was: "Client identified his feelings and thoughts about his father he has not seen in a long time" because he has been in jail. Although it may be implied that the clinician "assisted" client to identify his feelings, and that the note could have provided more information in regards to the specific intervention provided, it was unclear to the auditor what the intervention was, or that the clinician's intervention prevented deterioration. Nonetheless it is the MHP's policy, as stated in its required annual training, that all progress notes must describe how the service either reduced the impairment, restored functioning, or prevented deterioration. This annual required training will be to all MHP and Individual/Network provider staff by 12-1-19.

Regarding the lateness of documentation, a weekly report is automatically sent to all supervisors called the Late Notes Summary. This is a newer report that enables supervisory staff to follow-up with staff who ae struggling with adhering to these documentation standards and to come up with a plan to ensure that they are able to meet these standards going forward. Management is involved in these discussions as necessary.

Proposed Evidence/Documentation of Correction

Yearly Training Slides

Late Notes Summary Example

Implementation Timeline: December 1, 2019

Requirement

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

a) Every Service Contact:

i. Mental Health Services;

ii. Medication Support Services;

iii. Crisis Intervention;

iv. Targeted Case Management;

b) Daily:

i. Crisis Residential;

ii. Crisis Stabilization (1x/23hr);

iii. Day Treatment Intensive

c) Weekly:

i. Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, or marriage therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service;

ii. Day Rehabilitation

iii. Adult Residential

(MHP Contract, Ex. A, Attachment 9)

DHCS Finding: Progress Notes 5D

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

Line numbers 13 and 14: The type of SMHS (i.e. Targeted Case Management) documented on the progress note was not the same as the type of SMHS claimed (i.e. Collateral). **RR8b1**

Line numbers 11, 12, 13, 14, 15 and 19: For MHS 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 numbers 11 and 12: Family Therapy claimed; however, the beneficiary was not present for the service (Collateral service)

Line number 13: The service activity was Assessment; however, the claim was for Family Psychotherapy. Targeted Case Management documented; however, Collateral claimed.

Line number 14: Family Therapy claimed; however, there was no clear documentation of the family being present during the services. The documentation content is Plan Development (reference progress note 11/2/17).

Line numbers 15 and 19: Family therapy is claimed and client not present during services (i.e. Collateral services).

Line number 19: Collateral service claimed; however, documentation content was Assessment (reference progress note 11/2/17).

Corrective Action Description

It has been the practice of the MHP, as part of the on-going chart audit process, to ensure that the documented intervention matches the intervention that was claimed . This practice will be continued in the future, and will be reiterated to all Supervisors/Managers during the monthly QM Skype meeting where chart review issues are discussed, including the 9-17-19 meeting. As part of this POC, the MHP chart review tool will also be shared with the Organizational Providers to ensure that this element is also captured as part of their on-going review process. Providers are able to access MHP training materials and forms, including a copy of the chart review tool, on the MHP website here: https://www.placer.ca.gov/1981/Provider-Forms. In addition, the yearly required documentation and billing training was amended, which will be re-sent to all staff by 12-1-19, to highlight this important aspect of clinical documentation.

Proposed Evidence/Documentation of Correction

Mental Health Chart Audit Tool

MHP website for training materials

Yearly documentation and billing training slides

Implementation Timeline: December 1, 2019

Requirement

All entries in the beneficiary record (i.e. progress notes) include:

1) Date of service.

2) The signature of the person providing the service (or electronic equivalent);

3) The person's type of professional degree, licensure, or job title.

4) Relevant identification number (e.g. NPI number), if applicable.

5) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Att.9)

DHCS Finding: Progress Notes 5E

Documentation in the medical record indicated that one of the intervention service activities being provided was not in the scope of practice of the person delivering the service:

Line number 20: While the Rehabilitation service activity being provided was within the scope of practice of the person signing the progress note, a component of the service documentation was not, specifically the Mental Status Examination.

Corrective Action Description

The instance on Line 20 occurred with an Organizational Provider. This practice is not allowed at this provider, nor any provider, nor by any MHP staff as it is out of the scope of practice for the person delivering that service. All MHP staff, including all contracted providers, are required to undergo credentialing prior to hire and prior to providing any specialty mental health service. The credentialing process verifies the classification for the staff, which then determines the services they are allowed to bill. Prior to providing services to clients, all staff are required to take the Service Code and the Golden Thread trainings which highlight the requirements for billing specialty mental health services. Adherence to these requirements are then monitored by on-going chart monitoring activities.

Proposed Evidence/Documentation of Correction

Yearly documentation training slides

Implementation Timeline: December 1, 2019

Requirement

All entries in the beneficiary record (i.e. progress notes) include:

1) Date of service.

2) The signature of the person providing the service (or electronic equivalent);

3) The person's type of professional degree, licensure, or job title.

4) Relevant identification number (e.g. NPI number), if applicable.

5) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Att.9)

DHCS Finding: Progress Notes 5E2

The progress notes for the following line numbers indicate that the service provided was solely:

Clerical: **Line numbers 1 and 6. RR11f**

Corrective Action Description

There was one note in the sample in which a worker claimed for time for performing a mental status exam, which was out of the scope of practice for this staff member. This particular case occurred within an Organizational Provider where it was “practice” to begin documenting a progress note by first writing what they called a sort of shortened mental status. This practice has since stopped and staff have been directed to not document their observations of client behavior in this manner as it is out of their scope of practice. In addition to this, all MHP staff and Individual and Network/Organizational provider staff have been through a credentialing process through which they have been placed into one of the following categories of staff: LPHA; LPHA waived; MHRS; etc. Before new staff are hired, including Individual/Organizational providers, all staff are put through the credentialing process which includes primary source verification of documents, as appropriate. As staff become licensed or move into a different category, their Supervisor is responsible for notifying QM of the change so their status can be updated. In the future, the QM team will be working with the IT department to set-up a billing matrix within the electronic medical record as an additional safeguard to help prevent staff from billing for services that are outside of their scope of practice. It is the hope that this will be complete by end of calendar year 2019.

Regarding services billed that are solely clerical, the MHP agrees that no service performed by staff that is solely clerical should be billed to Medi-Cal. These services are included in the yearly required documentation training, and staff will again be reminded that although some of the duties they perform during the course of their employment may be required of them, not all of them are billable to Medi-Cal. This includes medication support staff, clinical staff, and non-clinical staff. To assist with this, QM created a new Service Code training which differentiates non-billable activities and activities that are otherwise billable to Medi-Cal, but are not for some reason (e.g. lockout, gap between service plans, etc.) This new training occurred on July 16th and July 23rd, and it is the hope that this will help improve the understanding of non-billable activities for staff, and improve their understanding of when services can appropriately be billed to Medi-Cal.

Proposed Evidence/Documentation of Correction

Uniform Registration and Credentialing and Re-Credentialing Policy

Yearly documentation training slides

Service Code Billing Training slides

Implementation Timeline:

Billing Code Training occurred July 16 and 23, 2019

IT Billing Code Matrix to be completed by December 31, 2019