San Francisco Department of Public Health Grant Colfax, MD
Director of Health

City and County of San Francisco
London N. Breed
Mayor

San Francisco County Mental Health Services

FY 2019-2020 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

Section A: Network Adequacy and Availability of Services

Requirement

The MHP did not furnish evidence to demonstrate that their subcontracted providers maintain hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the MHP shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the MHP, or another MHP. Per discussion during the review, the MHP will update its contract boilerplate to reflect this requirement.

DHCS Finding

A.I.G

Corrective Action Description

BHS Quality Management has started compiling MHP provider provisions to be incorporation into provider contracts. The BHS Contracts Unit is aware of the update and may need to run the changes by the City Attorney for approval. Upon approval of the new language the Managed Care Policy and Planning Coordinator will work with Contracts to implement new contract appendices within newly executed contracts or contract amendments.

Additionally, BHS's Business Office of Contract Compliance (BOCC) conducts annual program monitoring reviews. The monitoring protocol evaluates the program against their contract requirements and the annual MH Declaration of Compliance (MHDOC).

The DOC serves as notification and an attestation that providers are aware of any contract requirements that are subject to annual monitoring.

Current monitoring protocols require the review of posted hours of operations. The Declaration of Compliance will be updated to reflect annual monitoring of posted office hours, ensuring that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the MHP, or another MHP.

Providers can learn about contract changes at the annual BHS "What's New in Contracting" presentation facilitated by the Contract Development and Technical Assistance (CDTA) unit.

Proposed Evidence/Documentation of Correction

Executed Provider Contract

Declaration of Compliance

Ongoing Monitoring (if included)

The Business Office of Contract Compliance (BOCC) will conduct annual monitoring of the program's office hours.

Person Responsible: Managed Care Policy and Planning Coordinator, Elissa Velez; BOCC Manager, Tom Mesa; and Contracting Analyst, Arleen Lee.

Implementation Timeline:

October 31st, 2021

Requirement

The MHP did not submit evidence that the contractor is required to maintain data and records in an accessible location and condition, and that this audit right exists for 10 years from the final date of the contract period, or from the date of completion of any audit, whichever is later. However, per the discussion during the review, the MHP will update the contract boilerplate to reflect requirement.

DHCS Finding

A.VI.D10

Corrective Action Description

BHS Quality Management has started compiling MHP provider provisions to be incorporation into provider contracts. The BHS Contracts Unit is aware of the update and may need to run the changes by the City Attorney for approval. Upon approval of the new language the Managed Care Policy and Planning Coordinator will work with

Contracts to implement new contract appendices within newly executed contracts or contract amendments.

Additionally, BHS's Business Office of Contract Compliance (BOCC) conducts annual program monitoring reviews. The monitoring protocol evaluates the program against their contract requirements and the annual MH Declaration of Compliance (MHDOC). The DOC serves as notification and an attestation that providers are aware of any contract requirements that are subject to annual monitoring.

Current monitoring protocols require the review of program policies and procedures. The Declaration of Compliance will be updated to reflect monitoring of contractors record retention policies.

Providers can learn about contract changes at the annual BHS "What's New in Contracting" presentation facilitated by the Contract Development and Technical Assistance (CDTA) unit.

Proposed Evidence/Documentation of Correction

Executed Provider Contract

Declaration of Compliance

SF BHS Policy 3.10-07: Security and Retention of Behavioral Health Services Medical Records

Ongoing Monitoring (if included)

The Business Office of Contract Compliance (BOCC) will conduct annual monitoring of the program policies including record retention.

Person Responsible

Managed Care Policy and Planning Coordinator, Elissa Velez; BOCC Manager, Tom Mesa; and Contracting Analyst, Arleen Lee.

Implementation Timeline:

October 31st, 2021

Requirement

Report revealed one (1) of the 76 providers were overdue. Per discussion during the review, the MHP indicated they were aware of the overdue provider and is now in the process of working with DHCS to ensure they are in compliance.

DHCS Finding [Finding Number]

A.VI.E

Corrective Action Description

The provider in question was Westcoast Children's Clinic, of Oakland, California, Alameda County. This out-of-county provider was processing its requirements for a fire clearance with their local authority at the time of the DHCS audit.

Proposed Evidence/Documentation of Correction

The City and County of San Francisco's Department of Public Health Business Office mirrors its certification database on the state PMIS database. The state database documents that Westcoast Children's Clinic was last certified on May 19, 2020 and this is current. The state can research this fact/status for this provider in its Provider Management Information System.

Ongoing Monitoring (if included)

The Business Office utilizes its re-certification database to remind and prompt providers at six (6) months prior to certification expiration and at the three (3) months prior to certification expiration. This practice has been in place for years and the Business Office has confidence in its efficacy and efficiency. The Business Office, however, only can prompt providers; they must arrange for their fire clearance and pay any fees such inspections require in whichever county the program is sited. The Business Office is prepared to terminate certification for any provider who fails to meet the minimum requirements.

Person Responsible

The section within the Department of Public Health with responsibility is the Business Office Contract Compliance (BOCC) section. The Director is Thomas Mesa, MSW, MPH and the certification database manager is BOCC's Jerna Reyes, LFMT.

Section D: Access and Information Requirements

Requirement

The MHP did not submit evidence that the MHP ensures that information included in a paper provider directory is updated at least monthly and electronic provider directories are updated no later than 30 calendar days after the MHP receives updated provider information. Per the discussion during the review, the MHP will update the provider directory to reflect this requirement.

DHCS Finding

D.IV.B

Corrective Action Description

The Managed Care Policy and Planning Coordinator will make final edits to the MH Provider Director and post it online. To standardize the monthly update process a Provider Directory Standard Workflow will be developed as direction for a new Quality Management Healthcare Analyst position to complete appropriate steps for making monthly updates to the provider Directory. Going forward this position will be responsible for coordinating with other departments to run staff reports and make monthly updates to the Directory.

Proposed Evidence/Documentation of Correction

Provider Directory

Provider Directory Standard Workflow

Ongoing Monitoring (if included)

The San Francisco MHP Provider Directory will subject to ongoing DHCS monitoring.

Person Responsible (job title)

Managed Care Policy and Planning Coordinator, Elissa Velez

Implementation Timeline:

October 31st, 2021

DHCS Test Calls

Requirement

Pertaining to DHCS test calls: - While the MHP submitted evidence (Final Service Log FY19-20) to demonstrate compliance with this requirement, one (1) of five required DHCS test calls were not logged on the MHP's written log of initial request. DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1810, subdivision 405(f). The MHP must complete a CAP addressing this finding of partial compliance.

DHCS Finding

D.VI.C1

Corrective Action Description

In response to the finding, the MHP will monitor the accuracy of its Access Call Center's call log and report findings at the monthly Quality Assurance Meeting between the county's Behavioral Health Access Center (BHAC) and its after-hours call line subcontractor, San Francisco Suicide Prevention (SFSP). Review of the call log will be a standing item on the agenda, giving BHAC and SFSP an opportunity to reflect on discrepancies and identify and implement improvements.

During test caller training, the MHP will emphasize the importance of documenting details from test calls. The Quality Improvement Coordinator, who facilitates the training, will describe to test callers that details like the name used during a test call, the date and start and end time of the call, and the name of the clinician who answered the call, helps staff from BHAC identify the call on the log and lends an opportunity to cross check what the test caller and clinician documented for accuracy. This guidance will also be included in a training manual and made available to test callers.

Part of managing an accurate call log relies of timely feedback. One mechanism for ensuring timely feedback is promptly reviewing test calls. This can only happen when test callers submit test call summary forms immediately after completing test calls and notifying the designated staff that a test call was completed. To remind test callers to promptly submit notice of completion of test call and test call summary form, the Quality Improvement Coordinator will include guidance in the email notification that goes out to test callers with their test call assignment. Upon notification of completed test call, BHAC's designee will review the test call and provide timely feedback regarding discrepancies in the test call summary form or call log.

The CAP finding will be discussed on April 28, 2021 at the BHAC and SFSP Quality Assurance Meeting and a strategy for implementation will be agreed on.

Proposed Evidence/Documentation of Correction

BHAC / SFSP Quality Assurance Meeting Minutes – The meeting minutes will document monitoring of the call log, discussion of discrepancies, and interventions for improving accuracy of the log. The minutes will also serve as evidence of discussing the CAP's implementation plan and monitoring of the CAP.

24-7 Access Line Test Call Program Training Manual – The manual emphasizes to test callers the importance of documenting details about the call such as the name used, date of the call, start and end time of the call, and who answered the call.

Email Notifications to Test Callers Regarding Test Call Assignments – The notification will include guidance on how to promptly submit completed Test Call Summary Forms so that BHAC staff can track calls.

Ongoing Monitoring (if included)

Ensuring an accurate call log will require ongoing monitoring. Monitoring of the improvement interventions will happen at the monthly Access Call Center Quality Assurance Meeting.

Person Responsible

Quality Improvement Coordinator, Liliana De La Rosa and Behavioral Health Access Center Lead Eligibility Worker, Avis Thompson

Implementation Timeline:

Monitoring of call log at monthly Access Call Center Quality Assurance meeting – Implemented April 2021

Guidance on test call documentation – Implemented April 2021

Guidance on timely submission of test calls – Implemented April 2021

Timely feedback on test calls and call log – Implemented April 2021

Section E: Coverage and Authorization of Services

Requirement

The MHP did not furnish evidence to demonstrate that the MHP provides SMHS immediately, and without prior authorization, in situations when a foster child or youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition. Per the discussion during the review, the MHP will update the contract boilerplate to reflect this requirement.

DHCS Finding

E.III.M

Corrective Action Description

Comprehensive Child Crisis is a County operated program providing 24 hours crisis evaluation and intervention. Services include 24-hour, multilingual, crisis intervention and short-term stabilization for families and children who are experiencing emotional distress related to family violence, physical or emotional illness, school truancy, behavioral problems and other crises. Because this is a civil service program a contract does not exist between entities, and therefore cannot be updated to include the requirement citation.

To demonstrate evidence that Comprehensive Child Crisis provides SMHS immediately, and without prior authorization, in crisis situations when a foster child or youth is in imminent danger to themselves or others or experiencing an emergency psychiatric condition, BHS will submit the Comprehensive Child Crisis operations manual.

Proposed Evidence/Documentation of Correction

The Comprehensive Child Crisis Operations Manual

Ongoing Monitoring (if included)

Person Responsible

Comprehensive Child Crisis Program Director, Stephany Felder.

Implementation Timeline

October 31st, 2021

Requirement

The MHP did not furnish evidence to demonstrate they have a procedure for expedited transfers within 48-hours of placement of the foster child or youth outside of the county of original jurisdiction. Per the discussion during the review, the MHP will update the contract boilerplate to reflect this requirement.

DHCS Finding

E.III.N

Corrective Action Description

BHS and the San Francisco Human Service Agency (HSA) work collaboratively to coordinate Presumptive Transfer. HSA is its own city department, therefore we do not contract with them for services. HSA operates as the placing agency and therefore maintains ownership of expedited transfer. HSA has initiated a system change with their policy department. They have agreed to update the Presumptive Transfer policy materials to specify that expedited transfers occur within 48-hours of placement of the foster child or youth outside of the county of original jurisdiction.

Proposed Evidence/Documentation of Correction

Policy and/or Presumptive Transfer Workflow

Ongoing Monitoring (if included)

Person Responsible

Program Manager, Family & Children's Services, Human Service Agency, Liz Cudo.

Implementation Timeline

October 31st, 2021

Requirement

Per the service request log, the MHP did not furnish evidence to demonstrate they provide beneficiaries with a Notice of Adverse Beneficiary Determination (NOABD) under the required circumstances. The MHP is aware that they are out of compliance with this requirement and must complete a CAP addressing this finding.

DHCS Finding

E.IV.A.4

Corrective Action Description

In response to the finding, the MHP will provide beneficiaries with a NOABD upon failure to provide services in a timely manner and that such a provision will be reflected in the (NOABD) column of the service request log moving forward.

In an effort to expedite the implementation of this correction, 2 action steps were initiated;

1. On 4/23/21 a list of all potential NOABD recipients who contacted BHAC from 1/1/21-4/5/21 was created. The resultant 72 page list was then analyzed along with other relevant AVATAR client information to identify 33 beneficiaries who should have received timely NOABDs. This process, however, required several hours of staff time, and as such, was time prohibitive.

2. As a result, on 5/4/21 an AVATAR New Report Request Form was submitted for the creation of a "NOABD Report" which will pull from multiple data sets in the AVATAR data base to identify all San Francisco Medical beneficiaries who do not meet Medical Necessity for Specialty Mental Health services, and thus require a NOABD.

Subsequently, on 5/6/21 the following NOABD Protocol was developed;

- Clinical staff will be provided with a NOABD training (ASAP, date TBA) which will assist them in understanding the circumstances under which each of the 9 NOABD letters are to be issued and the appropriate time lines for notice deployment. Clinical staff will also be provided with "refresher" trainings as needed in order for staff to maintain proficiency.

- ***Daily*,** Clinical staff will;

1. Identify all SF medical beneficiaries they come in contact with who do not meet medical necessity for Specialty Mental Health Services.
2. Identify the proper NOABD letter to be sent.
3. Complete the beneficiary's demographics and other required information on the NOABD.
4. Down load the "Your Rights", "Nondiscrimination" and "Language Assistance" notices as required and add these 4 documents along with the appropriate NOABD to an envelope with the beneficiaries mailing address on it. (Beneficiaries without a valid mailing address with have their NOABD sent C/O their provider for delivery to the beneficiary.)
5. Place it in the outgoing mail prior to the end of the shift.
6. Store the original NOABD in the client file and send a copy to Quality Management @ 1380 Howard Street, 2nd Floor.

- ***Weekly,*** Clinical staff will submit a “NOABD Beneficiary List” to the MHA Coordinator for review (A fillable form will be created for this purpose) which will consist of all clients to whom NOABDs were sent and will include client #, disposition including NOABD type, mailing address and date of determination.

Proposed Evidence/Documentation of Correction

BHAC MHA Clinical Staff Meeting minutes (4.8.21 & 4.29.21) –Meeting minutes will document the reported need to begin issuing NOAB letters to certain San Francisco Medical beneficiaries and that there is no current process in place to do so. They will also document efforts to have a NOABD report developed which would identify all those who require NOABDs as well as a stop gap measures that can be utilized in the meantime.

AVATAR New Report Request Form (5.4.21.) –The submission of this request form documents efforts to quickly and efficiently identify all beneficiaries that require NOABDs as well as a way to provide timely Quality Assurance.

BHAC Mental Health Access Program NOABD Protocol (5.6.21.)-The development of this protocol, which will be added to BHAC Policies and Procedures, and illustrates clear, step by step procedures for staff to follow in order to provide all relevant beneficiaries with timely NOABDs.

Ongoing Monitoring (if included)

MHA Coordinator with cross reference all NOABD Beneficiary Lists provided weekly by clinical staff with the newly created NOABD Report as a quality control measure to assure that no San Francisco Medical beneficiary requiring a NOABD was missed.

Person Responsible (job title)

Craig Murdock, Behavioral Health Access Center Director and Ron Harris, Mental Health Access Program Coordinator.

Implementation Timeline

4/23/21 a list of all potential NOABD recipients who contacted BHAC from 1/1/21-4/5/21 was created.

5/4/21 an AVATAR New Report Request Form was submitted to Kellee Hom, Ph.D. for the creation of a “NOABD Report.” Once created, implementation planned for May/June, 2021.

5/5/21 Melissa Bloom, Ph.D. was contacted for technical assistance regarding beneficiaries who require NOABDs. A request was also placed for BHAC staff to receive training on proper NOABD deployment. Implementation planned for May/June, 2021.

5/6/21 BHAC NOABD Protocol was developed (implementation planned for May/June, 2021.)

Development of a fillable NOABD Beneficiary List to be utilized weekly by clinical staff to report to leadership all beneficiaries who were issued NOABDs that week. Implementation planned for May/June, 2021.

Section G: Program Integrity

Requirement

The MHP must submit disclosures and updated disclosures to the Department or HHS including information regarding certain business transactions within 35 days, upon request.

1. The ownership of any subcontractor with whom the MHP has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
2. Any significant business transactions between the MHP and any wholly owned supplier, or between the MHP and any subcontractor, during the 5-year period ending on the date of the request.
3. The MHP must obligate network providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.

DHCS Finding G.IV.F

The MHP did not furnish evidence to demonstrate they submit disclosures and updated disclosures to the Department or Health and Human Services including information regarding certain business transactions within 35 days, upon request.

Corrective Action Description

BHS Compliance and Quality Management will work with the Contract Development and Technical Assistance unit to develop a procedure to ensure that its contractors submit ownership disclosures within 35 days of any change in ownership, and prior to entering into or renewing any contract.

This requirement and procedure will be communicated to providers through the annual BHS “What’s New in Contracting” presentation.

Proposed Evidence/Documentation of Correction

BHS Disclosure Form and the “What’s New in Contracting” PowerPoint presentation.

Ongoing Monitoring (if included)

Based on the procedure, MHP will identify ongoing monitoring mechanisms.

Person(s) Responsible

Compliance Officer, Joe Turner; Managed Care Policy and Planning, Elissa Velez; and CDTA Point staff.

Implementation Timeline

December 26th, 2021

Requirement

The MHP shall submit the following disclosures to DHCS regarding the MHP's management:

1. The identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).)
2. The identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).) For this purpose, the word "agent" has the meaning described in 42 Code of Federal Regulations part 455.101.

DHCS Finding G.IV.G1-2

The MHP did not furnish evidence to demonstrate they submit disclosures to DHCS of the identity of any person who is a managing employee of the MHP who has been convicted of a crime related to federal health care programs, and the identity of any person who is an agent of the MHP who has been convicted of a crime related to federal health care programs.

Corrective Action Description

The BHS Compliance Officer will develop a policy and procedure to disclose the identity of any managing employee who has been convicted of a crime related to federal health care programs to DHCS. The MPH has already sought guidance from DHCS regarding necessary reporting information to begin developing the policy and procedure.

Proposed Evidence/Documentation of Correction

The MHP will submit the policy and procedure document to DHCS.

Ongoing Monitoring (if included)

BHS Compliance will report out annually.

Person Responsible

Compliance Officer, Joe Turner.

Implementation Timeline

December 26th, 2021

Section H: Other Regulatory and Contractual Requirements

Requirement

The MHP did not provide evidence that they allow inspection, evaluation and audit of its records, documents and facilities, and those of its subcontractors, for 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. However, per the discussion during the review, the MHP is aware that they are not in compliance with this requirement.

DHCS Finding

H.B.2

Corrective Action Description

BHS Quality Management has started compiling MHP provider provisions to be incorporation into provider contracts. The BHS Contracts Unit is aware of the update and may need to run the changes by the City Attorney for approval. Upon approval of the new language the Managed Care Policy and Planning Coordinator will work with Contracts to implement new contract appendices within newly executed contracts or contract amendments.

Additionally, BHS's Business Office of Contract Compliance (BOCC) conducts annual program monitoring reviews. The monitoring protocol evaluates the program against their contract requirements and the annual MH Declaration of Compliance (MHDOC). The DOC serves as notification and an attestation that providers are aware of any contract requirements that are subject to annual monitoring.

Current monitoring protocols require the review of program policies and procedures. The Declaration of Compliance will be updated to reflect monitoring of our contractor's policies related to record retention and availability for inspection, evaluation and audit of records, documents, and facilities.

Providers can learn about contract changes at the annual BHS "What's New in Contracting" presentation facilitated by the Contract Development and Technical Assistance (CDTA) unit.

Proposed Evidence/Documentation of Correction

Mental Health Declaration of Compliance and the "What's New in Contracting" PowerPoint presentation.

Ongoing Monitoring (if included)

The Business Office of Contract Compliance (BOCC) will conduct annual monitoring of the program policies including record retention.

Person Responsible

Managed Care Policy and Planning Coordinator, Elissa Velez; and BOCC Manager, Tom Mesa.

Implementation Timeline:

October 31st, 2021

Chart Review

Section I: Chart Review – Non-Hospital Services

<u>Section I, Item 1A-3b</u>

Requirement

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

The proposed and actual intervention(s) meet the intervention criteria listed below:

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).)

DHCS Finding 1A-3b

The actual interventions documented in the progress note(s) for the following Line number(s) do not meet medical necessity criteria since the intervention(s) were not reasonably likely to result in at least one of the following: a) significantly diminish the impairment; b) prevent deterioration in an important area of life functioning; c) allow the child to progress developmentally; d) correct or ameliorate the mental health condition of a beneficiary who is under age 21.

The MHP shall submit a CAP that describes how the MHP will ensure that all SMHS interventions are reasonably likely to correct or reduce the beneficiary's documented

mental health condition, prevent the condition's deterioration, or help a beneficiary who is under age 21 to progress developmentally as individually appropriate.

Corrective Action Description

BHS has been operating without Quality Assurance staff since December 2019. To support providers with clinical documentation that reflects that the SMHS interventions are reasonably likely to diminish impairments, prevent significant deterioration in functioning or allow a child to appropriately progress developmentally, BHS plans to hire a Quality Assurance Team.

The objective of this team will be to design and oversee clinical chart reviews and technical assistance processes that ensure accurate documentation to support billing of services, and identify areas for improvement in the quality of assessments, treatment plans, and progress notes.

Specific responsibilities for this team will include: Conducting a System of Care sponsored Training, Technical Assistance, Coaching: (a) staff-level documentation training; (b) supervisor-level training on efficient chart-review process; (c) Director- level training on Utilization Review for inter- rater reliability and consistency and use of Avatar reports for effective monitoring; (d) development of new documentation resources (e.g., manuals). Training will ensure that Weekly Summary is present and accurately reflects services provided. Structured Internal File Review/QA Reporting Activity (Using DHCS-BHS Protocol): (a) a structured file review process to monitor documentation quality assurance elements (e.g., a sample of every staff member's charts, twice a year); (b) reporting and aggregating QA elements at the program-, agency-, System Section-, and System-levels. Monitoring & internal reviews will ensure compliance with established written documentation requirements.

The hiring process for a Senior Behavioral Health Clinician to lead this team could take many months. In the meantime, the MHP is preparing to update the County Documentation Manual, which will also serve as support for providers making medical necessity determinations.

Proposed Evidence/Documentation of Correction

Sign in sheets from Trainings; updated MHP Documentation Manual; QA plan; select copies of reports of audits conducted by System of Care.

Ongoing Monitoring (if included)

Quality Assurance staff and Clinical staff complete peer chart audits to monitor medical necessity of services and provide plan of correction status report at quarterly Compliance Committee meetings.

Person Responsible

Acting Director of Quality Management, Diane Prentiss.

Implementation Timeline

QA hire December 26th, 2021

<u>Section I, Item 1A-3b1</u>

Requirement

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

The MHP shall ensure that progress notes describe how services provided reduced the impairment, restored functioning, or prevented significant deterioration in an important area of life functioning outlined in the client plan. (MHP Contract, Ex. A, Att. 9)

DHCS Finding 1A-3b1

The intervention(s) documented on the progress note(s) do not meet medical necessity since the service provided was solely clerical.

The MHP shall submit a CAP that describes how the MHP will ensure that services provided and claimed are not solely transportation, clerical, or payee related.

Corrective Action Description

BHS has been operating without Quality Assurance staff since December 2019. To support providers with clinical documentation that reflects that the SMHS interventions are reasonably likely to diminish impairments, prevent significant deterioration in functioning or allow a child to appropriately progress developmentally, BHS plans to hire a Quality Assurance Team.

The objective of this team will be to design and oversee clinical chart reviews and technical assistance processes that ensure accurate documentation to support billing of services, and identify areas for improvement in the quality of assessments, treatment plans, and progress notes.

Specific responsibilities for this team will include: Conducting a System of Care sponsored Training, Technical Assistance, Coaching: (a) staff-level documentation training; (b) supervisor-level training on efficient chart-review process; (c) Director- level training on Utilization Review for inter- rater reliability and consistency and use of Avatar reports for effective monitoring; (d) development of new documentation resources (e.g., manuals). Training will ensure that Weekly Summary is present and accurately reflects services provided. Structured Internal File Review/QA Reporting Activity (Using DHCS-BHS Protocol): (a) a structured file review process to monitor documentation quality assurance elements (e.g., a sample of every staff member's charts, twice a year); (b) reporting and aggregating QA elements at the program-, agency-, System Section-, and

System-levels. Monitoring & internal reviews will ensure compliance with established written documentation requirements.

The hiring process for a Senior Behavioral Health Clinician to lead this team could take many months. In the meantime, the MHP is preparing to update the County Documentation Manual, which will also serve as support for providers making medical necessity determinations.

Proposed Evidence/Documentation of Correction

Sign in sheets from Trainings; updated MHP Documentation Manual; QA plan; select copies of reports of audits conducted by System of Care.

Ongoing Monitoring (if included)

Quality Assurance staff and Clinical staff complete peer chart audits to monitor medical necessity of services and provide plan of correction status report at quarterly Compliance Committee meetings.

Person Responsible

Acting Director of Quality Management, Diane Prentiss.

Implementation Timeline

QA hire December 26th, 2021

<u>Section I, 2A</u>

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 2A

Assessments were not completed in accordance with regulatory and contractual requirements, specifically: One or more assessments were not completed within the initial timeliness and/or update frequency requirements specified in the MHP's written documentation standards. According to MHP policy, an Initial Assessment is due within 60 days of the Episode Opening Date (EOD) "or prior to first planned service – whichever comes first." According to the MHP policy, an updated Assessment occurs each year during the 30-day period before the anniversary of the episode opening date.

The MHP shall submit a CAP that provides evidence that the MHP has written documentation standards for assessments, including required elements or timeliness and frequency as required in the MHP Contract with the Department

Corrective Action Description

BHS has a number of written materials online to support clinical analysis, charting, and documenting. Current documentation reference materials include the Outpatient SMHS Documentation Manual and the SMHS Desk Reference, which clearly identify the timeliness and frequency of assessments. A table labeled "BHS Standards for Assessment Timeliness & Frequency" can be found on page 28 of the 2017 Documentation Manual-Outpatient SMHS (sfdph.org).

To further support quality assurance efforts for SMHS, BHS plans to hire a Quality Assurance Team. The objective of this team will be to design and oversee clinical chart reviews and technical assistance processes that ensure accurate documentation to support billing of services, and identify areas for improvement in the quality of assessments, treatment plans, and progress notes.

Specific responsibilities for this team will include: Conducting a System of Care sponsored Training, Technical Assistance, Coaching: (a) staff-level documentation training; (b) supervisor-level training on efficient chart-review process; (c) Director- level training on Utilization Review for inter- rater reliability and consistency and use of Avatar reports for effective monitoring; (d) development of new documentation resources (e.g., manuals). Training will ensure that Weekly Summary is present and accurately reflects services provided. Structured Internal File Review/QA Reporting Activity (Using DHCS-BHS Protocol): (a) a structured file review process to monitor documentation quality assurance elements (e.g., a sample of every staff member's charts, twice a year); (b) reporting and aggregating QA elements at the program-, agency-, System Section-, and System-levels. Monitoring & internal reviews will ensure compliance with established written documentation requirements.

The hiring process for a Senior Behavioral Health Clinician to lead this team could take many months. In the meantime, the MHP is preparing to update the County Documentation Manual, which will also serve as support for providers making medical necessity determinations.

Proposed Evidence/Documentation of Correction

Sign in sheets from Trainings; updated MHP Documentation Manual; QA plan; select copies of reports of audits conducted by System of Care.

Ongoing Monitoring (if included)

Quality Assurance staff and Clinical staff complete peer chart audits to monitor medical necessity of services and provide plan of correction status report at quarterly Compliance Committee meetings.

Person Responsible

Acting Director of Quality Management, Diane Prentiss.

Implementation Timeline

QA hire December 26th 2021

Section I, 2B

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 2B

One or more of the Assessments reviewed does not address all of the required elements specified in the MHP Contract. Specifically: a) Mental Health History, b) Medical History, c) Medications, d) Risks, specific to whether the beneficiary experienced past or current trauma, e) Mental Status Examination.

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

Corrective Action Description

BHS has been operating without Quality Assurance staff since December 2019. To support providers with clinical documentation that reflects all required elements specified in the MHP, BHS plans to hire a Quality Assurance Team.

The objective of this team will be to design and oversee clinical chart reviews and technical assistance processes that ensure accurate documentation to support billing of services, and identify areas for improvement in the quality of assessments, treatment plans, and progress notes.

Specific responsibilities for this team will include: Conducting a System of Care sponsored Training, Technical Assistance, Coaching: (a) staff-level documentation training; (b) supervisor-level training on efficient chart-review process; (c) Director- level training on Utilization Review for inter- rater reliability and consistency and use of Avatar reports for effective monitoring; (d) development of new documentation resources (e.g., manuals). Training will ensure that Weekly Summary is present and accurately reflects services provided. Structured Internal File Review/QA Reporting Activity (Using DHCS-BHS Protocol): (a) a structured file review process to monitor documentation quality assurance elements (e.g., a sample of every staff member's charts, twice a year); (b) reporting and aggregating QA elements at the program-, agency-, System Section-, and System-levels. Monitoring & internal reviews will ensure compliance with established written documentation requirements.

The hiring process for a Senior Behavioral Health Clinician to lead this team could take many months. In the meantime, the MHP is preparing to update the County Documentation Manual, which will also serve as support for providers making medical necessity determinations.

Proposed Evidence/Documentation of Correction

Sign in sheets from Trainings; updated MHP Documentation Manual; QA plan; select copies of reports of audits conducted by System of Care.

Ongoing Monitoring (if included)

Quality Assurance staff and Clinical staff complete peer chart audits to monitor medical necessity of services and provide plan of correction status report at quarterly Compliance Committee meetings.

Person Responsible

Acting Director of Quality Management, Diane Prentiss.

Implementation Timeline

QA hire December 26th 2021

Section I, 3A

Requirement

The provider obtains and retains 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 3A

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, and there is no documentation in the medical record of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent.

The MHP shall submit a CAP 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

BHS has been operating without Quality Assurance staff since December 2019. In an effort to support proper documentation and enforce use of required forms, such as consents BHS plans to hire a Quality Assurance Team.

The objective of this team will be to design and oversee clinical chart reviews and technical assistance processes that ensure accurate documentation to support billing of services, and identify areas for improvement in the quality of assessments, treatment plans, and progress notes.

Specific responsibilities for this team will include: Conducting a System of Care sponsored Training, Technical Assistance, Coaching: (a) staff-level documentation

training; (b) supervisor-level training on efficient chart-review process; (c) Director- level training on Utilization Review for inter- rater reliability and consistency and use of Avatar reports for effective monitoring; (d) development of new documentation resources (e.g., manuals). Training will ensure that Weekly Summary is present and accurately reflects services provided. Structured Internal File Review/QA Reporting Activity (Using DHCS-BHS Protocol): (a) a structured file review process to monitor documentation quality assurance elements (e.g., a sample of every staff member's charts, twice a year); (b) reporting and aggregating QA elements at the program-, agency-, System Section-, and System-levels. Monitoring & internal reviews will ensure compliance with established written documentation requirements.

The hiring process for a Senior Behavioral Health Clinician to lead this team could take many months. In the meantime, the MHP is preparing to update the County Documentation Manual, which will also serve as support for providers making medical necessity determinations.

Proposed Evidence/Documentation of Correction

Sign in sheets from Trainings; updated MHP Documentation Manual; QA plan; select copies of reports of audits conducted by System of Care.

Ongoing Monitoring (if included)

Quality Assurance staff and Clinical staff complete peer chart audits to monitor medical necessity of services and provide plan of correction status report at quarterly Compliance Committee meetings.

Person Responsible

Acting Director of Quality Management, Diane Prentiss.

Implementation Timeline

QA hire December 26th 2021

<u>Section I, 4B-1</u>

Requirement

The client plan has been updated at least annually and/or when there are significant changes in the beneficiary's condition.

DHCS Finding 4B-1

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).

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

1) Client plans are completed prior to the provision of planned services.

2) Planned services are not claimed when the service provided is not included on a current Client Plan.

Corrective Action Description

BHS has been operating without Quality Assurance staff since December 2019. To support providers in completing compliant documentation, BHS plans to hire a Quality Assurance Team.

The objective of this team will be to design and oversee clinical chart reviews and technical assistance processes that ensure accurate documentation to support billing of services, and identify areas for improvement in the quality of assessments, treatment plans, and progress notes.

Specific responsibilities for this team will include: Conducting a System of Care sponsored Training, Technical Assistance, Coaching: (a) staff-level documentation training; (b) supervisor-level training on efficient chart-review process; (c) Director- level training on Utilization Review for inter- rater reliability and consistency and use of Avatar reports for effective monitoring; (d) development of new documentation resources (e.g., manuals). Training will ensure that Weekly Summary is present and accurately reflects services provided. Structured Internal File Review/QA Reporting Activity (Using DHCS-BHS Protocol): (a) a structured file review process to monitor documentation quality assurance elements (e.g., a sample of every staff member's charts, twice a year); (b) reporting and aggregating QA elements at the program-, agency-, System Section-, and System-levels. Monitoring & internal reviews will ensure compliance with established written documentation requirements.

The hiring process for a Senior Behavioral Health Clinician to lead this team could take many months. In the meantime, the MHP is preparing to update the County Documentation Manual, which will also serve as support for providers making medical necessity determinations.

Proposed Evidence/Documentation of Correction

Sign in sheets from Trainings; updated MHP Documentation Manual; QA plan; select copies of reports of audits conducted by System of Care.

Ongoing Monitoring (if included)

Quality Assurance staff and Clinical staff complete peer chart audits to monitor medical necessity of services and provide plan of correction status report at quarterly Compliance Committee meetings.

Person Responsible

Acting Director of Quality Management, Diane Prentiss.

Implementation Timeline

QA hire December 26th 2021

<u>Section I, 4C</u>

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 impairment as a result of the mental health diagnosis.
2) Identify the proposed type(s) of interventions or modality, including a detailed description of the intervention to be provided.
3) Have a proposed frequency of the 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 or emotional disturbance.

6) Have interventions are consistent with client plan goal(s)/treatment objective(s).

7) Have interventions are consistent with the qualifying diagnoses.

DHCS Finding 4C

Client Plans do not include all of the required elements specified in the MHP Contract. Specifically:

• One or more goal/treatment objective is not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments.

• One or more proposed intervention does not include a detailed description. Instead, only a "type" or "category" of intervention was recorded.

• One or more proposed intervention does not include a specific expected frequency or frequency range.

• One or more proposed intervention does not include an expected duration.

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

• One or more client plan does not address the mental health needs and functional impairments identified as a result of the mental disorder.

• One or more proposed intervention is not consistent with client plan goals/treatment objectives

• One or more client plan is not consistent with the qualifying diagnosis.

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

1) 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) 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) Mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.

4) 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.

5) Mental health interventions proposed on client plans are consistent with client plan goals/treatment objectives.

6) Client plans are consistent with the qualifying diagnosis.

Corrective Action Description

BHS has been operating without Quality Assurance staff since December 2019. To support providers in completing compliant documentation, BHS plans to hire a Quality Assurance Team.

The objective of this team will be to design and oversee clinical chart reviews and technical assistance processes that ensure accurate documentation to support billing of services, and identify areas for improvement in the quality of assessments, treatment plans, and progress notes.

Specific responsibilities for this team will include: Conducting a System of Care sponsored Training, Technical Assistance, Coaching: (a) staff-level documentation training; (b) supervisor-level training on efficient chart-review process; (c) Director- level training on Utilization Review for inter- rater reliability and consistency and use of Avatar reports for effective monitoring; (d) development of new documentation resources (e.g., manuals). Training will ensure that Weekly Summary is present and accurately reflects services provided. Structured Internal File Review/QA Reporting Activity (Using DHCS-BHS Protocol): (a) a structured file review process to monitor documentation quality assurance elements (e.g., a sample of every staff member's charts, twice a year); (b) reporting and aggregating QA elements at the program-, agency-, System Section-, and

System-levels. Monitoring & internal reviews will ensure compliance with established written documentation requirements.

The hiring process for a Senior Behavioral Health Clinician to lead this team could take many months. In the meantime, the MHP is preparing to update the County Documentation Manual, which will also serve as support for providers making medical necessity determinations.

Proposed Evidence/Documentation of Correction

Sign in sheets from Trainings; updated MHP Documentation Manual; QA plan; select copies of reports of audits conducted by System of Care.

Ongoing Monitoring (if included)

Quality Assurance staff and Clinical staff complete peer chart audits to monitor medical necessity of services and provide plan of correction status report at quarterly Compliance Committee meetings.

Person Responsible

Acting Director of Quality Management, Diane Prentiss.

Implementation Timeline

QA hire December 26th 2021

<u>Section I, 4E</u>

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 4E

There is 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 a signature was required by the MHP Contract with the Department and/or by the MHP's written documentation standards: The beneficiary or legal representative was required to sign the Client Plan per the MHP's written documentation standards. However, the signature was missing.

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

1) Each beneficiary's participation in and agreement with all client plans are obtained and documented. 2) The beneficiary's signature is obtained on the Client Plan in accordance with the MHP policy. 3) Services are not claimed when the beneficiary's: a) Participation in and agreement with the Client Plan is not obtained and the reason for refusal is not documented; b) Signature is not obtained when required or not obtained and the reason for refusal is not documented.

Corrective Action Description

BHS has been operating without Quality Assurance staff since December 2019. To support providers in completing compliant documentation, BHS plans to hire a Quality Assurance Team.

The objective of this team will be to design and oversee clinical chart reviews and technical assistance processes that ensure accurate documentation to support billing of services, and identify areas for improvement in the quality of assessments, treatment plans, and progress notes.

Specific responsibilities for this team will include: Conducting a System of Care sponsored Training, Technical Assistance, Coaching: (a) staff-level documentation training; (b) supervisor-level training on efficient chart-review process; (c) Director- level training on Utilization Review for inter- rater reliability and consistency and use of Avatar reports for effective monitoring; (d) development of new documentation resources (e.g., manuals). Training will ensure that Weekly Summary is present and accurately reflects services provided. Structured Internal File Review/QA Reporting Activity (Using DHCS-BHS Protocol): (a) a structured file review process to monitor documentation quality assurance elements (e.g., a sample of every staff member's charts, twice a year); (b) reporting and aggregating QA elements at the program-, agency-, System Section-, and System-levels. Monitoring & internal reviews will ensure compliance with established written documentation requirements.

The hiring process for a Senior Behavioral Health Clinician to lead this team could take many months. In the meantime, the MHP is preparing to update the County Documentation Manual, which will also serve as support for providers making medical necessity determinations.

Proposed Evidence/Documentation of Correction

Sign in sheets from Trainings; updated MHP Documentation Manual; QA plan; select copies of reports of audits conducted by System of Care.

Ongoing Monitoring (if included)

Quality Assurance staff and Clinical staff complete peer chart audits to monitor medical necessity of services and provide plan of correction status report at quarterly Compliance Committee meetings.

Person Responsible

Acting Director of Quality Management, Diane Prentiss.

Implementation Timeline

QA hire December 26th 2021

Section I, 5B

Requirement

Items that shall be contained in the client record (i.e., Progress Notes) related to the beneficiary's progress in treatment include all of the following:

1) Timely documentation of relevant aspects of client care, including documentation of medical necessity.
2) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions
3) Interventions applied, beneficiary's response to the interventions, and the location of the interventions.
4) The date the services were provided.
5) Documentation of referrals to community resources and other agencies, when appropriate.
6) Documentation of follow-up care or, as appropriate, a discharge summary.
7) The amount of time taken to provide services
8) The following:
   c) The signature of the person providing the service (or electronic equivalent);
   d) The person's type of professional degree, and,
   e) Licensure or job title

DHCS Finding 5B

Progress notes do not include all required elements specified in the MHP Contract, and/or are not in accordance with the MHP's written documentation standards. Specifically:

• One or more progress note was not completed within the MHP's written timeliness standard of 5 days after provision of service. One hundred twenty (120), or 22% of all progress notes reviewed were completed late.

• One or more progress note was missing the provider's professional degree, licensure or job title. Thirteen (13), or 2% of all progress notes reviewed do not include the provider's professional degree, licensure, or job title.

• All 13 claims submitted for line number 17 had associated progress notes wherein the "Completion Timeliness" could not be determined because, while the Progress Notes contain the date of service, they do not contain a date of completion.

1) The MHP shall submit a CAP that describes how the MHP will ensure that the MHP has written documentation standards for progress notes, including timeliness and frequency, as required by the MHP Contract with the Department.

2) The MHP shall submit a CAP that describes how the MHP will ensure that progress notes document: • Timely completion and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.

• Date the progress note was completed and entered into the medical record in order to determine completion timeliness, as specified in the MHP Contract with the Department

• The provider's/providers' professional degree, licensure or job title

Corrective Action Description

BHS has been operating without Quality Assurance staff since December 2019. To support providers in completing compliant documentation, BHS plans to hire a Quality Assurance Team.

The objective of this team will be to design and oversee clinical chart reviews and technical assistance processes that ensure accurate documentation to support billing of services, and identify areas for improvement in the quality of assessments, treatment plans, and progress notes.

Specific responsibilities for this team will include: Conducting a System of Care sponsored Training, Technical Assistance, Coaching: (a) staff-level documentation training; (b) supervisor-level training on efficient chart-review process; (c) Director- level training on Utilization Review for inter- rater reliability and consistency and use of Avatar reports for effective monitoring; (d) development of new documentation resources (e.g., manuals). Training will ensure that Weekly Summary is present and accurately reflects services provided. Structured Internal File Review/QA Reporting Activity (Using DHCS-

BHS Protocol): (a) a structured file review process to monitor documentation quality assurance elements (e.g., a sample of every staff member's charts, twice a year); (b) reporting and aggregating QA elements at the program-, agency-, System Section-, and System-levels. Monitoring & internal reviews will ensure compliance with established written documentation requirements.

The hiring process for a Senior Behavioral Health Clinician to lead this team could take many months. In the meantime, the MHP is preparing to update the County Documentation Manual, which will also serve as support for providers making medical necessity determinations.

Proposed Evidence/Documentation of Correction

Sign in sheets from Trainings; updated MHP Documentation Manual; QA plan; select copies of reports of audits conducted by System of Care.

Ongoing Monitoring (if included)

Quality Assurance staff and Clinical staff complete peer chart audits to monitor medical necessity of services and provide plan of correction status report at quarterly Compliance Committee meetings.

Person Responsible

Acting Director of Quality Management, Diane Prentiss.

Implementation Timeline

QA hire December 26th 2021

Section I, 7A

Requirement

There is any evidence that mental health interpreter services are offered and provided, when applicable.

DHCS Finding 7A

The medical record did not include evidence that oral interpretation services were made available to the beneficiary and/or the beneficiary's parent(s)/legal guardian(s). Specifically, there was no evidence in the medical record that language interpretation services were offered or provided to the beneficiary and/or to the beneficiary's parent or legal guardian whose preferred language was not English.

The MHP shall submit a CAP that describes how the MHP will ensure that: 1) All beneficiaries and their parents/legal guardians are offered oral interpretation services,

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

Corrective Action Description

BHS has been operating without Quality Assurance staff since December 2019. To support providers in completing compliant documentation, BHS plans to hire a Quality Assurance Team. The hiring process for a Senior Behavioral Health Clinician to lead this team could take many months. In the meantime, the MHP is preparing to update the County Documentation Manual, which will also serve as QA support for providers.

The objective of this team will be to design and oversee clinical chart reviews and technical assistance processes that ensure accurate documentation to support billing of services, and identify areas for improvement in the quality of assessments, treatment plans, and progress notes.

Specific responsibilities for this team will include: Conducting a System of Care sponsored Training, Technical Assistance, Coaching: (a) staff-level documentation training; (b) supervisor-level training on efficient chart-review process; (c) Director- level training on Utilization Review for inter- rater reliability and consistency and use of Avatar reports for effective monitoring; (d) development of new documentation resources (e.g., manuals). Training will ensure that Weekly Summary is present and accurately reflects services provided. Structured Internal File Review/QA Reporting Activity (Using DHCS-BHS Protocol): (a) a structured file review process to monitor documentation quality assurance elements (e.g., a sample of every staff member's charts, twice a year); (b) reporting and aggregating QA elements at the program-, agency-, System Section-, and System-levels. Monitoring & internal reviews will ensure compliance with established written documentation requirements.

Additionally, Quality Management is discussing strategies with the BHS Office of Community Health Equity on ways to increase awareness of requirements found in the Cultural and Linguistic Competency Requirement for BHS policy. The policy link is here: KM_C454e-20180530202659 (sfdph.org). Awareness strategies include announcements and reminders at Provider Meetings or attesting to these requirements during onboarding.

Proposed Evidence/Documentation of Correction

Sign in sheets from Trainings; updated MHP Documentation Manual; QA plan; select copies of reports of audits conducted by System of Care.

Ongoing Monitoring (if included)

Quality Assurance staff and Clinical staff complete peer chart audits to monitor medical necessity of services and provide plan of correction status report at quarterly Compliance Committee meetings.

Person Responsible

Acting Director of Quality Management, Diane Prentiss. Administrative Analyst, Michael Rojas.

Implementation Timeline

QA hire December 26th, 2021