County of San Luis Obispo Health Agency Behavioral Health Department

FY 18/19 Specialty Mental Health Triennial Review

Corrective Action Plan

Systems Review

Requirement

Timely Access

DHCS Finding N/A

The MHP's Service Request Log for January 2018 and found that the MHP met timely access requirements for 85 out of the 87 requests for services that resulted in an offered assessment appointment.

Corrective Action Description

(Appealed – the MHP requested that this item be rated on a compliance percentage basis. The compliance rate in DHCS' audit sample was 97.7%.)

Effective immediately, MHP's Central Access Line staff will offer an assessment appointment within 10 business days in every instance. When a timely appointment is not available at the clinic or site nearest to the beneficiary, staff will offer an appointment plus transportation to the next nearest site or contact the site Program Supervisor to arrange a timely appointment.

Proposed Evidence/Documentation of Correction

N/A

Implementation Timeline: Effective Immediately

Requirement

The MHP has a process for resolving disputes between the MHP and the Managed Care Plan (MCP) that includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the disputes is being resolved (Cal. Code Regs., tit. 9 § 1810.370(a)(5)).

DHCS Finding N/A

The MHP did not furnish evidence to demonstrate it complies with California Code of Regulations, title 9, section 1810.370(a)(5). The MHP must enter into a Memorandum of Understanding (MOU) with any Medi-Cal MCP that enrolls beneficiaries covered by the MHP. The MOU must, at a minimum, address a process for resolving disputes between the

MHP and the Medi-Cal MCP that includes a means for beneficiaries to receive medically necessary services, including SMHS and prescription drugs, while the dispute is being resolved. When the dispute involves the Medi-Cal MCP continuing to provide services to a beneficiary the Medi-Cal MCP believes requires SMHS from the MHP, the MHP must identify and provide the Medi-Cal MCP with the name and telephone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to the Medi-Cal MCP provider responsible for the beneficiary's care.
The MHP submitted its MOU with CenCal Health, which has been actively in place since 2015, as documentation as evidence of compliance with this requirement. The MOU outlines the service responsibilities of each agency and the delegation of mental health management to Holman Professional Counseling Centers, which has been approved by the Department of Managed Health Care. Holman is also accountable for monitoring the county to ensure it meets the timely access standards.
In addition, the MHP also submitted its Dispute Resolution Matrix and Narrative as documentation as evidence of compliance with this requirement. However, the documentation does not address the requirement that beneficiaries receive services, including SMHS and prescription drugs, while the disputes is being resolved.
DHCS deems the MHP out-of-compliance with California Code of Regulations, title 9, section 1810.370(a)(5). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

MHP and MCP will revise MOU to include missing elements and seek BOS approval of the MOU

Action Steps:

1. MCP drafted a new MOU (Completed 8/12/19)
2. MHP will return edits by 8/26/2019. The missing elements were added to the draft.
3. MCP and MHP will agree to final language by 9/15/2019
4. Present to BOS for approval by approximately 10/15/19

Proposed Evidence/Documentation of Correction

Evidence:

• MOU (draft) with MCP email_8-12-19

• Draft MOU language insertions:

PROVISION OF MEDICALLY NECESSARY SERVICES PENDING RESOLUTION OF A DISPUTE

1. MHP agrees that disputes with CCH shall not delay the provision of medically necessary mental health services.

2. For disputes related to the start or continuation of mental health services that MHP believes require CCH covered mild to moderate outpatient mental health services or when there is disagreement whether the beneficiary's diagnosis as determined by the MHP is not a covered diagnosis, the MHP will initiate or continue to provide specialty mental health service(s) during the Dispute Resolution process.

PHARMACEUTICAL SERVICES, PRESCRIPTION DRUGS, AND CONSULTATION

The MHP Medical Director, (805) 781-4179, or their designee shall be available to provide clinical consultation, including consultation on medication, to the CCH provider responsible for the member's physical health care.

Implementation Timeline: 8/26/2019, 9/15/2019, 10/15/2019

Requirement

Cultural Competence Training

42 CFR §438.10(h)(1)(v)

CCR, Title 9, §1810.410

"…some employees did not complete the annual requirement that should have been completed by June 30, 2018"

DHCS Finding N/A

"…some employees did not complete the annual requirement that should have been completed by June 30, 2018"

Corrective Action Description

(Appealed – the MHP requested that this item be marked as a recommendation only as it was tied to the Provider Directory requirements)

MHP will require, track, and enforce annual cultural competence training for staff

Action Steps:

1. Conduct a mandatory 6-hour face-to-face training for all staff (Scheduled for 8/16/19 8/23/19, 8/30/19 to include all staff)

2. Assigned two Relias eLearning trainings to staff for completion by 6/30/20 (7/8/19)

3. Assign overview course for all new hires

4. Sponsored "Enhancing Cultural Humility" trainings on 6/20/19 and 8/20/19

5. Staff will upload completion certificates to NeoGov for tracking (beginning 8/1/19)

Proposed Evidence/Documentation of Correction

Evidence:

• Program Supervisor meeting minutes_7-9-19

• CC Training Annual assignment email_7-8-19

• All Staff August Training email_8-1-19

• Enhancing Cultural Humility training flyer

Implementation Timeline: 7/9/2019, 7/8/2019, 8/1/2019

Requirement

Regarding the statewide, 24 hours a day, 7 days a week toll-free telephone number (Cal. Code Regs., tit. 9, chapter 11, §§ 1810.405(d) and 1810.410(e)(1)).

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

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

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

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

DHCS Finding N/A

Test Call #1: DHCS deems the MHP in compliance with California Code of Regulations, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

Test Call #2: DHCS deems the MHP in compliance with California Code of Regulations, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

Test Call #3: DHCS deems the MHP in compliance with California Code of Regulations, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

Test Call #4: DHCS deems the MHP in compliance with California Code of Regulations, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

Test Call #5: DHCS deems the MHP out of compliance with specific requirements in California Code of Regulations, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1). The MHP did not demonstrate compliance by:

- The toll-free number providing information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met; and,
- The toll-free number providing information to beneficiaries about services needed to treat a beneficiary's urgent condition.

Test Call #6: DHCS deems the MHP in compliance with California Code of Regulations, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).

Test Call #7: DHCS deems the MHP out-of-compliance compliance with specific requirements in California Code of Regulations, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1). The MHP did not demonstrate compliance by providing information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing process.

In addition to the seven (7) test calls, the MHP submitted the following documentation as evidence of compliance with California Code of Regulations, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1):

 Policy and Procedure: 3.00 Access to Services;

 Scripted responses for the Central Access line calls; and,

 MHP's detailed Action Plan for their Central Access Line.

As part of the MHP's effort to improve the outcome of their test calls, they provide, at a minimum, quarterly trainings in which, its scripts and procedures are reviewed with their staff. In addition, the MHP conducts bi-monthly test calls to test the staff on the information that is provided during the trainings.

The MHP submitted evidence that demonstrates that it is in partial compliance with California Code of Regulations, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

(Appealed – the MHP appealed the findings in Test Call # 3 based on the test call script previously approved by DHCS)

POC for #5 and #7: MHP changed Central Access processes to ensure that beneficiaries get required information about how to access services or problem resolution processes.

Action Steps:

MHP made the following changes to processes:

1. Revised call transfer procedure (#5): Central Access administrative staff now transfer callers to a primary clinician or to a backup clinician. Only when both clinicians are on calls (or if the caller requests a call back rather than to hold) will a call back option be used. MHP changed to a VOIP phone system that will allow tracking of calls and call back attempts. (Completed 7/31/2019)

2. MHP provided training to staff Central Access staff and PRA staff regarding the grievance process and clarified that any caller may file a grievance (#7). (Completed 7/31/2019)

Proposed Evidence/Documentation of Correction

Evidence:

• Managed Care staff meeting minutes_7/31/19

• Access Line Script_7-31-19

Implementation Timeline: 7/31/2019

Requirement

The MHP shall adhere to the following record keeping, monitoring, and review requirement related to maintaining a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. (42 CFR § 438.416(a) and Cal. Code Regs., tit. 9, § 1850.205(d)(1).)

DHCS Finding N/A

The MHP did not furnish evidence to demonstrate it complies with 42 CFR Section 438.416(a). DHCS must require MHPs to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.

In addition, the MHP did not furnish evidence to demonstrate it complies with California Code of Regulations, title 9, section 1850.205(d)(1). For the grievance, appeal, and expedited appeal processes found in California Code of Regulations, title 9, sections 1850.206, 1850.207, and 1850.208, the MHP must maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance or appeal. The log entry must include, but not be limited to, the name of the beneficiary, the date of receipt of the grievance, appeal, or expedited appeal, and the nature of the problem.

The MHP has implemented a problem resolution process that includes informing beneficiaries of their rights when beginning services and upon request. The review was at a location, which allowed the DHCS team to see posted information explaining the

grievance, appeal, and expedited appeal processes. As part of the MHP's procedures, a drop box is available, at each clinic for beneficiaries to submit grievances and appeals.

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

 Policy and Procedure: 4.07 Beneficiary Grievances, Appeals, and Expedited Appeals and

 Grievance/Appeal log from July 5, 2017 to June 29, 2018

The policy confirms that all grievances, appeals, and expedited appeals are directed to the Patients' Rights Advocate (PRA) to log and to ensure confidentiality. However, this process did not require the grievances to be logged when received at each contracted provider site. Instead, the grievances and appeals must be sent to the PRA, which creates a delay for the grievances and appeals to be logged.

DHCS deems the MHP out-of-compliance with 42 CFR Section 438.416(a) and with California Code Regulations, title 9, section 1850.205(d)(1). The MHP must complete a POC addressing this finding of non-compliance.

Corrective Action Description

MHP will ensure that Grievances and Appeals are logged in a timely manner.

Action Steps:

1. Changed clinic closing procedure so that site Health Information Technicians receive and scan CRF into a shared folder on a daily basis (Completed 8/1/2019)

2. PRA will log and acknowledge daily (ongoing)

Proposed Evidence/Documentation of Correction

Evidence:

• Grievance & Appeals_Client Information Center Lock Box-CRF Procedure

Implementation Timeline: 8/1/2019

Requirement

The MHP must comply with the requirements of Welf. & Inst. Code Sections 14705(c) and 14712(e) regarding timely submission of its annual cost reports.

DHCS Finding [Finding Number]

The MHP did not furnish evidence to demonstrate it complies with Welf. & Inst. Code Section14705(c). With regard to county operated facilities, clinics, or programs for which claims are submitted to DHCS for Medi-Cal reimbursement for SMHS to Medi-Cal

eligible individuals, the county must ensure that all requirements necessary for Medi-Cal reimbursement for these services are complied with, including, but not limited to, utilization review and the submission of yearend cost reports by December 31 following the close of the fiscal year.

In addition, the MHP did not furnish evidence to demonstrate it complies with Welf. & Inst. Code Section14705(c). Whenever DHCS determines that a MHP has failed to comply with this chapter or any regulations, contractual requirements, state plan, or waivers adopted pursuant to this chapter, DHCS must notify the MHP in writing within 30-days of its determination and may impose sanctions, including, but not limited to, fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to promptly ensure contract and performance compliance. If DHCS imposes fines or penalties, to the extent permitted by federal law and state law or contract, it may offset the fines from either of the following:

- Funds from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund and funds from the Mental Health Account and the Behavioral Health Subaccount of the Local Revenue Fund 2011.
- Any other mental health realignment funds from which the Controller is authorized to make distributions to the counties, if the funds described in paragraph (1) are insufficient for the purposes described in this subdivision.

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

- DHCS reviewed the MHP's Cost Report information from July 1, 2016 through June 30, 2017;
- Correspondences between the MHP to DHCS;
- Additional financial data; and,
- Boilerplate Contract.

The Boilerplate Contract that was provided included evidence that requires contractors to collect and provide to the MHP with all data and information necessary to satisfy state reporting requirements. However, in accordance with Welf. & Inst. Code Section 14705(c), the cost report is due to DHCS by December 31st following the close of the FY. DHCS does not have the authority to alter this requirement. As such, the cost report is due regardless of the reason for delay (County and/or DHCS). If a county has any reason to believe that its cost report would not be filed by December 31st, it should seek an extension to file from DHCS at least two-weeks prior to the due date (reference MHSUDS Information Notice 17-025). Cost reports received after December 31st with no extension requests on file are considered delinquent and subject to provisions contained in Welf. & Inst. Code Section 14712(e).

DHCS deems the MHP out-of-compliance with Welf. & Inst. Code Sections14705(c) and 14705(c). The MHP must complete a POC addressing this finding of non-compliance

Corrective Action Description

SLOBHD does not have a record of late submission of the cost report without a timely request for extension except in FY 16-17, when the template wasn't released by DHCS until February and therefore the timeline could not be met.

Action Steps:

1. SLOBHD Fiscal Department created a calendar reminder so that if the cost report is not ready to upload, we will request an extension.

2. If the file is ready to submit, the Accountant II and ASM responsible for the MH Cost Report will sign and submit the report. This document then will be scanned and filed on the server with the Cost Report folder for that fiscal year.

Proposed Evidence/Documentation of Correction

N/A

Implementation Timeline: N/A

Chart Review

Requirement

Assessment/ Assessment Updates

DHCS Finding 2A

2A: Not all records reviewed had re-assessments completed annually

Corrective Action Description

We established an annual standard for completion of an adult assessment updates in 2018 and a schedule for completing youth assessments that include CANS elements on a six-month interval basis due to MHSUD IN 18-048.

Action Steps:

1. Updated Policy & Procedure 5.00 and 5.10

2. All clinical staff will complete documentation training on an annual basis and pass a posttest to ensure understanding of documentation requirements, including assessment update timeliness.

3. Added frequency of re-assessment to audit schedule

Proposed Evidence/Documentation of Correction

Evidence:

• Documentation Guidelines page 18 and Policy & Procedure 5.0 and 5.10 state frequency requirements. See attached policies for detail.

The Documentation Guidelines section says this:

Question: When (how often) do I use the Treatment Summary?

Answers:

Annually (ideally right before you develop the next Treatment Plan)

• To update progress during the past year and to identify usable strengths for ongoing treatment

• To help identify reasons for continued treatment (medical necessity)

• To help match objectives for the next Treatment Plan (TP) with current needs and strengths

• To generate ongoing outcome measure data by completing the Adult Needs and Strengths

Assessment (ANSA) and Children's Assessment of Needs and Strengths (CANS) rating questions

Whenever clinically indicated after a significant change for the client

• After a significant life event (i.e., D/C from a hospital, release from jail or after a trauma)

• When a client leaves treatment but returns and is reopened within 90 days of closing

• Whenever there is a significant change (positive or negative) in a client's level of functioning

• Any other time an update will provide useful clinical information

• Client Action Schedules in the MHP's EHR are set to remind staff of due dates

• QST staff will regularly audit timely completion of adult and youth assessment updates. See QST Audit Schedule.

Implementation Timeline: N/A

Requirement

Medication Consents

DHCS Finding 3A, 3B

3A: Not all records reviewed had a current medication consent for every medication prescribed.

3B: The medication consent form was missing specific required elements

Corrective Action Description

The SLOBHD Medical Director and UR Nurse provided training and created reminder checklists for prescribers to prompt completion of an Informed Consent for Medication whenever a new medication is prescribed.

Proposed Evidence/Documentation of Correction

Evidence 3A:

• Record review for completion of Medication Consent is part of monthly Peer Review. See Psychiatrist Assessment Peer Review Audit Tool. We require corrective action when a Medication Consent is missing or is incomplete.

• UR Nurse and Medical Director provided training for MD/NP staff and developed a documentation checklist to help ensure completion of medication consents. See attached Psychiatrist Checklist and UR Committee agenda.

Evidence 3B:

• We revised our BH Informed Consent for Medication to ensure that it contains all the required elements. See attached form for detail.

Implementation Timeline: N/A

Requirement

Client Plans

DHCS Finding 4A, 4C, 4E, 4G

4A: TPs must be updated annually or when a beneficiary's condition changes

4C: TP Content

• Goals & Objectives must be specific and observable

• Interventions must include a detailed description

• Interventions must specify frequency and duration

• Services must be tied to symptoms or functional impairments and qualifying diagnosis

• TP must be internally consistent and logical (i.e., Golden Thread)

4E: TP must contain client/responsible person signature or explanation when not available

4G: TP must contain evidence that a copy was offered

Corrective Action Description

Following the release of MHSDU IN 17-040, we revised our Documentation Guidelines and EHR set up to align with DHCS clarifications. We provided training for staff and contractor staff (completed in January and February of 2018 – the Triennial Review audit period was January through March 2018). Not all the records reviewed by DHCS had a new treatment plan (TP) that followed our guidance or set up requirements. Currently, we require a TP with goals, objectives, interventions, and services beginning with the initial assessment visit. Other than Crisis Intervention, all services must be on the TP and the TP is set to expire 364 days from the start date so that services may not be entered or claimed when not authorized on a valid TP. We made a slight change in wording to our Documentation Guidelines page 45 to highlight Intervention Duration:

Duration of Treatment

• Duration of treatment is the length of time the Intervention will be active/provided

• Set a Target Date for services you expect to be less than the duration of the TP. For example, if you are providing a 15-session structured group, estimate when the group will end and set a Target Date. You will not be able to provide the Intervention after the Target Date passes without updating the TP. Otherwise, leave Target Date blank.

• Interventions are valid for the entire duration of the TP unless a Target Date specifies a shorter duration

SLOBHD will provide mandatory face-to-face and/or eLearning documentation training for all clinical staff regarding items described in 4A, 4C, 4E, and 4G.

Action steps:

1. By 10/31/2019, all clinical staff will complete documentation training

2. By 12/31/19, all clinical staff will pass a competency-based posttest designed to confirm understanding of documentation requirements for Treatment Plan development

Proposed Evidence/Documentation of Correction

Evidence:

• SLOBHD Documentation Guidelines, pages 38-50

Implementation Timeline: 10/31/2019. 12/31/2019

Requirement

Progress Notes

DHCS Finding 5A, 5C, 5D, 6E

5A: PN must:

•Be completed on time, include beneficiary's response to interventions

•Match the DOS and date of claim

•Include credential, degree, or job title of staff

•Signature of all staff involved in the service

5C: Group progress notes must document DOS, # clients in group, # staff, and contribution of each staff member

5D: PN must be:

•Documented in the EHR

•Related to the Focus of Treatment in the TP

•Correctly coded (service and time)

•Completed on time

6E: ICC must be claimed correctly and coded when it is the most correct service

Corrective Action Description

SLOBHD will provide mandatory face-to-face and/or eLearning documentation training for all clinical staff. Training will include a review of items detailed in 5A, 5C, 5D, and 6E.

Action steps (5A, 5C, 5D, and 6E):

1. By 10/31/2019, all clinical staff will complete documentation training

2. By 12/31/19, all clinical staff will pass a competency-based posttest designed to confirm understanding of documentation requirements for Progress Notes

Additional actions:

1. (5A) By 9/30/19, will correct missing credential, degree, or job title for staff in the EHR.

2. (5C) Our EHR correctly identifies the number of clients in group services in the EHR, but this information does not print. We no longer allow co-staff to claim on one note, consistent with the requirements in MHSUD IN 18-002.Instead, each staff member

documents their role in the group separately because our EHR will not allow multiple NPI numbers on a claim line or separate claim lines from one note.

3. (5D) We voided the claims for Line 2, DOS 2/9/18 and Line 6DOS 2/22/18 on 8/2/19

4. (6E) ICC is correctly set up in our EHR for claiming. Training will remind staff to properly code ICC when in the context of a CFT.

Proposed Evidence/Documentation of Correction

Evidence:

•SLOBHD Documentation Guidelines pages 9-16

•5A_TMHA missing credentials email

•5A_TMHA missing credentials report

•5D_Recouped Claims-Void evidence

Implementation Timeline: 10/31/2019, 12/31/2019, 9/30/2019

Requirement

Documentation of Cultural and Linguistic Services

DHCS Finding 7A

7A:

• Line 12: Med Support service provided on 3/1/18 without documentation of language accommodation

• Line 17: Collateral Services with mother provided in English.

Corrective Action Description

We currently collect information about language needs when a beneficiary requests SMHS, and the answer about whether interpretation services are needed is a binary yes or no. Our Documentation Guidelines direct staff to code the provision of services in Spanish or other language and to make note of the presence of an interpreter.

The service for line 12 on 3/1/18 is missing a notation that an interpreter was present in the session. The interpreter is a Promotora provided for us by the Center for Family Strengthening.

The services for Line 17 on 1/29/18 and 2/1/18 were provided in English. The sessions were Collateral Services that included the beneficiary (who is bilingual, but the record states that he prefers services in English) and his GM/adoptive mother (bilingual). The

grandfather/adoptive father, whose English is limited, is the reason the record reports that caregivers preferred language is Spanish and that no interpreter is needed.

SLOBHD will provide mandatory face-to-face and/or eLearning documentation training for all clinical staff. Training will include a review of proper coding of alternate language services and a reminder to note the presence of an interpreter.

Action steps:

1. By 10/31/2019, all clinical staff will complete documentation training

2. By 12/31/19, all clinical staff will pass a competency-based posttest designed to confirm understanding of documentation requirements for coding language accommodations in Progress Notes

Proposed Evidence/Documentation of Correction

Evidence:

• SLOBHD Documentation Guidelines, page 33

• Line 12: Promotores claim and MD schedule

• Line 17: Language preference

Implementation Timeline: 10/31/2019, 12/31/2019