Napa County Mental Health Plan

Fiscal Year 21-22 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review

Requirement

The MHP shall meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services. (42 C.F.R. § 438.206(c)(1)(i); WIC, § 14197; MHP Contract, Ex. A, Att. 8, sec. 4(A)(1); see CCR, tit. 28, § 1300.67.2.2 (c)(5); BHIN No. 20-012.)

DHCS Finding 1.1.3

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP implements Department standards for timely access to care and services, taking into account the urgency of need for services. Per the discussion during the review, the MHP stated that timeliness for urgent and psychiatric appointments are tracked by assessing date of first assessment to date of first offered appointment. Post review the MHP submitted service request logs for psychiatric and urgent appointments. Of the submitted service requests, 29 psychiatric appointments and 21 urgent appointment were outside the Department's standards which assesses timeliness from date of initial request for service to date of first offered appointment.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i).

Corrective Action Description

1. An "Urgent MH (Crisis)" request option has been added to Central Authorization and Access Tool (CAAT) Log drop down menu for categorizing service requests.
2. A specific column/field for "urgent request" designation has been added to Psychiatry Service Request and Appointment Tracking Log.
3. A "Service Timeliness Quick Guide" will be created and distributed to Access staff receiving and scheduling service requests.
4. The "Coordinator of the Day Log" will be updated and relaunched such that timeliness of clinical response and disposition of "Urgent MH (Crisis)" calls are consistently captured.
5. Access Manual will be updated to reflect protocol for meeting timeliness standards for offering and scheduling appointments.
6. Staff receiving and scheduling service requests will attend training to review and protocol for meeting timeliness standards in offering and scheduling appointments.

Proposed Evidence/Documentation of Correction

1. Log: Updated CAAT Log with "Urgent MH (Crisis)" request option highlighted (attached to CAP).
2. Log: Updated Psychiatry Service Request and Appointment Tracking Log with column/field for "urgent request" designation highlighted (attached to CAP).
3. Document: Service Timeliness Quick Guide (attached to CAP).
4. Log: Updated "Coordinator-of-the-Day" log with sample response and disposition highlighted.
5. Training materials: Timeliness standards in offering and scheduling appointments.
6. Manual: Updated Access Manual.
7. Training completion log.

Ongoing Monitoring (if included)

Monitoring will be achieved via Network Adequacy Report submissions.

Person Responsible (job title)

Access Supervisor

Implementation Timeline:

Completed:	Update to CAAT Log – (see attachment)
Completed:	Updated to Psychiatry Service Request and Appointment Tracking Log – (see attachment)
Completed:	Timeliness Quick Guide – (see attachment)
June 30, 2022:	Training Materials on MHP timeliness standards is completed
August 31, 2022:	Update to Coordinator of the Day Log
August 31, 2022:	Update to Access Manual is completed
August 31, 2022:	Training on timeliness standards for staff receiving and scheduling service requests is completed

Requirement

The MHP shall certify, or use another MHP's certification documents to certify, the organizational providers that subcontract with the MHP to provide SMHS, in accordance with California Code of Regulations, title 9, section 1810, subsection 435.

DHCS Finding 1.4.4

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP monitors and updates the certifications of its contracted SMHS providers. Six (6) MHP contracted providers have overdue certifications. Per the discussion during the review, the MHP stated it was aware that two (2) residential sites were overdue due to COVID-19 related issues. The MHP stated it would investigate the other provider sites to address the discrepancies.
DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 8.

Corrective Action Description

1. Provider Services Coordinator will coordinate with DHCS to ensure that the contract provider list on file with the state is up to date to reflect that four (4) of the six (6) providers with "overdue certifications" were removed, as they are terminated contractors.
2. Provider Services Coordinator will certify the two (2) residential sites to bring them up to compliance.

Proposed Evidence/Documentation of Correction

1. Monitoring Report: Updated Napa County Provider Monitoring Report 5-17-22 reflecting all active contracted providers.
2. Document: Requests sent to DHCS to remove terminated contract providers from county list.
3. Certifications: Certifications of two (2) residential sites overdue for certification due to COVID issues.

Ongoing Monitoring (if included)

Certifications will be monitored and managed ongoing by Provider Services Coordinator.

Responsible (job title)

Provider Services Coordinator

Implementation Timeline:

Completed.

Requirement

In compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 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 specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.

3. The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
4. The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

DHCS Finding 4.3.2

Required Elements	Test Call Findings						Compliance Percentage
	#1	#2	#3	#4	#5	#6	
1	N/A	IN	N/A	IN	N/A	N/A	100%
2	IN	OOC	IN	OOC	N/A	N/A	50%
3	IN	IN	OOC	IN	N/A	N/A	75%
4	N/A	N/A	N/A	N/A	IN	IN	100%

Based on the test calls, DHCS deems the MHP *partial compliance* with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1).

Corrective Action Description

1. Access Line Response Script will be revised to include:
    a. reminders to address the multiple information requests of callers, and
    b. additional guidance on responding to requests for medication refills.
2. Access Line Responders, both business hours and after-hour responders, will be trained on updates to Access Line Response Script.

Proposed Evidence/Documentation of Correction

1. Document: Revised Access Line Response Script.
2. Training Materials: Access Line Response.
3. Training Completion Log.

Ongoing Monitoring (if included)

Monitoring will be conducted via quarterly test call reporting.

Person Responsible (job title)

Access Supervisor and Quality Coordinator

Implementation Timeline:

July 30, 2022: Access Line Response Script revision completion

July 30, 2022: Training materials development on updates to Access Line Response is completed

August 31, 2022: Training is completed for Access Line response staff

Requirement

The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. The written log(s) must contain name of the beneficiary, date of the request, and initial disposition of the request. (California Code for Regulations, title 9, chapter 11, section 1810, subdivision 405(f)).

DHCS Finding 4.3.4

While the MHP submitted evidence to demonstrate compliance with this requirement, three (3) of five (5) required DHCS test calls were not logged on the MHP's written log of initial requests. DHCS deems the MHP partial compliance with California Code of Regulations, title 9, section 1810, subdivision 405(f).

Corrective Action Description

1. Access response team (business hours response team) responsible for maintaining the Central Authorization and Access Tool (CAAT) Log will receive refresher training on protocol for logging calls.
2. Afterhours Access response team will receive refresher training on submission of afterhours call information to the Access response team (business hours response team) responsible for maintaining the CAAT Log.

Proposed Evidence/Documentation of Correction

1. Training materials: Access Line Response and Tracking Service Requests
2. Training Completion Logs.

Ongoing Monitoring (if included)

Monitoring will be conducted via quarterly test call reporting.

Person Responsible (job title)

Supervisor of Access and Quality Coordinator

Implementation Timeline:

July 30, 2022: Access Line Response Script revision completion.

July 30, 2022: Training materials on Access Line Response and Tracking Service Requests are completed.

August 31, 2022: Training is completed for Access Line response staff.

Requirement

The MHP must notify the requesting provider, and give the beneficiary written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

DHCS Finding 5.1.3

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP gives requesting providers or beneficiaries written notice of any decision to deny a treatment authorization request (TAR), or to authorize a service in an amount, duration, or scope that is less than requested. Of the 25 TARs reviewed, denial notices were not provided for two (2) requests. Per the discussion during the review, the MHP stated it would provide additional documentation for the TARs in question. No additional evidence was received post review. DHCS deems the MHP out of compliance with MHP contract; exhibit A, attachment 6, and Federal Code of Regulations, title 42, section 438, subdivision 210(c).

Corrective Action Description

1. NCMH is entering into a Participation Agreement for CalMHSA to provide TAR management (via their Kepro system) in the next weeks. The vendor will issue NOABDs as required by regulation.
2. Clinicians and staff involved in monitoring the TAR process will receive refresher training on NOABD policy with focus on NOABD-*Denial of Authorization* and NOABD-*Modification* procedures and logging NOABDs.

Proposed Evidence/Documentation of Correction

1. Document: Participant Agreement with CalMHSA.
2. Training Materials: NOABD Policy.
3. Training Completion Log.

Ongoing Monitoring (if included)

Monitoring will be achieved via CalMHSA Kepro reports review.

Person Responsible (job title)

Assistant Director of MH – Admin, Quality Coordinator

Implementation Timeline:

August 31, 2022: Participant Agreement process complete. TAR management process is transferred to CalMHSA.

Requirement

The MHP must review and make a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, and not to exceed five (5) business days from the MHP's receipt of the information reasonably necessary and requested by the MHP to make the determination. (MHSUDS IN 19-026).

DHCS Finding 5.2.8

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP reviews and makes a decision regarding a provider's request for prior authorization as expeditiously as the beneficiary's mental health condition requires, not to exceed five (5) business days from the MHP's receipt of the information. Two (2) of the ten (10) service authorizations were not completed within the required timeframe. Per the discussion during the review, the MHP acknowledged this finding. DHCS deems the MHP in partial compliance with MHSUDS 19-026.

Corrective Action Description

NCMH is entering into a Participant Agreement for CalMHSA to provide Treatment Authorization Request (TAR) management (via their Kepro system) in the next weeks. The vendor will issue NOABDs as required by regulation.

Proposed Evidence/Documentation of Correction

Document: Participant Agreement with CalMHSA.

Ongoing Monitoring (if included)

Monitoring will be achieved via CalMHSA reports review.

Person Responsible (job title):

Utilization Review Coordinator

Implementation Timeline:

August 31, 2022: Participant Agreement process complete. TAR management process is transferred to CalMHSA.

Requirement

The MHP must provide beneficiaries with a Notice of Adverse Beneficiary Determination under the circumstances listed below:
1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit.
2. The reduction, suspension or termination of a previously authorized service.

3. The denial, in whole or in part, of a payment for service.
4. The failure to provide services in a timely manner.
5. The failure to act within timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
6. The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities.
(Code of Federal Regulations, title 42, section 438, subdivision 400).

DHCS Finding 5.4.1

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides Notice of Adverse Beneficiary Determination (NOABDs) to beneficiaries for failure to provide services in a timely manner. Per the discussion during the review, the MHP stated it would provide evidence of NOABDs for failure to provide psychiatry and urgent care appointments in a timely manner. Post review the MHP submitted a single failure to meet medical necessity NOABD, however no timely access NOABDs were submitted. DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 400.

Corrective Action Description

1. Staff receiving and scheduling service requests will attend training to review protocol for meeting timeliness standards in offering and scheduling appointments and on NOABD policy with focus on NOABD-*Delay of Services*.
2. Psychiatry Service Log will be updated to include a column for tracking issuing NOABD - *Delay of Service* notices.

Proposed Evidence/Documentation of Correction

1. Training Materials: NOABD Policy.
2. Training Completion Log.
3. Log: Psychiatry Service Log with column for tracking Delay of Services notices.

Ongoing Monitoring (if included)

Monitoring will be achieved via annual NOABD review.

Person Responsible (job title)

Supervisor of Access, Quality Coordinator, Psychiatric Medical Director

Implementation Timeline:

July 30, 2022: Training materials development on NOABD Policy is completed.

August 31, 2022: Training is completed for staff receiving and scheduling service requests.

Requirement

The MHP must ensure, at the request of the beneficiary when the MHP or its network provider has determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria, the MHP provides for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse).

(California Code of Regulations, title 9, section 1810, subdivision 405(e)).

DHCS Finding 5.5.2

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP, at the beneficiary's request, provides a second opinion from a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse) when it is determined that the beneficiary is not entitled to SMHS due to not meeting the medical necessity criteria. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it has never had this type of request occur and that it would review its policy. Post review, the MHP submitted a compliant policy that it will implement moving forward.
DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 405(e).

Corrective Action Description

1. Second Opinion/Appeals/SFH Policy will be updated to include provision for staff taking an appeal to remind appellant of right to second opinion.
2. Information on right to a Second Opinion is already included as part of the Beneficiary Handbook. MHP will amend "appeals" section of poster on Grievances, Change of Provider and Appeals to include additional detail on Second Opinions.

Proposed Evidence/Documentation of Correction

1. Policy: Second Opinions, Appeals and State Fair Hearings.
2. Document: Beneficiary Rights poster and Grievances, Change of Provider, and Appeals poster.
3. Document: Beneficiary Handbook.

Ongoing Monitoring (if included)

Requests for Second Opinions will be tracked via a log as requests are presented.

Person Responsible (job title)

MH Quality Coordinator

Implementation Timeline:

August 31, 2022: Second Opinions, Appeals and State Fair Hearing policy update completed.

August 31, 2022: Grievances, Change of Provider, and Appeals poster update completed.

Requirement

The MHP must have only one level of appeal for beneficiaries. (MHP contract, exhibit A, attachment 12, and Code of Federal Regulations, title 42, section 438, subdivision 402(b) and 228(a)).

DHCS Finding 6.1.4

While the MHP submitted evidence to demonstrate compliance with this requirement, is not evident that the MHP has only one level of appeal for beneficiaries. Per the discussion during the review, the MHP acknowledge this language is present in the MHP policy, however it is not clearly included in the beneficiary handbook. Post review, the MHP submitted an updated beneficiary handbook with the required language that it will implement moving forward.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12, and Federal Code of Regulations, title 42, section 438, subdivision 402(b) and 228(a).

Corrective Action Description

1. Information on the MHP having only one level of appeal will be added to the Appeal Request Form (both English and Spanish).
2. Information on the MHP having only one level of appeal will be added to the Grievance, Change of Provider, Appeal poster (both English and Spanish).

Proposed Evidence/Documentation of Correction

1. Document: Appeal Request Form – updated.
2. Document: Grievance, Change of Provider, Appeal, Second Opinions poster – updated.

Ongoing Monitoring (if included)

Appeal requests will be tracked via a log as requests are presented.

Person Responsible (job title)

MH Quality Coordinator

Implementation Timeline:

August 31, 2022: Appeal Request Form update completed.

August 31, 2022: Grievance, Change of Provider, Appeal poster – update completed.

Requirement

The MHP must provide a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative. Code of Federal Regulations, title 42, section 438, subdivision 408(d)(2); California Code of Regulations, title 9, section 1850, subdivision 207(h).

DHCS Finding 6.4.16

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP makes reasonable efforts to provide oral notice to the beneficiary and/or his or her representative regarding expedited appeal dispositions. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that there have been instances when the MHP communicated orally with a beneficiary's representative, however, it was acknowledged that this requirement was not included in the policy. Post review, the MHP submitted a compliant policy that it will implement moving forward.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(d)(2); California Code of Regulations, title 9, section 1850, subdivision 207(h).

Corrective Action Description

MHP Second Opinions, Appeals and State Fair Hearings policy will be updated to include provision to make reasonable effort to provide oral notice to beneficiary and/or their representative regarding expedited appeal dispositions.

Quality Coordinator manages appeals and is the author of this CAP – no training needed.

Note: There were no appeals requested during this audit cycle.

Proposed Evidence/Documentation of Correction

1. Document: Updated Second Opinions, Appeals, State Fair Hearings Policy

Evidence previously submitted during audit:

2. Document: Grievance, Change of Provider, Appeal, Second Opinions poster.
3. Document: Beneficiary Handbook.

Ongoing Monitoring (if included)

Requests for Appeals and Expedited Appeals will be tracked via a log as requests are presented.

Person Responsible (job title)

Quality Coordinator

Implementation Timeline:

August 31, 2022: Policy update completed.

Chart Review

Requirement

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

Assessments were not completed in accordance with regulatory and contractual requirements.

DHCS Finding 8.2.1

One assessment was not completed within the update frequency requirements specified in the MHP's written documentation standards. Per the Napa County HHSA Mental Health Division Documentation Manual, "Assessments should be completed as soon as possible but no later than 60 days from the individual's first face to face assessment service."

The following are specific findings from the chart sample:

Line number 10. The assessment MHP provided for the virtual on-site review was the MH Children's Reassessment, signed completed on 9/20/2020. Based on the provided 1/30/2020 episode opening date (EOD) and the MHP policy, the initial assessment following the first face-to-face service should have been dated on or by 3/30/2020.

CORRECTIVE ACTION PLAN 8.2.1:

The MHP shall submit a CAP that describes how the MHP will ensure that assessments are completed in accordance with the initial timeliness and update frequency requirements specified in the MHP's written documentation standards.

Corrective Action Description

The Napa County MHP Clinical Documentation Manual includes written documentation standards for assessments, including DHCS required elements of timeliness and frequency.

Beginning July 1, 2022, Napa County's policy on documentation standards will not require comprehensive annual reassessments at regular intervals. The time period for providers to complete an initial assessment and subsequent assessments for SMHS is

up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice based on BHIN-22-019 requirements.

Per updated CalAIM Documentation requirements effective July 1, 2022, Napa County will:

1. update documentation requirements policy,
2. update the documentation manual,
3. update chart review protocol, and
4. train existing clinical staff on the new documentation standards outlined in BHIN 22-019 and train new clinical staff on documentation standards upon hire.

Proposed Evidence/Documentation of Correction

1. Updated documentation requirements policy,
2. Updated clinical documentation manual,
3. Updated chart review protocol, and
4. Training materials on the new documentation standards outlined in BHIN 22-019,
5. Training completion log.

Ongoing Monitoring (if included)

The chart review team provides direct feedback to program supervisors and staff so that the results can be addressed in supervision as well as during staff meetings a means to promote competency development on documentation requirements. Additionally, Supervisors conduct 100% review of all progress notes of all new hire staff, until staff consistently meet DHCS and the MHP clinical documentation standards.

In addition, the Napa County Quality Management Team--a separate division from Mental Health--conducts periodic audits of Mental Health Plan charts which closely mirror the audits conducted by DHCS. The Quality Management team provides findings and recommendations and requires Plans of Correction where applicable.

Person Responsible (job title)

Utilization Review Coordinator

Implementation Timeline:

July 1, 2022 – Training materials on the new documentation standards outlined in BHIN 22-019 completed.

July 31, 2022 – Staff training completion

September 30, 2022 - Updated documentation requirements policy.

September 30, 2022 - Updated clinical documentation manual.

September 30, 2022 - Updated chart review protocol.

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:
   a) The signature of the person providing the service (or electronic equivalent).
   b) The person's type of professional degree and,
   c) Licensure or job title.

(MHP Contract, Ex. A, Att. 9, Sec. 1(C)(1)(a)-(h)).

DHCS Finding 8.5.1

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

- Line numbers 2, 3, 4, 6, 7, 8, and 9. One or more progress note was not completed within the MHP's written timeliness standard of five business days after provision of service. 59 or 67 percent of all progress notes reviewed were completed late.
- Line number 5. One or more progress note did not match its corresponding claim in terms of service date. The MHP reported during the virtual on-site review that two claims both dated 8/13/2020, for 61 minutes and 112 minutes, were billing errors belonging to another beneficiary.
- A third claim for Individual Rehab on 8/21/2020 was billed to the incorrect date; the MHP later submitted an 8/31/2020 Individual Rehab progress note, which was the correct date of service.

CORRECTIVE ACTION PLAN 8.5.1

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

1) 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.
2) The MHP shall submit a CAP that describes how the MHP will ensure that both service dates and times recorded on progress notes match their corresponding claims.
3) The MHP shall submit a CAP that describes how the MHP will ensure that Specialty Mental Health Services claimed are accurate and are actually provided to the beneficiary.

Corrective Action Description

1) Per updated CalAIM Documentation requirements effective July 1, 2022 Napa County will update our written documentation requirements policy, the documentation manual, chart review protocol and training to reflect the new documentation standards outlined in BHIN 22-019.
2) Progress Note Timeliness: Monthly chart review will audit for progress notes completed greater than three days and alert supervisors of these findings.
3) Incorrect Dates of Service: The contract provider quality staff will audit claim submissions to confirm accuracy prior to submission to the Napa County Fiscal department.
4) Training will be provided to internal and external contract providers on the new documentation standards and to reinforce accuracy of claims submission.
5) In 2023 our new electronic health record will be programmed to alert clinicians of progress note deadlines.

Proposed Evidence/Documentation of Correction

5. updated documentation manual,
6. updated chart review protocol,
7. training materials on the new documentation standards outlined in BHIN 22-019, and
8. screen shot of sample clinician alert of progress note deadline.

Ongoing Monitoring (if included)

1) Monthly chart review will audit for progress notes completed greater than three days and alert supervisors of these findings.
2) In 2023 alerts will be added to the Electronic Health Record.
3) Quality Management will audit providers periodically to verify compliance.

Person Responsible (job title)

Utilization Review Coordinator, Principal Quality MGT Specialist

Implementation Timeline:

July 31, 2022 – Training materials on the new documentation standards outlined in BHIN 22-019.

September 30, 2022 - Updated documentation requirements policy.

September 30, 2022 - Updated clinical documentation manual.

September 30, 2022 - Updated chart review protocol.

September 30, 2022 – Staff training completion.

2023 – Implementation of EHR with alert feature.

Requirement

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

9) Every service contact for:
    a) Mental health services
    b) Medication support services
    c) Crisis intervention
    d) Targeted Case Management
    e) Intensive Care Coordination
    f) Intensive Home-Based Services
    g) Therapeutic Behavioral Services
10) Daily for:
    a) Crisis residential
    b) Crisis stabilization (one per 23-hour period)
    c) Day treatment intensive
    d) Therapeutic Foster Care
11) Weekly for:
    a) Day treatment intensive (clinical summary)
    b) Day rehabilitation
    c) Adult residential

(MHP Contract, Ex. A, Att. 9, Sec. 1(C)(2)(a)-(c)).

DHCS Finding 8.5.3

Progress notes were not documented according to the contractual requirements specified in the MHP Contract. Specifically:

- **Line number 3**: For Mental Health Services claimed, the Individual Rehab service activity identified on the 7/9/2020 progress note was not consistent with

the specific service activity actually documented in the body of the progress note, which appeared to describe Individual Therapy.

The intervention states, "explored [client's] beliefs about mental illness, psychotropic medications, and definitions of normal. Attempted to find middle ground between confrontation and appearing to confirm client's beliefs. Examined 'normalcy'…from a CBT perspective…"

CORRECTIVE ACTION PLAN 8.5.3:

The MHP shall submit a CAP that describes how the MHP will ensure that all SMHS claimed are for the correct service modality billing code and units of time.

Corrective Action Description

Napa County MHP Clinical Documentation Manual includes written documentation standards directing that service activity described in the body of all progress notes should be consistent with the specific service activity claimed. The standards specify that all claims submitted must be accurate and consistent with the actual service provided in terms of type of service, date of service and time of service.

1) The UR Coordinator will meet monthly with supervisors in the Monthly Clinical Utilization Review Meeting to discuss and troubleshoot clinical documentation and service coding issues or inconsistencies as they arise.

2) All staff will be re-trained on documentation and appropriate use of progress note service codes at 2022 annual compliance training.

Proposed Evidence/Documentation of Correction

1) Sample agenda for Monthly Clinical Utilization Review Meeting.
2) MHP training materials on guidance on progress note and service coding accuracy.

Ongoing Monitoring (if included)

1) UR Coordinator will meet with supervisors in the Monthly Clinical Documentation Meeting to discuss all findings and plans of correction related to the 2022 DHCS Triennial Audit as they arise.

2) Napa County MHP's quality assurance mechanisms include monthly Chart Review, Supervisor 100% review of new staff, and Quality Management periodic

audits/reviews. The ongoing monthly Chart Review process also provides direct feedback to staff and their supervisors when the progress notes reviewed do not meet county/state standards.

3) Clinical documentation skills are also discussed by supervisors in their weekly staff meetings on an as needed basis; and feedback is provided monthly in the monthly chart review findings.

Person Responsible (job title)

Utilization Review Coordinator, Unit Supervisors

Implementation Timeline:

September 30, 2022 - Sample agenda for Monthly Clinical Utilization Review Meeting available.

September 30, 2022 – Re-training on progress note and service coding accuracy completed.

Requirement

The ICC Coordinator and the CFT reassesses the strengths and needs of children and youth, and their families, at least every 90 days, and as needed.

(Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi- Cal B beneficiaries, (3d ed. 2018), p. 26; MHSUDS IN No. 18-007).

DHCS Finding 8.6.2

The medical record for the beneficiary who was receiving ICC services did not contain evidence that the MHP had reassessed the strengths and needs of the beneficiary, at least every 90 days, for the purpose of determining if ICC services should be modified:

Line number 7. Weekly ICC and quarterly Child and Family Team (CFT) meetings were listed as needed interventions on the client plan signed completed 8/26/2020. However, there were no claims for ICC services nor documented evidence of CFT meetings during the review period from July 1 through September 31 of 2020, specifically the month of September following Assessment and Plan Development services delivered in July and August.

The MHP was given the opportunity to locate evidence of ICC services and CFT meetings for the month of September and submitted an ICC tracking log; however, the beneficiary in question was not among those listed.

CORRECTIVE ACTION PLAN 8.6.2

The MHP shall submit a CAP that describes how it will ensure that all beneficiaries under age 22 who receive ICC services have a case consultation, team or CFT meeting at least every 90 days to discuss the beneficiaries' current strengths and needs.

Corrective Action Description:

1. A desk guide on the requirements for serving ICC beneficiaries will be developed and distributed to staff assigned as ICC Coordinators. Desk guide will feature the requirement for reassessing the strengths and needs of ICC beneficiaries at least every 90 days.
2. QA/UR Clinician will train Supervisors and Contract Providers overseeing ICC services on use of the desk guide.

Proposed Evidence/Documentation of Correction

1. Desk Guide on requirements for serving ICC beneficiaries.
2. Training logs.

Ongoing Monitoring (if included)

For each outpatient case, Napa County MHP assigns a "Single Accountable Individual" (SAI). For children/youth receiving intensive services, the SAI functions as the ICC Coordinator.

Supervisors of ICC Coordinators (SAI) will monitor to ensure that identified services and activities are progressing appropriately and that cases are reassessed according to requirements.

Person Responsible (job title)

ICC Coordinator (Single Accountable Individual), Unit Supervisors, QA/UR Clinician

Implementation Timeline:

September 30, 2022 – Desk Guide completed.

September 30, 2022 – Training on desk guide completed.

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