Colusa County Department of Behavioral Health

FY 20/21 Specialty Mental Health Triennial Review

Corrective Action Plan

System Review & Chart 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),CCR, tit. 28 § 1300.67.2.2 (c)(5)(D))

DHCS Finding: 1.1.3
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i). The MHP must 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. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP meets, and requires its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services. The MHP provided evidence of urgent and physician appointments, however many of the appointments were outside the required timelines. Per the discussion during the review, the MHP acknowledged challenges with meeting timeliness standards and provision of timely appointment services. The MHP stated that it has been difficult to recruit professional staff to maintain the timeliness standards.
DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i).

Corrective Action Description
The MHP has recently created a crisis team to respond to urgent requests for services. The team consists of a Clinical Program Manager (LCSW), two Therapist II (ACSWs), one Mental Health Specialist, and two Case Managers. The Crisis Team meets every morning to discuss the current needs of the day, which includes recent crises and requests for urgent intakes. The Clinical Program Manager then schedules and assigns the daily tasks of the urgent needs to ensure timeliness of appointments within 48 hours and follows-up on these the next day.

Since our Triennial Review, the MHP has also expanded their contract with Traditions Behavioral Health and Kingsview to increase telepsychiatry services to a total of 7.5 days. The MHP is in discussion with Traditions to add a task of an “on-call” psychiatrist to meet urgent needs of consumers that may come up in-between scheduled medication appointments.

Proposed Evidence/Documentation of Correction
- Organizational Chart (Submitted with CAP)
- On-Call Crisis Team Calendar (Submitted with CAP)
- Email of added intake appointment slots for urgent requests
- Contracts for Traditions and Kingsview

Ongoing Monitoring (if included)
The MHP will continue to monitor this item during its quarterly Quality Improvement Committee meetings. The standing agenda item in QIC states, “Beneficiaries requesting mental health services with an urgent condition will be scheduled an appointment with 48 hours of request”. This data is likely to improve now that the MHP has a dedicated Crisis Team designed to respond to urgent requests in a timely manner to meet the 48-hour requirement. When the MHP receives urgent medication requests, the MHP staff schedules these appointments for our telehealth psychiatrists. Then the psychiatrists document in the

MHP's Electronic Health Record giving the MHP the needed data to track timeliness and complete monitoring of this item.

Person Responsible (job title)
Bessie Rojas, LCSW
Quality Assurance Coordinator

Implementation Timeline:

The MHP's Crisis Team began February 1st, 2022. The MHP expanded contract with Traditions in October 2021 and expanded contract with Kingsview in January 2022 for telepsychiatry. The next QIC meeting to monitor this item quarterly is scheduled for May 3rd, 2022.

Requirement
The MHP shall establish mechanisms to ensure that network providers comply with the timely access requirements. (42 C.F.R. § 438.206(c)(1)(iv).)
1. The MHP shall monitor network providers regularly to determine compliance with timely access requirements. (42 C.F.R. § 438.206(c)(1)(v).)
2. The MHP shall take corrective action if there is a failure to comply with timely access requirements. (42 C.F.R. § 438.206(c)(1)(vi).)

DHCS Finding: 1.1.6
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulation, title 42, section 438, subdivision 206(c)(1)(iv), (v), and (vi). The MHP shall establish mechanisms to ensure that network providers comply with the below timely access requirements:
1. The MHP shall monitor network providers regularly to determine compliance with timely access requirements.
2. The MHP shall take corrective action if there is a failure to comply with timely access requirements.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has established mechanisms to ensure its network providers comply with timely access requirements. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that its only contractor began providing services for telepsychiatry in July of 2021 and it has not had issues with timely access. DHCS requested evidence of a monitoring process for this provider, however, the evidence submitted does not demonstrate psychiatric appointments are monitored or a corrective action process is in place.
DHCS deems the MHP out of compliance with Federal Code of Regulation, title 42, section 438, subdivision 206(c)(1)(iv), (v), and (vi).

Corrective Action Description
The MHP schedules all appointments for all contracted providers. MHP Staff enter into the Electronic Health Record time of request, first offered appointment, and scheduled appointments. Therefore, the MHP has the capabilities to monitor contracted providers. Psychiatric appointments are monitored via the Access to Services Assessment, tracked and reported during quarterly Quality Improvement Committee meetings, and ongoing timeliness issues are then taken to the Director so that a discussion regarding contract compliance can be had.

Proposed Evidence/Documentation of Correction
- Access to Services Assessment (Submitted with CAP)
- QIC minutes (Submitted with CAP)
- Boilerplate Contract with highlights (Submitted with CAP)

Ongoing Monitoring (if included)
Moving forward, the MHP will monitor each contract provider's timeliness individually and report per contract during QIC meetings. If contract providers fall outside of compliance, then the issue will be brought to the attention of the Director and documented within Compliance Log.

Person Responsible (job title)
Tracking and reporting by – Bessie Rojas, LCSW, Quality Assurance Coordinator
Monitoring and compliance by – Heather Bullis-Cruz, Compliance Officer

Implementation Timeline:
The MHP will add this item into our FY 22-23 QI Work Plan which is expected to be completed by 6/30/2022. Tracking, reporting, monitoring, and compliance of this item will occur during the first QIC meeting in FY 22-23.

Requirement
The MHP has an affirmative responsibility to determine if children and youth who meet medical necessity criteria need ICC and IHBS. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

DHCS Finding: 1.2.2
The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must have an affirmative responsibility to determine if children and youth meet medical necessity criteria need ICC and IHBS.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP determines if children and youth who meet medical necessity criteria need ICC and IHBS. Per the discussion during the review, the MHP stated it does not have a screening tool for ICC and IHBS; however, the MHP reported that staff informally discuss beneficiary needs during intake and assessment. Post review, the MHP provided a screening tool and an authorization form for ICC and IHBS that it will implement moving forward.

Corrective Action Description
The MHP has developed a screening tool to determine the need for ICC and IHBS services. The screening tool will be administered at intake for each youth client, and can be administered later in treatment as the need for such services may arise. During the ACCESS and assigning process the Children's Team Clinical Program Manager will approve or deny ICC and IHBS services which will be logged in the ACCESS binder.

Proposed Evidence/Documentation of Correction
- Updated ACCESS Log (Submitted with CAP)
- Updated ICC/IHBS Screening Tool (Submitted with CAP)
- Updated ACCESS Team Form (Submitted with CAP)
- Updated Intake Checklist (Submitted with CAP)

Ongoing Monitoring (if included)
The Front Office Staff assigned to the records room will log ICC/IHBS approvals and denials in the ACCESS Log binder. The ACCESS Team will monitor the completion of ICC/IHBS screening tool at intake by routing back charts to the clinician for cases that are missing the screening tool. If ICC/IHBS is added after intake and during the course of treatment, then the ACCESS Team Form notates the need for the screening tool. The ACCESS Team will not approve ICC/IHBS services without the completed screening tool.

Person Responsible (job title)
Intake clinicians
Front Desk Staff
ACCESS Team

Implementation Timeline: New procedures will be discussed at Leadership on 3/22/22. Training on the Screening Tool will be determined during leadership with plans to complete the training and implement new procedures at the start of the FY 22-23.

Requirement
The MHP must provide Therapeutic Foster Care (TFC) services to all children and youth who meet medical necessity criteria for TFC. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

DHCS Finding: 1.2.7
The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must provide TFC services to all children and youth who meet medical necessity criteria for TFC.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides TFC services to all children and youth who meet medical necessity criteria for TFC. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it does not have the ability to assess or provide TFC services to children and youth. Post review, the MHP provided a statement declaring that there are no children receiving TFC or TFC providers in the county or service area.

Corrective Action Description
The MPH has created a TFC Screening Tool to determine need for TFC services. This tool is available for MHP Staff to utilize, but will mostly be completed by Colusa County Child Protective Services (CPS) staff and then referred to the MHP. CPS is aware of all children in foster care and better understand their needs. If/when CPS identifies a youth in need of TFC, then the MHP will coordinate with CPS to ensure TFC services are located and funded by the MHP through presumptive transfer, as Colusa County currently does not have a Therapeutic Foster home in the county. The Clinical Program Manager of Children Services will meet monthly with CPS to continue to monitor the need of TFC services for Colusa County youth.

Proposed Evidence/Documentation of Correction
- TFC Tracking Log (Submitted with CAP)
- TFC Screening Tool (Submitted with CAP)

Ongoing Monitoring (if included)
A monthly report will be ran from the Electronic Health Record to identify the number of clients receiving TFC services. The QA Team will review this report to ensure that these beneficiaries have a completed the TFC screening tool which documents the need for this service. The number of TFC beneficiaries will be presented quarterly in Leadership meetings.

Person Responsible (job title)
Tracking/Monitoring: Bessie Rojas, LCSW, Quality Assurance Coordinator
Reporting/Coordination: Mark McGregor, LCSW, Clinical Program Manager

Implementation Timeline: New procedures will be discussed at Leadership in the near future to receive feedback from the Children's Team Clinical Program Manager. Training on the TFC Screening Tool will be determined during leadership with plans to complete the training and implement new procedures at the start of the FY 22-23.

Requirement
The MHP has an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC. (Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

DHCS Finding: 1.2.8
The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must have an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP assesses children and youth to determine if they meet medical necessity criteria for TFC. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it does not have a formal process or a screening tool in place to assess for TFC. The MHP stated it would have to develop a process to assess children and youth for the need for TFC services. Post review, the MHP provided a TFC screening tool it will implement moving forward.

Corrective Action Description
The MPH has created a TFC Screening Tool to determine need for TFC services. This tool is available for MHP Staff to utilize, but will mostly be completed by Colusa County Child Protective Services (CPS) staff and then referred to the MHP. CPS is aware of all children in foster care and better understand their needs. If/when CPS identifies a youth in need of TFC, then the MHP will coordinate with CPS to ensure TFC services are located and funded by the MHP through presumptive transfer, as Colusa County currently does not have a Therapeutic Foster home in the county. The Clinical Program Manager of Children Services will meet monthly with CPS to continue to monitor the need of TFC services for Colusa County youth.

Proposed Evidence/Documentation of Correction
- TFC Tracking Log (Submitted with CAP)
- TFC Screening Tool (Submitted with CAP)

Ongoing Monitoring (if included)
A monthly report will be ran from the Electronic Health Record to identify the number of clients receiving TFC services. The QA Team will review this report to ensure that these beneficiaries have a completed the TFC screening tool which documents the need for this service. The number of TFC beneficiaries will be presented quarterly in Leadership meetings.

Person Responsible (job title)
Tracking/Monitoring: Bessie Rojas, LCSW, Quality Assurance Coordinator
Reporting/Coordination: Mark McGregor, LCSW, Clinical Program Manager

Implementation Timeline: New procedures will be discussed at Leadership on 3/22/22. Training on the TFC Screening Tool will be determined during leadership with plans to complete the training and implement new procedures at the start of the FY 22-23.

Requirement

The MHP shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract. (42 C.F.R. § 438.12(a)(1).)

DHCS Finding: 1.4.3
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 12(a) (1). The MHP must comply with following;

- The MHP shall give practitioners or groups of practitioners who apply to be MHP contract providers and with whom the MHP decides not to contract written notice of the reason for a decision not to contract.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP provides written notice not to contract with practitioners or groups of practitioners. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP did not have a policy in place and stated it has not encountered a need, citing the lack of SMHS providers in the county. While the MHP developed and submitted a template to use for this process post review that the MHP intends to use moving forward, this process had not been implemented at the time of the review.

Corrective Action Description
The MHP will create a Policy and Procedure outlining the process of notifying a practitioner or a group of practitioners that their request to contract with Colusa County Behavioral Health has been denied.

Proposed Evidence/Documentation of Correction

- P&P – Decision Not to Contract with Practitioners or Groups of Practitioners 160.00 (To be submitted by Implementation timeline)
- Template denial Letter of Request to Contract with practitioner (Submitted with CAP)

Ongoing Monitoring (if included)
When the MHP decides not to contract with a practitioner or group of practitioners, then Fiscal Administrative Officer will inform the MHP's Leadership Team and Quality Management, at which point the Clinical Program Manager will ensure a notification letter has been mailed.

Person Responsible (job title)
Bonnie Briscoe, Fiscal Administrative Officer
Jeannie Scroggins, LMFT, Clinical Program Manager

Implementation Timeline: 7/1/2022

Requirement
The MHP shall monitor the performance of its subcontractors and network providers on an ongoing basis for compliance with the terms of the MHP contract and shall subject the subcontractors' performance to periodic formal review. (MHP Contract, Ex. A, Att. 8)

DHCS Finding: 1.4.5
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 8. The MHP must monitor the performance of its contractors and network providers on an ongoing basis for compliance with the terms of the MHP contract and shall subject the contractors' performance to periodic formal review.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP monitors the performance of its contracted providers. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it is not monitoring its telepsychiatry service provider it recently contracted with in July of 2021. The MHP has not implemented a monitoring process, formal or otherwise, for contracted providers.

Corrective Action Description
Moving forward, the MHP will monitor compliance with agreed upon services provided that are listed within each provider's contract. This requirement will be listed as a standing agenda item on the quarterly Compliance meetings held within the MHP. Ongoing issues will be brought to the attention of the Director and documented within the Compliance Log. While the MHP recently contracted for telepsychiatry, the MHP has a Medication Monitoring tool that has been in place, and in practice, with our civil-servant psychiatrist. Now that the MHP has additional psychiatrists to monitor, this Medication Monitoring tool will also be utilized with these new contracted providers. Annually, the MHP will review each providers' contract to ensure that they remained in good standing with the MHP during the last year. If the contract provider remained in compliance within their contract, then the MHP will continue to utilize them as a provider, if needed.

Proposed Evidence/Documentation of Correction
- Internal Utilization Review form (Submitted with CAP)
- Contract Compliance Monitoring Log (monitoring of sub-contractors) (Submitted with CAP)
- Compliance meeting agenda (Submitted with CAP)

Ongoing Monitoring (if included)
The MHP will add this item as a set agenda item for each quarterly Compliance meeting. The Compliance Officer will investigate issues and take appropriate steps, involving the Director as needed, to resolve any issues with subcontractors' contracts.

Person Responsible (job title)
Heather Bullis-Cruz, Compliance Officer
Leadership Team & Director

Implementation Timeline: The MHP will add this item into the next Compliance meeting scheduled for April 19th, 2022.

Requirement
The MHP shall make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving SMHS from the MHP. (CCR, title 9, section 1810.415(a).).

DHCS Finding: 2.3.1
The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 415(a). The MHP must make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving SMHS from the MHP.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP makes clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving SMHS from the MHP. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that this has occurred informally but there are not specific trainings implemented due to lack of staffing. The MHP stated it is hiring a psychiatrist and clinical consultation will be included in the job description. DHCS requested evidence of this practice, however, no additional evidence was provided.

Corrective Action Description
The MHP is currently in discussions internally and with our contracted providers to determine how to implement this requirement. A more definitive plan will be developed soon as we determine training topics and dates that our telehealth psychiatrists will provide to community Primary Care Physicians.

8/25/2023 – Colusa County Behavioral Health has a meeting with Iris Telehealth on 8/28/2023 to discuss a possible contract due to the addition of a Medical Director, and increased hours of child telepsychiatry. It may be that this Medical Director facilitates these trainings within our community.

2/15/2024 – Colusa County did not contract with Iris Telehealth for a Medical Director. Instead we expanded our current contract with Traditions Psychology Group to include a Medical Director with a modified contract date of 11/15/2023. Colusa County Behavioral Health had discussions with our new Medical Director, Dr. Mercy Perdomo, who is agreeable to provide medication education, training, and consultation for Primary Care Physicians in our community. We are working on developing a training agenda and a meeting date with Dr. Perdomo. This psychiatric training will occur before the end of the fiscal year.

4/19/2024 – Colusa County has updated our Care Coordination P&P (610.01) which discusses making clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by CCBH or for beneficiaries who are receiving treatment from another health care provider in addition to receiving SMHS from CCBH. In addition, a document introducing Dr. Perdomo to Primary Care Physicians is being created and will include information regarding consultation and training that will be mailed out to local primary care physicians.

8/14/2024 – A flyer introducing Dr. Perdomo as our Medical Director has been created and mailed out to local PCPs to let them know that they can consult with her about their patients who have a mental health disorder or mutual clients.

Proposed Evidence/Documentation of Correction
- Telehealth contracts (Submitted with CAP)
- Care Coordination P&P 610.01
- Dr. Perdomo flyer
- Dr. Perdomo flyer email

Ongoing Monitoring (if included)

- Log of consultations with PCPs

Person Responsible (job title)
Tony Hobson, CCBH Director
Tracking of trainings: Heather Bullis-Cruz, Compliance Office

Implementation Timeline:
12/1/2023
6/30/2024
8/14/2024

Requirement
The MHP has a written description of the Quality Assessment and Performance Improvement (QAPI) Program that:
1. Clearly defines its structure and elements,
2. Assigns responsibility to appropriate individuals, and
3. Adopts or establishes quantitative measures to assess performance and identify and prioritize areas for improvement.
(MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.330(a)(e)(2).)

DHCS Finding: 3.1.1
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(a)(e)(2). The MHP must have a written description of the Quality Assessment and Performance Improvement Program (QAPI) addressing the below listed requirements:
1. Clearly defines its structure and elements,
2. Assigns responsibility to appropriate individuals, and
3. Adopts or establishes quantitative measures to assess performance and identify and prioritize areas for improvement.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a written QAPI that assigns responsibility to appropriate individuals. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that it has a work plan template that has assigned staff for each goal. Post review, the MHP provided a Quality Improvement Committee (QIC) Agenda however the MHP did not provide a QAPI work plan that has staff assigned for each goal.
DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(a)(e)(2).

Corrective Action Description
When the QAPI is created for FY 22-23, the MHP shall ensure that staff assignments will appear in the QAPI as well as the quarterly QIC agendas.

Proposed Evidence/Documentation of Correction
- QAPI FY 22-23 (To be submitted by Implementation timeline)

Ongoing Monitoring (if included)
Annually when updating the QAPI, the MHP will review the assigned staff to ensure the appropriate and relevant staff remain assigned.

Person Responsible (job title)
Bessie Rojas, LCSW
Quality Assurance Coordinator

Implementation Timeline: 7/1/2022

Requirement
The MHP shall conduct performance-monitoring activities throughout the MHP's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.330(a)(e)(2).)

DHCS Finding 3.1.3
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(a)(e)(2). The MHP must conduct performance-monitoring activities throughout the MHP's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP conducts performance-monitoring activities throughout the MHP's operations. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it has had challenges with this requirement due to insufficient staffing for performance monitoring activities. DHCS requested evidence for this requirement, but no additional evidence was provided. DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(a)(e)(2).

Corrective Action Description
Due to the MHP lack of staffing in this area, the MHP is looking into contracting with Kingsview Consulting to help assist in quality assurance and improvement tasks. These tasks may include analyzing data to transform them into actionable results. Recently, the MHP has also expanded their Dashboards to include an Over/Under Utilization Management dashboard. Kingsview has also improved our CANS Dashboard so that the MHP can better monitor the youth clients' outcomes.

8/25/2023 – Colusa County Board of Supervisors approved Behavioral Health to expand its quality management program with the addition of a new position, Quality Assurance Coordinator II within FY23-24. Behavioral Health is hopeful that with the addition of another full-time staff dedicated to quality assurance duties, including performance-monitoring activities, this CAP will soon be resolved.

2/15/2024 – Colusa County Behavioral Health did not utilize the contract with Kingsview Consulting, as mentioned above, as it unfortunately was not a direct resolution to our needs. In FY23-24, we budgeted for an additional county employee Quality Assurance Coordinator position. That position was filled in December 2023. We are in the process of developing a plan to better track, monitor, and analyze MHP operations. However, we have encountered a barrier with our new electronic health record, SmartCare, in regards to pulling some needed data out of our system. We are meeting weekly with CalMHSA SmartCare's team to develop the reports we need to conduct performance monitoring activities. We submitted a list of needed reports to CalMHSA on 2/9/2024, and will continue to meet weekly until our EHR data report needs are met.
Submitted as evidence Quality Improvement Work Plan FY23-24 to show evidence of items the department tracks and monitors.

4/19/2024 – Colusa County ensures provider credentialing and monitoring occurs based on processes outlined in Policy and Procedure 111.02, which is current and active. Tracking and monitoring of provider credentialing and monitoring is a set agenda item in CCBH's quarterly Compliance Committee meeting.

Proposed Evidence/Documentation of Correction
- Screenshot of Dashboards (Over/Under Utilization Management and CANS) (Submitted with CAP)
- QAPI FY 22-23 (submitted 2/15/24)
- Compliance Committee meeting agenda
- Organizational Provider Selection and Retention P&P 111.02

Ongoing Monitoring (if included)
The MHP will updated the QAPI for FY 22-23 to include an Over/Under Utilization Management item to be tracked, monitored, and reported quarterly during QIC meetings.

Person Responsible (job title)
Bessie Rojas, LCSW
Quality Assurance Coordinator

Implementation Timeline: 4/19/2024

Requirement
The MHP shall have mechanisms to detect both underutilization and overutilization of services. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.330(b)(3).)

DHCS FINDING 3.1.4
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(b)(3). The MHP must have mechanisms to detect both underutilization and overutilization of services.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has mechanisms to detect underutilization and overutilization of services. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it runs service utilization reports using the electronic health record system. The MHP stated that these reports would be provided post review; however, no additional evidence was provided.
DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(b)(3). The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, and Federal Code of Regulations, title 42, section 438, subdivision 330(b)(3).

Corrective Action Description
Due to the MHP lack of staffing in this area, the MHP is looking into contracting with Kingsview Consulting to help assist in quality assurance and improvement tasks. These tasks may include analyzing data to transform them into actionable results. Recently, the MHP has also expanded their Dashboards to include an Over/Under Utilization Management dashboard. Kingsview has also improved our CANS Dashboard so that the MHP can better monitor the youth clients' outcomes.

Proposed Evidence/Documentation of Correction
- Screenshot of Dashboards (Over/Under Utilization Management and CANS) (Submitted with CAP)
- QAPI FY 22-23 (To be submitted by Implementation timeline)

Ongoing Monitoring (if included)
The MHP will updated the QAPI for FY 22-23 to include an Over/Under Utilization Management item to be tracked, monitored, and reported quarterly during QIC meetings.

8/25/2023 – Please see Quality Improvement Work Plan (QIWP) FY 23-24, Item 4.C.

Person Responsible (job title)
Bessie Rojas, LCSW
Quality Assurance Coordinator

Implementation Timeline: 7/1/2022

Requirement
The Contractor has mechanisms to:
1. Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.
2. Take appropriate follow-up action when such an occurrence is identified.
3. Evaluate the results of the intervention at least annually.
(MHP Contract, Ex. A, Att. 5)

DHCS FINDING 3.1.10
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5. The MHP must have mechanisms for the below requirements:
1. Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.
2. Take appropriate follow-up action when such an occurrence is identified.
3. Evaluate the results of the intervention at least annually.

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns; take appropriate follow up action when such an occurrence is identified; and evaluate the results of the intervention at least annually. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that quality of care concerns are tracked by the front office staff on an internal form, as well the QIC meeting. Post review, the MHP provided an email as evidence for making changes due to COVID-19, however, this evidence failed to meet the criteria of this requirement. DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5.

Corrective Action Description
The 22/23 QAPI will be updated to include “Other Quality Assurance Concerns” and will be a standing agenda item on the QIC meetings for issues to be brought up by stakeholders and/or MHP staff. A subcommittee of QIC will be formed to address these “Other Quality Assurance Concerns” and possible resolutions will be presented to the Leadership Team. The Compliance Officer will work with MHP staff to ensure improvement in these areas of concern, and add these issues to the Compliance meetings when appropriate. When necessary, if these improvement areas are specific to an individual MHP staff, then this information will be given to their direct supervisor to discuss a potential corrective action plan.

Proposed Evidence/Documentation of Correction
- QIC Agenda with “Other Quality Assurance Concerns” item (To be submitted by Implementation timeline)
- Minutes from subcommittee meetings (To be submitted by Implementation timeline)
- Log of information presented to Leadership with possible resolutions of QA concerns (To be submitted by Implementation timeline)
- Compliance meeting agenda to follow-up on “Other Quality Assurance Concerns” items (To be submitted by Implementation timeline)

Ongoing Monitoring (if included)
Monitoring will occur at least quarterly by both QIC and Compliance meetings

Person Responsible (job title)
Bessie Rojas, LMFT, Quality Assurance Coordinator
Heather Bullis-Cruz, Compliance Officer

Implementation Timeline: 7/1/2022

Requirement
The MHP has practice guidelines, which meet the requirements of the MHP Contract.
(MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.236(b); CCR, title 9, § 1810.326.)

DHCS FINDING 3.5.1
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must have practice guidelines, which meet the requirements of the MHP Contract. While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has practice guidelines, which meet the requirements of the MHP Contract. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that there are informal discussions with clinicians on what practices they use when providing services to the beneficiary. The MHP stated it has not developed formal practice guidelines. DHCS requested evidence of these informal discussions, however no additional evidence was provided.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326.

Corrective Action Description
The MHP is in the process of updating our Practice Guidelines and Outcome Tools Policy and Procedure. This updated P&P will more specifically speak to the types of treatment provided by the MHP.

Proposed Evidence/Documentation of Correction
- Revised P&P (Practice Guidelines and Outcome Tools, 612.01) (To be submitted by Implementation timeline)
- Updated Internal Utilization Review form (Submitted with CAP)

Ongoing Monitoring (if included)
During monthly chart audits, QA staff will look for language within progress notes to ensure documentation of MHP preferred treatment in line with the Practice Guidelines and Outcome Tools P&P.

Person Responsible (job title)
Bessie Rojas, LCSW
Quality Assurance Coordinator

Implementation Timeline: 6/1/2022

Requirement
The MHP disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.
(MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.236(b); CCR, title 9, § 1810.326.)

DHCS FINDING 3.5.2
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision n236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP disseminates practice guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries. This requirement was

not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it does not use formalized practice guidelines, therefore it is unable to disseminate the practice guidelines to all providers, beneficiaries, and potential beneficiaries. DHCS requested evidence of how the MHP would disseminate practice guidelines or similar material, however, no additional evidence was provided. DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326.

Corrective Action Description
The updated Practice Guidelines and Outcome Tools Policy and Procedure will be included in all Intake Assessment packets, available on our county website, and posted within the clinic lobby so that beneficiaries (and potential beneficiaries) can easily access this document. This P&P will also be shared with all MHP providers upon hire and posted within the MHP's common drive so staff can continuously refer to it as needed.

Proposed Evidence/Documentation of Correction
- Website link to the Practice Guidelines and Outcome Tools Policy and Procedure (To be submitted by Implementation timeline)
- Revised P&P (Practice Guidelines and Outcome Tools, 612.01) (To be submitted by Implementation timeline)
- Client Receipt of Intake Documents form (which will include the information about practice guidelines) (To be submitted by Implementation timeline)

Ongoing Monitoring (if included)
During review of intake charts, the ACCESS Team will ensure that the Client Receipt of Intake Documents form is completed, acknowledging the dissemination of the practice guidelines.

Person Responsible (job title)
Bessie Rojas, LCSW, Quality Assurance Coordinator

Implementation Timeline: 7/1/2022

Requirement
The MHP take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted. (MHP Contract, Ex. A, Att. 5; 42 C.F.R. § 438.236(b); CCR, title 9, § 1810.326.)

DHCS FINDING 3.5.3
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326. The MHP must take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP takes steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other area to which the guidelines apply are consistent with the guidelines adopted. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it has not developed formalized practice guidelines, therefore it cannot ensure guidelines are applied consistently throughout the system. DHCS requested additional evidence regarding practice guidelines; however, no additional evidence was provided.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 5, Federal Code of Regulations, title 42, section 438, subdivision 236(b), and California Code of Regulations, title 9, section 1810, subdivision 326.

Corrective Action Description
The MHP is working to update their practice guidelines policy and procedures to include models of treatment and frequently utilized evidence-based interventions to are provided at the MHP. This information will be shared to beneficiaries upon intake assessment and reassessment via an updated Member Services Guide, which will also be available in the MHP's clinic and on our website.

Proposed Evidence/Documentation of Correction
- Revised P&P (Practice Guidelines and Outcome Tools, 612.01) (To be submitted by Implementation timeline)
- Member Services Guide (To be submitted by Implementation timeline)

Ongoing Monitoring (if included)
During review of intake charts, the ACCESS Team will ensure that the Client Receipt of Intake Documents form is completed, acknowledging the dissemination of the Member Services Guide.

Person Responsible (job title)
Bessie Rojas, LCSW, Quality Assurance Coordinator
Jeannie Scroggins, LMFT, Clinical Program Manager

Implementation Timeline: 7/1/2022

Requirement
The MHP shall make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider. (42 C.F.R. § 438.10(f)(1).)

DHCS FINDING 4.1.1
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(f)(1). The MHP must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP's process includes notifying beneficiaries within 15 calendar days after receipt or issuance of a provider's termination notice. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated it has not terminated a contract with a provider and does not currently have a template in place to meet this requirement. While post review, the MHP submitted a template to use for this process that the MHP intends to implement moving forward, this process had not been implemented at the time of the review.
DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 10(f)(1).

Corrective Action Description
The MHP is prepared to provide written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider. The MHP has this template in place, which was provided as evidence after the Triennial, though currently a situation has not arisen that notification was required to be given. The MHP will keep a log of all clients that have received notice of termination with a contract provider.

Proposed Evidence/Documentation of Correction
- Template of Client Termination Notice for Contracted Services (Submitted with CAP)
- Termination of Contracted Providers tracking log (Submitted with CAP)

Ongoing Monitoring (if included)
The Compliance Officer will add this item to the quarterly Compliance meetings to ensure that these notices have been sent when the MHP terminates a contract with a provider.

Person Responsible (job title)
Sally Cardenas, Front Office Supervisor
Heather Bullis-Cruz, Compliance Officer

Implementation Timeline: 4/1/2022

Requirement

Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:
1) The MHP provides a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county.
2) The toll-free telephone number provides information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met.
3) The toll-free telephone number provides information to beneficiaries about services needed to treat a beneficiary's urgent condition.
4) The toll-free telephone number provides information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.
(CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1).)

DHCS FINDING 4.3.2

DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number. The seven (7) test calls must demonstrate compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). The tollfree telephone number provides information to beneficiaries to the below listed requirements:
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.
The seven (7) test calls are summarized below.
TEST CALL #1
Test call was placed on Monday, December, 14, 2020, at 11:40 a.m. The call was initially answered after one (1) ring via a live operator. The caller requested information about accessing mental health services for his/her son's behavior and emotional issues. The operator asked the caller if he/she had Medi-Cal and the caller replied in the affirmative. The operator informed the caller about the intake and assessment process, medical necessity and referrals, hours of operation, clinic locations, and crisis information.
The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met.
FINDING
The call is deemed in compliance with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).
TEST CALL #2
Test call was placed on Friday, March 19, 2021, at 9:55 a.m. The call was answered after one (1) ring via a live operator. The caller asked for help with symptoms of depression lasting more than two (2) weeks. The operator asked the caller if he/she had received services at Colusa MHP before, and whether the caller had Medi-Cal. The caller denied having received services at Colusa MHP and confirmed Medi-Cal coverage. The operator then requested the caller's Medi-Cal number or Social Security Number as a condition to provide the caller with information on how to access services. The caller was unable to provide his/her Medi-Cal number and did not want to provide his/her Social Security Number over the phone. The operator proceeded to ask if the caller was in crisis and the caller responded in the negative. The operator asked the caller's name, which the caller provided. The operator explained that he/she was unable to provide appointment services and information without the caller's Medi-Cal

information and asked the caller to call back when he/she had their Medi-Cal number available. The operator instructed the caller to call back 24/7 if the caller felt he/she was in crisis.
The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria were met. The caller was provided information about services needed to treat a beneficiary's urgent condition
FINDING
The call is deemed in partial compliance with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).
TEST CALL #3
Test call was placed on Thursday, December 3, 2020, at 1:28 p.m. The call was answered after one (1) ring via a live operator. The caller requested information about accessing mental health services for depression related to taking care of his/her elderly mother. The operator asked the caller to provide his/her name and contact information. The caller provided his/her name. The operator briefly explained how Medi-Cal coverage works in relation to managed care plans. The operator explained the intake and assessment process and also explained the availability of 24/7 crisis services. The operator asked the caller if he/she was in crisis. The caller replied in the negative. The operator provided clinic hours so the caller could call back with his/her Medi-Cal information and complete the intake process.
The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller provided information about services needed to treat a beneficiary's urgent condition.
FINDING
The call is deemed in compliance with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).
TEST CALL #4
Test call was placed on Friday, April 23, 2021, at 5:37 p.m. The call was answered immediately via a phone tree directing the caller to select a language option, which included the MHP's threshold language. The caller selected the option for English and was immediately transferred to a live operator. The caller stated that he/she needed assistance with a refill for anxiety medication as a new beneficiary in the county. The operator told the caller to call back on Monday at 8:00 a.m. because it was Friday and after hours. The caller asked what he/she was supposed to do without medication over the weekend. The operator stated caller could go to the emergency room. The operator stated that this was the caller's only option if he/she was out of medication. The operator stated that it was the patient's responsibility to call ahead for refills when he/she was running low and that the caller had reached crisis/suicide line and was not in a crisis. The caller acknowledged what the operator had said, but wanted to clarify that the telephone number was a 24/7 access line. The operator answered in the negative and reiterated that is was a crisis line for serious issues, such as suicide. The operator then asked if the caller could reach out to his/her primary care provider and the caller stated that he/she did not have one. The operator once again told the caller to either go to the emergency room or call back on Monday. No additional information about SMHS was provided to the caller. Upon ending the call the caller verified that he/she had called MHP's correct statewide 24/7 toll-free number.
The caller was not provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.
FINDING
The call is deemed partial compliance with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).
TEST CALL #5
Test call was placed on Monday, December 7, 2020, at 11:30 p.m. The call was answered via a phone tree directing the caller to select a language option, which included the MHP's threshold languages. The caller selected the option for English and

was immediately transferred to a live operator. The caller requested information about accessing mental health services for help with symptoms of depression. The operator assessed for urgent and crisis service needs by asking if the caller felt like harming himself/herself or others. The caller replied in the negative. The operator advised the caller of the screening process. The operator advised the caller of the walk-in process. The operator verified the caller's insurance and provided clinic address and hours of operation.
The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met. The caller was provided information about services needed to treat a beneficiary's urgent condition.
FINDING
The call is deemed in compliance with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).
TEST CALL #6
Test call was placed on Friday, March 19, 2021, at 10:42 a.m. The call was answered after one (1) ring via a live operator. The caller asked how to file a complaint. The operator advised the caller that the grievance forms are located at the front desk of the clinic. The operator provided office hours and locations as well as instructions for completing and returning the form. The operator stated that Outside Patient's Rights Advocate would likely follow up regarding the grievance. The operator also offered to transfer the caller to the Outside Patients' Rights Advocate's voicemail so the caller could leave a message with personally identifying information and then wait for a return call to complete the grievance verbally.
The caller was provided information about how to use the beneficiary problem resolution and fair hearing process.
FINDING
The call is deemed in compliance with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).
TEST CALL #7
Test call was placed on Monday, December 7, 2020, at 7:36 a.m. The call was answered after three (3) rings via a phone tree that provided a menu of service options, including, crisis, information on how to access SMHS, how to treat an urgent condition, and information on how to use the beneficiary problem resolution process. After the recording, the phone tree directed the caller to select a language option, which included the MHP's threshold languages. After selecting the option for English, the call was answered immediately via a live operator. The caller requested information about how to file a complaint. The operator informed the caller how to file a complaint by picking up a grievance package at the office. The operator provided the office's hours of operation and also offered to mail a grievance package to the caller. The operator informed the caller that when he/she completed the package, the caller could either mail or drop the complaint at the office. The operator provided the address of the office.
The caller was provided information about how to use the beneficiary problem resolution and fair hearing process.
FINDING
The call is deemed in compliance with the regulatory requirements with California Code of Regulations, title 9, chapter 11, section 1810 subdivision 405(d) and 410(e)(1).
SUMMARY OF TEST CALL FINDINGS

Required Elements	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
1	N/A	N/A	N/A	IN	IN	N/A	N/A	100%
2	IN	OOC	IN	OOC	IN	N/A	N/A	60%
3	N/A	IN	IN	IN	IN	N/A	N/A	100%
4	N/A	N/A	N/A	N/A	N/A	IN	IN	100%

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

Corrective Action Description
The Compliance Officer provided a 24-Hour Access Line Support Training to all staff who answer our access line, which included both MHP staff and staff we contract with to answer after-hours.

Proposed Evidence/Documentation of Correction
- 24-Hour Access Line Support Training materials and sign-in sheet (Submitted with CAP)

Ongoing Monitoring (if included)
Test Calls is a standing agenda item on our quarterly Quality Improvement Committee meeting. If test call outcomes/results fall below standard, then the Compliance Officer will address the issue with the direct supervisors and schedule one-on-one training when necessary. The 24-Hour Access Line Support Training will be provided annually, and upon hire for new employees who answer the access line.

Person Responsible (job title)
Heather Bullis-Cruz, Compliance Officer

Implementation Timeline: CAP completed on 3/25/2022.

Requirement
The written log(s) contain the following required elements:
a) Name of the beneficiary.
b) Date of the request.
c) Initial disposition of the request.
(CCR, title 9, chapter 11, section 1810.405(f).)

DHCS Finding: 4.3.4
The MHP did not furnish evidence to demonstrate compliance with California Code for Regulations, title 9, chapter 11, section 1810, subdivision 405(f). 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.
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 as specified in regulations. The table below summarizes DHCS' findings pertaining to its test calls:

Test Call #	Date of Call	Time of Call	Log Results		
			Name of the Beneficiary	Date of the Request	Initial Disposition of the Request
1	12/14/2020	11:40 a.m.	IN	IN	IN
2	3/19/2021	9:55 a.m.	IN	IN	IN
3	12/3/2020	1:28 p.m.	IN	IN	OOC
4	4/23/2021	5:37 p.m.	OOC	IN	IN
5	12/7/2020	11:30 p.m.	OOC	OOC	OOC
Compliance Percentage			**60%**	**80%**	**60%**

Note: Only calls requesting information about SMHS, including services needed to treat a beneficiary's urgent condition, are required to be logged.

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1810, subdivision 405(f).
Repeat deficiency Yes

Corrective Action Description
The Compliance Officer provided a 24-Hour Access Line Support Training to all staff who answer our access line, which included both MHP staff and staff we contract with to answer after-hours.

Proposed Evidence/Documentation of Correction
- 24-Hour Access Line Support Training materials and sign-in sheet (Submitted with CAP)

Ongoing Monitoring (if included)
Test Calls is a standing agenda item on our quarterly Quality Improvement Committee meeting. If test call outcomes/results fall below standard, then the Compliance Officer will address the issue with the direct supervisors and schedule one-on-one training when necessary. The 24-Hour Access Line Support Training will be provided annually, and upon hire for new employees who answer the access line.

Person Responsible (job title)
Heather Bullis-Cruz, Compliance Officer

Implementation Timeline: CAP completed on 3/25/2022.

Requirement
The CCC completes its Annual Report of CCC activities as required in the CCPR. (CCR title 9, section 1810.410).

DHCS Finding: 4.4.3
The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 410. The MHP must complete its Annual Report of Cultural Competence Committee activities as required in the CCPR.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP completes its Annual Report of Cultural Competence Committee activities as required in the CCPR. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that a summary would be provided post review. While post review, the MHP provided a draft version of its Cultural Competence Plan, no evidence of an annual update was received.
DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 410.

Corrective Action Description
The MHP completed the Annual Report of CCC with an evaluation of the plan towards the end of December 2021 and submitted this document to DHCS.

Proposed Evidence/Documentation of Correction
- 2021 (CY) Cultural Competency Plan with Red Line Evaluation (Submitted with CAP)

Ongoing Monitoring (if included)
The MHP Ethnic Services Manager (ESM) annually updates and evaluates the CCPR with guidance from the MHP's Leadership Committee.

Person Responsible (job title)
Mayra Puga, MHSA Coordinator and ESM

Implementation Timeline: 12/29/2021

Requirement
The MHP has evidence of the implementation of training programs to improve the cultural competence skills of staff and contract providers. (CCR, title 9, § 1810.410 (c)(4)).

DHCS Finding: 4.4.6
The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 410(c)(4). The MHP must have evidence of the implementation of training programs to improve the cultural competence skills of staff and contract providers.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has implemented training programs to improve the cultural competence skills of all staff and contract providers. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that MHP staff have received cultural competence trainings but the contracted telepsychiatry providers have not. Post review, the MHP provided evidence demonstrating that contracted providers had not taken cultural competence trainings, but that these trainings would be set up soon.
DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 410(c)(4).

Corrective Action Description
The MHP has informed its contracted providers that at least one hour of cultural competency/humility training is needed annually. The MHP's subcontracted agencies (Traditions Behavioral Health and Kingsview) provide their own cultural competency trainings to individuals assigned to work with the MHP. The MHP has requested that upon completion of these cultural competency trainings, subcontracted

agencies provide the MHP with the training material, and/or training certificate. In the event that an individual contracts with the MHP, the MHP will provide the trainings to the individual virtually or in person along with the MHP staff when these trainings are offered quarterly. The MHP will also work to amended subcontractors' contracts so there is updated language on the need to complete cultural competency training at least on an annual basis.

Proposed Evidence/Documentation of Correction

- Cultural Humility Training tracking FY21-22 (Submitted with CAP)
- Amended contracts to include language about cultural competency training (To be submitted by Implementation timeline)

Ongoing Monitoring (if included)

The Ethnic Services Manager tracks, logs, and reports on completed cultural competence trainings. The MHP's contracted providers have been added to this log. Annually, the MHP will review each providers' contract to ensure that they remained in compliance with cultural competency training with the MHP during the last year. If the contract provider remained in compliance within their contract, then the MHP will continue to utilize them as a provider, if needed.

Person Responsible (job title)

Mayra Puga, MHSA Coordinator and ESM
Heather Bullis-Cruz, Compliance Officer

Implementation Timeline: 7/1/2022

Requirement
The MHP provides referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area, to a key point of contact that does have interpreter services in that threshold language (CCR, Title 9, Section 1810.410 (e)(2)(B))

DHCS Finding: 4.4.8
The MHP did not furnish evidence to demonstrate compliance with California Code of Regulations, title 9, section 1810, subdivision 410(e)(2)(B). The MHP must have evidence of referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area, to a key point of contact that does have interpreter services in that threshold language.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has evidence of referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area with interpreter services in threshold languages. Per the discussion during the review, the MHP has many bilingual providers and the MHP reserves slots for some provider caseloads however no evidence of this process was provided.

DHCS deems the MHP out of compliance with California Code of Regulations, title 9, section 1810, subdivision 410(e)(2)(B).

Corrective Action Description
The MHP tracks any language accommodations needed in the request for services log to ensure they are met. The MHP has had this in place since July 2020, unfortunately the MHP missed submitting this evidence to show compliance with this item.

Proposed Evidence/Documentation of Correction
- Screenshot sample of log showing language accommodations at time of request (Submitted with CAP)

Ongoing Monitoring (if included)
The Compliance Officer reports monthly to the Behavioral Health Advisory Board regarding the number of intakes requested for the previous month, which includes the beneficiaries' ethnicity and preferred language. To prepare for this report, the Compliance Officer ensures that the excel spreadsheet that tracks initial requests for services is complete, which includes a column for language accommodation and need for bilingual provider and/or interpreter.

Person Responsible (job title)
Sally Cardenas, Front Office Supervisor
Heather Bullis-Cruz, Compliance Officer

Implementation Timeline: CAP completed as MHP already offers language accommodations for threshold languages and has been tracking/monitoring/reporting this item since July 2020.

Requirement

The MHP must provide beneficiaries with a NOABD under the following circumstances:

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.(42 C.F.R. § 438.400(b)(1))
2) The reduction, suspension or termination of a previously authorized service. (42 C.F.R. § 438.400(b)(2))
3) The denial, in whole or in part, of a payment for service. (42 C.F.R. § 438.400(b)(3))
4) The failure to provide services in a timely manner. (42 C.F.R. § 438.400(b)(4))
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. (42 C.F.R. § 438.400(b)(5)).
6) The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities. (42 C.F.R. § 438.400(b)(7)) (MHSUDS IN No. 18-010E)

DHCS Finding: 5.4.1

The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 400. 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.

While the MHP submitted evidence to demonstrate with this requirement, it is not evident that the MHP provides beneficiaries with Notice of Adverse Beneficiary Determinations (NOABD). This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP tracks timeliness requirements by having its front office staff complete the required NOABD when timeliness is not met. Post review, the MHP submitted additional timeliness NOABDs for beneficiaries that did not meet timeliness requirements, however, 25 out of 33 psychiatric appointment and zero (0) of the required urgent appointment NOABDs were provided to DHCS.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 400.

Corrective Action Description

The MHP will create a training for all staff who complete NOABDs to ensure that they are sent timely under the correct circumstances.

Proposed Evidence/Documentation of Correction

- NOABD Training materials and sign-in sheet (To be submitted by Implementation timeline)

Ongoing Monitoring (if included)

This item is already on the quarterly QIC agenda. However, the MHP needs to improve the tracking of this item. The MHP recently hired a Marketing and Administrative Specialist who will be tasked with keeping data updated on the initial request log to ensure that NOABDs are mailed out timely and appropriately.

Person Responsible (job title)

Bessie Rojas, LCSW, Quality Assurance Coordinator
Haley Amundson, Marketing and Administrative Specialist

Implementation Timeline: 6/1/2022

Requirement

1) The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(1).)
2) The acknowledgment letter shall include the following:
    a. Date of receipt
    b. Name of representative to contact
    c. Telephone number of contact representative
    d. Address of Contractor
    (MHSUDS IN No. 18-010E)
3) The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS IN 18-010E)

DHCS Finding: 6.1.5
The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E. The MHP must acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing meeting the below listed requirements:
1. The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing.
2. The acknowledgment letter shall include the following: a. Date of receipt
b. Name of representative to contact
c. Telephone number of contact representative
d. Address of Contractor
3. The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted by that the MHP acknowledges receipt of each grievance and appeal within five (5) calendar days. Per the discussion during the review, the MHP stated that this information is tracked in a log which would be submitted post review. The log submitted did not provide the date of when acknowledgement letters are sent to the beneficiary. The MHP submitted four (4) of seven (7) acknowledgement letters for the specified grievances. Of the provided letters, one (1) of four (4) was postmarked as required.
In addition, DHCS reviewed grievance, appeals and expedited appeals samples to verify compliance with this requirement. The sample verification findings are as detailed below:

	# OF SAMPLE REVIEWED	ACKNOWLEDGMENT		COMPLIANCE PERCENTAGE
		# IN	# OOC	
GRIEVANCES	7	1	6	14%
APPEALS	N/A	N/A	N/A	N/A
EXPEDITED APPEALS	N/A	N/A	N/A	N/A

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E.

Corrective Action Description
The MHP updated its acknowledgment letter for grievances and appeals to include date of receipt, and of representative to contact, telephone number of contact representative, and address of contractor. The

Grievance and Appeal log was also updated to remind the Patient's Rights Advocate that that Acknowledgment Letter must be mailed within 5 days of the date of receipt.

Proposed Evidence/Documentation of Correction

- Updated Grievance and Appeal Log (Submitted with CAP)
- Grievance and Appeal Acknowledgement Letter (Submitted with CAP)

Ongoing Monitoring (if included)

Patients' Rights Advocate reports on grievance and appeals during the quarterly QIC meeting and Compliance meetings. Monitoring of all the necessary data components will be assured during these meetings.

Person Responsible (job title)

Cindy Pilaczynski, Patients' Rights Advocate

Implementation Timeline: 4/1/2022

Requirement
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, appeal, or expedited appeal. (42 C.F.R. § 438.416(a); Cal. Code Regs., tit. 9, § 1850.205(d)(1).)

DHCS Finding: 6.2.1
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205. 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, appeal, or expedited appeal.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident in the documentation submitted that the MHP records grievances and appeals in the log within one (1) working day of the date of receipt of the grievance and appeal. Per the discussion during the review, the MHP stated that all grievances, appeals, and expedited appeals are date stamped upon receipt. Post review, the MHP provided an updated grievance log, but this log does not show the receipt date of the grievances.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 416 and California Code of Regulations, title 9, section 1850, subdivision 205.

Corrective Action Description
The MHP will update the Grievance/Appeal log to include, and clearly identify, the date of receipt and date of logging of the grievance/appeal.

Proposed Evidence/Documentation of Correction
- Updated Grievance and Appeal Log (Submitted with CAP)

Ongoing Monitoring (if included)
Patients' Rights Advocate reports on grievance and appeals during the quarterly QIC meeting and Compliance meetings. Monitoring of all the necessary data components will be assured during these meetings.

Person Responsible (job title)
Cindy Pilaczynski, Patients' Rights Advocate

Implementation Timeline: 4/1/2022

Requirement
The MHP includes in the written Notice of Appeal Resolution (NAR) results of the resolution process and the date the process was completed. (42 C.F.R. § 438.408(e)(1)).

DHCS Finding: 6.4.8
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(e)(1). The MHP must include in the written Notice of Appeal Resolution (NAR) results of the resolution process and the date the process was completed.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP includes in the written NAR results of the resolution process and the date the process was completed. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that a NAR template would be provided post review as evidence for this requirement. Post review, the MHP provided additional evidence, but the NAR template was not included.
DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(e)(1).

Corrective Action Description
The MHP has created a NAR letter template to use to correct this deficit. Both a
The MHP has also added in the "date the NAR was sent" to the Grievance and Appeal Log.

Proposed Evidence/Documentation of Correction
- Updated Grievance and Appeal Log (Submitted with CAP)
- Notice of Appeal Resolution – Overturned (Submitted with CAP)
- Notice of Appeal Resolution – Upheld (Submitted with CAP)

Ongoing Monitoring (if included)
Patients' Rights Advocate reports on grievance and appeals during the quarterly QIC meeting and Compliance meetings. Monitoring of all the necessary data components will be assured during these meetings.

Person Responsible (job title)
Cindy Pilaczynski, Patients' Rights Advocate

Implementation Timeline: 4/1/2022

Requirement
If the MHP finds a party that is excluded, it must promptly notify DHCS. (42 C.F.R. §438.608(a)(2), (4).

DHCS Finding: 7.5.3
The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 608(a)(2), (4). The MHP promptly notify DHCS if the MHP finds a party that is excluded.
While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP promptly notifies DHCS if the MHP finds a party that is excluded. This requirement was not included in any evidence provided by the MHP. Per the discussion during the review, the MHP stated that an excluded provider policy and procedure would be submitted, however, the document submitted does not identify a process to notify DHCS regarding excluded providers.
DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 608(a)(2), (4).

Corrective Action Description
The MPH will update their Policy and Procedure to include notifying DHCS if the MHP finds a party that is excluded.

Proposed Evidence/Documentation of Correction
- Updated P&P – Excluded Providers 105.02 (To be submitted by Implementation timeline)

Ongoing Monitoring (if included)
The Electronic Health Record Manager will continue to monitor all providers' lines to identify exclusions on a monthly basis.

Person Responsible (job title)
William McCloud, Electronic Health Record Manager

Implementation Timeline: 5/1/2022

Requirement
The MHP shall ensure that all medically necessary SMHS are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
(MHP Contract, Ex. A, Att. 2)

DHCS Finding: 8.4.2b
Services claimed and documented on the beneficiary's progress notes were not sufficient and consistent in amount, duration or scope with those documented on the beneficiary's current Client Plan. Specifically:

- **Line numbers 1 and 4.**
    - **Line number 1.** Per the Client Plan completed on 11/20/2019, collateral services with a frequency of one time monthly was listed as a needed intervention. However, no collateral services were provided during the three-month review period. Furthermore, the MHP was unable to provide any documentation to confirm that this service was provided at any time before or after the review period.
    - **Line number 4.** Per the Client Plan completed on 8/6/2019, Group Rehabilitation and Group Therapy, both with a frequency of one time monthly were listed as needed interventions. However, no Group Rehabilitation or Group Therapy services were provided during the three-month review period. Furthermore, the MHP was unable to provide any documentation to confirm that these services were provided at any time before or after the review period.

CORRECTIVE ACTION PLAN 8.4.2b:
The MHP shall submit a CAP that describes how the MHP will ensure that services are provided in the amount, duration, and scope as specified in the Individualized Client Plan for each beneficiary.

Corrective Action Description
The MHP will conduct a training once new Cal-Aim requirements are released to ensure all staff are properly trained on creating individualized client plans and updating as often as needed to ensure that interventions not needed are ended and planned interventions are added for each beneficiary that are medically necessary SMHS which sufficiently identifies amount, duration, and scope of interventions.

Proposed Evidence/Documentation of Correction

- Training Materials (To be submitted by Implementation timeline)
- Training Agenda (To be submitted by Implementation timeline)
- Training Rosters (To be submitted by Implementation timeline)

Ongoing Monitoring (if included)
The MHP will train all staff after new Cal-Aim requirements are released, train new staff upon hire and conduct yearly refresher trainings

Person Responsible (job title)
Bessie Rojas, LCSW, Quality Assurance Coordinator

Implementation Timeline: 8/1/2022

Requirement
The client plan has been updated at least annually and/or when there are significant changes in the beneficiary's condition. (MHP Contract, Ex. A, Att. 2)

DHCS Finding: 8.4.3
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). Specifically:

- **Line numbers 6 and 8**: The Initial Client Plan was not completed until after one or more planned service was provided and claimed. **RR4a, refer to Recoupment Summary for details.**

CORRECTIVE ACTION PLAN 8.4.3:
The MHP shall submit a CAP that describes how the MHP will ensure that Client Plans are completed prior to the provision of planned services.

Corrective Action Description
The MHP emails clinicians each month about treatment plans that need to be completed or are due for an annual update. The MHP has recently begun to track and log all such emails so that QA staff can follow-up on ensuring these items are completed. When clinicians continue to lag on updating treatment plans annually, their direct supervisor will be notified of the need of their staff's improved timeliness.

Proposed Evidence/Documentation of Correction

- Route Back and Corrections Tracking Log (Submitted with CAP)

Ongoing Monitoring (if included)
The Quality Assurance Coordinator tracks and logs all communication regarding case files in need of correction/ updating.

Person Responsible (job title)
Bessie Rojas, LCSW, Quality Assurance Coordinator

Implementation Timeline: March 1, 2022

Requirement
The client plan has been updated at least annually and/or when there are significant changes in the beneficiary's condition. (MHP Contract, Ex. A, Att. 2)

DHCS Finding: 8.4.3a
One or more client plans was not updated at least annually and/or when there were significant changes in the beneficiary's condition. Specifically:
• **Line number 2**: There was a **lapse** between the prior and current Client Plans. However, this occurred outside of the audit review period. o **Line number 2.** The prior Client Plan expired on 10/25/2019; the current Client Plan completed on 11/27/2019.

CORRECTIVE ACTION PLAN 8.4.3a:
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) Client plans are updated at least on an annual basis, as required by the MHP Contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards.

Corrective Action Description
The MHP emails clinicians each month about treatment plans that need to be completed or are due for an annual update. The MHP has recently begun to track and log all such emails so that QA staff can follow-up on ensuring these items are completed. When clinicians continue to lag on updating treatment plans annually, their direct supervisor will be notified of the need of their staff's improved timeliness.

Proposed Evidence/Documentation of Correction
- Route Back and Corrections Tacking Log (Submitted with CAP)

Ongoing Monitoring (if included)
The Quality Assurance Coordinator tracks and logs all communication regarding case files in need of correction/ updating.

Person Responsible (job title)
Bessie Rojas, LCSW, Quality Assurance Coordinator

Implementation Timeline: March 1, 2022

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: 8.4.4

Client Plans did not include all of the required elements identified in the MHP Contract. Specifically:

- One or more goal/treatment objective was not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments. **Line number 3.**
- One or more proposed intervention did not include an expected frequency or frequency range that was specific enough. **Line numbers 1, 2, 3, 5, 9, and 10.**
    - **Line number 1.** Per the Client Plan completed on 11/20/2019, Medication Refill, Medication Management, and Medication Evaluation were listed as needed interventions, all with a proposed frequency of "ad hoc;" which is not a specific description of time.
    - **Line number 2.** Per the Client Plan completed on 11/27/2019, Medication Refill, Medication Management, Medication Evaluation, and TCM were listed as needed interventions, all with a proposed frequency of "ad hoc;" which is not a specific description of time.
    - **Line number 3.** Per the Client Plan completed on 9/29/2019, Medication Refill, Medication Management, Medication Evaluation, Collateral, and TCM were listed as needed interventions, all with a proposed frequency of "ad hoc;" which is not a specific description of time.
    - **Line number 5.** Per the Client Plan completed on 9/6/2019, Collateral and TCM were listed as needed interventions, all with a proposed frequency of "ad hoc;" which is not a specific description of time.
    - **Line number 9.** Per the Client Plan completed on 11/7/2019, TCM was listed as a needed intervention, with a proposed frequency of "ad hoc;" which is not a specific description of time.
    - **Line number 10.** Per the Client Plan completed on 7/29/2019, Medication Refill, Medication Management, Medication Evaluation, and TCM were listed as needed interventions, all with a proposed frequency of "ad hoc;" which is not a specific description of time.
- One or more proposed intervention did not include an expected duration. **Line numbers 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10.**
    - **Line number 1.** The Client Plan completed on 11/20/2019 does not include an expected duration for each of the proposed interventions listed.
    - **Line number 2.** The Client Plan completed on 11/27/2019 does not include an expected duration for each of the proposed interventions listed.
    - **Line number 3.** The Client Plans completed on 9/29/2019 and 1/16/2020 do not include an expected duration for each of the proposed interventions listed.
    - **Line number 4.** The Client Plan completed on 8/6/2019 does not include an expected duration for each of the proposed interventions listed.
    - **Line number 5.** The Client Plan completed on 9/6/2019 does not include an expected duration for each of the proposed interventions listed.
    - **Line number 6.** The Client Plan completed on 1/30/2020 does not include an expected duration for each of the proposed interventions listed.

- **Line number 7.** The Client Plan completed on 1/24/2020 does not include an expected duration for each of the proposed interventions listed.
- **Line number 8.** The Client Plan completed on 1/24/2020 does not include an expected duration for each of the proposed interventions listed.
- **Line number 9.** The Client Plans completed on 11/7/2019 and 12/5/2019 do not include an expected duration for each of the proposed interventions listed.
- **Line number 10.** The Client Plans completed on 7/29/2019 and 2/28/2020 do not include an expected duration for each of the proposed interventions listed.

CORRECTIVE ACTION PLAN 8.4.4:
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.

Corrective Action Description
The MHP will conduct a training once new Cal-Aim requirements are released to ensure all staff are properly trained on creating individualized client plans to ensure that 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.

Proposed Evidence/Documentation of Correction
- Training Materials (To be submitted by Implementation timeline)
- Training Agenda (To be submitted by Implementation timeline)
- Training Rosters (To be submitted by Implementation timeline)
- Client Treatment Plan Checklist (Submitted with CAP)

Ongoing Monitoring (if included)
The MHP will train all staff after new Cal-Aim requirements are released, train new staff upon hire, and conduct yearly refresher trainings. The MHP created a form for providers to self-monitor their creation of client treatment plans to ensure they are meeting all requirements. This form will be reviewed with their direct supervisor for compliance with this item.

Person Responsible (job title)
Bessie Rojas, LCSW, Quality Assurance Coordinator

Implementation Timeline: July 1, 2022

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. 2)

DHCS Finding: 8.5.2
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 1, 2, 3, and 10.** One or more progress note was not completed within the MHP's written timeliness standard of 3 business days after provision of service. Thirteen (or 6 percent) of all progress notes reviewed were completed late (94% compliance).

CORRECTIVE ACTION PLAN 8.5.2:
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.

Corrective Action Description
The MHP audits charts at least on a quarterly basis. A line item for timeliness of notes will be added to Internal Utilization Review tool.

Proposed Evidence/Documentation of Correction

- Updated Internal Utilization Review tool (Submitted with CAP)

Ongoing Monitoring (if included)
The MHP audits charts on at least a quarterly basis. If specific staff are struggling to meet timeliness of their progress notes, then QA staff will inform their direct supervisor of the need for improvement.

Person Responsible (job title)
Bessie Rojas, LCSW, Quality Assurance Coordinator

Implementation Timeline: April 1, 2002

Requirement
The MHP must make individualized determinations of each child's/youth's need for ICC and IHBS, based on the child's/youth's strengths and needs.
(Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018)

DHCS Finding: 8.6.1

1. The MHP did not furnish evidence that it has a standard procedure for providing and documenting individualized determinations of eligibility for ICC services and IHBS on behalf of beneficiaries under age 22 that is based on their strengths and needs.
2. The medical record associated with the following Line numbers did not contain evidence that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS, and that if appropriate, such services were included in their Client Plan.
   During the virtual on-site review, MHP staff indicated that they do not have a formal screening process in place for determining eligibility and need for ICC services and IHBS. MHP staff further explained that while individual children's cases are discussed informally, MHP staff were not accurately capturing this determination process within the medical records of all youth beneficiaries during the review period.

It should be noted that the MHP was given the opportunity to locate written evidence of any formal (or informal) determination process for the need for ICC/IHBS services; however, the MHP was unable to locate it in the medical record for the following:
• **Line numbers 6, 7, 8, and 9.**

CORRECTIVE ACTION PLAN 8.6.1:
The MHP shall submit a CAP that describes how it will ensure that:
1) Written documentation is in place describing the process for determining and documenting eligibility and need for ICC Services and IHBS.
2) Training is provided to all staff and contract providers who have the responsibility for determining eligibility and need for ICC and IBHS.
3) Each beneficiary under age 22 who is authorized to receive Specialty Mental Health Services also receives an individualized determination of eligibility and need for ICC Service and IHBS prior to or during the development of the beneficiary's Initial Client Plan.

Corrective Action Description
The MHP has created screening tools for ICC and IHBS to be added to the intake packet to ensure that all children under the age of 22 are screened for these programs. The tools will also be available for staff to reassess as the need arises. New P&Ps to describe the process for documenting and determining eligibility to ICC and IHBS have been created. The QA Team will train clinicians regarding the use of the ICC/IHBS Screening Tool before the end of the fiscal year.

Proposed Evidence/Documentation of Correction
- ICC & IHBS P&P (Submitted with CAP)
- ICC/IHBS Screening Tool (Submitted with CAP)
- Updated ACCESS Team Add-On Services form (Submitted with CAP)
- Updated Clinician Checklist (Submitted with CAP)
- Sign-in sheet of the ICC/IHBS Training (To be submitted by Implementation timeline)

Ongoing Monitoring (if included)
QA staff review all intakes for completed assessments and will begin monitoring for the ICC/IHBS Screening Tool.

Person Responsible (job title)
Bessie Rojas, LCSW, Quality Assurance Coordinator

Implementation Timeline: July 1, 2022