

Kings County Plan of Corrections FY 2016-17

SECTION A: NETWORK ADEQUACY AND ARRAY OF SERVICES

I. Deficiencies: A1

Citation: Does the MHP have a current Implementation Plan, which meets title 9 requirements? • CCR, title 9, chapter 11, section 1810.310

Finding: The MHP did not furnish evidence it has a current Implementation Plan, which meets the title 9 requirements. DHCS reviewed the following documentation presented as evidence of compliance: Implementation Plan (dated July 28, 1997) and a Quality Management Addendum. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the Implementation Plan has not been updated to reflect current changes in policies, processes, and procedures that would modify its Implementation Plan. Protocol question A1 is deemed OOC.

Describe how the deficiency will be corrected: The county Implementation plan is a county document that threads together all services provided to Medi-Cal beneficiaries. It has not been updated since July of 1997. Kings County Behavioral Health (KCBH) will update the plan through establishment of a workgroup that will review the existing plan and make all necessary updates.

Describe how the program will ensure future compliance: KCBH will add the monitoring and review of the Implementation plan to its standing items for the review of the Quality Improvement Committee. Currently the Quality Improvement Committee is headed by the KV MHP. KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. The management and oversight of the Quality Improvement Committee will shift to KCBH.

Proposed Implementation Date: 1) Establishment of Workgroup; January 31, 2018. 2) Proposed Completion; November 30, 2018

II. Deficiencies : 4a1 & 4a2

Citation: Regarding the MHP's Implementation of Pathways to Wellbeing (Katie A Settlement agreement): 1) Does the MHP have a mechanism in place to ensure appropriate identification of Katie A subclass members? 2) Does the MHP have a mechanism in place to identify children who are eligible for ICC and IHBS services? Katie A

settlement agreement Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care of Katie A Subclass members.

SECTION A: NETWORK ADEQUACY AND ARRAY OF SERVICES

Finding:

The MHP did not furnish evidence it has a mechanism in place to ensure appropriate identification of Katie A subclass members and identify children who are eligible for ICC and IHBS services. Kings County did not provide documentation of a process for the identification of children/youth in the subclass and/or children eligible to receive ICC and IHBS services. Protocol questions 4a1 and 4a2 are deemed OOC

Describe how the deficiency will be corrected: 1) Yes; Child Welfare Services (CWS) screens all substantiated cases and refers to the MHP and MHP identifies if clients meet eligibility, medical necessity for being a Katie A subclass member. 2) No; Representatives from the MHP KV, CWS, KCBH, Probation and Various Schools meet regularly by way of the Planning for the Children's Mental Health System of Care Development Committee. The purpose of the meeting is effectively provide for a shared management, collaboration and care coordination structure to meet the Mental Health needs of children in the community and to work as the primary workgroup for Continuum of Care Reform (CCR) This committee is currently working on determining what data, reports, and pertinent information is needed to be shared amongst the agencies to identify non-subclass youth that are eligible for ICC and IHBS services. The County is currently in the process of establishing a contract with a new Wraparound services provider with the capacity to deliver more ICC /IHBS services if deemed necessary.

Describe how the program will ensure future compliance: The Mental Health Plan provider Kings View (MHP KV) maintains a log ("Katie A Subclass Verifications Process") identifying Katie a subclass members' status. Units and subunits are also assigned that specify Katie A status when subclass members' status is active. The CCR Workgroup will monitor the effectiveness of the process of identification of Katie A subclass members and the identification of children who are eligible for ICC and IBHS Services.

Proposed Implementation Date: A4a1) Completed. A4a2) Proposed Implementation; March 31, 2018

SECTION B: ACCESS

I. Deficiencies:B2c6

Citation: Regarding the provider list, does it contain the following?

1) Alternatives and options for cultural services? CFR, title 42, section 438.10(f) (6) (I) and 438.206(a). CCR, title 9, chapter 11, section 1810.410. CMS/DHCS, section 1915(b) Waiver. DMH information Notice Nos. 10-02 and 10-17. MHP contract Exhibit A, Attachment I

SECTION B: ACCESS cont.

Finding: The MHP did not furnish evidence its provider list contains all of the required components. DHCS reviewed the MHP's current provider list. The list did not include the following components: alternatives and options for cultural services (e.g., transition-age youth, veterans, older adults, Lesbians, Gay, Bisexual, and Transgender individuals). Protocol call question B2c6 is deemed Ok.

Describe how the deficiency will be corrected: The MHP KV will maintain a provider list that contains all of the following information regarding it's providers; 1) Names of providers, 2) locations in which they serve, 3) their telephone numbers, 4) Alternative and options for linguistic services including non-English languages, plus ASL, spoken by the provider, 5) Providers by category 6) Alternatives and options for cultural services, and whether or not the provider is accepting new referrals. (EXHIBIT 3A) This list will be maintained by the KV & KCBH Quality Management teams.

Describe how the program will ensure future compliance: MHP KV provider list will be reviewed updated by the KCBH Quality Management team each time a new provider is hired. KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. The new hire will start in mid-December and begin taking on this task. At each update all provider names will be reviewed in order to confirm that the information listed regarding providers is current. Current copies of the provider list will be given to beneficiaries at the time of their initial mental health assessment.

Proposed Implementation Date: Completed See Exhibit 3A

II. Deficiencies: B6d3

Citation: Does the MHP have policies, procedures, and practices that comply with the following requirements of title VI of the Civil Right ACT of 1964 and section 504 of the rehabilitation Act of 1973? 3) Minor children should not be used as interpreters. CFR, title 42, section 438.10 (c)(4), 438.6(f)(1), 438.100(d), CFR, title 28, Part 35, 35.160(b)(1), CFR title 28, Part 36, 36.303 (c). CCR, title 9, chapter 11, section 1810.410(a)-(e). DMH information Notice 10-02 and 10-17. Title VI, Civil Rights Act of 1964 (U.S. Code 42, section 2000d; CFR, title 45, Part 80). MHP contract, Exhibit A, Attachment I. CMS/DHCS, section 1915(b) waiver

Finding: The MHP did not furnish evidence it has policies, procedures, and practices, in compliance with title VI of the Civil Rights Act of 1964, prohibiting the use of minor children as interpreters.

Describe how the deficiency will be corrected: The MHP KV Administrative Directive (AD) AO #17 (Exhibit 4A) was reviewed and updated on 10/11/16, in order to clarify when and how friends and family may be used to interpret. Administrative Directive AO#17 now clearly documents the following. 3) That minor children should not be used as interpreters.

Describe how the program will ensure future compliance: All MHP KV staff have been provided a copy of Administrative Directive AO#17 and asked to review it, and demonstrate completion of that review by turning in an acknowledgement of receipt (EXHIBIT 4B) to the MHP KV Quality Management Team.

Proposed Implementation Date: Completed. See Exhibit 4A & 4B

III. Deficiencies: B10a & B10b

Citation: Regarding the written log of initial requests for SMHS: Does the MHP maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing? Does the written log(s) contain the following required elements? 1) Name of the beneficiary? 2) Date of the request? 3) Initial disposition of the request? CCR, title 9, chapter 11, section 1810.405(f)

Finding: The MHP did not furnish evidence its written log(s) of initial requests for SMHS includes requests made by phone, in person, or in writing. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: the MHP's written log. However, it was determined there is insufficient evidence the MHP consistently logs request made by phone, in person and in writing. The logs made avail be by the MHP did not include all required elements.

Describe how the deficiency will be corrected: The MHP KV has amended AD MC#8 (EXHIBIT 5A) in order to provide clear instructions on where, how and what is to be logged when requests for information come in through our phone lines. This Administrative Directive will be distributed to MHP staff with a requirement that the acknowledge review by signing the Receipt of Acknowledgement form (EXHIBIT 4B). Weekly reminders will be sent out by the Office Manager as a reminder to log all requests for information.

Describe how the program will ensure future compliance: The MHP KV Quality Improvement Committee will continue to support quarterly test calls as a means of monitoring this requirement. Eventually this responsibility will shift to the KCBH Quality Management Team.

Proposed Implementation Date: Completed: See Exhibit (5A & 4B)

IV. Deficiencies: B13a1 & B13a2 & B13b

Citation: B13a) regarding the written log of initial requests for SMHS: Does the MHP maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing? Does the written log(s) contain the following required elements? 1) Name of the beneficiary? 2) Date of the request? CCR, title 9, chapter 11, section 1810.405(f). B13b) Does the MHP have evidence of the implementation of training programs to improve the cultural competence skills of staff and contract providers? CCR, title 9, chapter 11, section 1810.410 (a)-(e)

Finding: The MHP did not furnish evidence it has a plan for annual cultural competence training necessary to ensure the provision of culturally competent services. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy# 38 AD (dated 2/27/14) and Cultural Competency Training for Staff 2015-2016. The MHP's P&P requires all staff to meet a minimum of 4-hours training each Fiscal Year (FY). However, the MHP's records indicated that several staff did not meet the required minimum training hours.

Furthermore, the MHP indicated it did not have a process for following up when employees did not meet the 4-hour training requirement. Protocol question(s) B13a1, B13a2 and B13b are deemed OOC.

Describe how the deficiency will be corrected: The MHP KV has updated AD AO#38 “Cultural Competency Training for Staff” (EXHIBIT 6A). Point (3) of AO#38 describes the steps that are taken in order to monitor employee compliance and steps taken to address deficiencies. Point (4) mandates this requirement to be built into the Quality Work Plan and to be regularly monitored by the Quality Improvement Committee. Evidence can be seen in the 2016-2017 Quality Work Plan Annual Summary. The Quality Improvement Committee authorized the creation of the Kings View Cultural Competency Committee. This committee is tasked with sponsoring up to six, 1 hour, cultural competency training opportunities each year. (EXHIBIT 6B) These trainings are offered to all staff and attendance is reported to the Clinical Director for monitoring purposes. Trainings so far in 2017 have been “African- American Cultural Considerations in Counseling” (January 4, 2017); “Gang Culture in Kings County” (February 1, 2017); “The Culture of Drugs in Kings County” (April 4, 2017); and “LGBTQ Cultural Sensitivity” (June 7, 2017). All trainings provided by Kings View and/or reported by staff are recorded in the “Staff training Log.” (EXHIBIT 6C) In addition, KCBH provides guidance to all contracted providers regarding the requirements for cultural competence training necessary to ensure the provision of culturally competent services. The MHP KV is a mandatory member of The Cultural Competency Taskforce (CCTF) managed by KCBH. KCBH requires all MHP staff meet a minimum of 4 hours training in cultural competency each Fiscal Year.

Describe how the program will ensure future compliance: MHP KV Employee evaluations have begun to include a review of cultural competency training compliance. Verification that this issue is addressed is ensured by our Human Resource Specialist before the evaluation can be submitted to the Executive Director and Clinical Director for their co-signatures.

Proposed Implementation Date: Completed: See Exhibit (6A & 6B & 6C)

V. Deficiencies: C1c

Citation:C1c) Does the MHP approve or deny TARs within 14 calendar days of the receipt of the TAR and in accordance with title 9 regulations? CCR, title 9, chapter 11, sections 1810.242, 1820.220(c), (d), 1820.220 (f), 1820.220 (h), and 1820.215. CFR, title 42, section 438.210(d)

Finding: The MHP did not furnish evidence it complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services. DHCS reviewed the following documentation presented by

the MHP as evidence of compliance: P&P MCQ#5: Managed Care Claims Processing and a sample of 100 TARs to verify compliance with regulatory requirements. The MHP's P&P is consistent with state and federal requirements; however, four (4) of the 100 TARs in the sample were not approved or denied within 14 calendar days of receipt.

Describe how the deficiency will be corrected: The MHP KV updated Policy and Procedure MCQ: 04 in order to clearly define a review process for ensuring that TARs are acted upon within the 14 day requirement. MCQ: 04, II, 3. States that when a decision regarding a Treatment Authorization Request has not be completed by the 10th day, that the Quality Management Administrative Support staff will send a reminder e-mail to the reviewing clinician. This e-mail will also be copied to the Quality Management team for monitoring.

Describe how the program will ensure future compliance: The timeliness of TAR responses will be monitored by the Quality Management team who will report to the Quality Management Manager, the frequency that 10 day reminders were required and the response from the reviewing clinician, to those e-mails. This information will be reported to the Quality Improvement Committee on a quarterly basis. KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. The management and oversight of the Quality Improvement Committee will shift to KCBH. KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. The management and oversight of the Quality Improvement Committee will shift to KCBH.

Proposed Implementation Date: Monitoring Process after sign off of all required parties; January 31, 2018

SECTION D: BENEFICIARY PROTECTION

I. Deficiencies:D4a1

Citation: Regarding notification to beneficiaries: 1) Does the MHP provide written acknowledgment of each grievance to the beneficiary in writing? CFR, title 42, section 438.406(a) (2). CCR, title 9, chapter 11, section 1850.205(d) (4). CFR, title 42, section 438.408(d) (1) (2). CCR, title 9, chapter 11, sections 1850.206(b), (c), 1850.207(c), (h), and 1850.208(d), (e).

SECTION D: BENEFICIARY PROTECTION

D4a1 cont.:

Finding: The MHP did not furnish evidence it provides written acknowledgement and notifications of dispositions to beneficiaries for all grievances. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: P&P PR: 02 Problem Resolution Process (dated 2/27/14) and a sample of 15 grievances and 1 appeal. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, after reviewing 15 grievances and one (1) appeal, it was noted that three (3) grievances did not have required acknowledgment letters. In addition, DHCS inspected a sample of grievances, appeals, and expedited appeals to verify compliance with regulatory requirements.

Describe how the deficiency will be corrected: The MHP KV has not logged verbal complaints, however, written complaints are logged and acknowledgment letters are sent out for written complaints. However, during the 2016 Triennial Review this misunderstanding was clarified and now verbal complaints will follow the same process. The MHP KV will modify Policy & Procedure PR: 02, "Problem Resolution Process," to amend the definition of "Grievance" as including any complaint, regardless of the mode of expression used by the client in communicating the complaint. The letter also notifies beneficiaries of their grievance disposition Evidence of adherence to the policy will be the log, which clearly shows the date that the acknowledgment letter was sent.

Describe how the program will ensure future compliance: KCBH will add the monitoring and review of the verbal grievances as a standing item for the review of the Quality Improvement Committee. Currently the Quality Improvement Committee is headed by the KV MHP. KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. The management and oversight of the Quality Improvement Committee will shift to KCBH.

Proposed Implementation Date: Update PR: 02 & Begin Quality Improvement oversight February, 2018

II. Deficiencies :F1a

Citation: Regarding coordination of physical and mental health care: Does the MHP have a process in place to provide clinical consultation and training, including consultation and training on medications?

Finding: The MHP did not furnish evidence it has processes in place to provide clinical consultation and training on medication. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy MS25 Consultations between Physicians (dated 8/11/08). However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP identified they had not provided training in the last three years. Protocol question(s) F1a is deemed OOC.

Describe how the deficiency will be corrected: A letter from the MHP KV, co-signed by the Medical Director of KV has been drafted and sent out to all physicians in Kings County, (EXHIBIT 9A) offering the opportunity for them to consult with Kings View providers regarding the initiation and monitoring of psychotropic medication. KV will also collaborate with regional pharmacy representatives to provide in-service opportunities regarding commonly prescribed psychotropic medications.

Describe how the program will ensure future compliance: The MHP KV Quality Improvement Committee, as it reviews the monthly minutes of the Medication Monitoring Committee will ensure compliance of this outreach strategy. Currently the Medication Monitoring Committee is headed by the KV MHP. KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. The management and oversight of the Medication Monitoring Committee may shift to KCBH.

Proposed Implementation Date: Review by existing Medication Monitoring Committee; January 31, 2018

III. Deficiencies :G3a & G3b

Citation: Regarding the MHP's ongoing monitoring of county-owned and operated and contracted organizational providers: a) Does the MHP have an ongoing monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and recertified as per title 9 regulations? b) Is there evidence the MHP's monitoring system is effective? CCR, title 9, chapter 11, section 1810.435 (d) I. MHP Contract, Exhibit A, Attachment I

Finding: The MHP did not furnish evidence it has an ongoing and effective monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and recertified per title 9 regulations. The MHP does not have an ongoing monitoring system in place for provider certification and re-certification to verify certification dates. DHCS reviewed its Online Provider System (OPS) and generated an Overdue Provider Report, which indicated the MHP has providers overdue for certification and/or re-certification.

Describe how the deficiency will be corrected: KCBH provides ongoing monitoring of contracted organizational providers and county owned operated providers to ensure that they are certified and recertified per title 9 regulations. KCBH has completed the recertification of the 2 overdue providers. KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. This will be handled by the KCBH Quality Management Team. KCBH will issue a policy and/or procedure to outline this process.

Describe how the program will ensure future compliance: KCBH will review the Kings Overdue Provider Report Letter issued by DHCS and creates a schedule for upcoming Certifications. KCBH Quality Management will review the ITWS OPS system on a quarterly basis to ensure providers are certified and all information is up to date.

Proposed Implementation Date: 2 Overdue Provider Recertification's have been COMPLETED. Develop P&P; March 31, 2018

IV. Deficiencies: G4a

Citation: Regarding the MHP's network providers, does the MHP ensure the following: a) Mechanisms have been established to ensure that network providers comply with timely access requirements?

Finding: The MHP did not furnish evidence it has established mechanisms to ensure that network providers comply with timely access requirements. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: the MHP's TBS service contract, its Family Builders Contract, and the Network Provider Manual (dated 9/2013). Timely access requirement were not identified in the Family Builders contract. Protocol question(s) G4a is deemed OOC.

Describe how the deficiency will be corrected: KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. This will be handled by the KCBH Quality Management Team. KCBH will need to establish mechanisms to ensure that network providers comply with timely access requirements. KCBH will issue a policy and/or procedure to outline this process.

Describe how the program will ensure future compliance: Timely Access requirements will be reported to the Quality Improvement Committee on a quarterly basis. KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. The management and oversight of the Quality Improvement Committee will shift to KCBH.

Proposed Implementation Date: Develop P&P; March 31, 2018. Begin Review at Quality Improvement Committee; April 2018"

V. Deficiencies:J5d

Citation: Does the County ensure that PSC/Case Manager or other qualified individual known to the client/family is available to respond to the client/family 24 hours a day, 7 days a week to provide after-hours interventions? CCR, title 9, chapter 14, section 3620

Finding: The County did not furnish evidence its PSC/Case Managers are available to respond to the FSP client/family 24 hours a day, 7 days a week to provide after-hours interventions. DHCS did not review any documentation presented by the County as evidence of compliance. The MHP indicated it does not have a PSC/Case Manager available to respond 24 hours a day, 7 days a week. PSC/Case Managers are only available at the permanent support housing project. Protocol question(s) J5d is deemed ok.

Describe how the deficiency will be corrected: KCBH has awarded a contract to a new provider to deliver FSP/WRAP and KATIE A services 24 hours a day, 7 days a week. The next step will be to build capacity for our FSP adult services. KCBH is currently developing an RFP to contract for these services.

Describe how the program will ensure future compliance: KCBH CSOC & ASOC Program Managers will continue to provide trainings and policy reviews to build team capacities to develop comprehensive ISSPs and culturally competent and responsive services to FSP clients and will monitor contracts to ensure clients/family are receiving services 24 hours a day, 7 days a week.

Proposed Implementation Date: Implementation of Children's FSP/WRAP; March 1, 2018. Issuance of RFP for Adult FSP Services; March 1, 2018. Implementation of Adults FSP Services; July 1, 2018"

VI. Deficiencies: J6a & J6b

Citation :Regarding the County's MHPA Issue Resolution Process: a) Does the County have in place an Issue Resolution Process to resolve issues related to MHPA community planning process, consistency between approved MHPA plans and program implementation, and the provision of MHPA funded mental health services) Does the County's Issue Resolution Log contain the following information? 1) Dates the issues were received? 2) A brief description of the issues? 3) Final resolution outcomes of those issues? 4) The date the final issue resolution was reached? W&IC 5650.W&IC 5651. County Performance Contract

Finding: The County does not maintain an MHPA Issue Resolution Log with all required components. DHCS did not review any documentation presented by the MHP as evidence of compliance. Specifically, the MHP indicated it does not have an MHPA Issue Resolution Process or maintain a log to track issues related to the MHPA community planning process, consistency between approved MHPA plans and program implementation, and the provision of MHPA funded mental health services. Protocol question(s) J6a and J6b are deemed OOC.

Describe how the deficiency will be corrected: No; KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. This will be handled by the KCBH Quality Management Team. KCBH will need to establish an Issue Resolution Process to resolve issues related to MHPA community planning processes. KCBH will issue a policy and/or procedure to outline this process.

Describe how the program will ensure future compliance: The Quality Management team will monitor this process as necessary.

Proposed Implementation Date: Develop P&P; March 31, 2018. Establish a MHPA Issue Resolution Log; April 1, 2018"

VII. Deficiencies:A4d

Citation: SURVEY ONLY: Does the MHP maintain and monitor an appropriate network of providers to meet the anticipated need of children/youth eligible for ICC and IHBS services? Katie A Settlement Agreement. Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care for Katie A Subclass Members.

Finding: SURVEY FINDING: No documentation was provided for review by DHCS for this survey item.
SUGGESTED ACTIONS: DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: maintain and monitor an appropriate network of providers to meet the anticipated need to children/youth eligible for ICC and IHBS services.

Describe how the deficiency will be corrected: KCBH, in collaboration with CWS is currently working on constructing a new MOU between both agencies which will make KCBH the initial point of contact for all referrals. We are developing a plan to improve methods and strategies to monitor the children who are receiving services by the various agencies and to ensure a collaborative cross-system approach to the delivery of services to children and youth. Components of this plan will include shared data management, shared care coordination tools and establishment of an appropriate network of providers to meet the anticipated need of children/youth eligible for ICC & IHBS Services.

VIII. Deficiencies: A4d

Citation: SURVEY ONLY: Does the MHP have a mechanism to ensure all children/youth referred and/or screened by the MHP's county partners (i.e., child welfare) receive an assessment, and/or referral to a MCP for non-specialty mental health services, by a licensed mental health professional or other professional designated by the MHP? Katie A Settlement Agreement. Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services and Therapeutic Foster Care for Katie A Subclass Members.

Suggested Actions/Survey Findings: DHCS reviewed the following documentation provided by the MHP for this survey item: MHP tracking report, which included: referral dates, service, service descriptions, receipt dates, and the disposition. The documentation provides sufficient evidence of compliance with federal and State requirements. SUGGESTED ACTIONS: No further action required at this time.

Deficiencies: C4e

Citation: SURVEY ONLY 1) Does the MHP ensure an assessment has been conducted and authorization of services occurs within 4 business days of receipt of a referral for SMHS for a child by another MHP? 2) Does the MHP have a mechanism to track referrals for assessments and authorizations of services for children placed in its county? CCR, title 9, chapter 11, section 1830.220(b) (3) and (b) (4) (A); sections 1810.220.5, 1830.220 (b) (3), and b (4) (A), WIC sections, 11376, 16125, 14716; 14717, 14684, 14718 and 16125. DMH Information Notice No. 09-06/DMH Information Notice No. 97-06.DMH Information Notice No. 08-24

Suggested Actions/Survey Findings: No documentation was provided for review by DHCS for this survey item. SUGGESTED ACTIONS: DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: develop a mechanism to ensure timely transfer within 48-hours of the operation and provision of SMHS for a child who will be placed out of county. The MHP should also develop a mechanism to track authorization and provision of services for beneficiaries served by another MHP. The MHP will ensure an assessment has been conducted an authorization of services occur within four business days of receipt of a referral for SMHS for a child by another MHP, and will have a mechanism to track referrals for assessment and authorizations of services for children placed in its county.

Describe how the deficiency will be corrected: These items are being address by county-wide, multi-agency efforts to define and develop protocols that are compliant with regulations for a system of access to care for dependents of the court. At present, Kings County has not identified a point of contact for presumptive eligibility. Our recommendation has been for the Human Services Agency's Eligibility section to identify the point of contact, since the MHP cannot manipulate eligibility. The MHP is prepared to provide an assessment (or accept a recent assessment) within 4 business days of the Medi-Cal change being effected. At this time, any tracking of referrals for assessments and authorizations of services for children placed in this county are tracked through the existing SAR system that is maintained by the MHP.

SECTION H: PROGRAM INTEGRITY

I. Deficiencies: H4b

Citation: SURVEY ONLY. Does the MHP require its providers to consent to criminal background checks as a condition of enrollment per 42 CFR 455.434(a)? CFR, title 42, sections 455.101, 455.104, and 455.416. MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements.

Suggested Actions/Survey Findings: SURVEY FINDING. DHCS reviewed the following documentation provided by the MHP for this survey item: Email documentation from Personnel Specialist identifying criminal background checks were in the process of being completed for a specific provider. If completed as indicated, the MHP will likely be in compliance with State and Federal requirements. SUGGESTED ACTIONS: No further action required at this time.

II. Deficiencies H4c

Citation: SURVEY ONLY. Does the MHP require providers, or any person with a 5 percent or more direct or indirect ownership interest in the provider to submit a set of fingerprints per 42 CFR 455.434(b)(1)? CFR, title 42, sections 455.101, 455.104, and 455.416. MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements

Suggested Actions/Survey Findings: SURVEY FINDING. DHCS reviewed the following documentation provided by the MHP for this survey item: Email documentation form Personnel Specialist identifying that Live Scan Fingerprints for a specific provider was cleared. The documentation provides sufficient evidence of compliance with federal and State requirements. SUGGESTED ACTIONS: No further action required at this time."

III. Deficiencies H5a3

Citation: SURVEY ONLY. Is there evidence that the MHP has a process in place to verify new and current (prior to contracting/employing) providers and contractors are not in the Social Security Administration's Death Master File? CFR, title 42, sections 438.214(D), 438.610, 455.400-455.470, 455.436(B). DMH Letter No. 10-05. MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements

Suggested Actions/Survey Findings: SURVEY FINDING: No documentation was provided for review by DHCS for this survey item. SUGGESTED ACTIONS: DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: establish a process to verify new and current (prior to contracting/employing) providers and contractors are not in the Social Security Administration's Death Master File.

Describe how the deficiency will be corrected: KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. This will be handled by the KCBH Quality Management Team. KCBH will issue a policy and/or procedure to outline this process.

IV. Deficiencies :H7 SURVEY ONLY

Citation: Does the MHP verify that all ordering, rendering, and referring providers have a current National Provider Identifier (NPI) number? CFR, title 42, sections 455.410, 455.412 and 455.440/

SURVEY FINDING: DHCS reviewed the following documentation provided by the MHP for this survey item: P&P #MCQ6 Credentialing and Recredentialing Criteria dated 10/13/16. Policy identifies that an applicant for initial credentialing or subsequent re-credentialing as a MHP Network Provider shall meet the following standards: NPI number with the appropriate taxonomy, measured by search of the NPES site. List of providers with current NPI Numbers, database of all providers including license and NPI type with expiration date. The documentation provides sufficient evidence of compliance with federal and State requirements. SUGGESTED ACTIONS: No further action required at this time.

V. Deficiencies: I3b

Citation: Does the MHP have a policy and procedure in place regarding monitoring of psychotropic medication use, including monitoring psychotropic medication use for children/youth? CFR, title 42, sections 455.410, 455.412, and 455.440

SUGGESTED ACTIONS/SURVEY FINDINGS: DHCS reviewed the following documentation provided by the MHP for this survey item: P&P #MCQ:01 Managed Care/OM Medication Monitoring Review, Medication Monitoring Committee minutes and Medication Monitoring Plan and Procedures Practice Guidelines for Physicians, Physician Assistants and Family Nurse Practitioners. The documentation lacks specific elements to demonstrate compliance with federal and state requirements. Specifically, the documentation does not include monitoring psychotropic medication use for children/youth. SUGGESTED ACTIONS: DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: develop procedures for monitoring psychotropic medication use by children/youth.

Describe how the suggested action or survey finding will be addressed: The MHP KV has created Policy and Procedure MCQ: 07 (EXHIBIT 26a) which describes the practice of monitoring the use of psychotropic medications for Children and Youth. MCQ: 07 Requires that the use of psychotropic medications for children/youth occur in a manner consistent with guidelines set forth by the Food and Drug Administration, the American Academy of Child and Adolescent Psychiatry Practice Parameter for the Use of Atypical Antipsychotic Medications in Children and Adolescents, and with the Kings View Medication Monitoring Plan. The MHP KV will begin the process of revising our Medication Monitoring Plan. A final draft version is expected to be completed by June 1, 2018. The MHP KV Quality Improvement Committee, as it reviews the monthly minutes of the Medication Monitoring Committee will begin reviewing the use of psychotropic medication use for children/youth. Currently the Medication Monitoring Committee is headed by the KV MHP.

VI. Deficiencies: I3c

Citation: SURVEY ONLY. If a quality of care concern or an outlier is identified related to psychotropic medication use is there evidence that the MHP took appropriate action to address the concern?

SUGGESTED ACTIONS/SURVEY FINDINGS: SURVEY FINDING. No documentation was provided for review by DHCS for this survey item. The MHP identified that a chart review is conducted using a random chart sample by one of their contracted pharmacists. This information is reported at the Medication Monitoring meetings and documented in the meeting minutes. The documentation provides sufficient evidence of compliance with Federal and State requirements.

Describe how the suggested action or survey finding will be addressed: No further action required at this time. KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. This will be handled by the KCBH Quality Management Team. KCBH will issue a policy and/or procedure to outline this process. The final version of the Clinical Practices Guidelines will be tentatively completed by September 2018 and Implemented in October 2018.

VII. Deficiencies: I10 a & b& c

Citation: Regarding the adoption of practice guidelines: SURVEY ONLY. a) Does MHP have practice guidelines, which meet the requirements of the MHP contract, in compliance with CFR 42 CFR 438.236 and CCR title 9, section 1810.326? b) Does the MHP disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries? c) Does the MHP take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other areas to which the guidelines apply are consistent with the guidelines adopted? MHP Contract, Exhibit A, Attachment I

SUGGESTED ACTIONS/SURVEY FINDINGS: SURVEY FINDING: No documentation was provided for review by DHCS for this survey item. SUGGESTED ACTIONS: DHCS recommends the MHP implement the following actions in an effort to meet regulatory and/or contractual requirements: develop a process that ensures practice guidelines are developed in accordance with state and federal requirements and disseminated to beneficiaries and contracted providers.

Describe how the suggested action or survey finding will be addressed: KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. This will be handled by the KCBH Quality Management Team. KCBH will issue a policy and/or procedure to outline this process. The final version of the Clinical Practices Guidelines will be tentatively completed by September 2018 and Implemented in October 2018.

Proposed Implementation Date

VIII. Deficiencies 1c-1

Citation: Do the proposed and actual intervention(s) meet the intervention criteria listed below: 1) the focus of the proposed and actual intervention(s) is to address the condition identified in No. 1b. (1-3) above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate per No. 1b(4)

FINDING: 1c-1: The medical record associated with the following Line number(s) did not meet the medical necessity criteria since the focus of the proposed intervention(s) did not address the mental health condition as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A): Line numbers # ,# , # , # and #. RR3, refer to Recoupment Summary for details. PLAN OF CORRECTION 1c-1: The MHP shall submit a POC that indicates how the MHP will ensure that interventions are focused on a significant functional impairment that is directly related to the mental health condition as specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(A).

Describe how the deficiency will be corrected: MHP KV will ensure that interventions are focused on a significant functional impairment that is directly related to the mental health condition as specified in CCR, title 9, chapter 11, section 1830.205(b) (3) (A) by establishing a new Administrative Directive CL#11 that provides guidance to staff regarding the necessity to establish Medical Necessity before non-crisis services can be offered. (EXHIBIT 14A) Administrative Directive CL#11 is consistent with other related policies (MCC: 07; MCC: 11; and MCC: 12) and clearly articulates the definition of medical necessity and the requirement to establish medical necessity in order to provide Medi-Cal reimbursed services.

Describe how the program will ensure future compliance: An annual review of Medi-Cal compliance is provided to staff every year. This training reviews all components required for the establishment of medical necessity. Each month the QM Department oversee a UR process in which opened charts undergo a clinical review.

Results of the UR process are shared with the individual service providers as well as with Kings View's Management Team and the Quality Improvement Committee. KCBH is currently hiring a new Quality Manager that will be leading a new Quality Management Team at KCBH. Ultimately, UR will be handled by the KCBH Quality Management Team.

Proposed Implementation Date: Additional Training will be held in January 2018. Establishment of the UR process for KCBH will be October 2018

IX. Deficiencies : 2a

Citation: Regarding the Assessment, are the following conditions met: 1) Has the Assessment been completed in accordance with the MHP's established written documentation standards for timeliness? 2) Has the Assessment been completed in accordance with the MHP's established written documentation standards for frequency? CCR, title 9, chapter 11, section 1810.204. CCR, title 9, chapter 11, section 1840.112(b) (1-4). CCR, title 9, chapter 11, section 1840.314(d) (e). CCR, title 9, chapter 4, section 851-Lanterman-Petris Act. MHP Contract, Exhibit A, Attachment I

FINDING: 2a: Assessments were not completed in accordance with regulatory and contractual requirements, specifically: 1) One or more assessments were not completed within the timeliness and frequency requirements specified in the MHP's written documentation standards. The following are specific findings from the chart sample: Line number #: The updated assessment was completed late. PLAN OF CORRECTION 2a: The MHP shall submit a POC that: 1) Indicates how the MHP will ensure that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.

Describe how the deficiency will be corrected: Kings View's Administrative Directive AO#34 (Supervision Strategies for Working with Poor Compliance of Documentation Standard) requires that 80% of all clinical documentation must be completed within the same day as the service was provided. This standard is reviewed monthly by reviewing the "Timeliness of Services Report". Each staff is provided a monthly update on their compliance with the standard and that data is reported to their supervisors. Compliance with this standard is recorded on the employee's annual evaluation report with points being added/subtracted accordingly as demonstrated by the annual employee evaluation report.

Describe how the program will ensure future compliance: The MHP KV Managed Care Clerk will track and monitor timeliness of assessments. Additional Training will need to be provided.

Proposed Implementation Date: UR Review; ongoing. Training on Timelines Standard's; February 2018

X. Deficiencies 3b

Citation: Does the medication consent for psychiatric medications include the following required elements: 1) The reasons for taking such medications? 2) Reasonable alternative treatments available, if any? 3) Type of medication? 4) Range of frequency (of administration)? 5) Dosage? 6) Method of administration? 7) Duration of taking the medication? 8) Probable side effects? 9) Possible side effects if taken longer than 3 months? 10) Consent once given may be withdrawn at any time? CCR, title 9, chapter 11, section 1810.204. CCR, title 9, chapter 11, section 1840.112(b) (1-4). CCR, title 9, chapter 11, section 1840.314(d) (e). CCR, title 9, chapter 4, section 851-Lanterman-Petris Act. MHP Contract, Exhibit A, Attachment I

FINDING 3b: Written medication consents did not contain all of the required elements specified in the MHP Contract with the Department. The following required elements were not documented on the medication consent forms found in the beneficiary's medical record: 1) The reason for taking each medication: Line numbers #, # and #. 2) Type of medication: Line numbers #, # and #. 3) Range of frequency: Line numbers #, # and #. 4) Dosage: Line numbers #, # and #. 5) Method of administration (oral or injection): Line numbers #, # and #. PLAN OF CORRECTION 3b: The MHP shall submit a POC that indicates how the MHP will ensure that every medication consent includes documentation of all of the required elements specified in the MHP Contract with the Department.

Describe how the deficiency will be corrected: The MHP KV's Policy and Procedure MS: 8 will need to be updated to establish guidelines that meet the legal references provided in the DHCS Protocol. Some additions have been recently made in order to clarify when medication consents must be initiated and renewed. P & P MS: 8 will clearly instruct prescribers that authorized medication consents must contain: the reason for taking the medication, the type of medication, the range of frequency, dosage, and method of administration.

Describe how the program will ensure future compliance: The MHP KV is contracting a Supervising RN who will work with the prescribers and will randomly review 20 medication charts every month, of consumers who have seen their prescriber in the last 30 days. The supervising RN will record their findings on the Medication Consent Review Sheet. (EXHIBIT 15A) A copy of the Medication Consent Review sheet will be forwarded to the prescribers. The prescriber will be given 60 days to update the medication consent form. Quarterly results of this review process will be forwarded to the Quality Improvement Committee.

Proposed Implementation Date: Update P&P MS: 8; January 2018. Training of RN in medication consent documentation; February 2018

Proposed Implementation Date

XI. Deficiencies: 4a-2

Citation: Has the client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition? CCR, title 9, chapter 11, section 1810.205.2. CCR, title 9, chapter 11, section 1810.254. CCR, title 9, chapter 11, section 1810.440(c) (1) (2). CCR, title 9, chapter 11, section 1840.112(b) (2-5). CCR, title 9, chapter 11, section 1840.314(d) (e). DMH Letter 02-01, Enclosure A. WIC, section 5751.2. MHP Contract, Exhibit A, Attachment I. CCR, title 16, section 1820.5. California Business and Profession Code, Section 4999.20.

Finding: FINDING 4a-2: The client plan was not updated at least annually or 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):• Line number #: There was a lapse between the prior and current client plans. However, this occurred outside of the audit review period. The MHP should review all services and claims identified during the audit that were claimed outside of the audit review period and for which there was no client plan in effect and disallow those claims as required. PLAN OF CORRECTION 4a-2: The MHP shall submit a POC that indicates how the MHP will: 1) Ensure that client plans are completed at least on an annual basis as required in the MHP Contract with the Department, and within the timelines and frequency specified in the MHP's written documentation standards.2) Provide evidence that all services identified during the audit that were claimed outside of the audit review period for which no client plan was in effect are disallowed.

Describe how the deficiency will be corrected : The MHP KV's policy MCQ:02, Section II., point B requires staff to complete all Plan of Care Reviews at least annually and before the expiration of the current Plan of Care.

Once the Plan of Care has expired, the Electronic Health Record System (Anasazi) will not allow a progress note to be final approved until a current Plan of Care has been created. Non-Final Approved progress notes are not moved forward through our billing process.

Describe how the program will ensure future compliance: All MHP KVs will receive a copy of MCQ: 02 and asked to review it, (EXHIBIT 16A) demonstrating completion of that review by turning in an acknowledgement of receipt (EXHIBIT 4B) to the Quality Management Department. The MHP runs the "Non-Final Approved Progress Note Report" in the electronic health record system on a monthly basis. This data is presented to the individual service provider and to the supervisor. All MHP KVs will submit acknowledgement of receipt. •

Proposed Implementation Date: Submission of Acknowledgement of Receipt; February 2018

XII. Deficiencies: 4b-1 & 4b-2

Citation: Does the client plan include the items specified in the MHP contract with the Department? 1) Specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health need and functional impairments as a result of the mental health diagnosis 2) The proposed type(s) of intervention/modality including a detailed description of the intervention to be provided. • CCR, title 9, chapter 11, section 1810.205.2 • CCR, title 9, chapter 11, section 1810.254 • CCR, title 9, chapter 11, section 1810.440(c)(1)(2) • CCR, title 9, chapter 11, section 1840.112(b)(2-5) • CCR, title 9, chapter 11, section 1840.314(d)(e) • DMH Letter 02-01, Enclosure A • WIC, section 5751.2 • MHP Contract, Exhibit A, Attachment I • CCR, title 16, section 1820.5 • California Business and Profession Code, Section 4999.20

Describe how the deficiency will be corrected: MHP Policy & Procedure MCQ: 02 "Plan of Care Authorization Process," Section II, A, 3, ii states that objectives are to be "observable and measurable and relate back to presenting symptoms and diagnoses, and are integrated to include all services provided." At the time of hire, each staff who may develop, update or review plans of care will receive training on how to create an appropriate plan of care objective that is specific, observable, quantifiable and related to the functional impairment. An annual training event will be provided to staff who have demonstrated that they are struggling with any aspect of the plan of care development. An instructional memo will be sent to all current staff reviewing and reminding them of Medi-Cal requirements related to Plan of Care development.

Describe how the program will ensure future compliance: Quality Management staff will ensure that all incoming staff receive an initial training on Plan of Care development. All initial plans of care must be reviewed and co-signed by the Clinical Director before they can be final approved. All plan of care annual reviews must be reviewed and co-signed by the relevant Program Manager. Through this review process, staff who struggle with developing appropriate objectives will receive immediate feedback from the reviewing supervisor via an e-mail. (EXHIBIT 17A)

Proposed Implementation Date: Development and distribution of Instructional Memo; March 2018. Plus, from this review, staff who are struggling with the development of appropriate plan of care objectives will be identified and scheduled for the annual training review.

XIII. Deficiencies: 4d-1

Citation: Does the client plan include the items specified in the MHP Contract with the Department? 1) Is the documentation of the beneficiary's degree of participation and agreement with the client plan as evidenced by, but not limited to? Reference to the beneficiary's participation in and agreement in the body of the client plan; or b. The beneficiary signature on the client plan; or c. A description of the beneficiary's participation and agreement in the medical record. • CCR, title 9, chapter 11, section 1810.205.2 • CCR, title 9, chapter 11, section 1810.254 • CCR, title 9, chapter 11, section 1810.440(c)(1)(2) • CCR, title 9, chapter 11, section 1840.112(b)(2-5) • CCR, title 9, chapter 11, section 1840.314(d)(e) • DMH Letter 02-01, Enclosure A • WIC, section 5751.2 • MHP Contract, Exhibit A, Attachment I • CCR, title 16, section 1820.5. California Business and Profession Code, Section 4999.20.

FINDING 4d-1: 1. There was no documentation of the beneficiary's or legal representative's degree of participation in and agreement with the plan, and there was no written explanation of the beneficiary's refusal or unavailability to sign the plan, as required in the MHP Contract with the Department: • Line number #: There was no documentation of the beneficiary's or legal representative's participation in and agreement with the client plan for services provided during the review period. RR7, refer to Recoupment Summary for details PLAN OF CORRECTION 4d: The MHP shall submit a POC that indicates how the MHP will: 1) Ensure that each beneficiary's participation and agreement is obtained and documented in a timely manner as specified in the MHP Contract with the Department and CCR, title 9, chapter 11, section 1810.440(c)(2). 2) Ensure that

services are not claimed when the beneficiary's: a) Participation in and agreement with the client plan is not obtained or not obtained in a timely manner and the reason for refusal is not documented. b) Signature is not obtained when required or not obtained in a timely manner and the reason for refusal is not documented.

Describe how the deficiency will be corrected: MCQ: 02 (exhibit 16A) documents the expectation that initial Plans of Care are to be developed at the time of the initial assessment. These plans of care are to be completed collaboratively with the consumer and signed by the consumer or legal representative, as evidence of their involvement and agreement. Signatures are to be obtained electronically whenever possible. When not possible, the signature should be captured on a printed version of the Plan of Care and filed into the chart. A progress note must also be generated to support the billing of the Assessment and Plan of Care. A statement should be placed within that note that confirms the consumer's participation in the plan of care development and their agreement. If an electronic signature is not captured, the progress note should state the provider's plan for securing the consumer's signature and why an electronic signature was not obtained. When this occurs, the provider should submit an e-mail to the designated QM staff, indicating that a plan of care was created without the presence of an electronic signature. It will then become the responsibility of the SAI to secure some form of signature before non-crisis services commence. Dependent of the Court children sometime pose an unusual challenge as the Plan of Care must be signed by a social worker from Child Welfare Services. In order to expedite services for DOC children, assessments are sometimes completed without the presence of the social worker. When that occurs, the above steps should be taken with the addition of the following. If the provider determines that the child is mature enough to give consent, then the child will be asked to sign the plan of care. The progress note will explain the absence of the social worker and the plan for securing the social workers signature.

Describe how the program will ensure future compliance: When QM is notified of a plan of correction that does not have an acceptable consumer signature, they will keep a log of these cases and will review the chart within 30 days to ensure that a signature is present, OR there is a progress note further explaining the steps taken by the SAI to secure a signature, OR that no non-crisis services have been provided. When the SAI is assigned a new case, they are responsible to ensure that a signed plan of care is in place and there is a progress note documenting the consumer's agreement. When no signature is present they are to secure a consumer at the very next service. As soon as an appropriate signature is secured, they will notify QM. QM will review the plan of care and remove the case from the log.

Proposed Implementation Date: Completed

XIV. Deficiencies: 5a-1

Citation: Do the progress notes document the following: 1) Timely documentation (as determined by the MHP) of relevant aspects of client care, including documentation of medical necessity? CCR, title 9, chapter 11, section 1810.205.2._CCR, title 9, chapter 11, section 1810.440(c). CCR, title 9, chapter 11, section 1840.112(b) (2-6). CCR, title 9, chapter 11, section 1840.314. CCR, title 9, chapter 11, sections 1840.316-1840.322._CCR, title 22, chapter 3, section 51458.1._CCR, title 22, chapter 3, section 51470._MHP contract, Exhibit A, Attachment I

FINDING: 5a: Progress notes were not completed in accordance with regulatory and contractual requirements and/or with the MHP's own written documentation standards: One or more progress note was not completed within the timeliness and frequency standards in accordance with regulatory and contractual requirements. Progress notes did not document the following: 5a-1) Line numbers #, #, #, #, #, #, # and #: Timely documentation of relevant aspects of beneficiary care as specified by the MHP's documentation standards (i.e., progress notes completed late based on the MHP's written documentation standards in effect during the audit period). PLEASE NOTE: The exact same verbiage was recorded on multiple progress notes, and therefore those progress notes were not individualized, did not accurately document the beneficiary's response and the specific interventions applied, as specified in the MHP Contract with the Department for: Line number #. PLAN OF CORRECTION: The MHP shall submit a POC that indicates how the MHP will: 1) Describe how the MHP will ensure that progress notes are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards. 2) The MHP shall submit a POC that indicates how the MHP will ensure that progress notes document: 5a-1) Timely completion by the person providing the service and relevant aspects of client care, as specified in the MHP Contract with the Department and the MHP's written documentation standards. 3) The documentation is individualized for each service provided.

Describe how the deficiency will be corrected: Kings View's Administrative Directive AO#34 (Supervision Strategies for Working with Poor Compliance of Documentation Standard) requires that 80% of all clinical documentation must be completed within the same day as the service was provided. This standard is reviewed monthly by reviewing the "Timeliness of Services Report". Each staff is provided a monthly update on their compliance with the standard and that data is reported to their supervisors. Compliance with this standard is recorded on the employee's annual evaluation report with points being added/subtracted accordingly as

demonstrated by the annual employee evaluation report. Administrative Directive #10 also states that progress notes should not contain the same verbiage but rather, should, “reflect a unique clinical event provided to a unique individual. Cookie cutter looking progress notes are not acceptable. In addition to the above steps, Kings View has initiated the “Collaborative Documentation Model.” Staff are encouraged to engage in a collaborative processes with their consumers, in the completion of their daily documentation. When this model is observed, all progress notes are completed before the end of the day and are by their very nature, individualized.

Describe how the program will ensure future compliance: Initial training for the Collaborative Documentation model occurred on April 17, 2017 with a follow up training on June 13, 2017. Kings View is tracking both the responses of the consumers involved in Collaborative Documentation as well as responses by the staff providing Collaborative Documentation.

Proposed Implementation Date: A.D #10 & distribution Completed. Collection of Receipt of Acknowledgement will be complete by January 15, 2018.

XV. Deficiencies: 5a3

Citation: Do the progress notes document the following: 3) Interventions applied, beneficiary’s response to the interventions, and the location of the interventions? CCR, title 9, chapter 11, section 1810.205.2. CCR, title 9, chapter 11, section 1810.440(c). CCR, title 9, chapter 11, section 1840.112(b) (2-6). CCR, title 9, chapter 11, section 1840.314. CCR, title 9, chapter 11, sections 1840.316-1840.322. CCR, title 22, chapter 3, section 51458.1. CCR, title 22, chapter 3, section 51470. MHP contract, Exhibit A, Attachment I

FINDING 5a3: The progress note for the following Line number indicates that the service provided was solely for: Clerical: Line number #. RR17, refer to Recoupment Summary for details. **PLAN OF CORRECTION:** The MHP shall submit a POC that indicates how the MHP will ensure that: 1) Each progress note describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning, as outlined in the client plan. 2) Services provided and claimed are not solely transportation, clerical or payee related. 3) All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205 (a) (b).

Describe how the deficiency will be corrected: Kings View has written Administrative Directive #10 "PROGRESS NOTES: Necessary Elements to bill Medi-Cal." This A.D. describes all the elements necessary for a Progress Note to support a billable Medi-Cal Services. One element of this A.D. speaks to the requirement that sole clerical activities are not billable to Medi-Cal.

Describe how the program will ensure future compliance: A.D. #10 will be distributed to all staff providing clinical services. Staff will complete a receipt of acknowledgement that they have received and read the policy. Supervisors will review this A.D. with all of their supervisees. Whenever a progress note is discovered that does not comply with these guidelines, the services will be voided and reimbursement returned.

Proposed Implementation Date: A.D CL # 12 & distribution Completed. The amended URC Worksheets will be rolled out by January 2018.

XVI. Deficiencies: 5b

Citation: When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes include: 1) Documentation of each person's involvement in the context of the mental health needs of the beneficiary? 2) The exact number of minutes used by persons providing the service? 3) Signature(s) of person(s) providing the services? CCR, title 9, chapter 11, section 1810.254. CCR, title 9, chapter 11, section 1810.440(c). CCR, title 9, chapter 11. Section 1840.112(b) (2-6). CCR, title 9, chapter 11, section 1840.314. CCR, title 9, chapter 11, sections 1840.316-1840.322. CCR, title 22, chapter 43, section 51458. CCR, title 22, chapter 3, section 51470. MHP Contract, Exhibit A, Attachment I

FINDING 5b: Documentation of services being provided to, or on behalf of, a beneficiary by two or more persons at one point in time did not include all required components. Specifically: Line number #: Progress notes did not document the contribution, involvement or participation of each staff member as it relates to the identified functional impairment and mental health needs of the beneficiary. **PLAN OF CORRECTION** 5b: The MHP shall submit a POC that indicates how the MHP will ensure that: 1) Group progress notes clearly document the contribution, involvement or participation of each staff member as it relates to the identified functional impairment and mental health needs of the beneficiary. 2) There is medical necessity for the use of multiple staff in the group setting.

Describe how the deficiency will be corrected: Kings View has created Administrative Directive CL #12 (EXHIBIT 21A) that describes how Medi-Cal documentation standards, specific to group service, is to occur. CL #12 States that “When group services are provided to a Medi-Cal beneficiary and when more than one facilitator is billed for, the progress note must clearly document each staff member’s involvement in the group, how each staff contributed to the needs of each group member, and the amount of time represented by each staff member.” This A.D. will be distributed to all staff, with follow up training provided by the Program Manager and/or their designee.

Describe how the program will ensure future compliance: This protocol will be incorporated into the Peer Review Worksheet. Compliance to this standard will be reviewed as part of the monthly utilization review process. Results from the URC are shared with service staff, supervisors, and QIC membership. Special Note: Kings View does operate an authentic Dialectical Behavioral Therapy Program. One of the 4 essential elements of a DBT program is the skills training group. In order to meet DBT validation levels two DBT facilitators are required for each DBT skills group. Each facilitator has a specific role which is clearly defined by DBT protocols. There is no inherent conflict between Medi-Cal guidelines and DBT protocols. It will be the responsibility of the ASOC Program Manager to ensure that staff are provided adequate DBT training and that said training incorporates how to demonstrate Medi-Cal compliance when writing the group progress notes.

Proposed Implementation Date: Information Notice will be completed and distributed by January 2018; •Update to Intake Providers Documentation Requirement; February 2018. The amended URC Worksheets will be rolled out by January 2018

XVII. Deficiencies:6d

Citation: When applicable, was treatment specific information provided to beneficiaries in an alternative format (e.g., braille, audio, large print, etc.)? CFR, title 42, section 438.10(c) (4), (5). CCR, title 9, chapter 11, section 1810.405(d). CCR, title 9, chapter 11, section 1810.410.

FINDING 6d: The following Line number was not provided information in an alternative format (e.g. braille, large print, or sign language as preferred by the beneficiary: The following Line number or the parent(s)/legal guardian(s) of the following Line number were speech impaired and there was no evidence that mental health interpreter services or sign language were offered and provided to: Line number r#. PLAN OF CORRECTION Gd: The MHP shall submit a POC that indicates how the MHP will: 1) Ensure that beneficiaries/parents/legal guardians are provided information in alternative formats, when applicable.2) Ensure that there is documentation substantiating that beneficiaries were provided information in an alternative format, when applicable. 3) Provide evidence that the requirement to provide alternative formats for beneficiaries who have special needs in including limited reading proficiency are in accordance with Title 9 and Title 42 and the MHP Contract with the Department.

Describe how the deficiency will be corrected: In order to ensure that beneficiaries, parents, legal guardians are provided necessary accommodations, MHP KV will take the following steps. At the time of the initial assessment, the assessing clinician will document special needs that impact service delivery (vision, hearing, or reading needs), in the "Intake Provider Documentation Requirements" form. Once completed, the "Intake Providers Documentation Requirement" form will be scanned into the electronic health record system. Service providers will routine include in their service documentation if said barrier impacted services delivery, what type of impact was observed and what steps were taken to reduce said barrier. Once a barrier is identified and in order to ensure an appropriate response, MHP KV will consider the need for braille, audio information, or reading difficulties as a cultural competency issue. As such, MHP Provider will ensure that one hour of cultural competency training, related to hearing, visual and reading impairment will be provided to staff each year.

Describe how the program will ensure future compliance: When visual, hearing and/or reading barriers are identified at the time of assessment, URC reviewers will check to see if the barriers were addressed and documented in the consumer electronic chart. Deficiencies in this area will be reported to the service provider's Program Manager. Program Managers will address compliance issues associated with this standard. The MHP KV Quality Management Department will distribute an informational notice providing instruction and guidance to staff regarding the identification and appropriate response to identified visual, hearing and/or reading related barriers. Program Managers will also ensure that when staff did not receive the required cultural competency training related to visual, hearing and/or reading barriers, that they are required to acquire this training by their next evaluation. The informational notice will be drafted and distributed to all staff.

Proposed Implementation Date: Information Notice will be completed and distributed by January 2018; •Update to Intake Providers Documentation Requirement; February 2018. The amended URC Worksheets will be rolled out by January 2018.