Finding-Napa County MH Plan of Correction

SECTION A: ACCESS

2. Regarding the provider list:

2a. Does the MHP provide beneficiaries with a current provider list upon request and when first receiving a SMHS?

2b. Is the provider list available in English and in the MHPs identified threshold language(s)?

- CFR, title 42, section 438.10(f)(6)(and 438.206(a) DMH Information Notice Nos. 10-02 and 10-17
- CCR, title 9, chapter 11, section 1810.410 MHP Contract Exhibit A, Attachment I
- CMS/DHCS, section 1915b Waiver

FINDINGS

The MHP did not furnish evidence it provides beneficiaries with a current provider list upon request and when first receiving a SMHS. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy and Procedure (P&P) #2000201 (10/03/15) Medi-Cal MH Beneficiary Brochure; Intake check list; and, the provider listing. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the P&P does not include a process for ensuring beneficiaries receive the provider list when first receiving a SMHS. The MHP's intake check list does not indicate if a beneficiary has received a provider list nor did the MHP provide a policy addressing this requirement. Protocol question(s) A2a is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides beneficiaries with a current provider list upon request and when first receiving a SMHS. The MHP should also provide a beneficiary booklet in all MHP's identified threshold languages.

- The MHP created a new Registration checklist form with a signature line for Access secretaries to attest that they have offered the Provider List and Beneficiary Booklet, in the beneficiary's preferred language, to beneficiaries during intake. (see attachment) After the form is completed and signed, it is scanned into the individual's electronic health record as an attachment.

The policy requirements and procedural guidelines for completing this checklist have been added to the Medi-Cal Beneficiary Rights Policy. (see attachment)

The Threshold Spanish Language Beneficiary Booklet and Provider List are available in all lobbies and to beneficiaries at all times and were provided to reviewers during the audit.

Due Date: Completed

5d. I Do these written materials take into consideration persons with limited reading proficiency (e.g., 6th grade reading level for general information)?

- CFR, title 42, section 438.10(d)(i),(ii)
- CCR, title 9, chapter 11, sections 1810.110(a) and 1810.410(e)(4)
- CFR, title 42, section 438. 10(d)(2)
- MHP Contract, Exhibit A, Attachment I

FINDINGS

The MHP did not furnish evidence its written materials take into consideration persons with limited reading proficiency (e.g., 6th grade reading level). The MHP does not have a P&P or other documentation addressing the reading level in which written informing materials are developed. Protocol question(s) A5d is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its written materials take into consideration persons with limited vision and/or persons with limited reading proficiency (e.g., 5th grade reading level).-The MHP added language to the Medi-Cal Beneficiary Rights Policy, specifying that the Guide and Providers list are to be scanned by the WORD proofing utility for 6th grade reading level. This has been done.

See attachment.

Due Date: Completed
PROTOCOL REQUIREMENTS

9a. Regarding the statewide, 24 hours a dav, 7 days a week (24/7) toll-free telephone number:

1) Does the MHP provide 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) Does the toll-free telephone number provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity PROTOCOL REQUIREMENTS are met?

3) Does the toll-free telephone number provide information to beneficiaries about services needed to treat a beneficiary's urgent condition?

4) Does the toll-free telephone number provide information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes?

- DMH Information Notice No. 10-02, Enclosure,

Page 21, and DMH Information Notice No. 10- 17, Enclosure,

Page 16 MHP Contract, Exhibit A, Attachment I

1810.410(e)(1) CFR, title 42, section 438.406 (a)(1)

Test Call Findings:

2 calls found OOC on item 9a4.

PLAN OF CORRECTION The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a statewide, toll-free telephone number 24 hours a day, 7 days per week, with language capability in all languages spoken by beneficiaries of the county that will provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.-The understanding of the MHP from the verbal feedback provided during the exit conference regarding the OOC component of this item, that the issue of concern was that although the 24/7 access line greeting which had been created in consultation with DHCS (John Lessley and Carol Sakai), does provide an option for callers to speak directly to a live person, who can provide problem resolution information, if one listens through to the end of the message it also states:
“For more information on the Medi-Cal beneficiary problem resolution and State Fair Hearing process, please call the Mental Health Access line at 707/259-8151 during county business hours from 8am to 5pm Monday-Friday, except holidays.”

Inasmuch as live responders to the calls are trained in answering questions about problem resolution, per the reviewers' suggestion, the MHP is meeting this part of the POC by deleting the above language from the greeting. (See revised greeting script below.)

To address the POC regarding being explicit about the fact that callers can have urgent care needs met, the recorded greeting has been revised to include this. See below:

"You have reached the Napa County Mental Health Access team.
Se ha comunicado con el Equipo de Autorización y Acceso Central. Para español oprima el número 2.

(If you don't press 2 the following message will continue in English):

If you are experiencing a mental health crisis, or have an <u>urgent</u> mental health need, please press the number 1. To speak to someone directly about receiving mental health services, or if you need help in another language, please press the number 3.

If this is not an emergency or <u>urgent</u> situation, and you are interested in receiving mental health services, you may leave your name and a phone number with the best time to reach you. We are very interested in speaking to you and will call you back promptly during business hours.

Thank you."

Due Date: Completed
PROTOCOL REQUIREMENTS 9c.J Does the MHP provide training for all staff and contractors with responsibilities related to providing a statewide (24/7) toll-free telephone line?

• CCR, title 9, chapter 11, sections 1810.405(d) and • DMH Information Notice No. 10-02, Enclosure, 1810.410(e)(1)Page 21, and DMH Information Notice No. 10-17, Enclosure

FINDING The MHP did not furnish evidence it provides training for all staff and contractors with responsibilities related to providing a statewide (24/7) toll-free telephone line. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Calendar entry identifying date of training for ERT staff and the MHP's call script. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. The MHP did not provide any detailed information about the content of the training or staff participation (i.e., sign in sheets) in the training. Protocol question(s)

A9c is deemed OOC.

PLAN OF CORRECTI ON The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides training for all staff and contractors with responsibilities related to providing a statewide (24/7) toll-free telephone line.-NCMH is contracting with a new Organizational Provider, Exodus, to open a Crisis Stabilization Services Unit in late Spring, 2017. The clinical staff of the CSSU will hold responsibility, among other things, for answering and handling the 24/7 Access Line after hours. Prior to the opening of this service, training will be provided to all answering staff and supervisors. Training will be documented by curricula, scripts, sample logging forms, sign-in sheets. Documentation of the training(s) will be submitted to DHCS as evidence of compliance with the POC.

Due Date: July 1, 2017
10.

10a. 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?

10b. 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?

FINDINGS

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. The MHP did not present a P&P regarding the written log of initial requests. There is insufficient evidence the MHP logs requests made by phone, in person and in writing.

In addition, the logs made available by the MHP did not include all required elements for Three (3) of the Five (7) test calls made by DHCS that were required to be logged (two test calls requesting information about the beneficiary problem resolution process were not required to be logged) . The name of the beneficiary was logged for Two (2) of the Seven (7) test calls (71%). The date of the call was logged for Two (2) of the Seven (7) test calls (71%). The initial disposition of the call was logged for Two (2) of the Seven (7) test calls (71%).

Protocol question(s) 10b1-3 is deemed in partial compliance. PLAN OF CORRECTION:

The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its written log of initial requests for SMHS (including requests made via telephone, in person or in writing) complies with all regulatory requirements. -NCMH, like all other California MHP's, conducts regular test calls of its 24/7 access line system. The results of these test calls are reported quarterly to the County Liaison office. One element of this testing and reporting is the accurate logging of these calls. Internal test calls have corroborated the state audit's findings that accurate logging of after- hours calls is inconsistent. The Quality Coordinator reported the findings to the Unit Supervisors of the ERT unit (the unit that answers after hours calls) and Mental Health Access (the unit that maintains the log.) We met and reviewed the procedure and forms that had

been created to transfer call information from ERT staff to Access secretaries. It was determined that the breakdown was occurring in ERT, where the staff were inconsistently filling out the call form. The ERT Supervisor issued a directive to her staff reminding them of this responsibility.

As noted above, in Spring, 2017, ERT will no longer carry this responsibility, and it will be transferred to the contracted CSU. Planning discussions have already occurred between the Quality Coordinator and Contractor management outlining the protocol for recording calls. The contractor currently performs this service for another MHP and is familiar with the state requirements. The staff training detailed above will include instructions on how to record calls on the designated form and transmit this information to the MH Access Unit.

Under the direction of the Quality Coordinator, the MHP will continue to routinely test this system, analyze the results, and make appropriate recommendations and changes as needed.

Due Date: Current with continued quarterly reports to DHCS

SECTION G: PROVIDER RELATIONS

PROTOCOL REQUIREMENTS

2. Regarding the MHP's ongoing monitoring of county-owned and operated and contracted organizational providers:

2a. 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?

2b. 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

FINDINGS

The MHP 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. However, 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. The table below summarizes the report findings :

TOTAL ACTIVE PROVIDERS

(per OPS) NUMBER OF OVERDUE PROVIDERS (at the time of the Review)

COMPLIANCE PERCENTAGE

26 3 88%

Protocol question(s) G2b is deemed in partial compliance.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that 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.-As the review notes, "The MHP 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."

At the time of the review, the OPS reflected 3 overdue providers, but the report was not current for 2 organizational providers for whom site certification documentation had been submitted but not yet recorded. One other was an inactive provider whose certification had expired, but needed to be formally terminated. This was done.

The MHP has been in communication with the DHCS Site Certification Unit in an effort to more proactively coordinate its monitoring efforts and ensure that the OPS accurately reflects current certification status.
These efforts will continue.

Due Date: Ongoing
SECTION H: PROGRAM INTEGRITY

PROTOCOL REQUIREMENTS

4. Does the MHP ensure that it collects the disclosure of ownership, control, and relationship information from its providers, managing employees, including agents and managing agents, as required in CFR, title 42, sections 455 .101 and 455 .104 and in the MHP Contract, Program integrity Requirements?

• CFR, title 42, sections 455.101 and 455.104 • MHP Contract, Exhibit A, Attachment I, Program Integrity

Requirements

FINDING

The MHP did not furnish evidence it collects the disclosure of ownership, control, and relationship information from its providers, managing employees, including agents and managing agents as required in regulations and the MHP Contract. DHCS reviewed the following documentation presented by the MHP as evidence of compliance : MHP submitted HHSA Contract Preparation Worksheet Instructions indicating contractor must be verified whether or not a 700 form is required. MHP also submitted a HHSA 700 form tracking sheet. This documentation verifies compliance of contracted providers but does address the requirement for MHP staff. The documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Protocol question H4 is deemed OOC.

PLAN OF CORRECTI ON

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it collects the disclosure of ownership, control, and relationship information from its providers, managing employees, including agents and managing agents as required in regulations and the MHP Contract.

-See attached Napa County Board of Supervisors COIC Proclamation outlining the requirements for County, HHSA (and thereby Mental Health) employees' disclosure of conflicts of interest by submitting a completed 700 form annually. The current 700 Form is also attached.

Due Date: Completed

SECTION I: QUALITY IMPROVEMENT

PROTOCOL REQUIREMENTS

2d. Does the MHP inform providers of the results of beneficiary/family satisfaction activities?

- MHP Contract, Exhibit A, Attachment I

FINDINGS

The MHP did not furnish evidence it inform providers of the results of beneficiary/family satisfaction activities. Protocol question(s) 12d is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has mechanisms to assess beneficiary/family satisfaction and to inform providers of the results of beneficiary/family satisfaction activities.-Historically, the MHP provided results of the Consumer Perception Surveys to organizational providers at the annual compliance meeting each April, and to providers in the Individual Provider Network each May. This practice will be reinstated in Spring, 2017. In addition, as CIBHS and DHCS begin to process CPS results in a more timely manner and, utilizing EBHS, offer the opportunity to display results in a more user friendly manner, NCMH will commence electronically distributing these results to providers semi-annually as they become available.

Due Date: June 15, 2017

PROTOCOL REQUIREMENTS

6. Regarding the QM Work Plan:

6b. Does the QM Work Plan include evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review?

6f. Does the QM work plan include evidence of compliance with the requirements for cultural competence and linguistic competence?

- CCR, title 9, chapter 11, section 1810.440(a)(5)
- DMH Information Notice No. 10-17, Enclosures, Pages 18 & 19, and DMH Information Notice No. 10-02, Enclosure, Page 23
- MHP Contract. Exhibit A, Attachment I
- CCR, tit. 9, § 1810.410
- CFR, title 42, Part 438-Managed Care, sections 438.204, 438.240 and 438.358.

FINDINGS

The MHP did not furnish evidence it has a QM/QI work plan covering the current contract cycle, with documented annual evaluations and necessary revisions, which meets MHP Contract requirements. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Work Plans for various fiscal years including 2014-15 and dashboard of data and analysis. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements.

Specifically, the work plans did not include expedited fair hearings and clinical records review. The MHP states these activities are practiced but not addressed in the work plan. Protocol question(s) 16b and 16f are deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has a QM/QI work plan covering the current contract cycle, with documented annual evaluations and necessary revisions, which meet the MHP Contract requirements.

-The QI Work Plan is due for its annual evaluation and revision. The revision will more directly and overtly include the documentation of clinical record review efforts previously contained only in the Utilization Review Dashboard, which was presented during the review. The Dashboard will be renamed the Mental Health Data Dashboard and annually included in the Quality Improvement Work Plan. The revision will add language to the section regarding monitoring of appeals to specify that expedited fair hearings, if they occur, are tracked as well.

Due Date: March 31, 2017
SECTION J: MENTAL HEALTH SERVICES (MHSA)

PROTOCOL REQUIREMENTS

4d. Does the County ensure that a 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

FINDINGS

The County did not furnish evidence its PSC/Case Managers are available to respond to the client/family 24 hours a day, 7 days a week to provide after-hours interventions. DHCS reviewed the following documentation presented by the County as evidence of compliance: P&P #2000200-0009-15 Access and Availability. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, P&P does not address PSC/Case Manager availability to client/family 24 hours a day, 7 days a week. MHP stated there is no job position regarding PSC/Case Manager that is available to respond 2417. Protocol question(s) J4d is deemed OOC.

PLAN OF CORRECTION

The County must submit a POC addressing the OOC findings for these requirements. The County is required to provide evidence to DHCS to substantiate its POC and to demonstrate that its PSC/Case Managers are responsible for developing an ISSP with the client and, when appropriate, the client's family and available to respond to the client/family 24 hours a day, 7 days a week to provide after-hours interventions. The County does not ensure its PSC/Case Managers assigned to FSP clients are culturally and linguistically competent or, at a minimum, educated and trained in linguistic and cultural competence and have knowledge of available resources within the client/family's racial/ethnic community.-All FSP Case Managers are responsible for developing with their clients, with family member involvement when appropriate, an ISSP, referred to locally as a Wellness and Recovery Plan. (see attached Documentation Manual and Wellness and Recovery Plan P&P for detailed directions provided to Case Managers through orientation, training and practice).

Due Date: current practice

The Crisis Stabilization Services Unit, which will open this Spring, will be available on-call 24/7 to provide after-hours FSP interventions as needed. CSS staff will be given updated current case information on FSP clients at the outset of their on-call shifts, and routine case review meetings between FSP Supervisors and CSS Supervisors will be conducted. FSP clients will be given the names of CSS staff who will be available to them after hours.

Due Date: September 15, 2017

All Mental Health staff are required to participate in a Foundations in Diversity cultural competence training, a 12 hour course in Implicit Bias, and an LGBTQ training, and be proficient in the use of ATT Language Line if they themselves are not bilingual. FSP teams have many bi-lingual staff positions in order to meet the needs of Spanish speaking consumers. Many certified Bi-Lingual staff are also available to provide live interpretive services. (see attached evidence: training curricula, org chart (notation BiL indicates bi-lingual position) Translation and Interpretation P&P)

Due Dates:
Foundations in Diversity and LGBTQ Trainings: done during new hire orientation, ongoing practice
Implicit Bias Training: in process; complete by 6/1/17
PROTOCOL REQUIREMENTS

5. Regarding the County's MHSA Issue Resolution Process:

5a. Does the County have in place an Issue Resolution Process to resolve issues related to the MHSA community planning process, consistency between approved MHSA plans and program implementation, and the provision of MHSA funded mental health services?

5b. Does the County's Issue Resolution Log contain the following information:

1) Dates the issues were received?

2) A brief description of the issues? Has the County submitted the Annual MHSA Revenue and Expenditure Report within the established timeframe

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

FINDINGS

The County did not furnish evidence it has an Issue Resolution Process to resolve issues related to the MHSA community planning process, consistency between approved MHSA plans and program implementation, and the provision of MHSA funded mental health services. The County does not maintain an MHSA Issue Resolution Log with all required components. DHCS reviewed the following documentation presented by the County as evidence of compliance: MHP submitted implementation documentation of an Issue Resolution process. The MHP is in the process of creating this process. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, The MHP is maintaining grievance information but has not yet created a MHSA Issue Resolution log. Protocol question(s) J5a; JSb-1; JSb-2; JSb-3; and JSb-4 are deemed OOC.

PLAN OF CORRECTI ON

The County must submit a POC addressing the OOC findings for these requirements. The County is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has an Issue Resolution Process to resolve issues related to the MHSA community planning process, consistency between approved MHSA plans and program implementation, and the provision of MHSA funded mental health services. The County must maintain an MHSA Issue Resolution Log with all required components.-The MHSA Issue Resolution Process that was in draft form at the time of the review, awaiting Stakeholder approval, was approved and implemented in January, 2016. See attached Process, Form and Log.

Due Date: Completed

-

Chart Review Finding

-Napa County MH Plan of Correction

FINDING 1c-1:

The medical record associated with the following Line numbers did not meet the medical necessity criteria since the focus of the proposed interventions did not address the mental health condition as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(A):

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).
-In order to ensure that clinical documentation demonstrates that the focus of the proposed intervention was to address the mental health condition Napa County Mental Health has and will be taking the following steps:

1. Completed September 2015: A new clinical progress note template was implemented and all clinical staff received training to ensure the template is used properly. This template prompts the note author to ensure that all required components of a progress note are present and underscores the importance of linking the interventions provided back to the client's treatment goals/objectives. Any progress notes reviewed that do not meet medical necessity requirements are written off and staff receive direct feedback and training to ensure future documentation is in compliance. This progress note template is outlined in depth in the current Napa County Documentation Manual and includes examples of notes using the template along with definitions of what is expected to be included under each section.

2. Completed August 2016: A complete overhaul of our monthly auditing system was implemented and the chart review process now supports a holistic chart review that uses a review tool that is directly based upon the most current DHCS chart audit protocols. The newly implemented process also increases supervisory involvement with the review and findings process and supports continued understanding of documentation requirements. A chart from every program is reviewed each month and direct feedback is provided to program supervisors and staff so that the results can be processed in supervision as well as during staff meetings a means to continue dialogue about documentation requirements.

3. Completed October 2016: Four hour Annual Compliance Training was provided to all mental health staff and two of the total four hours of this year's presentation covered updates made to the Napa County Documentation Manual, DHCS Final Audit Report results, and reasons for recoupment and how to address them moving forward. Specifically, staff were given instruction regarding writing effective progress notes and Assessments that meet medical necessity and creating Wellness and Recovery Plans (Client Plans) that meet all documentation requirements including but not limited to ensuring client plan objectives are specific, measurable and/or observable; making sure client plan clinical interventions are noted clearly, ensuring that client plans are completed on time. The revised Documentation Manual was published on October 31, 2016 and provides additional guidance for staff on how to meet documentation requirements of Napa County and the Department of Healthcare Services. The documentation manual contains information including but not limited to the following: General Flow of Service Delivery, Medical Necessity, Assessments/Re-Assessments, Diagnosis Review Forms, Wellness and Recovery Plans (Client Plans), Progress Notes, Discharge/Termination and appendices that include but are not limited to reasons for recoupment, audit standards, Language Line instructions and the most recent DHCS included diagnosis crosswalk.

4. Ongoing: Quarterly program-specific trainings will continue to be provided by the UR Coordinator throughout the year to ensure that documentation requirements are reviewed, understood and processed in depth. Specifically, topics covered during these trainings include but are not limited to: Reviewing recent causes of documentation disallowance, reiterating the importance of ensuring progress notes include all necessary information in order to meet medical necessity; ensuring clinical documentation (Assessments, client plans, progress notes) is completed in a timely manner/problem solving when there are roadblocks to timely documentation; ensuring WRPs include all of the necessary requirements (Specific, measurable and/or observable objectives) and a description of the interventions to be utilized to support clients with meeting their goals. During these trainings (and at any time outside of these trainings) staff are given the opportunity to check in about pressing documentation questions.

FINDING 1c-2:

The medical record associated with the following Line number did not meet the medical necessity criteria since there was no expectation that the documented intervention would meet the intervention criteria as specified in the CCR, title 9, chapter 11, section 1830.205(b)(3)(8)(1-4):

PLAN OF CORRECTION 1c-2:

The MHP shall submit a POC that indicates how the MHP will ensure that the interventions provided meet the intervention criteria specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(B)(1-4).

-
The following steps have been taken to ensure that interventions provided meet the intervention criteria specified in Title 9:

1. Completed September 2015: A new clinical progress note template was implemented and all clinical staff received training to ensure the template is used properly. This template prompts the note author to ensure that all required components of a progress note are present and underscores the importance of linking the interventions provided back to the client's treatment goals/objectives. Any progress notes reviewed that do not meet medical necessity requirements are written off and staff receive direct feedback and training to ensure future documentation is in compliance. This progress note template is outlined in depth in the current Napa County Documentation Manual and includes examples of notes using the template along with definitions of what is expected to be included under each section.

2. Completed August 2016: A complete overhaul of our monthly auditing system was implemented and the chart review process now supports a holistic chart review that uses a review tool that is directly based upon the most current DHCS chart audit protocols. The newly implemented process also increases supervisory involvement with the review and findings process and supports continued understanding of documentation requirements. A chart from every program is reviewed each month and direct feedback is provided to program supervisors and staff so that the results can be processed in supervision as well as during staff meetings a means to continue dialogue about documentation requirements.

3. Completed October 2016: Four hour Annual Compliance Training was provided to all mental health staff and two of the total four hours of this year's presentation covered updates made to the Napa County Documentation Manual, DHCS Final Audit Report results, and reasons for recoupment and how to address them moving forward. Specifically, staff were given instruction regarding writing effective progress notes and Assessments that meet medical necessity and creating Wellness and Recovery Plans (Client Plans) that meet all documentation requirements including but not limited to ensuring client plan objectives are specific, measurable and/or observable; making sure client plan clinical interventions are noted clearly, ensuring that client plans are completed on time. The revised Documentation Manual was published on October 31, 2016 and provides additional guidance for staff on how to meet documentation requirements of Napa County and the Department of Healthcare Services. The documentation manual contains information including but not limited to the following: General Flow of Service Delivery, Medical Necessity, Assessments/Re-Assessments, Diagnosis Review Forms, Wellness and Recovery Plans (Client Plans), Progress Notes, Discharge/Termination and appendices that include but are not limited to reasons for recoupment, audit standards, Language Line instructions and the most recent DHCS included diagnosis crosswalk.

4. Ongoing: Quarterly program-specific trainings will continue to be provided by the UR Coordinator throughout the year to ensure that documentation requirements are reviewed, understood and processed in depth. Specifically, topics covered during these trainings include but are not limited to: Reviewing recent causes of documentation disallowance, reiterating the importance of ensuring progress notes include all necessary information in order to

meet medical necessity; ensuring clinical documentation (Assessments, client plans, progress notes) is completed in a timely manner/problem solving when there are roadblocks to timely documentation; ensuring WRPs include all of the necessary requirements (Specific, measurable and/or observable objectives) and a description of the interventions to be utilized to support clients with meeting their goals. During these trainings (and at any time outside of these trainings) staff are given the opportunity to check in about pressing documentation questions.

FINDINGS 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.

PLAN OF CORRECTION 2a:

The MHP shall submit a POC that:

1) Provides evidence that the MHP has written documentation standards for assessments, including required elements or timeliness and frequency as required in the MHP Contract with the Department.
2) 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.

-To ensure timely completion of assessments Napa County has and will be taking the following steps:

1. Completed August 2016: A complete overhaul of our monthly auditing system was implemented and the chart review process now supports a holistic chart review that uses a review tool that is directly based upon the most current DHCS chart audit protocols. The newly implemented process also increases supervisory involvement with the review and findings process and supports continued understanding of documentation requirements. A chart from every program is reviewed each month and direct feedback is provided to program supervisors and staff so

that the results can be processed in supervision as well as during staff meetings a means to continue dialogue about documentation requirements.

2. Completed October 2016: Four hour Annual Compliance Training was provided to all mental health staff and two of the total four hours of this year's presentation covered updates made to the Napa County Documentation Manual, DHCS Final Audit Report results, and reasons for recoupment and how to address them moving forward. Specifically, staff were given instruction regarding writing effective progress notes and Assessments that meet medical necessity and creating Wellness and Recovery Plans (Client Plans) that meet all documentation requirements including but not limited to ensuring client plan objectives are specific, measurable and/or observable; making sure client plan clinical interventions are noted clearly, ensuring that client plans are completed on time. The revised Documentation Manual was published on October 31, 2016 and provides additional guidance for staff on how to meet documentation requirements of Napa County and the Department of Healthcare Services. The documentation manual contains information including but not limited to the following: General Flow of Service Delivery, Medical Necessity, Assessments/Re-Assessments, Diagnosis Review Forms, Wellness and Recovery Plans (Client Plans), Progress Notes, Discharge/Termination and appendices that include but are not limited to reasons for recoupment, audit standards, Language Line instructions and the most recent DHCS included diagnosis crosswalk.

3. Ongoing: Quarterly program-specific trainings will continue to be provided by the UR Coordinator throughout the year to ensure that documentation requirements are reviewed, understood and processed in depth. Specifically, topics covered during these trainings include but are not limited to: Reviewing recent causes of documentation disallowance, reiterating the importance of ensuring progress notes include all necessary information in order to meet medical necessity; ensuring clinical documentation (Assessments, client plans, progress notes) is completed in a timely manner/problem solving when there are roadblocks to timely documentation; ensuring WRPs include all of the necessary requirements (Specific, measurable and/or observable objectives) and a description of the interventions to be utilized to support clients with meeting their goals. During these trainings (and at any time outside of these trainings) staff are given the opportunity to check in about pressing documentation questions.

4. By March 31, 2017: Napa County will begin conducting quarterly audits (in addition to the regular monthly audit process) to identify gaps in assessment timeliness and direct training/feedback will be provided as necessary.

FINDING 2b:

One or more of the assessments reviewed did not include all of the items specified in the MHP Contract with the Department. The following required elements were incomplete or missing:

1) Client Strengths: [1]
2) Risks: [2]
3) A mental status examination: [3]

PLAN OF CORRECTION 2b:

The MHP shall submit a POC that indicates how the MHP will ensure that every assessment contains all of the required elements specified in the MHP Contract with the Department-To ensure assessments include all of the items specified in the MHP Contract with the Department Napa County has and will be taking the following steps:

[1] Line number(s) removed for confidentiality
[2] Line number(s) removed for confidentiality
[3] Line number(s) removed for confidentiality

1. Completed August 2016: A complete overhaul of our monthly auditing system was implemented and the chart review process now supports a holistic chart review that uses a review tool that is directly based upon the most current DHCS chart audit protocols. The newly implemented process also increases supervisory involvement with the review and findings process and supports continued understanding of documentation requirements. A chart from every program is reviewed each month and direct feedback is provided to program supervisors and staff so that the results can be processed in supervision as well as during staff meetings a means to continue dialogue about documentation requirements.

2. Completed October 2016: Four hour Annual Compliance Training was provided to all mental health staff and two of the total four hours of this year's presentation covered updates made to the Napa County Documentation Manual, DHCS Final Audit Report results, and reasons for recoupment and how to address them moving forward. Specifically, staff were given instruction regarding writing effective progress notes and Assessments that meet medical necessity and creating Wellness and Recovery Plans (Client Plans) that meet all documentation requirements including but not limited to ensuring client plan objectives are specific, measurable and/or observable; making sure client plan clinical interventions are noted clearly, ensuring that client plans are completed on time. The revised Documentation Manual was published on October 31, 2016 and provides additional guidance for staff on how to meet documentation requirements of Napa County and the Department of Healthcare Services. The documentation manual contains information including but not limited to the following: General Flow of Service Delivery, Medical Necessity, Assessments/Re-Assessments, Diagnosis Review Forms, Wellness and Recovery Plans (Client Plans), Progress Notes, Discharge/Termination and appendices that include but are not limited to reasons for recoupment, audit standards, Language Line instructions and the most recent DHCS included diagnosis crosswalk.

3. By February 28, 2017: Napa County will review and revise, if necessary, the current Assessment forms to ensure that all required elements are noted as "required" before staff can final approve their document in the EHR.

4. Ongoing: Quarterly program-specific trainings will continue to be provided by the UR Coordinator throughout the year to ensure that documentation requirements are reviewed, understood and processed in depth. Specifically, topics covered during these trainings include but are not limited to: Reviewing recent causes of documentation disallowance, reiterating the importance of ensuring progress notes include all necessary information in order to meet medical necessity; ensuring clinical documentation (Assessments, client plans, progress notes) is completed in a timely manner/problem solving when there are roadblocks to timely documentation; ensuring WRPs include all of the necessary requirements (Specific, measurable and/or observable objectives) and a description of the interventions to be utilized to support clients with meeting their goals. During these trainings (and at any time outside of these trainings) staff are given the opportunity to check in about pressing documentation questions.

5. By March 31, 2017: The section of the Napa County Documentation Manual that outlines the required elements of Assessments will be changed to bold type and the manual will be republished on the Napa County intranet.

FINDING 3a:

The provider did not obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication.

There was no documentation in the medical record of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent:

PLAN OF CORRECTION 3a:

The MHP shall submit a POC that indicates how the MHP will ensure that:

1) A written medication consent form is obtained and retained for each medication prescribed and administered under the direction of the MHP.
2) Written medication consent forms are completed in accordance with the MHP's written documentation standards.

-To ensure a written medication form is obtained and retained for each medication prescribed and administered under the direction of the MHP and to ensure Written medication consent forms are completed in accordance with the MHP's written documentation standards Napa County will be taking the following steps:

1. In process and to be completed by March 31, 2017: Medication Clinic staff will receive training specifically related to the completion of Medication Consents to ensure they are completed in compliance with State and program standards and to ensure that they are signed appropriately and that it is clearly documented when a client is unavailable or refuses to sign the form.

2. By March 31, 2017 the Medication Clinic manual will be updated to include clear guidelines regarding Medication Consents and the process for obtaining them and accurately completing them.

3. By March 31, 2017 electronic Medication Consent Forms will be completed in the EHR and quarterly audits will be conducted to confirm consents are in place for each medication prescribed.

4. In process and to be implemented by June 30, 2017, a Physician Peer Review process has been initiated and checking for presences of required consents will be added to the review checklist.

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:

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.

-In order to ensure that future medication consents include all of the required elements Napa County has taken the following steps:

1. In process and to be completed by March 31, 2017: Napa County's Psychiatric Medical director has revised the Medication Consent forms used by the Medication Clinic and the forms include all required elements specified in the MHP Contract with the Department and these forms will be made available to staff via the Electronic Health Record.
2. In process and to be completed by March 31, 2017: Medication Clinic staff will receive training specifically related to the completion of Medication Consents to ensure they are completed in compliance with State and program standards and to ensure that they are signed appropriately and that it is clearly documented when a client is unavailable or refuses to sign the form.
3. By March 31, 2017: Electronic Medication Consents forms will be completed in the EHR and quarterly audits will be conducted to confirm consents are in place for each medication prescribed.
4. In process and to be implemented by June 30, 2017: A Physician Peer Review process has been initiated and checking for presences of required Medication Consents will be added to the review checklist.
5. On January 4, 2017: All applicable external providers were noticed of the requirements of Medication Consent forms and by March 31, 2017 these providers shall submit proof to Napa County that their forms have been updated to reflect all of the required elements (if their forms require updating).

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):

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 claimed outside of the audit review period for which no client plan was in effect are disallowed.

-To 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 Napa County has and will be taking the following steps:

1. Completed August 2016: A complete overhaul of our monthly auditing system was implemented and the chart review process now supports a holistic chart review that uses a review tool that is directly based upon the most current DHCS chart audit protocols. The newly implemented process also increases supervisory involvement with the review and findings process and supports continued understanding of documentation requirements. A chart from every program is reviewed each month and direct feedback is provided to program supervisors and staff so that the results can be processed in supervision as well as during staff meetings a means to continue dialogue about documentation requirements.

2. Completed October 2016: Four hour Annual Compliance Training was provided to all mental health staff and two of the total four hours of this year's presentation covered updates made to the Napa County Documentation Manual, DHCS Final Audit Report results, and reasons for recoupment and how to address them moving forward. Specifically, staff were given instruction regarding writing effective progress notes and Assessments that meet

medical necessity and creating Wellness and Recovery Plans (Client Plans) that meet all documentation requirements including but not limited to ensuring client plan objectives are specific, measurable and/or observable; making sure client plan clinical interventions are noted clearly, ensuring that client plans are completed on time. The revised Documentation Manual was published on October 31, 2016 and provides additional guidance for staff on how to meet documentation requirements of Napa County and the Department of Healthcare Services. The documentation manual contains information including but not limited to the following: General Flow of Service Delivery, Medical Necessity, Assessments/Re-Assessments, Diagnosis Review Forms, Wellness and Recovery Plans (Client Plans), Progress Notes, Discharge/Termination and appendices that include but are not limited to reasons for recoupment, audit standards, Language Line instructions and the most recent DHCS included diagnosis crosswalk.

3. Ongoing: Quarterly program-specific trainings will continue to be provided by the UR Coordinator throughout the year to ensure that documentation requirements are reviewed, understood and processed in depth. Specifically, topics covered during these trainings include but are not limited to: Reviewing recent causes of documentation disallowance, reiterating the importance of ensuring progress notes include all necessary information in order to meet medical necessity; ensuring clinical documentation (Assessments, client plans, progress notes) is completed in a timely manner/problem solving when there are roadblocks to timely documentation; ensuring WRPs include all of the necessary requirements (Specific, measurable and/or observable objectives) and a description of the interventions to be utilized to support clients with meeting their goals. During these trainings (and at any time outside of these trainings) staff are given the opportunity to check in about pressing documentation questions.

4. [4] were explored in depth as they were both noted as having a lapse between the prior and current client plans that occurred outside of the audit review period. [5] services identified that occurred during the time that no valid plan was

[4] Line number(s) removed for confidentiality
[5] Line number(s) removed for confidentiality

in place and so these services were disallowed (See enclosed evidence of write off). Upon further exploration, [6] did not appear to have any treatment plan gaps and so no services were disallowed.

FINDING 4b:

The following Line numbers had client plans that did not include all of the items specified in the MHP Contract with the Department:

PLAN OF CORRECTION 4b:

The MHP shall submit a POC that indicates how the MHP will ensure that:

(4b-l.) All 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.

(4b-2.) All mental health interventions/modalities proposed on client plans include a detailed description of the interventions to be provided and do not just identify a type or modality of service (e.g. "therapy", "medication", "case management", etc.).

(4b-3, 4b-4.) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.

(4b-5.) All mental health interventions/modalities proposed on client plans address the mental health needs and identified functional impairments of the beneficiary as a result of the mental disorder.

(4b-6.) All mental health interventions proposed on client plans are consistent with client plan goals/treatment

[6] Line number(s) removed for confidentiality

objectives.

-To ensure that client plan include all of the items specified in the MHP Contract with the Department Napa County has and will be taking the following steps:

1. Completed August 2016: A complete overhaul of our monthly auditing system was implemented and the chart review process now supports a holistic chart review that uses a review tool that is directly based upon the most current DHCS chart audit protocols. The newly implemented process also increases supervisory involvement with the review and findings process and supports continued understanding of documentation requirements. A chart from every program is reviewed each month and direct feedback is provided to program supervisors and staff so that the results can be processed in supervision as well as during staff meetings a means to continue dialogue about documentation requirements.

2. Completed October 2016: Four hour Annual Compliance Training was provided to all mental health staff and two of the total four hours of this year's presentation covered updates made to the Napa County Documentation Manual, DHCS Final Audit Report results, and reasons for recoupment and how to address them moving forward. Specifically, staff were given instruction regarding writing effective progress notes and Assessments that meet medical necessity and creating Wellness and Recovery Plans (Client Plans) that meet all documentation requirements including but not limited to ensuring client plan objectives are specific, measurable and/or observable; making sure client plan clinical interventions are noted clearly, ensuring that client plans are completed on time. The revised Documentation Manual was published on October 31, 2016 and provides additional guidance for staff on how to meet documentation requirements of Napa County and the Department of Healthcare Services. The documentation manual contains information including but not limited to the following: General Flow of Service Delivery, Medical Necessity, Assessments/Re-Assessments, Diagnosis Review Forms, Wellness and Recovery Plans (Client Plans), Progress Notes, Discharge/Termination and appendices that include but are not limited to reasons for recoupment, audit standards, Language Line instructions and the most recent DHCS included diagnosis crosswalk.

3. Ongoing: Quarterly program-specific trainings will continue to be provided by the UR Coordinator throughout the year to ensure that documentation requirements are reviewed, understood and processed in depth. Specifically, topics covered during these trainings include but are not limited to: Reviewing recent causes of documentation disallowance, reiterating the importance of ensuring progress notes include all necessary information in order to meet medical necessity; ensuring clinical documentation (Assessments, client plans, progress notes) is completed in a timely manner/problem solving when there are roadblocks to timely documentation; ensuring WRPs include all of the necessary requirements (Specific, measurable and/or observable objectives) and a description of the interventions to be utilized to support clients with meeting their goals. During these trainings (and at any time outside of these trainings) staff are given the opportunity to check in about pressing documentation questions.

FINDING 4e:

There was no documentation that the beneficiary or legal guardian was offered a copy of the client plan.

PLAN OF CORRECTION 4e:

The MHP shall submit a POC that indicates how the MHP will:

1. Ensure that there is documentation substantiating that the beneficiary was offered a copy of the client plan.

2. Submit evidence that the MHP has an established process to ensure that the beneficiary is offered a copy of the client plan.

-To ensure that there is documentation substantiating that the beneficiary was offered a copy of the client plan Napa County has and will be taking the following steps:

1. Completed August 2016: A complete overhaul of our monthly auditing system was implemented and the chart review process now supports a holistic chart review that uses a review tool that is directly based upon the most current DHCS chart audit protocols. The newly implemented process also increases supervisory

involvement with the review and findings process and supports continued understanding of documentation requirements. A chart from every program is reviewed each month and direct feedback is provided to program supervisors and staff so that the results can be processed in supervision as well as during staff meetings a means to continue dialogue about documentation requirements.

2. Completed October 2016: Four hour Annual Compliance Training was provided to all mental health staff and two of the total four hours of this year's presentation covered updates made to the Napa County Documentation Manual, DHCS Final Audit Report results, and reasons for recoupment and how to address them moving forward. Specifically, staff were given instruction regarding writing effective progress notes and Assessments that meet medical necessity and creating Wellness and Recovery Plans (Client Plans) that meet all documentation requirements including but not limited to ensuring client plan objectives are specific, measurable and/or observable; making sure client plan clinical interventions are noted clearly, ensuring that client plans are completed on time. The revised Documentation Manual was published on October 31, 2016 and provides additional guidance for staff on how to meet documentation requirements of Napa County and the Department of Healthcare Services. The documentation manual contains information including but not limited to the following: General Flow of Service Delivery, Medical Necessity, Assessments/Re-Assessments, Diagnosis Review Forms, Wellness and Recovery Plans (Client Plans), Progress Notes, Discharge/Termination and appendices that include but are not limited to reasons for recoupment, audit standards, Language Line instructions and the most recent DHCS included diagnosis crosswalk.

3. Ongoing: Quarterly program-specific trainings will continue to be provided by the UR Coordinator throughout the year to ensure that documentation requirements are reviewed, understood and processed in depth. Specifically, topics covered during these trainings include but are not limited to: Reviewing recent causes of documentation disallowance, reiterating the importance of ensuring progress notes include all necessary information in order to meet medical necessity; ensuring clinical documentation (Assessments, client plans, progress notes) is completed in a timely manner/problem solving when there are roadblocks to timely documentation; ensuring WRPs include all of the necessary requirements (Specific, measurable and/or

observable objectives) and a description of the interventions to be utilized to support clients with meeting their goals. During these trainings (and at any time outside of these trainings) staff are given the opportunity to check in about pressing documentation questions.

4. Beginning February 28, 2017 Napa County will begin quarterly auditing of a sample of treatment plans to confirm informational notes are written to document that a copy of the treatment plan was offered to the beneficiary.

5. Note: The current version of the Napa County Documentation Manual includes the following information regarding documenting that a copy of the WRP was offered: “Documenting Offer of Copy of WRP: Staff is required to offer a copy of the WRP to the client and/or responsible part and document this through an Information Note using the subject ‘MH Copy WRP Offered to Client’. This Information Note is required upon creation of the initial WRP, and for all major revisions of WRP’s.

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

Sa-1) [7]: 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

[7] Line number(s) removed for confidentiality

during the audit period).

PLAN OF CORRECTION 5a:

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

Sa-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.
-To ensure timely completion of written documentation Napa county has been and will take the following steps:

1. Completed August 2016: A complete overhaul of our monthly auditing system was implemented and the chart review process now supports a holistic chart review that uses a review tool that is directly based upon the most current DHCS chart audit protocols. The newly implemented process also increases supervisory involvement with the review and findings process and supports continued understanding of documentation requirements. A chart from every program is reviewed each month and direct feedback is provided to program supervisors and staff so that the results can be processed in supervision as well as during staff meetings a means to continue dialogue about documentation requirements.

2. Completed October 2016: Four hour Annual Compliance Training was provided to all mental health staff and two of the total four hours of this year's presentation covered updates made to the Napa County Documentation Manual, DHCS Final Audit Report results, and reasons for recoupment and how to address them moving forward. Specifically, staff were given instruction regarding writing effective progress notes and Assessments that meet medical necessity and creating Wellness and Recovery Plans (Client Plans) that meet all documentation requirements including but not limited to ensuring client plan objectives are specific, measurable and/or observable;

making sure client plan clinical interventions are noted clearly, ensuring that client plans are completed on time. The revised Documentation Manual was published on October 31, 2016 and provides additional guidance for staff on how to meet documentation requirements of Napa County and the Department of Healthcare Services. The documentation manual contains information including but not limited to the following: General Flow of Service Delivery, Medical Necessity, Assessments/Re-Assessments, Diagnosis Review Forms, Wellness and Recovery Plans (Client Plans), Progress Notes, Discharge/Termination and appendices that include but are not limited to reasons for recoupment, audit standards, Language Line instructions and the most recent DHCS included diagnosis crosswalk.

3. Ongoing: Quarterly program-specific trainings will continue to be provided by the UR Coordinator throughout the year to ensure that documentation requirements are reviewed, understood and processed in depth. Specifically, topics covered during these trainings include but are not limited to: Reviewing recent causes of documentation disallowance, reiterating the importance of ensuring progress notes include all necessary information in order to meet medical necessity; ensuring clinical documentation (Assessments, client plans, progress notes) is completed in a timely manner/problem solving when there are roadblocks to timely documentation; ensuring WRPs include all of the necessary requirements (Specific, measurable and/or observable objectives) and a description of the interventions to be utilized to support clients with meeting their goals. During these trainings (and at any time outside of these trainings) staff is given the opportunity to check in about pressing documentation questions.

4. Ongoing: Quarterly (at least) use of “Timeliness of Service Entry” reports from the Electronic Health Record so that supervisors can track timeliness of progress note completion and process barriers to timely completion during supervision. See enclosed for example of a Timeliness of Service Entry report.

FINDING 5a3:

The following Line number had documentation indicating a Specialty Mental Health Service was provided while

the beneficiary resided in a setting that was ineligible for Federal Financial Participation or resided in a setting subject to lockouts:

PLAN OF CORRECTION 5a3:

The MHP shall submit a POC that indicates how the MHP will ensure that services claimed were provided in a setting where the beneficiary was eligible for FFP or not subject to lockouts.

-To ensure that services claimed were provided in a setting where the beneficiary was eligible for FFP or not subject to lockouts Napa County will take the following steps:

1. Completed December 23, 2016 all applicable external providers were given clarifying feedback via email with regard to ensuring that services are not claimed in a lockout setting.

2. By March 31, 2017: Billing controls will be put into place in the Electronic Health Record (EHR) to assist with identifying whether concurrent services were submitted on the same day as Day Treatment services so they can be written off/not claimed.

FINDING 5c:

Documentation in the medical record did not meet the following requirements:

- [8]: There was no progress note in the medical record for the service claimed. RR9, refer to Recoupment Summary for details.

  During the review, the MHP staff was given the opportunity to locate the documents in question but could not find written evidence of them in the medical record.
- [9]: The type of specialty mental health service (SMHS) documented on the progress note was not the same type of SMHS claimed. RR9, refer to Recoupment Summary for details.

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[8] Line number(s) removed for confidentiality
[9] Line number(s) removed for confidentiality

PLAN OF CORRECTION 5c:

The MHP shall submit a POC that indicates how the MHP will:

1) Ensure that all specialty mental health services (SMHS) claimed are:
   a. Documented in the medical record.
   b. Claimed for the correct service modality and billing code.
2) Ensure that all progress notes are:
   a) Accurate and meet the documentation requirements described in the MHP Contract with the Department.
   b) Completed within the timeline and frequency specified in the MHP Contract with the Department.

-Napa County will take the following steps to ensure that that all specialty mental health services (SMHS) claimed are

a. Documented in the medical record.
b. Claimed for the correct service modality and billing code.

and to ensure that all progress notes are:

c) Accurate and meet the documentation requirements described in the MHP Contract with the Department.
d) Completed within the timeline and frequency specified in the MHP Contract with the Department:

1. Completed December 23, 2016 all applicable external providers were given clarifying feedback with regard to ensuring that all services claimed have a progress note present in the beneficiary chart.

2. Completed August 2016: A complete overhaul of our monthly auditing system was implemented and the chart review process now supports a holistic chart review that uses a review tool that is directly based upon the most current DHCS chart audit protocols. The newly implemented process also increases supervisory

involvement with the review and findings process and supports continued understanding of documentation requirements. A chart from every program is reviewed each month and direct feedback is provided to program supervisors and staff so that the results can be processed in supervision as well as during staff meetings a means to continue dialogue about documentation requirements.

3. Completed October 2016: Four hour Annual Compliance Training was provided to all mental health staff and two of the total four hours of this year's presentation covered updates made to the Napa County Documentation Manual, DHCS Final Audit Report results, and reasons for recoupment and how to address them moving forward. Specifically, staff were given instruction regarding writing effective progress notes and Assessments that meet medical necessity and creating Wellness and Recovery Plans (Client Plans) that meet all documentation requirements including but not limited to ensuring client plan objectives are specific, measurable and/or observable; making sure client plan clinical interventions are noted clearly, ensuring that client plans are completed on time. The revised Documentation Manual was published on October 31, 2016 and provides additional guidance for staff on how to meet documentation requirements of Napa County and the Department of Healthcare Services. The documentation manual contains information including but not limited to the following: General Flow of Service Delivery, Medical Necessity, Assessments/Re-Assessments, Diagnosis Review Forms, Wellness and Recovery Plans (Client Plans), Progress Notes, Discharge/Termination and appendices that include but are not limited to reasons for recoupment, audit standards, Language Line instructions and the most recent DHCS included diagnosis crosswalk.

4. Ongoing: Quarterly program-specific trainings will continue to be provided by the UR Coordinator throughout the year to ensure that documentation requirements are reviewed, understood and processed in depth. Specifically, topics covered during these trainings include but are not limited to: Reviewing recent causes of documentation disallowance, reiterating the importance of ensuring progress notes include all necessary information in order to meet medical necessity; ensuring clinical documentation (Assessments, client plans, progress notes) is completed in a timely manner/problem solving when there are roadblocks to timely documentation; ensuring WRPs include all of the necessary requirements (Specific, measurable and/or observable objectives) and a description of the

interventions to be utilized to support clients with meeting their goals. During these trainings (and at any time outside of these trainings) staff is given the opportunity to check in about pressing documentation questions.

5. Ongoing: Napa County is moving toward integrating external providers into our Electronic Health Record (EHR) and controls are in place in the EHR to prevent billing without a progress note. By July 31, 2017 Napa County will likely have at least 2 additional external providers integrated into our EHR which will assist with ensuring all claims have a corresponding progress note.