Humboldt County Department of Health and Human Services
Fiscal Year (FY) 2019-2020 Specialty Mental Health Triennial Review
Corrective Action Plan

System Review

Requirement

The MHP shall meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services. (Fed. Code Regs, tit. 42, § 438, subd. 206(c)(1)(i).)

DHCS Finding

A1 [A.I.E] - The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i). The MHP must meet, and require its providers to meet, Department standards for timely access to care and services, taking into account the urgency of need for services.

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

• Service Request Log

• 0704.520 Network Adequacy

• Timeliness Report FY 19-20

• Network Adequacy Remediation Tool

• QRO Timely access report

While the MHP submitted evidence to demonstrate compliance with this requirement, 6 of the 400 service requests on the Service Request Log exceeded the timeline. The Service Request Log also indicates the MHP does not meet timely access standards for the routine psychiatric appointments and urgent appointments. In addition to the evidence submitted by the MHP, DHCS reviewed the most recent Network Adequacy Remediation Tool. The MHP was out of compliance on timely access.

DHCS deems the MHP out of compliance with Federal Code of Regulations, title 42, section 438, subdivision 206(c)(1)(i). The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

Previously, the urgency of requests for access to care and services was documented by clerical Reception staff based on the beneficiary's self-report. Clinical staff would then

follow up within one hour to determine acuity and offer an appointment. This procedure caused many non-urgent requests that were initially classified as urgent. In order to more effectively document the urgency of requests, the MHP will implement a procedure and system update to make documenting the urgency of requests a clinical decision. Acuity will still be determined by a licensed clinician, rather than Reception staff, but now the clinician will document the acuity in the Request for Access to Services (RAS) Log. The RAS Log will be also updated to provide more nuanced selection options for initial disposition. This will ensure the RAS Log will accurately reflect the urgent acuity of each client's request for access, and that truly urgent requests are responded to in compliance with timeliness requirements. See attachments A1.1 through A1.8, QI Bulletin 20-Q023 RAS Log Updates - Urgent Requests [draft] and associated policies.

Adult Behavioral Health psychiatry appointments have been in compliance with timeliness requirements for the past five fiscal years, as evidenced on the annual EQRO timeliness self-assessments, but Children's Behavioral Health psychiatry appointments are less consistent. Children's psychiatry appointments have been in compliance for the last two quarters.

The MHP would like to note that the most recent NACT Findings Report, following the April 2020 submission, resulted in a passing grade for the Timely Access standard. See attachment A1.9, Humboldt_MHP_NACT_FindingsReport_FY20.21 -p4 timely access pass.

1. Secure Behavioral Health Director approval for the updated policy and procedures approved by the Policy & Procedure Committee in December 2020.

2. Give Information Services the go-ahead to implement the planned changes to the RAS Log.

3. Release draft bulletin 20-Q023 announcing the changes to all staff.

4. Train staff to utilize the new procedure and RAS Log options.

Implementation is expected to be completed by the end of December 2020.

Proposed Evidence/Documentation of Correction

Attachments:

A1.1, 20-Q023 RAS Log Updates - Urgent Requests [draft]

A1.2, 0100.600 Request for Access to Mental Health Services policy 12-9-19

A1.3, 0100.600 Request for Access to Mental Health Services policy -superseded 2019-12-9

A1.4, 0100.600 Request for Access to Mental Health Services policy -superseded 2018-12-20

A1.5, 0100.601 Emergency Psychiatric Conditions - Request for Treatment 12-30-19

A1.6, 0100.601 Emergency Psychiatric Conditions - Request for Treatment -superseded 2019-12-30

A1.7, 0100.602 Urgent Psychiatric Conditions - Request for Treatment 2-6-20

A1.8, 0100.602 Urgent Psychiatric Conditions - Request for Treatment -superseded 2020-2-6

A1.9, Humboldt_MHP_NACert_FindingsReport_FY20-21 -p4 timely access pass

A1.10, OP CQI Agenda Tracking

A1.11, OP CQI Agenda 2020-11-25

A1.12, OP CQI Draft Minutes 2020-11-25

A1.13, Timeliness Report FY 20-21 Q1

Ongoing Monitoring

A timeliness report is reviewed by the MHP's Continuous Quality Improvement (OP CQI) Committee quarterly in August, November, February, and May. Timeliness data is also reported annually at CAEQRO on the timeliness self-assessment tool. See attachments A1.10, OP CQI Agenda Tracking; A1.11 OP CQI Agenda 2020-11-25; A1.12, OP CQI Draft Minutes 2020-11-25; and A1.13, Timeliness Report FY 20-21 Q1.

Person Responsible (job title)

QI Administrative Analyst

Implementation Timeline: 12/31/2020

Requirement

The MHP is required to cover acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older. (MHSUDS IN No. 18-008; Cal. W&I Code §14053, subd. (a) and (b)(3); Fed. Code of Regs, tit. 42, § 1396, subd. d(a)(29)(B), (a)(16) & (h)(1)(c); Fed. Code of Regs, tit. 42, § 441, subd.13 and §435, subd.1009)

DHCS Finding

A2 [A.IV.B] - The MHP did not furnish evidence to demonstrate compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-008, California Welfare and Institutions Code, section 14053, subdivision (a) and (b)(3), and Federal Code of Regulations, title 42, section 1396, subdivision d(a)(29)(B), (a)(16), (h)(1)(c), and Federal Code of Regulations, title 42, section 441.subdivision 13 and

section 435, subdivision 1009. The MHP must cover acute psychiatric inpatient hospital services provided in an Institution for Mental Disease (IMD) to Medi-Cal beneficiaries under the age of 21, or 65 years or older.

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

• Realignment 1991 (allocation document)

• General Fiscal Policies of DHHS

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP uses 1991 Realignment funding to cover acute psychiatric inpatient hospital services provided in an IMD to beneficiaries under the age of 21, or 65 years or older. The evidence does not distinguish beneficiaries under the age of 21, or 65 years or older.

DHCS deems the MHP out of compliance with Mental Health and Substance Use Disorder Services, Information Notice, No. 18-008, California Welfare and Institutions Code, section 14053, subdivision (a) and (b)(3), and Federal Code of Regulations, title 42, section 1396, subdivision d(a)(29)(B), (a)(16), (h)(1)(c), and Federal Code of Regulations, title 42, section 441, subdivision 13, and section 435, subdivision 1009. The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

Create a policy and procedure to formalize the MHP's current business practice for IMD exception and use of 1991 realignment funds.

1. Continue to meet the MHP's fiscal responsibility to cover acute psychiatric inpatient hospital services provided in an IMD to beneficiaries under the age of 21, or 65 years and older.

2. Create a policy and procedure to formalize the current business practice for IMD exception and use of 1991 realignment funds.

3. Implement a procedure for QI staff to better document IMD exceptions in the Treatment Authorization Request (TAR) ELog.

Proposed Evidence/Documentation of Correction

The MHP reviewed Treatment Authorization Requests (TARs) for Fiscal Years 2017-2018, 2018-2019, 2019-2020 and 2020-2021 to date, and found only one case in which a beneficiary under the age of 21 or 65 years or older received acute psychiatric inpatient hospital services in an IMD. The MHP confirmed with the Humboldt County DHHS Fiscal Department that this claim was processed as a Short-Doyle Inpatient stay to pay for the services rendered in this case. See attachments:

A2.2, IMD Exclusion Case

A2.3, Evidence of paid claim to John Muir BH

To review the draft policy and procedure formalizing the MHP's current IMD exclusion business practice, see attachment A2.1, 0100.XXX IMD Exception and Use of 1991 Realignment Funds [draft]. This draft policy is pending review and approval by the MHP's Policy and Procedure Committee, after which a policy number will be issued.

Ongoing Monitoring

Incoming TARs are logged in the TAR Elog. The Elog includes a "payor" column, which is completed for each TAR. The drop-down options in the payor column include "IMD Exclusion." In cases where a beneficiary under the age of 21, or 65 years and older, is hospitalized in an IMD, this option is selected and the TAR is processed with 1991 Realignment funding rather than Medi-Cal funding. See attachment A2.4, TAR ELog IMD Exception Tracking. The TAR ELog is reviewed monthly for quality control.

Person Responsible (job title)

QI Administrative Analyst

Implementation Timeline: 2/1/2021

Requirement

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

DHCS Finding

A3 [A.III.G] - The MHP did not furnish evidence to demonstrate compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must have an affirmative responsibility to determine if children and youth who meet medical necessity criteria need TFC.

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

• Policy and Procedure 09-55 Family TFC

• Policy and Procedure 1001.204 Katie A. Subclass Identification and Tracking

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has a process to determine the need for Therapeutic Foster Care. Furthermore, during the review the MHP stated that it is not currently assessing for TFC.

DHCS deems the MHP out of compliance with the Medi-Cal Manual for Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018. The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

Have a process for regular screening and referral to TFC for eligible SMHS recipients in place.

1. Develop a TFC Policy and Procedure.

2. Develop a TFC screening/referral form to support staff in screening and referral for TFC services.

3. Add TFC screening questions to the 1238 Youth Behavioral Health Assessment to support affirmative screening of all clients.

Collaborate with organizational provider Redwood Community Services to support completion of policies, screening/referral process, and hiring and training TFC providers.

Proposed Evidence/Documentation of Correction

See attachment A3.1, policy 1001.XXX Therapeutic Foster Care [draft]. Once all steps are completed, proof of correction will include: approved policies, screening/referral form, revised form 1238 Youth Behavioral Health Assessment with TFC screening questions, and Redwood Community Services records documenting the hiring and training of TFC providers.

Ongoing Monitoring

Monthly meetings with Redwood Community Services and other partners.

Once the services are in place, a report will be developed and presented quarterly at the OP CQI Committee. The report will capture the number of referrals and monitor quality metrics.

Person Responsible (job title)

Senior Program Manager, Children's Behavioral Health

Implementation Timeline: Hiring and training TFC providers has been slowed by COVID-19. Completion would ideally be July 1, 2021, but is pending the lowering of current Shelter-in-Place restrictions.

Requirement

The MHP shall comply with the provisions of the MHP's Implementation Plan as approved by the Department. (MHP contract, Ex. A, Att. 1; Cal. Code Regs., tit. 9, § 1810, subd.310)

The Implementation Plan shall include: A description of the processes for problem resolution.

DHCS Finding

A4 [A.VII.A.3] - The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 1, and California Code of Regulations, title 9, section 1810, subdivision 310. The MHP must comply with the provisions of the MHP's Implementation Plan as approved by the Department.

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

• Humboldt County Current Implementation Plan-February 16, 2017

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP has updated its' Implementation Plan to include current problem resolution policies and procedures.

DHCS deems the MHP out of compliance with the MHP contract, exhibit A, attachment 1, and California Code of Regulations, title 9, section 1810, subdivision 310. The MHP must complete a CAP addressing this finding of non-compliance.

Corrective Action Description

Amend the Implementation Plan

1. Create an amendment to the Implementation Plan to update the Client Problem Resolution Process section (G1).

2. Obtain DHCS approval for this draft language in accordance with regulation (i.e. to obtain written approval by DHCS prior to making any changes to the Implementation Plan).

3. Update the Implementation Plan with the new language once approved by DHCS.

Proposed Evidence/Documentation of Correction

See attachment A4.1, Implementation Plan Amendment - Section G1 update [draft].

Ongoing Monitoring

Review Implementation Plan bi-annually for any necessary updates.

Person Responsible (job title)

QI Program Manager

Implementation Timeline: 6/30/2021

Requirement

Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: (Cal. Code Regs., tit. 9, chap. 11, § 1810, subd.405(d) and 410(e)(1).)

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

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

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

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

DHCS Finding

D1 [D.VI.B] - DHCS' review team made seven (7) calls to test the MHP's statewide 24/7 toll-free number. The seven (7) test calls must demonstrate compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). Each MHP must 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, that will provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes. The seven (7) test calls are summarized below.

Required elements: 1 - 50% (n=2); 2 - 75% (n=5); 3 - 60% (n=5); 4 - 50% (n=2)
NOTE: #2 SHOULD BE 80%, NOT 75%; APPEAL WAS APPROVED BY DHCS

Based on the test calls, DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1). The MHP must complete a CAP addressing this finding of partial compliance. This is a repeated deficiency identified in the previous triennial review.

Corrective Action Description

The MHP had identified 24/7 access line test call compliance of 80% or better as a QI Work Plan goal in FYs 18-19 and 19-20, and has carried the goal forward to the QI Work Plan for FY 20-21. Due to continued failure to reach this goal, the MHP

implemented innovative staff training and test call feedback approaches starting in November 2019. The MHP has noted that Triennial Audit test calls occurred in October-December 2019, before and during the implementation of this training. MHP internal test calls conducted since December 2019 show a steady upward trend towards reaching the compliance goal, and the MHP anticipates the goal will be reached in FY 20-21 with current interventions in place.

1. Continue to provide increased training implemented in November 2019 (meetings with staff and supervisors, in vivo practice calls, revised flow charts and checklists, and sharing performance metrics with line staff quarterly).

2. Continue to provide individualized feedback and education to staff and supervisors after each test call.

3. Complete a Plan-Do-Study-Act (PDSA) cycle if goal is unmet for two consecutive quarters.

Lacuna Health is a subcontracted answering service for after hours Access Line calls.

1. Continue to utilize revised call script.

2. Continue to provide individualized feedback and education to staff and supervisors after each test call.

3. Complete a Plan-Do-Study-Act (PDSA) cycle if goal is unmet for two consecutive quarters.

Proposed Evidence/Documentation of Correction

In November 2019, QI met with all staff who answer the access line to discuss required criteria for access line calls, current test call performance, and training needs. Based on staff feedback in these meetings, QI distributed a revised access line flow chart training tool. QI also conducted additional training with Reception staff via in vivo practice calls. See attachments D1.1, Access Line Flow Chart - Reception Staff and D1.2, Access Line Flow Chart - Crisis Staff.

Based on additional training needs for CSU staff who answer after hours access line calls, QI and CSU leadership met in November 2019, December 2019, and January 2020. QI and CSU leadership developed an access line checklist that could be kept by the phone, used to easily document whether required criteria were met during a call, and stored for later data entry into the Request for Access to Services (RAS) Log during times when CSU was too busy to complete immediate data entry. CSU leadership created a comprehensive training binder containing the access line checklist, access line flow chart, and test call reports for staff reference. CSU leadership conducted one-on-one training with staff on the unit in winter 2019/2020, and continued providing this training to all new staff joining the unit. See attachment D1.3, CSU Access Line Checklist.

In January 2020, QI provided New Connections Answering Services with a revised script for after-hours access line calls. In April 2020, New Connections Answering Services came under the new ownership of Lacuna Health. QI staff met virtually with new and returning leadership and supervisory staff at Lacuna Health to discuss access line goals and review performance. After hours test calls conducted in June and July 2020 showed issues continued to recur.

In August 2020, Lacuna Health and QI collaborated to redesign the access line script for after-hours calls. This script was revised to simplify and streamline the call process, specifically addressing the key points where after hours calls failed to meet required guidelines. See attachment D1.4 Lacuna Health Answering Service Access Line Script.

The overall test call compliance rate has increased steadily since FY 17-18, and in FY 20-21 Q1 performance exceeded the performance goal of 80%. See attachment D1.6, Access Line Test Call Summary FY 20-21 Q1.

Overall compliance rate FY 17-18: 59%

Overall compliance rate FY 18-19: 65%

Overall compliance rate FY 19-20: 75%

Overall compliance rate FY 20-21 Q1: 86%

Ongoing Monitoring

The MHP will conduct an increased number of test calls per month (five test calls monthly, rather than the previous goal of three test calls per month), and will continue to report the results of the test calls to DHCS on a quarterly basis, and internally to the OP CQI Committee quarterly in January 2021, April 2021, July 2021, and September 2021. See attachments D1.7, D1.8, and D1.9 for OP CQI agenda tracking, example agenda, and example minutes.

Person Responsible (job title)

QI Administrative Analyst

Implementation Timeline: 6/30/2021

Requirement

The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. (Cal. Code Regs., tit. 9, chap. 11, §1810, subd.405(f)). The written log(s) contain the following required elements:

Name of the beneficiary.

Date of the request.

Initial disposition of the request.

DHCS Finding

D2 [D.VI.C.1-2] - The MHP did not furnish evidence to demonstrate compliance with California Code for Regulations, title 9, chapter 11, section 1810, subdivision 405(f). The MHP must maintain a written log(s) of initial requests for SMHS that includes requests made by phone, in person, or in writing. The written log(s) must contain name of the beneficiary, date of the request, and initial disposition of the request.

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

• 24-7 Access Line Call Log

• RAS Log

While the MHP submitted evidence to demonstrate compliance with this requirement, three of five required DHCS test calls were not logged on the MHP's written log of initial request. The table in the original findings report summarizes DHCS' findings pertaining to its test calls: N=5, 3 OOC, 2 IN. Compliance percentage for all three criteria: name of beneficiary= 40%; Date of request = 40%; Initial Disposition of Request = 40%.

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

DHCS deems the MHP in partial compliance with California Code of Regulations, title 9, section 1810, subdivision 405(f). The MHP must complete a CAP addressing this finding of out of compliance. This is a repeated deficiency identified in the previous triennial review.

Corrective Action Description

The MHP had identified overall 24/7 Access Line test call compliance of 80% or better as a QI Work Plan goal in FYs 18-19 and 19-20, and has carried the goal forward to the QI Work Plan for FY 20-21. Due to continued failure to reach this goal, the MHP implemented innovative staff training and test call feedback approaches starting in November 2019. The MHP has noted that Triennial Audit test calls occurred in October-December 2019, before and during the initial implementation of this training. MHP internal test calls conducted since December 2019 show a steady upward trend towards reaching the compliance goal, and the MHP anticipates the goal will be reached in FY 20-21 with current interventions in place.

In addition, after reviewing the regulations, the MHP noted that the requirement to maintain a written log of initial requests for SMHS does not include callers with informational questions only. This concern will be shared with DHCS County Supports / county liaison.

1. Continue to provide the increased training implemented in November 2019 (meetings with staff and supervisors, in vivo practice calls, revised flow charts and checklists, and sharing performance metrics with line staff quarterly).

2. Continue to provide individualized feedback and education to staff and supervisors after each test call.

3. Complete a Plan-Do-Study-Act (PDSA) cycle if goal is unmet for two consecutive quarters.

Lacuna Health is a subcontracted answering service for after hours Access Line calls.

1. Continue to utilize revised call script.

2. Continue to provide individualized feedback and education to staff and supervisors after each test call.

3. Complete a Plan-Do-Study-Act (PDSA) cycle if goal is unmet for two consecutive quarters.

Proposed Evidence/Documentation of Correction

In November 2019, QI met with all staff who answer the access line to discuss required criteria for access line calls, current test call performance, and training needs. Based on staff feedback in these meetings, QI distributed a revised access line flow chart training tool. QI also conducted additional training with Reception staff via in vivo practice calls. See attachments D2.1, Access Line Flow Chart - Reception Staff and D2.2, Access Line Flow Chart - Crisis Staff.

Based on additional training needs for CSU staff who answer after hours access line calls, QI and CSU leadership met in November 2019, December 2019, and January 2020. QI and CSU leadership developed an access line checklist that could be kept by the phone, used to easily document whether required criteria were met during a call, and stored for later data entry into the Request for Access to Services (RAS) Log during times when CSU was too busy to complete immediate data entry. CSU leadership created a comprehensive training binder containing the access line checklist, access line flow chart, and test call reports for staff reference. CSU leadership conducted one-on-one training with staff on the unit in winter 2019/2020, and continued providing this training to all new staff joining the unit. See attachment D2.3, CSU Access Line Checklist.

In January 2020, QI provided New Connections Answering Services with a revised script for after-hours access line calls. In April 2020, New Connections Answering Services came under the new ownership of Lacuna Health. QI staff met virtually with new and returning leadership and supervisory staff at Lacuna Health to discuss access line goals and review performance. After hours test calls conducted in June and July 2020 showed issues continued to recur.

In August 2020, Lacuna Health and QI collaborated to redesign the access line script for after-hours calls. This script was revised to simplify and streamline the call process, specifically addressing the key points where after hours calls failed to meet required guidelines. See attachment D2.4 Lacuna Health Answering Service Access Line Script.

The overall test call compliance rate has increased steadily since FY 17-18, and in FY 20-21 Q1 performance exceeded the performance goal of 80%. See attachment D2.6, Access Line Test Call Summary FY 20-21 Q1.

Overall compliance rate FY 17-18: 59%

Overall compliance rate FY 18-19: 65%

Overall compliance rate FY 19-20: 75%

Overall compliance rate FY 20-21 Q1: 86%

Ongoing Monitoring

The MHP will conduct an increased number of test calls per month (five test calls monthly, rather than the previous goal of three test calls per month), and will continue to report the results of the test calls to DHCS on a quarterly basis, and internally to the Outpatient Continuous Quality Improvement Committee quarterly in January 2021, April 2021, July 2021, and September 2021. See attachments D2.7, D2.8, and D2.9 for OP CQI agenda tracking, example agenda, and example minutes.

Person Responsible (job title)

QI Administrative Analyst

Implementation Timeline: 6/30/2021

Requirement

The MHP shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing. (MHP contract, Ex. A, Att. 12; Fed. Code. Regs., tit. 42, § 438, subd.406(b)(1).)

The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance. (MHSUDS., IN., 18-010E)

DHCS Finding

F1 [F.I.E.3] - The MHP did not furnish evidence to demonstrate compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E. The MHP must acknowledge receipt of each

grievance, appeal, and request for expedited appeal of adverse benefit determinations to the beneficiary in writing meeting above listed standards.

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

• Grievance and Appeal Log FY 18-19

• Grievance and Appeal Samples

• 0704.460 Client Problem Resolution Process REVISED 6.17.19

• 0704.460 Client Problem Resolution Process REVISED 2.28.17

• 0704.460 Client Problem Resolution Process REVISED 10.23.17

• 0100.119 Client Problem Resolution Process 11.13.17

• 0704.500 Notice of Adverse Benefit Determination 1.28.19 (Appeal Process)

• 0704.500 Notice of Action 2.1.18

In addition, DHCS reviewed grievance, appeals and expedited appeals samples to verify compliance with this requirement. The sample verification findings are as detailed below:

Grievances: n=38, 37 IN, 1 OOC. Compliance Percentage = 97%

Appeals: n=3, 3 IN, 0 OOC = 100%

Ex. Appeals: n=0, N/A

DHCS deems the MHP in partial compliance with the MHP contract, exhibit A, attachment 12, Federal Code of Regulations, title 42, section 438, subdivision 406(b)(1), and Mental Health and Substance Use Disorder Services, Information Notice, No. 18-010E. The MHP must complete a CAP addressing this finding of partial compliance.

Corrective Action Description

This finding was a rare oversight by QI staff. The MHP's overall compliance rate is 97%, and policies and procedures are in place to ensure compliance with the requirement to acknowledge receipt of each grievance, appeal, and expedited appeal in writing within the required timeframe.

The MHP will continue to send out acknowledgment letters within 5 days of receipt, even if multiple grievances, appeals, and/or expedited appeals are received from the same client with the same manager assigned for investigation and follow-up. QI staff will continue to check the Client Concerns Database each business day to double-check that an acknowledgment letter has been sent for each grievance, appeal, and expedited appeal within the required timeframe.

Contracted organizational providers are held to the same standards as MHP staff. Procedures, including timelines, are outlined in the Organizational Provider Manual. See attachment F2.12 Excerpts from Organizational Provider Manual [draft]. Organizational providers must report grievances and appeals to the MHP's Quality Improvement Coordinator as soon as possible upon receipt of a grievance or appeal. MHP staff coordinates, logs, and tracks all grievances and appeals that involve organizational provider clients.

Proposed Evidence/Documentation of Correction

See attachment F1.1, Client Concerns Database - Acknowledgment Letter Field. This field in the Client Concerns Database is utilized to track when acknowledgement letters are sent. See attachment F1.2, policy 0704.460 Client Problem Resolution Process 11-16-20 and F1.3, Excerpts from Org Provider Manual 2020-2022 [draft].

Ongoing Monitoring

Continue to use the Client Concerns Database to log grievances, appeals, and expedited appeals, and to ensure acknowledgment letters have been sent out within the required 5 day timeframe for each concern.

Person Responsible (job title)

QI Improvement Coordinator

Implementation Timeline: Process is already in place/ongoing.

Requirement

Resolve each grievance as expeditiously as the beneficiary’s health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance. (Fed. Code Regs. tit. 42, § 438, subd. 408(a)-(b)(1).)

DHCS Finding

F2 [F.III.B] - The MHP did not furnish evidence to demonstrate compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1). The MHP must resolve each grievance as expeditiously as the beneficiary’s health condition requires not to exceed 90 calendar days from the day the Contractor receives the grievance

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

• Grievance and Appeal Log FY 18-19

• Grievance and Appeal Samples

• 0704.460 Client Problem Resolution Process REVISED 6.17.19

• 0704.460 Client Problem Resolution Process REVISED 2.28.17

• 0704.460 Client Problem Resolution Process REVISED 10.23.17

• 0100.119 Client Problem Resolution Process 11.13.17

In addition, DHCS reviewed grievances, appeals, and expedited appeal samples to verify compliance with standards. Results of the sample verifications are detailed below:

Grievances: n=38, 36 IN, 2 OOC. Compliance Percentage = 95%

Appeals: n=0, N/A

Ex. Appeals: n=0, N/A

DHCS deems the MHP in partial compliance with Federal Code of Regulations, title 42, section 438, subdivision 408(a)-(b)(1). The MHP must complete a CAP addressing this finding of partial compliance.

Corrective Action Description

QI Staff already track grievances in the Client Concerns Database, and send reminders to program staff as the deadline to resolve a grievance approaches. For this reason, QI Staff already have procedures in place to ensure consistent compliance with this requirement.

The MHP previously assigned Program Managers and Program Supervisors to resolve grievances, including the responsibility to send beneficiaries a form 1045 NOABD - Grievance/Appeal Resolution if resolution was not reached within the 90 day timeframe. The MHP has changed its business practice and policy to make QI Staff responsible to send the NOABD when a grievance is not resolved within 90 days.

1. Update policy 0704.460 Client Problem Resolution Process and policy 0704.500 Notice of Adverse Benefit Determination (NOABD) to state that QI staff will issue NOABD Grievance/Appeal Resolution (form 1045) if a grievance is not resolved within the 90 day timeframe.

2. QI staff will send NOABDs to beneficiaries if a grievance resolution is not reached within 90 days.

3. Continue to track and monitor grievance and appeal resolution timeliness.

4. Continue to provide training on required timelines to staff resolving grievances and appeals.

5. Continue to provide written reminders to staff when grievances are assigned and as due date’s approach, to ensure resolution is reached on time.

Contracted organizational providers are held to the same standards as MHP staff. Procedures, including timelines, are outlined in the Organizational Provider Manual. See

attachment F2.12 Excerpts from Organizational Provider Manual [draft]. Organizational providers must report grievances and appeals to the MHP's Quality Improvement Coordinator as soon as possible upon receipt of a grievance or appeal. MHP staff coordinates, logs, and tracks all grievances and appeals that involve organizational provider clients.

Proposed Evidence/Documentation of Correction

See attachments F2.1 through F2.6 to review the revision history of policy 0704.460 Client Problem Resolution Process. Attachment F2.1 is the current policy, which states in item 5.6.2 that the QIC or designee is responsible to send a NOABD 1045 - Grievance/Appeal Resolution when the MHP fails to act within the required timeframe for disposition of grievances.

See attachments F2.7 through F2.9 to review the revision history of policy 0704.500 Notice of Adverse Benefit Determination (NOABD). Attachment F2.7 is the current policy, which states in item 9.2 that the QIC or designee is responsible to send a NOABD 1045 - Grievance/Appeal Resolution when the MHP fails to act within the required timeframe for disposition of grievances.

Ongoing Monitoring

Continue to use Client Concerns Database to monitor due dates. Attachment F2.10 policy 0704.940 Quality Improvement Tracking Process will be followed to address non-compliance.

When QI discovers a situation or issue that warrants a response and/or a corrective action, attachment F2.11 QI-55 Quality Improvement Tracking Form will be used to track the progress resolving the concern.

Person Responsible (job title)

QI Improvement Coordinator

Implementation Timeline: 11/16/2020

Chart Review

Requirement

The beneficiary must meet medical necessity criteria outlined in subsections (1-3) to be eligible for services. (CCR, title 9, § 1830.205(b).)

1) The beneficiary meets DSM criteria for an included ICD diagnosis for outpatient SMHS in accordance with the MHP contract. (MHSUDS IN Nos., 15-030, 16-016, 16-051, and 17-004E)

The beneficiary must have at least one of the following impairments as a result of the mental disorder or emotional disturbance (listed above in A1):

1. A significant impairment in an important area of functioning.

2. A probability of significant deterioration in an important area of life functioning.

3. A probability that the child will not progress developmentally as individually appropriate

4. 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.

(CCR, title 9, § 1830.205 (b)(2)(A-C).)

The proposed and actual intervention(s) meet the intervention criteria listed below:

b) The focus of the proposed and actual intervention(s) addresses 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 the SMHS can correct or ameliorate per No. 1 (b)(4).

(CCR, title 9, § 1830.205(b) (3)(A).)

c) The expectation is that the proposed and actual intervention(s) will do at least one (1) of the following (A, B, C, or D):

A. Significantly diminish the impairment.

B. Prevent significant deterioration in an important area of life functioning.

C. Allow the child to progress developmentally as individually appropriate.

D. For full-scope MC beneficiaries under the age of 21 years, correct or ameliorate the condition.

(CCR, title 9, § 1830.205 (b)(3)(B)(1-4).)

The condition would not be responsive to physical health care based treatment.

(CCR, title 9, § 1830.205(b)(3)(C).)

DHCS Finding

1A-3b - The actual interventions documented in the progress note(s) for the following Line number(s) did not meet medical necessity criteria since the intervention(s) were not reasonably likely to result in at least one of the following: a) significantly diminish the impairment; b) prevent deterioration in an important area of life functioning; c) allow the child to progress developmentally; d) correct or ameliorate the mental health condition of a beneficiary who is under age 21. Specifically:

Line number 1. The intervention documented on the progress note did not meet the definition of a valid Specialty Mental Health Service. RR15b, refer to Recoupment Summary for details.

The progress note for the Targeted Case Management (TCM) claim on 2/11/19 for 60 minutes, describes the provider being informed about a plumbing repair for the client for passing inspection; there is no clear documentation on the progress note that a Specialty Mental Health Service was provided during this visit.

The MHP shall submit a CAP that describes how the MHP will ensure that all SMHS interventions are reasonably likely to correct or reduce the beneficiary's documented mental health condition, prevent the condition's deterioration, or help a beneficiary who is under age 21 to progress developmentally as individually appropriate.

Reasons for Recoupment (RR): Refer to the enclosed Recoupment Summary for additional details about disallowances.

RR15. The MHP did not submit documentation that a valid service was provided to, or on behalf of, the beneficiary:

a) No show / appointment cancelled, and no other eligible service documented (e.g., chart review to prepare for an appointment that turns out to be a 'no

show'), or

b) Service provided did not meet the applicable definition of a SMHS.

Corrective Action Description

MHP staff training will continue to emphasize that documented interventions must correspond with care plan goals, which directly respond to mental health functional impairments, per instructions in the Documentation Manual.

1. Provide additional documentation training to MHP staff, emphasizing that functional impairments must be documented and that interventions must address mental health impairments as per instruction from the Documentation Manual.

2. Continue to deliver monthly documentation training, which all direct service staff are required to attend annually.

3. Continue to use the monthly chart review process to review client plan goals and progress notes, ensuring functional impairment is addressed.

4. Continue to use the corrective action request form to request corrections and any necessary staff training when deficiencies are found in chart review.

1. Invite organizational provider staff to attend relevant additional documentation training. This training emphasizes that functional impairments must be documented and that interventions must address mental health impairments as per instruction from the Documentation Manual.

2. Continue to use the monthly chart review process to review client plan goals and progress notes, ensuring functional impairment is addressed.

3. Continue to use the corrective action request form to request corrections and any necessary staff training when deficiencies are found in chart review.

5. Organizational providers will continue to follow their internal chart review processes as well.

Proposed Evidence/Documentation of Correction

The QI Training Unit developed and delivered additional training to MHP staff, including contracted organizational provider staff, to facilitate better understanding of service codes and develop clinical writing skills. In September 2020, QI offered courses called "Understanding Service Codes" and "How to Write Progress Notes." In February 2020, QI offered a course called "Notes, Codes and Calendar," to similar effect. See attachments 1A-3b.5 through 1A-3b.7 for training flyers.

These courses were supplemental to routine Documentation Training, and focused on teaching writing skills for unlicensed staff. All trainings use the Documentation Manual as the authoritative resource. The Documentation Manual advises that each note must include a statement of the client's current and continued functional impairment, as well as tying the note to the care plan. See attachment 1V-3b.1, Progress Note Interventions OP Doc Manual pp63-71.

Refer to Documentation Training attachments: All Documentation Course Completions in 2019-2020 and 2020-09 Training Sign Ups.

Ongoing Monitoring

QI conducts monthly chart reviews of MHP staff, including all contracted organizational providers. Chart review includes monitoring the client plan goals and their fit with regard to the client's mental health impairment, as well as integrity of progress notes tying service intervention to the client's functional impairment and goals. See attachment 1A-3b.3, QI-86 Corrective Action Need on Chart Reviewed at QM; 1A-3b.4, Corrective Action Example of Intervention Addressing Impairment; and 1A-3b.11, Example Corrective Action - FIRP Notes.

Chart review outcomes are reported quarterly at the Outpatient Continuous Quality Improvement Committee (OP CQI) in September, December, March and June. See attachments 1A-3b.8 OP CQI Agenda Tracking, 1A-3b.9 OP CQI Agenda 2020-9-24, and 1A-3b.10 OP CQI Final Minutes 2020-9-24.

Person Responsible (job title)

Quality Improvement Coordinator

Quality Improvement staff

Implementation Timeline: Ongoing

Requirement

Assessment

The MHP must establish written standards for (1) timeliness and (2) frequency of the Assessment documentation.

(MHP Contract, Ex. A, Att. 9)

DHCS Finding

2A - Assessments were not completed in accordance with regulatory and contractual requirements, specifically:

1) One or more assessments were not completed within the update frequency requirements specified in the MHP's written documentation standards. Per the MHP's documentation standards, reassessments are due on a "two year interval".

The following are specific findings from the chart sample:

• Line Number 1. The beneficiary's most recent assessment was completed as signed on 10/16/17, however, their prior assessment was completed as signed almost four years previously, on 9/24/13.

During the review, the MHP staff informed the reviewers that their usual policy and practice would have been to close this case after the client had not been presenting for ongoing treatment around 2015, and acknowledged that this gap in assessments was inconsistent with their practice.

• Line Number 2. The beneficiary's most recent assessment was completed as signed on 6/6/19, three months late. The prior assessment was completed as signed on 3/7/17.

The MHP shall submit a CAP that:

1) Describes how the MHP will ensure that assessments are completed in accordance with the initial timeliness and update frequency requirements specified in the MHP's written documentation standards.

Corrective Action Description

MHP staff training will continue to emphasize the requirement to complete timely assessments and reassessments, per instructions in the Documentation Manual.

1. Revise policy 0407.611 Closing Patients to Outpatient Medication Support Services and implement a new Discharge from Outpatient Services policy to formalize the process to review and update all cases annually, including completing the annual

assessment; to transfer cases than can be served at a lower level of care; and to close cases when clients are no longer participating in services.

2. Utilize the "Chart Console" view in Avatar, the MHP's Electronic Health Record, to help MHP staff identify when assessments are due and to provide pop-up reminders when assessments come due.

3. Utilize the A/C Team Report to monitor charts that are inactive and assessments that have expired.

4. Mobilize more staff resources, including extra help clinicians and dedicated staff, to help complete assessments in a timely manner.

5. Continue to deliver monthly documentation training, which all direct service staff are required to attend annually. Continue to reinforce timeliness of assessments and protocol to close inactive charts, as per instruction from the Documentation Manual.

The regular monthly chart review process has not identified an ongoing timeliness issue with organizational provider assessments and assessment updates. If assessment timeliness does become an issue, it will be addressed through the chart review corrective action process.

Proposed Evidence/Documentation of Correction

For policy changes: See attachments 2A.1 through 2A.3 for the revision history of policy 0407.611 Closing Patients to Outpatient Medication Support Services. Items 1.1 and 1.2 were added to the policy to formalize the process to review and update all cases annually, including completing the annual assessment; to transfer cases than can be served at a lower level of care; and to close cases when clients are no longer participating in services. See attachment 2A.4 0406.135 Discharge from Outpatient Services to review the new policy implemented 9/7/20 to formalize annual case review and case transfer and closure for outpatient services other than medication support.

See attachment 2A.5 19-A002 New Chart Summary Console to review the bulletin announcing the implementation of the "Chart Console" view in Avatar. See attachment 2A.6 2020_11 A-C Team Report for an example of the monitoring tool used to identify inactive charts and expired assessments.

See attachment 2A.7 OP Manual Page on Closing Chart and Treatment Summary to review the Documentation Manual guidance on this topic. Refer to Documentation Training attachments: All Documentation Course Completions in 2019-2020 and 2020-09 Training Sign Ups.

Ongoing Monitoring

The Medical Records department utilizes the A/C Team Report to identify assessments that are expired and inactive cases that should be closed. Twice per month, this report is shared with Managers and Supervisors, who are responsible to request their staff to

take necessary actions (e.g. updating an assessment or closing a case) indicated by the report.

The Quality Improvement department uses the monthly chart review process to review assessment timeliness. Corrective action request forms are utilized to request corrections and any necessary staff training when deficiencies are found in chart review.

Chart review outcomes are reported quarterly at the Outpatient Continuous Quality Improvement Committee (OP CQI) in September, December, March and June.

Person Responsible (job title)

Quality Improvement Coordinator

Quality Improvement staff

Medical Records Manager

Medical Records staff

Implementation Timeline:

1. The policy update and new policy were completed on 9/7/20.

2. The Chart Console view in Avatar was released 1/22/19.

3. The A/C Team Report is generated bimonthly on an ongoing basis.

4. Additional staff resources were deployed to help complete assessments in May 2019 and the process is still ongoing. See attachment 2A.8.8 19-Q002 Transition to Annual Assessments.

5. Monthly documentation training is ongoing.

Requirement

All entries in the beneficiary record (i.e., Assessments) include:

1) Date of service.

2) The signature of the person providing the service (or electronic equivalent).

3) The person's type of professional degree, licensure, or job title.

4) Relevant identification number (e.g., NPI number), if applicable.

5) The date the documentation was entered in the medical record.

(MHP Contract, Ex. A, Att. 9)

DHCS Finding

2C - One or more of the assessments reviewed did not include the signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, job title, or the date the documentation was entered into the medical record. Specifically:

• The type of professional degree, licensure, or job title of person providing the service:

• During the review, MHP staff discussed their previous problem with their EHR failing to include licensure information on the Assessment Forms prior to 2018. Per the MHP, this problem has since been corrected.

• Line number 1.

• Line number 3.

• Line number 7.

The MHP shall submit a CAP that describes how the MHP will ensure that all documentation includes:

1) The signature (or electronic equivalent) with the professional degree, licensure or title of the person providing the service.

2) The signature of the qualified person (or electronic equivalent) with the professional degree, licensure or title of the person providing the service.

Corrective Action Description

The MHP will ensure that the electronic signature equivalent providing MHP staff name and title appear on all assessment documents, per instructions in the Documentation Manual.

1. Update the assessment form in Avatar to correctly and clearly display the authorship and their professional title.

Proposed Evidence/Documentation of Correction

The licensure fields and associated ScriptLink was implemented in Avatar in February 2018. See attachment 2C.1, 1096 Assessment with Author Title and Licensure, and 2C.2, 1096 End Note, Form Approver Licensure. The form displays the name and licensure of the form author, as was mentioned in the review. This includes documents authored by pre-licensed associates.

Ongoing Monitoring

Item completed 2/28/2018

Person Responsible (job title)

Medical Records Manager,

Information Services Application Development team

Implementation Timeline: 2/28/2018

Requirement

Written medication consents shall include, but not be limited to, 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.

(MHP Contract, Ex. A, Att. 9)

DHCS 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 form, and/or documented to have been reviewed with the beneficiary, and/or provided in accompanying written materials to the beneficiary:

Possible side effects if taken longer than 3 months: Line numbers 3, 4, 5, 6, and 10. The MHP's medication consent form only notes potential tardive dyskinesia side-effects when taking antipsychotic medications longer than 3 months, as opposed to describing additional possible side effects of any psychotropic medications after 3 months of use.

The MHP shall submit a CAP that describes how the MHP will ensure that every medication consent process addresses all of the required elements specified in the MHP Contract with the Department.

Corrective Action Description

Update Medication Consent Form to include all required elements.

1. Update and release medication consent form (1042 Outpatient Medication Advisement).

Proposed Evidence/Documentation of Correction

See attachment 3B.1, form 1042 Outpatient Medication Advisement.

Ongoing Monitoring

Item completed 5/22/2020

Person Responsible (job title)

Quality Improvement Coordinator

Medical Records Manager

Implementation Timeline: 5/22/2020

Requirement

The client plan has been updated at least annually and/or when there are significant changes in the beneficiary's condition.

(MHP Contract, Ex. A, Att. 2)

DHCS Finding

4B-2 - One or more client plan(s) was not updated at least annually and/or when there were significant changes in the beneficiary's condition. Specifically:

• Line numbers 1 and 3: There was a lapse between the prior and current Client Plans. However, this occurred outside of the audit review period.

- Line number 1. The prior Client Plan expired on 11/3/2018; the current Client Plan was completed as signed on 11/28/2018.
- Line number 3. The prior Client Plan expired on 5/24/18; the current Client Plan was completed as signed on 11/16/18.

The MHP shall submit a CAP that describes how the MHP will ensure that:

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

Corrective Action Description

MHP staff training will continue to emphasize the requirement to complete timely client plan updates, per instructions in the Documentation Manual.

1. Continue to deliver monthly documentation training, which all direct service staff are required to attend annually. Continue to reinforce timeliness of client plan updates, as per instruction from the Documentation Manual.

2. Continue to use the monthly chart review process to review client plan update timeliness.

4. Continue to use the corrective action request form to request corrections and any necessary staff training when deficiencies are found in chart review.

1. Continue to deliver monthly documentation training, which organizational provider staff are invited to attend. Continue to reinforce timeliness of client plan updates, as per instruction from the Documentation Manual.

2. Continue to use the monthly chart review process to review client plan update timeliness.

4. Continue to use the corrective action request form to request corrections and any necessary staff training when deficiencies are found in chart review.

5. Organizational providers will continue to follow their internal chart review processes as well.

Proposed Evidence/Documentation of Correction

See attachment 4B-2.1 Client Plan Timelines in OP Documentation Manual p50. The Documentation Manual advises that "The Client Treatment Plan must be updated at least annually or when there are significant changes in the client's condition. “This requirement is reviewed at monthly documentation training.

Refer to Documentation Training attachments: All Documentation Course Completions in 2019-2020 and 2020-09 Training Sign Ups.

Ongoing Monitoring

QI conducts monthly chart reviews of MHP staff, including all contracted organizational providers. Chart review includes monitoring the timeliness of client plan updates. See attachment 4B-2.2, QI-76 Chart Review - Change in Treatment Plans Highlight.

Chart review outcomes are reported quarterly at the Outpatient Continuous Quality Improvement Committee (OP CQI) in September, December, March and June.

Person Responsible (job title)

Quality Improvement Coordinator

QI Staff

Implementation Timeline: Ongoing

Requirement

C. The MHP shall ensure that Client Plans:

1) Have specific observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.

2) Identify the proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.

3) Have a proposed frequency of the intervention(s).

4) Have a proposed duration of intervention(s).

5) Have interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance (CCR, title. 9, § 1830.205(b).

6) Have interventions that are consistent with client plan goal(s)/treatment objective(s).

7) Have interventions consistent with the qualifying diagnosis.

(MHP Contract, Ex. A, Att. 9)

DHCS Finding

4C - Client Plans did not include all of the required elements specified in the MHP Contract. Specifically:

• One or more proposed interventions did not include an expected frequency or frequency range that was specific enough. Line numbers 3, 5, and 10.

- Line number 3. For the majority of listed interventions, the expected frequency or frequency range could not be clearly identified or the frequency was listed "as needed".
- Line number 5. For several listed interventions, the expected frequency or frequency range was listed as "as needed" or "as indicated", which are insufficient descriptions of the expected frequency.
- Line number 10. For the listed interventions, the expected frequency or frequency range either could not be clearly identified, or was listed as "at each MD appointment", which does not provide clear information on the expected frequency of proposed interventions.

The MHP shall submit a CAP that describes how the MHP will ensure that Mental Health interventions proposed on client plans indicate an expected frequency for each intervention.

Corrective Action Description

MHP staff training will continue to emphasize the requirement to specify intervention frequency in the client plan, per instructions in the Documentation Manual.

1. Continue to deliver monthly documentation training, which all direct service staff are required to attend annually. Continue to reinforce requirement to specify intervention frequency in the client plan, as per instruction from the Documentation Manual.

2. Continue to use the monthly chart review process to review client plan update timeliness.

4. Continue to use the corrective action request form to request corrections and any necessary staff training when deficiencies are found in chart review.

1. Continue to deliver monthly documentation training, which organizational providers are invited to attend. Continue to reinforce timeliness of client plan updates, as per instruction from the Documentation Manual.

2. Continue to use the monthly chart review process to review client plan update timeliness.

4. Continue to use the corrective action request form to request corrections and any necessary staff training when deficiencies are found in chart review.

5. Organizational providers will continue to follow their internal chart review processes as well.

Proposed Evidence/Documentation of Correction

See attachment 4C.1 Treatment Plan Interventions in OP Documentation Manual pp56-58. The Documentation Manual states “Interventions must address objectives and must include anticipated duration and frequency.” This requirement is reviewed at monthly documentation training.

Refer to Documentation Training attachments: All Documentation Course Completions in 2019-2020 and 2020-09 Training Sign Ups.

Ongoing Monitoring

QI conducts monthly chart reviews of MHP staff, including all contracted organizational providers. Chart review includes monitoring that the client plan interventions indicate frequency and duration of services. See attachments 4C.2, QI-76 Chart Review Plan Goal Duration Highlight and 4C.3, Corrective Action Example of Plan Intervention Frequency.

Chart review outcomes are reported quarterly at the Outpatient Continuous Quality Improvement Committee (OP CQI) in September, December, March and June.

Person Responsible (job title)

Quality Improvement Coordinator

QI Staff

Implementation Timeline: Ongoing

Requirement

Items that shall be contained in the client record (i.e., Progress Notes) related to the beneficiary's progress in treatment include all of the following:

a) Timely documentation of relevant aspects of client care, including documentation of medical necessity;

b) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;

c) Interventions applied, beneficiary's response to the interventions and the location of the interventions;

d) The date the services were provided;

e) Documentation of referrals to community resources and other agencies, when appropriate;

f) Documentation of follow-up care, or as appropriate, a discharge summary; and

g) The amount of time taken to provide services; and

h) The signature of the person providing the service (or electronic equivalent) with the person's type of professional degree, licensure, or job title.

(MHP Contract, Ex. A, Att. 9)

DHCS Finding

5B - Progress notes did not include all required elements specified in the MHP Contract, and/or were not in accordance with the MHP's written documentation standards. Specifically:

• Line numbers 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10. One or more progress note was not completed within the MHP's written timeliness standard of one (1) business days after provision of service. 92 or 38 percent of all progress notes reviewed were completed late.

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

• Timely completion and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.

Corrective Action Description

The MHP will develop a tool and process to support staff with timely completion of progress notes that include all requirements, and to monitor the timeliness of notes at the group and individual level.

1. Implement a new EHR tool, the ElectroSAL (eSAL) report, which enables users and supervisors to monitor their individual charting and identify incomplete progress notes.

2. Release a weekly Late Note Report to department supervisors who are in charge of program decisions, training, or remediation as each circumstance requires.

2. Provide a specialized support team called ""E-SAL Pal"" consisting of Medical Records, Claims Data Management, Quality Improvement, and program staff to provide additional training to supervisors and staff identified as needing additional assistance in finishing timely and complete progress notes.

3. Continue to use the monthly chart review process.

4. Continue to use the corrective action request form to request corrections and any necessary staff training when deficiencies are found in chart review.

Organizational providers are responsible to monitor their charting and progress note timeliness.

The QI monthly chart review process has not identified an ongoing timeliness issue with organizational provider progress notes. If note timeliness does become an issue, it will be addressed through the chart review corrective action process. Organizational providers will continue to follow their internal chart review processes as well.

Proposed Evidence/Documentation of Correction

The eSAL and eSAL Pal support team have been developed. On 5/22/20, the eSAL Report was released to staff and supervisors via bulletin. Training was also provided to staff and supervisors in 2020. See attachments 5B.1 20-A005 Introduction to eSAL Report and 5B.2 Introduction to eSAL Training. The eSAL has been integrated into the regular weekly Avatar orientation training.

A Late Note Report has been developed by QI and is distributed to supervisors weekly. See attachment 5B.3 Late Note Report.

Ongoing Monitoring

A Late Note Report has been developed by QI and is distributed to supervisors weekly. See attachment 5B.3 Late Note Report. The timeliness of progress note completion is reviewed by the Outpatient Continuous Quality Improvement Committee monthly in September, December, and June as part of the Sustainability Dashboard. See attachments 5B.4 OP CQI Agenda Tracking, 5B.5 OP CQI Agenda 2020-9-24, and 5B.6 OP CQI Final Minutes 2020-9-24.

QI conducts monthly chart reviews of MHP staff, including all contracted organizational providers. Chart review corrective actions are requested when progress notes are left in draft and not finalized. See attachment 5B.7, Corrective Action Example - Progress Note Left in Draft.

Person Responsible (job title)

Quality Improvement Coordinator

Medical Records Manager

Fiscal Officer (Claims Data Management)

Implementation Timeline: Ongoing

Requirement

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

a) Every service contact for:

i. Mental health services;

ii. Medication support services;

iii. Crisis intervention;

iv. Targeted Case Management;

b) Daily for:

i. Crisis residential;

ii. Crisis stabilization (one per 23/hour period);

iii. Day Treatment Intensive;

iv. Therapeutic Foster Care

c) Weekly:

i. Day Treatment Intensive: (clinical summary);

ii. Day Rehabilitation;

iii. Adult Residential.

(MHP Contract, Ex.A, Att. 9); (CCR, title 9, §§ 1840.316(a-b);1840.318(a-b), 840.320(a-b),)

DHCS Finding

5D - Progress notes were not documented according to the frequency requirements specified in the MHP Contract. Specifically:

- Line numbers 2 and 4. The type of Specialty Mental Health Service (SMHS) (e.g., Medication Support, Targeted Case Management) documented on the progress note was not the same type of SMHS claimed. RR8b1, refer to Recoupment Summary for details.
- Line number 2. For services claimed as Plan Development on 2/15/19 (44 Units of Time), 2/21/19 (52 Units of Time), 2/25/19 (59 Units of Time), and 3/12/19 (36 minutes), progress notes describe a Targeted Case Management service being provided.
- Line number 4. For the service claimed as Plan Development on 3/13/19 (45 Units of Time), the progress note describes a Targeted Case Management service being provided.
- Line number 2. For Mental Health Services claimed, the service activity (e.g., Assessment, Plan Development, Rehab) identified on the progress note was not consistent with the specific service activity actually documented in the body of the progress note.
- Line number 2. For the service claimed as Plan Development on 3/29/19 (95 Units of Time), the progress note describes a Rehabilitation service being provided.

The MHP shall submit a CAP that describes how the MHP will:

1) Ensure that all Specialty Mental Health Services claimed are:

a) Claimed for the correct service modality billing code, and units of time.

2) Ensure that all progress notes:

a) Are accurate, complete and legible and meet the documentation requirements described in the MHP Contract with the Department.

b) Describe the type of service or service activity, the date of service and the amount of time to provide the service, as specified in the MHP Contract with the Department.

Reasons for Recoupment (RR): Refer to the enclosed Recoupment Summary for additional details about disallowances.

RR8. The MHP did not submit a progress note corresponding to the claim submitted to DHCS for reimbursement, as follows:

a) No progress note submitted

b) The progress note provided by the MHP does not match the claim submitted to DHCS for reimbursement in terms of the following:

1) Specialty Mental Health Service claimed.

2) Date of service, and/or

3) Units of time.

(MHSUDS IN No. 18-054, Enclosure 4)

Corrective Action Description

MHP staff training will continue to emphasize correct service code usage in progress notes, per instructions in the Documentation Manual.

1. Continue to deliver monthly documentation training, which all direct service staff are required to attend annually. Continue to reinforce material covered in the Documentation Manual chapter on service codes.

2. Provide specialty trainings for staff requesting extra help in understanding service codes and distinguishing between interventions in their charting.

3. Continue to use the monthly chart review process to review appropriate service code usage.

4. Continue to use the corrective action request form to request corrections and any necessary staff training when deficiencies are found in chart review." "1. Continue to deliver monthly documentation training, which organizational providers are invited to attend. Continue to reinforce material covered in the Documentation Manual chapter on service codes.

2. Invite organizational provider staff to attend specialty trainings for staff requesting extra help in understanding service codes and distinguishing between interventions in their charting.

3. Continue to use the monthly chart review process to review appropriate service code usage.

4. Continue to use the corrective action request form to request corrections and any necessary staff training when deficiencies are found in chart review.

5. Organizational providers will continue to follow their internal chart review processes as well.

Proposed Evidence/Documentation of Correction

The QI Training Unit developed and delivered additional training to MHP staff, including contracted organizational provider staff, to facilitate better understanding of service codes and documentation. QI offered the "Notes, Codes and Calendar" course in February 2020, and the "Understanding Service Codes" course and "How to Write Progress Notes" course in September 2020. See attachments 5D.3 through 5D.4 for training flyers.

These courses were supplemental to routine Documentation Training, and focused on teaching writing skills for unlicensed staff. All trainings use the Documentation Manual as the authoritative resource. The Documentation Manual contains an entire chapter on service codes. See attachment 5D.1, Specialty Mental Health Service Codes OP Doc Manual pp 78-100. Refer to Documentation Training attachments: All Documentation Course Completions in 2019-2020 and 2020-09 Training Sign Ups. Based on these courses and staff feedback, QI also published a QI bulletin and a Provider bulletin answering Frequently Asked Questions about documentation. The bulletin and training was assigned to all direct service staff in Relias, our e-learning platform, and released to organizational providers via email. See attachments 5D.6 and 5D.7.

QI training clinicians are also available on an ad hoc basis to staff who have documentation questions.

Ongoing Monitoring

QI conducts monthly chart reviews of MHP staff, including all contracted organizational providers. Chart review includes monitoring that the client plan interventions indicate frequency and duration of services. See attachment 5D.1, QI-76 Chart Review correct SMHS intervention and code highlight and attachment 5D.8 Corrective Action Example - Service Code Correction.

Person Responsible (job title)

Quality Improvement

Implementation Timeline: Ongoing. Specialty trainings on service codes have been offered starting 2/21/2020.