Merced Mental Health Services

FY 19/20 Specialty Mental Health Triennial Review

System Review

Requirement

MHP must maintain a written log of initial request for SMHS that includes requests made by phone, in person or in writing (CCR, Title 9, 1810.405 (f)

Repeat Deficiency from last Triennial. Partial compliance with CCR, Title 9, chapter 11, section 1810, subdivision 405 (d) and 410 (e)(1).

Based on the test calls, DHCS deems the MHP is in partial compliance with CCR, Title 9, chapter 11, section 1810, subdivision 405(d) and 410(e)(1).

Two calls resulted in information not provided on: accessing SMHS and how to use the beneficiary problem resolution and fair hearing process.

Test Call #4 and #6 were out deemed out of compliance, due to either call disconnect or no answer following transfer.

DHCS Finding

System Review – Summary of Test Call (page 8)

Corrective Action Description

Ensure that calls received are routed correctly to the ACCESS Team for inquires relating to Specialty MH services, Problem Resolution and Fair Hearing or information to beneficiaries about services needed to treat a beneficiary urgent condition **Change:** Staff answering phones for BHRS will understand the procedure for routing calls related to inquiries for SMHS/grievances/appeals to ACCESS Division.

Proposed Evidence/Documentation of Correction

1) BHRS Office Assistant Manual
2) Training Roster Attestations
3) BHRS Access call Routing Procedure
4) Test Call Schedule for FY 19/20
5) Test Call – monthly meeting Agenda/Minutes/ Signature

Measures of Effectiveness

(1) Monthly Test Calls – QPM shall coordinate;

(2) Test Call Workgroup – Frequency monthly

a) Update on Findings
b) Date of the request.
c) Initial disposition of the request.

(3) Program Staff Meetings:

(4) Program Response on interventions

(5) Monthly Test Calls – QPM shall coordinate;

Frequency:

(1) Test Calls -monthly;

(2) Test Call – Workgroup - Monthly

Implementation Timeline:

07/01/2020

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. (CCR, title 9, chapter 11, section 1810.405(f)).
The written log(s) contain the following required elements:

a) Name of the beneficiary.
b) Date of the request.
c) Initial disposition of the request.

(Cal. Code Regs., tit. 9, chapter 11, §1810, subd. 405(f)

Citation:

This is a repeated deficiency identified in the previous triennial review. Evidence to demonstrate it complies with maintaining a log(s) of initial requests for SMHS. Log must contain: name of beneficiary, date of request and initial disposition of the request for calls/walk-ins or writing. *Three of the five test calls – were not logged within the ACCESS log, resulting in 40% overall compliance with logging of name, date of request and initial disposition of request.

DHCS Finding

System Review – Summary of Test Call (page 8)

Steps to Implement:

1) Develop a Standardized Training for Access and Crisis Team

2) After-Hour Calls- ring on more than one extension/phone

3) Cross training of Triage and Mobile Crisis Response Team – Access Log and documentation of calls

4) New staff hired for crisis team shall receive training on requirements within the first 30 days of hire

Corrective Action Description

Increase compliance with documenting within the ACCESS phone log for initial SMHS requests: (a) Name of the Beneficiary, (b) Date of Request and (c) Initial disposition of the requests from 40% to 100% compliance.

Change:

Staff answering phone for 24/7 ACCESS line shall understand the requirements of the 24/7 ACCESS line and documentation standards.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

1) Monthly Test Calls – QPM shall coordinate;

(2) Test Call Workgroup – Frequency monthly

(3) Program Staff Meetings: Update on Findings

<u>Frequency</u>:

(1) Test Calls- monthly;

(2) Test Call Workgroup – Monthly

Implementation Timeline:

06/01/2020

Requirement

Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one (1) working day of the date of receipt of the grievance, appeal, or expedited appeal. (Fed. Code Regs., tit. 42, § 438, subd.416(a); Cal. Code Regs., tit. 9, § 1850, subd.205(d)(1).)

Citation:

While the MHP submitted evidence to demonstrate compliance with this requirement, it is not evident that the MHP logs grievances and appeals within one (1) working day of the date of the receipt.

DHCS Finding

System Review – Beneficiary Rights and Protections (page 10)

Corrective Action Description

BHRS to ensure that within the grievance log, the calculation of amount of days from receipt to entry into the log is reflected within the grievance/appeal log.

Add table/field within the grievance log to reflect amount of time captured from date receive and date entered into the log. If found to be out of compliance, QAS staff shall notify QPM Director of the time non-compliance.

Implementation Plan: 1) Add calculation field to Access data base grievance log

2) Update procedure for logging of grievance/appeal within the Grievance Log.

3) Provide point in time training to Quality Assurance Specialist of procedural change.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

1) Establish Run chart to reflect the progress and monitoring of entries since the noted change.

At the very minimum, QAS specialist to provide a generated report of appeals/expedited appeals as tracked in the Access Log on a Quarterly basis.

2) Quarterly – run report on outcome of the change and compliance.

3) Provide point in time training to Quality Assurance Specialist of procedural change.

Implementation Timeline:

06/30/2020

Requirement

The MHP's expedited appeal process shall at a minimum: Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's expedited appeal. (Fed. Code Regs., tit 42, § 438, subd.410(b).)

The MHP did not submit any evidence of compliance with this requirement.

DHCS Finding

System Review – Beneficiary Rights and Protections (page 10)

Corrective Action Description

Ensure that punitive action is not taken against a beneficiary and/or provider who has requested an expedited appeal.

Revise the Appeal Form template – adding language regarding pertaining to the requirement of the statue.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

1) Review of the generated appeal report to ensure compliance that service disruptions did not occur for beneficiaries filing an appeal.

2) Monthly informing materials check performed to ensure that Appeal forms readily available at the clinic/contractor lobby sites.

Implementation Timeline:

06/30/20

Requirement

The MHP shall implement and maintain written policies for all employees of the MHP, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State Laws, including information about rights of employees to be protected as whistleblowers. (MHP contract, Ex. A, Att. 13; Fed. Code Regs., tit. 42, § 438, subd.608(a)(6).)

The MHP did not furnish evidence to demonstrate it complies with the MHP contract, exhibit A, attachment 13, and Federal Code of Regulations, title 42, section 438, subdivision 608(a)(6).

DHCS Finding

System Review: Program Integrity (Page 12)

Corrective Action Description

Ensure BHRS employees/contract providers or agents are provided with information about the False Claims Act and other Federal and State Laws including information about rights of employees to be protected as whistleblowers.

CIEP Training revised to reflect whistleblower protection.

Evidence demonstrating compliance with regulation secured by Compliance Division.

Contract language to be included in with all BHRS contracts.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

CIEP Training

Monthly County Integrated Ethics Plan Training (all BHRS staff and contract providers are required to attend on an annual basis)

Implementation Timeline:

06/30/20

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).

The actual interventions documented in the progress note(s) for the following Line numbers 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.

DHCS Finding

Medical Necessity

Corrective Action Description

Clinical documentation shall reflect interventions that are reasonably likely to correct or reduce the beneficiary's documented mental health condition, prevent deterioration or help a beneficiary who is under age 21 to progress developmentally as individually appropriate.

Clinical documentation shall reflect that the SMHS interventions are reasonably like to correct or reduce the mental health condition.

BHRS Documentation training shall be provided to any new hire providing clinical services within the first 30 days of hire.

BHRS clinical staff shall attend the refresher documentation training on an annual basis thereafter.

ASOC/CSOC Program Manager (s) and/or Division Director(s) will provide close monitoring for new hires the first 90 days.

ASOC/CSOC managers – establish on staff meeting agenda parcels of the documentation training.

1. Subcontractors administrators and/or designee – will attend the monthly contract meeting
2. Documentation training shall be provided to any new hire providing clinical services within the first 30 days of hire contracting agency will coordinate with QPM Program Manager.
3. QPM will coordinate a refresher documentation training on an annual basis.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

The county will conduct monthly utilization reviews and a director's report compiled.

Documentation Employee Training Program (ETP- for new hires) will continue on a monthly basis by QPM.

Refresher documentation training – QPM to schedule and train as outlined within the schedule.

Implementation Timeline:

06/30/20

Requirement

Documentation that a valid services was provided to or on behalf of the beneficiary.

The intervention(s) documented on the progress note(s) for Line number(s) did not meet medical necessity since the service provided was solely Transportation.

Citation: Line number 1 and 3.

DHCS Finding

Chart Review: 1A-3b1(page 4): Medical Necessity

Corrective Action Description

Documentation shall reflect services provided and claimed are not solely transportation.

Case managers shall understand documentation requirements and that interventions shall tie back to service provided and not based solely on transportation.

Case Managers and MH Clinician with PC/PG/PA will attend the refresher documentation training annually.

Review of Documentation (ETP) and Documentation Refresher Training to ensure material SMHS definitions and documentation examples for Targeted Case Management examples are addressed.

<u>Plan for Subcontractors</u>:

1. Discuss findings report at Contractors meeting

QPM to schedule with contractors: a documentation refresher training within the next 06 months.

ASOC/CSOC Program Manager (s) and/or Division Director(s) will provide close monitoring for new hires the first 90 days.

ASOC/CSOC managers – establish on staff meeting agenda parcels of the documentation training.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

The county will conduct monthly utilization reviews and a director's report compiled.

Documentation Employee Training Program (ETP- for new hires) will continue on a monthly basis by QPM.

Refresher documentation training – QPM to schedule and train as outlined within the schedule

New hire training: monthly. Refresher training at a minimum offered to BHRS Program/Contract Providers to occur on a: Quarterly by specific program. Utilization Clinical Peer Review- monthly

Implementation Timeline:

07/01/20

Requirement

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

One or more assessments were not completed within the update frequency requirements specified in the MHPs written documentation standards. MHPs documentation standards indicate that the Merced County Assessment (MCA) Initial Assessment is to be completed at the conclusion.

Specific Findings: Line 01, 03, 07, 08, 13 and 15.

DHCS Finding

Chart Review: 2A- (page 5): Assessment

Corrective Action Description

Assessment updates will occur at a minimum on an annual basis to ensure compliance with timeliness and frequency of assessment documentation cited within BHRS Policy II.b.10.

1. Verify documentation trainings to ensure requirements are addressed.
2. Documentation training → add to slides that services provided in between assessments are not allowed, with exception of crisis services.
3. ASOC/CSOC Program Manager (s) and/or Division Director(s) will provide close monitoring for new hires the first 90 days.
4. ASOC/CSOC managers – establish on staff meeting agenda parcels of the documentation training.

Subcontractors:

1. 1. Meet with contract agency and review finding.
2. Contract Administrator to identify/develop an internal plan to ensure that monitoring of documentation standards are performed.
3. QPM to schedule with contractors: documentation refresher training within the next 06 months.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

The county will conduct monthly utilization reviews and a director report.

Documentation Employee Training Program (ETP- for new hires) will continue on a monthly basis by QPM.

Refresher documentation training – QPM to schedule and train as outlined within the schedule.

New hire training: monthly

Refresher training at a minimum offered to BHRS Program/Contract Providers to occur on a: Quarterly by specific program.

Utilization Clinical Peer Review- monthly.

Implementation Timeline:

07/01/20

Requirement

MHP Contract, Ex. A, Att. 9; CCR, Title 9, § 1810.204 and 1840.112 - MHP shall ensure that the following areas (A-K) are included as appropriate as part of a comprehensive beneficiary record when an assessment has been performed.

A Mental Status Examination (MSE) was left incomplete for an Assessment Update for Line #13.

DHCS Finding

Chart Review: 2B- (page 7): Assessment

Corrective Action Description

Assessments and assessment updates will have a MSE completed.

Verify documentation trainings to ensure requirements are addressed within the training materials within the next 30 days.

New hires providing clinical status to attend the ETP onboarding training within the first 2 weeks of hire.

Refresher training shall be available for all clinical staff providing direct care on an annual basis.

Steps to Implement

Documentation Training.

Utilization Review.

ASOC/CSOC Program Manager (s) and/or Division Director(s) will provide close monitoring for new hires the first 90 days.

The provider obtains and retains a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication.

ASOC/CSOC managers – establish on staff meeting agenda parcels of the documentation training.

Plan for Subcontractors

Meet with contract agencies to review findings report for Triennial.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

Utilization Reviews:

Utilization Reviews will be conducted on a monthly basis.

Implementation Timeline:

07/01/20

Requirement

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

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 and there was no documentation of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent.

DHCS Finding

Chart Review: 3A- (page 8): Medication Consent

Corrective Action Description

Medication consent forms shall be completed, reviewed with patient and retained for medications prescribed.

Medication consent forms will be readily available in the Electronic Health Record.

In-Service Training/review with Med Team: Policy II.A.13

Med Team will incorporate agenda item for review of MMR findings (specifically medication review) at monthly staff meeting.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

Medication Monitoring Review (MMR)

Med Team will incorporate agenda item for review of MMR findings (specifically medication review) at monthly staff meeting.

Monthly basis Medication Monitoring Review

Implementation Timeline: [Date(s)]

Not provided in the CAP.

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 and (10) consent once given may be withdrawn at any time (MHP Contract, Ex.A, Att.9).

Written medication consents did not contain all of the required elements specified in the MHP Contract with Department. The following required elements were not documented on the medication consent form, and/or documented to have been reviewed with beneficiary and/or provided in accompanying written materials to the beneficiary:

The reason for taking each medication: Line number 9

Type of medication: Line number 18

Duration of taking each medication: Line number 1,3,4,7 and 9

Consents once given may be withdrawn at any time: Line number: 3,5, 6 and 8.

DHCS Finding

Chart Review: 3B- (page 9): Medication Consent

Corrective Action Description

100% of BHRS medication consents will be completed thoroughly with required elements specified within the MHP Contract.

1. MDs to ensure that all medication consents shall include required elements.

2. Nurses assisting with consent documentation shall ensure that the form is completed as per the regulations.

1. Medical Director to revisit Triennial Chart Review Findings with Medical Team at Med Team meeting.

2. Review requirements of required elements for the medication consent form and how to fill out thoroughly within next Med Team meeting and BHRS Policy II.A.13 –Medical Services- Informed Consent.

3. Medication Consent – have available on electronic format within the Electronic Health Record.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

Medication Review Utilization Review conduct on a monthly basis.

Implementation Timeline:

07/01/20

Requirement

All entries in the beneficiary record (i.e., Medication Consents) include: (1) Date of Service (2) The signature of the person providing the service. (3) The person's type of professional degree, licensure or job title of the person providing the service. (4) Relevant identification number, if applicable. (5) The date the documentation was entered in the medical record (MHP Contract Ex. A, Att.9).

Citation(s)

Medication Consent(s) in the chart sample did not include the signature of the prescribing provider of service (or electronic equivalent) that includes the provider's professional degree licensure, job title, and/or date the provider completed and entered the document into the medical record. Line number 9: : one medication consent made available for review was signed by a nurse only on 5/23/2019 and not signed by the prescribing physician.

DHCS Finding

Chart Review: 3C- (page 10): Medication Consent

Corrective Action Description

100% of BHRS medication consents will be completed thoroughly with required elements specified within the MHP Contract.

1. MDs to ensure that all medication consents shall include required elements.

2. Nurses assisting with consent documentation shall ensure that the form is completed as per the regulations.

Implementation Plan:

1. Medical Director to revisit Triennial Chart Review Findings with Medical Team at Med Team meeting.
2. Review requirements of required elements for the medication consent form and how to fill out thoroughly within next Med Team meeting and BHRS Policy II.A.13 Medical Services- Informed Consent.
3. Medication Consent – have available on electronic format within the Electronic Health Record.
4. Electronic Med Consent form to have parameters/fields set to mandatory fields completed by 12/2020.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

Medication Review Utilization – monthly basis.

Implementation Timeline:

12/31/20

Requirement

MHP Contract, Ex. A, Att.9 – client plans shall ensure that client plans have listed #1-7.

Citation(s):

Client plans did not include all of the required elements specified in the MHP Contract. One or more proposed intervention did not include an expected frequency or frequency range that was specific – several intervention frequency were identified on treatment plans as “ad hoc”, “ad hoc” does not meet the intervention requirement that the intervention be stated specifically. Line numbers: 1,4,5,7,9,12,13 and 16. Also, one or more proposed intervention did not include an expected duration for specific expected duration for planned interventions. Line numbers: 2,3,4,5,6,7,10, 13 and 17.

DHCS Finding

Chart Review: 4C- (page 11): Client Plan

Corrective Action Description

Mental Health interventions proposed on client plans indicate both an expected frequency and duration for each intervention identified. Review policy and staff structuring to ensure meet the goal outlined.

Verify documentation trainings to ensure requirements are addressed.

New hires providing clinical status to attend the ETP onboarding training within the first 2 weeks of hire.

Refresher training shall be available for all clinical staff providing direct care on an annual basis.

ASOC/CSOC Program Manager (s) and/or Division Director(s) will provide close monitoring for new hires the first 90 days.

ASOC/CSOC managers – establish on staff meeting agenda parcels of the documentation training.

Automation Services to deactivate the "ad hoc" option within the treatment plan template. Contacted Cerner regarding this request submitted April of 2020. Anticipating completion of deactivating Ad Hoc feature by August 2020.

1. Documentation Training

2. Utilization Review

3. Staff meeting

Meet with contract agencies to review findings report for Triennial.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

Utilization Reviews will be conducted on a monthly basis.

Implementation Timeline:

07/01/20

Requirement

MHP Contract, Ex. A, Att. 9. All entries in the beneficiary record (i.e., Client Plan) include:

(1) Date of service, (2) 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, if applicable, (5) The date the documentation was entered in the medical record.

Citation(s):

One or more client plans did not include the provider's professional degree, licensure, job title or relevant identification number. Line number: 4 and 5 (missing provider's professional degree, licensure or job title on the client plan.

DHCS Finding

Chart Review: 4H- (page 12): Client Plan

Corrective Action Description

Ensure that all documentation within the Cerner system will include the provider signature (or electronic equivalent) with the professional degree, licensure or job title.

1. Update Automation Services procedure to ensure all Credentials, Licensure, Job title are printing next to staff name on Signature Pages within the electronic health record..

Implementation:

1. Issued service request to Automation Services for verification that all providers within BHRS and Contract providers utilizing the BHRS Cerner electronic record system that their licensure, job title will printing next their name.

2. Automation Services verified the credential tab within Cerner and noted that not all staff with credentials/licensure had the box "Print on Billing" selected. To correct this error, Automation services went through all active providers to ensure that Print on Billings was checked and verified and that a credential/job title was listed.

3. Automation Services updated their procedure for staff setup.

Proposed Evidence/Documentation of Correction

None was provided within the CAP document.

Measures of Effectiveness (if included)

Automation Services to perform, at a minimum, semi-annual check to verify that all credentialed providers are entered with proper set-up within the electronic health record system: At a minimum, quarterly basis.

Implementation Timeline:

11/2020

Requirement

MHP Contract, Ex. A, Att.9. Items that shall be continued in the client record (i.e, Progress Notes related to the beneficiary's progress in treatment include all elements A-H of the MHP contract.

Line number 2 – progress note did not match its corresponding claim in terms of amount of time to provide services. The service time documented on the Progress Note was less than the time claimed or the service time was entirely missing on the progress note. Progress note dated 3/13/19 for Individual Therapy claimed 15 hours for documentation time. MHP.

Citation(s):

1) One ore more progress notes were not completed within the written timeliness standard of 3 days after provision of service. Approximately 24% of all progress notes reviewed were completed late.

Line numbers: 2,3,4,5,6,7,8,10,11,12,13,14,15,16,17 and 20.

2) Line number 10-One or more progress notes did not document the beneficiary's response to the interventions provided. Progress note on 3/5/19 for Plan Development has portion of note that appears to describe a different beneficiary. This is evidenced by progress note describing a female who is having impairment in "her abilities as a mother" whereas the client is a male.

4) Line number 20 –One or more progress note was missing documentation of referrals to community resources and/or to other agencies, when appropriate. Specifically, in progress note dated: 2/28/2019 for Individual Therapy, client reports teeth pain to provider.

(5) Line numbers 1,2,3,4,5,6,11,14,16

6) 17 and 20 – progress notes was missing the providers professional degree, licensure, or job title. Approximately, 32% of all progress notes reviewed did not include the provider's professional degree.

DHCS Finding

Chart Review: 5B- (page 14): Progress Note

Corrective Action Description

1. Progress Notes shall be entered timely in accordance with Policy II.B.10;

2. Progress Notes should include elements of the MHP contract requirements.

Changes:

1. Verify and update documentation trainings to ensure requirements are addressed.

2. New hires providing clinical status to attend the ETP onboarding training within the first 2 weeks of hire.

3. Refresher training shall be available for all clinical staff providing direct care on an annual basis.

4. Pilot within the ASOC Division to track timeliness submission of progress notes

5. ASOC/CSOC Program Manager (s) and/or Division Director(s) will provide close monitoring for new hires the first 90 days.

6. ASOC/CSOC managers – establish within the staff meeting dedicated agenda item that specifically addresses documentation requirements review.

1. Documentation Training

2. Utilization Review

3. ASOC Pilot

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

Utilization Reviews on monthly basis.

Implementation Timeline:

07/01/21

Requirement

CCR, Title9, §1840.314(c) – When services are being provided to, or on behalf of, a beneficiary by two or more persons at one point in time, do the progress notes include:

1) Documentation of each person's involvement in the context of the mental health needs of the beneficiary.

2) The exact number of minutes used by persons providing the services.

3) Signature(s) of person(s) providing the services.

Citation(s);

Documentation of services provided to, or on behalf of, a beneficiary by one or more persons at one point in time did not include all required components. Line number 2 and 7 – While the MHP was able to provide separate documentation listing the number of participants in each group, the progress note(s)) themselves did not accurately document the number of group participants on one or more group progress notes.

DHCS Finding

Chart Review: 5C- (page 15): Progress Note

Corrective Action Description

Verify and update documentation trainings to ensure requirements are addressed.

New hires providing clinical status to attend the ETP onboarding training within the first 2 weeks of hire.

Refresher training shall be available for all clinical staff providing direct care on an annual basis.

ASOC/CSOC Program Manager (s) and/or Division Director(s) will provide close monitoring for new hires the first 90 days.

ASOC/CSOC managers – establish within the staff meeting dedicated agenda item that specifically addresses documentation requirements review.

Documentation Training

Utilization Review

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

Utilization Reviews on monthly basis.

Implementation Timeline:

07/01/21

Requirement

MHP Contract, Ex A, Att9, CCR Title 9 §1840.316(a-b), §1840.318 (a-b)

Citation(s):

Progress Notes were not documented according to the frequency requirements specified in the MHP contract.

Line Number 6, 13, 14, 15 and 20 progress notes were not the same type of SMHS claimed.

DHCS Finding

Chart Review: 5D- (page 17): Progress Note

Corrective Action Description

Progress notes will be document services accurately.

Changes:

Verify and update documentation trainings to ensure requirements are addressed.

New hires providing clinical status to attend the ETP onboarding training within the first 2 weeks of hire.

Refresher training shall be available for all clinical staff providing direct care on an annual basis.

ASOC/CSOC Program Manager (s) and/or Division Director(s) will provide close monitoring for new hires the first 90 days.

ASOC/CSOC managers – establish within the staff meeting dedicated agenda item that specifically addresses documentation requirements review.

Implement:

1. Documentation Training

2. Utilization Review

Plan for Subcontractors:
1. Meet with contract agencies to review findings report for Triennial

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

Utilization Reviews – monthly basis.

Implementation Timeline:

07/01/21

Requirement

The MHP must make individualized determinations of each child's/youth's need for ICC and IHBS, based on the child's/youth's strengths and needs. Medi-Cal Manual for

Intensive Care Coordination, Intensive Home Based Services, and Therapeutic Foster Care Services for Medi-Cal Beneficiaries, 3rd Edition, January 2018.

Citation(s):

Medical records associated with line number(s) did not contain evidence that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS.

DHCS Finding

Chart Review: 6A- (page 18): Progress Note- ICC

Corrective Action Description

Ensure individual determinations of each child's/youth's need for ICC and IHBS is based on their strengths and needs. Youth identified to have increased need for services beyond outpatient therapy and medication services or another adjunct service including ITFC or ISFC.

1. CSOC to provide training to all clinical staff assigned to youth regarding requirements for ICC and IHBS.

2. Add ICC/IHBS to initial treatment plan if requirements are met. plan if requirements are met.

3. IHBS is only provided through subcontractor.

Changes:

Develop procedure for ICC/IHBS.

Provide training on procedure for ICC/IHBS to clinicians and mental health workers providing services to youth.

Ongoing training to ensure integrity of process for clinicians and mental health workers.

Provide training to contractors.

Steps to Implement:

1. Develop procedure for ICC/IHBS.

2. Provide training on procedure for ICC/IHBS to clinicians and mental health workers providing services to youth.

3. Ongoing training to ensure integrity of process for clinicians and mental health workers.

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

Utilization Review of charts.

Supervision with staff to review charts.

Implementation Timeline:

07/01/21

Requirement

Each participating provider in a CFT meeting may claim for the time they have contributed to the CFT meeting, up to the length of the meeting, plus documentation and travel time, in accordance with CCR, tit.9, §1840.316(b)(3).

Citation(s):

The content of one or more progress note claimed as Targeted Case Management indicated that the service provided was actually for an ICC service activity, and should have been claimed as ICC case management service.

DHCS Finding

Chart Review: 6E- (page 18): Progress Note- CFT

Corrective Action Description

1. Verify and update documentation trainings to ensure requirements are addressed within the documentation trainings.

2. New hires providing clinical status to attend the ETP onboarding training within the first 2 weeks of hire.

3. Refresher training shall be available for all clinical staff providing direct care on an annual basis.

Implement:

1. Develop procedure for CFT for BHRS Providers

2. Train providers on procedure for CFTs

3. Training on CFT process

4. CSOC team to monitor process for CFTs

5. Provide contractors with training on CFT process

Proposed Evidence/Documentation of Correction

None provided within the CAP document.

Measures of Effectiveness (if included)

Supervision with staff on at least a quarterly basis.

Implementation Timeline:

07/01/21