State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

May 24, 2019

Sent via e-mail to: vkelley@dbh.sbcounty.gov

Veronica A. Kelley, LCSW, Director, AOD Administrator
San Bernardino County Dept. of Behavioral Health
303 Easy Vanderbilt Way
San Bernardino, CA 92415-0026

SUBJECT: Annual County Performance Unit Report

Dear Director Kelley:

The Department of Health Care Services (DHCS) is responsible for monitoring compliance to requirements of the Substance Abuse Block Grant (SABG) and operated by San Bernardino County.

The County Performance Unit (CPU) within the Substance Use Disorder Program, Policy, and Fiscal Division (SUDPPFD) of DHCS conducted a review of the County's compliance with contract requirements based on responses to the monitoring instrument, discussion with county staff, and supporting documentation provided by the County.

Enclosed are the results of San Bernardino County's 2018-19 SABG compliance review. The report identifies deficiencies, required corrective actions, advisory recommendations, and referrals for technical assistance.

San Bernardino County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 6/24/2019. Please follow the enclosed instructions when completing the CAP. Supporting CAP documentation may be e-mailed to the CPU analyst or mailed to the address listed below.

If you have any questions regarding this report or need assistance, please contact me.

Sincerely,

Michael Bivians

Michael Bivians
(916) 713-8966
michael.bivians@dhcs.ca.gov

Distribution:

To: Director Kelley

CC: Tracie Walker, Performance & Integrity Branch Chief
Sandi Snelgrove, Prevention and Family Services Section Chief.
Janet Rudnick, Utilization Review Section Chief
Cynthia Hudgins, Quality Monitoring Section Chief
Susan Jones, County Performance Supervisor
Tianna Hammock, Drug Medi-Cal Monitoring Unit I Supervisor
Stephanie Quok, Drug Medi-Cal Monitoring Unit II Supervisor
Tiffiny Stover, Postservice Postpayment Unit I Supervisor
Eric Painter, Postservice Postpayment Unit II Supervisor
Jessica Fielding, Office of Women, Perinatal and Youth Services Supervisor
Terri Franklin, San Bernardino County Deputy Director Substance Use Disorder & Recovery Services
Alyce Belford, San Bernardino County Senior Program Manager Substance Use Disorder & Recovery Services

Lead CPU Analyst: Jessica Jenkins **Assisting CPU Analyst(s):** Mike Bivians Jamari Robinson	**Date of Review:** 4/9/2019 - 4/11/2019
County: San Bernardino County	**County Address:** 303 East Vanderbilt Way San Bernardino, CA 92415-0026
County Contact Name/Title: Alyce Belford, Senior Program Manager	**County Phone Number/Email:** 909-386-9761 alyce.belford@dbh.sbcounty.gov
Report Prepared by: Mike Bivians	**Report Approved by:** Susan Jones

REVIEW SCOPE

I. Regulations:
   a. 45 CFR; Part 96; Subpart L; §96.121 through 96.137: Substance Abuse Prevention and Treatment Block Grant
   b. 42 USC, Section 300x-21 through 300x-66: Substance Abuse Prevention and Treatment Block
   c. HSC, Division 10.5, Section 11750 – 11970: State Department of Health Care

II. Program Requirements:
   a. State Fiscal Year (SFY) 2018-19 State County Contract, herein referred to as State County Contract
   b. State of California *Youth Treatment Guidelines Revised August 2002*
   c. DHCS *Perinatal Services Network Guidelines SFY 2016-17*
   d. National Culturally and Linguistically Appropriate Services (CLAS)
   e. Mental Health and Substance Use Disorders Services (MHSUDS) Information Notices

ENTRANCE AND EXIT CONFERENCE SUMMARIES

Entrance Conference:
An entrance conference was conducted at 621 East Carnegie Dr. San Bernardino, CA 92408 on 4/9/2019. The following individuals were present:

- Representing DHCS:
  Jessica Jenkins, Associate Governmental Program Analyst (AGPA)
  Mike Bivians, AGPA
  Jamari Robinson, AGPA

- Representing San Bernardino County:
  Terri Franklin, Deputy Director Substance Use Disorder & Recovery Services
  Alyce Belford, Senior Program Manager Substance Use Disorder & Recovery Services
  Teresa Frausto, Chief Psychiatric Officer
  Marina Espinosa, Deputy Director
  Shanice Hightower, Program Specialist I
  Lois Mergener, Program Specialist II
  Shue Xiong, Compliance Analyst
  Toni Harris, Cultural Competency
  Jonathan Avalos, Addiction Medicine Physician
  Jennifer Alsina, Program Manager I
  Justine Rangel, Administrative Manager II
  Tan Suphavarodom, Deputy Director
  Marlen Partida, Admin Supervisor I
  Robert LoPatriello, Social Worker II
  Stephanie Williams, Supervising Social Worker
  Catherine Smith, Clinical Therapist II
  Manuel Ted Rodriguez, Business Application Manager
  Michelle Liu, Supervising Accountant II
  Christopher Schreur, Assistant Medical Director
  Natalie Kessee, Admin Supervisor II
  Kim Carson, Business Systems Analyst III
  Anthony Saldona, Research Analyst
  Sandra Sesma-Ramirez, Business Systems Analyst II
  Kathy Allen, Prevention Program Coordinator
  Cecilia Coyazo, Administrative Manager
  Mark Kennedy, Social Worker II

During the Entrance Conference the following topics were discussed:

- Introductions
- Overview of monitoring purpose and process
- County system of service overview

Exit Conference:

An exit conference was conducted at 303 East Vanderbilt Way San Bernardino, CA 92415 on 4/11/2019. The following individuals were present:

- Representing DHCS:
  Jessica Jenkins, AGPA
  Mike Bivians, AGPA
  Jamari Robinson, AGPA

- Representing San Bernardino County:
  Veronica Kelley, Director
  Terri Franklin, Deputy Director
  Alyce Belford, SPM
  Maria Espinosa, Deputy Director
  Catherine Smith, CT II
  Stephanie Williams, SSW
  Jennifer Alsina, PM I
  Shanice Hightower, PS I
  Lois Mergener, PS II
  Robert LoPatriello, SW II
  Christopher Schreur, Psych IV
  Jonathan Avalos, AM Dr.
  Shue Xiong, CA
  Toni Harris, CC

During the Exit Conference the following topics were discussed:

- Technical assistance regarding specific questions on the monitoring tools.
- Review of follow-up items for the County and DHCS.
- Final review of compliance deficiencies and recommendations.

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	1
2.0 SABG Monitoring	4
3.0 Perinatal	0
4.0 Adolescent/Youth Treatment	0
5.0 Primary Prevention	0
6.0 Cultural Competence	0
7.0 CalOMS and DATAR	2
8.0 Privacy and Information Security	2

PREVIOUS CAPs

During the SFY 2018-19 review, the following CAPs with CDs were discussed and are still outstanding.

2015-16:

CD # 10:
Finding: The County did not submit CalOMS Tx discharge data or annual updates as required.

2016-17:

CD 10.57d:
Finding: The County and its providers did not submit CalOMS Tx discharge data or annual updates as required.

2017-18:

CD 7.41b:
Finding: The County and its providers' annual updates or client discharges for beneficiaries in treatment over one year were not submitted. No provider should have open admissions for more than 12 months; all open admissions require an annual update or to be discharged
Reason for non-clearance of CD: County stated staff turnover is one critical reason this issue was not resolved during each of the last 3 years. "DBH has the same challenge many other counties face in that Admissions are not in DBH's database because: Status and required action is inconsistent with status within DBH's database (will require State assistance), Item does not exist within the county's systems" and "Those that can be resolved through the system are being assigned to trained staff."
County plan to remediate: The County has submitted the same plan, word for word, to fix the issue for multiple years. **"**DBH (County) Substance Use Disorder and Recovery Services (SUDRS) and DBH IT will work together to resolve this deficiency. It is estimated that full resolution will take a minimum of 6 months. Monthly updates will be provided to the DHCS CPA regarding status of resolution. DBH will also be requesting technical assistance from DHCS to resolve this deficiency."

The County requested Cal-OMS TA again. The Cal-OMS team has already been notified of the TA request. The Open Admissions report is currently 184 pages long and has multiple examples of issues resulting in non-compliance.
Original expected date of completion: 1-31-19
Updated/revised date of completion: October 3, 2019

In each of the review years cited above, the county's plan to remediate deficiencies regarding CalOMS has been the same as documented in CD 7.41b verbatim. CalOMS deficiencies are cited again this year as well. Accurate data submission from counties is critical for the evaluation of the success of the DMC ODS Demonstration Project. The County must bring these deficiencies into compliance by the above date of October 3, 2019. Please describe in the Corrective Action Plan (CAP) what new efforts will be utilized other than what has been stated in previous CAPs to ensure compliance by the deadline.

CORRECTIVE ACTION PLAN

Pursuant to the State County Contract, Exhibit A, Attachment I A1, Part I, Section 3, 7, (a-d) each compliance deficiency (CD) identified must be addressed via a Corrective Action Plan (CAP). The CAP is due within thirty (30) calendar days of the date of this monitoring report. Advisory recommendations are not required to be addressed in the CAP.

Please provide the following within the completed 2018-19 CAP.

a) A statement of the compliance deficiency (CD).
b) A list of action steps to be taken to correct the CD.
c) A date of completion for each CD.
d) Who will be responsible for correction and ongoing compliance?

The CPU analyst will monitor progress of the CAP completion.

1.0 ADMINISTRATION

A review of the County's Organizational Chart, subcontracted contracts, and policies and procedures was conducted to ensure compliance with applicable regulations and standards. The following deficiency in regulations, standards, or protocol requirements was identified:

COMPLIANCE DEFICIENCY:

CD 1.6:

SABG State-County Contract, Exhibit A, Attachment I AI, Part III, F
Contractor shall document the total number of referrals necessitated by religious objection to other alternative SUD providers. The Contractor shall annually submit this information to DHCS' Program Support and Grants Management Branch by e-mail at CharitableChoice@dhcs.ca.gov by October 1…

Finding: The County did not submit documentation of the total number of referrals necessitated by religious objection to DHCS Program Support and Grants Management Branch by October 1, 2018.

2.0 SABG MONITORING

The following deficiencies in the SABG monitoring requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 2.9:

SABG State-County Contract Exhibit A, Attachment I A1, Part I, Section 3, A, 1, (e)
Contractor's performance under this Exhibit A, Attachment I, Part I, shall be monitored by DHCS during the term of this Contract. Monitoring criteria shall include, but not be limited to:

e) Whether the Contractor conducted annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of its monitoring and audit reports to DHCS within two weeks of issuance. Reports shall be sent by secure, encrypted email to:
SUDCountyReports@dhcs.ca.gov or Substance Use Disorder-Program, Policy, and Fiscal Division
Performance Management Branch
Department of Health Care Services
PO Box 997413, MS-2627
Sacramento, CA 95899-7413

Finding: The County did provide 48 monitor reports out of a total of 67 reports completed by the County for all SABG program and fiscal requirements. The County did not provide 19 of the completed reports for SABG program and fiscal requirements for FY 17-18.

CD 2.10:

SABG State-County Contract Exhibit A, Attachment I A1, Part I, Section 3, A, 1 (a-e)
Contractor's performance under this Exhibit A, Attachment I, Part I, shall be monitored by DHCS during the term of this Contract. Monitoring criteria shall include, but not be limited to:

a) Whether the quantity of work or services being performed conforms to Exhibit B.
b) Whether the Contractor has established and is monitoring appropriate quality standards.
c) Whether the Contractor is abiding by all the terms and requirements of this Contract.
d) Whether the Contractor is abiding by the terms of the Perinatal Services Network Practice Guidelines (Document 1G).
e) Whether the Contractor conducted annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of its monitoring and audit reports to DHCS within two weeks of issuance. Reports shall be sent by secure, encrypted email to:
SUDCountyReports@dhcs.ca.gov or Substance Use Disorder-Program, Policy, and Fiscal Division
Performance Management Branch
Department of Health Care Services
PO Box 997413, MS-2627
Sacramento, CA 95899-7413

Finding: The County did not have all SABG program requirements within their monitoring tool. The following criteria is missing:

Minimum Quality Drug Treatment Standards 2F (b).

CD 2.15:

SABG State-County Contract Exhibit A, Attachment I A1, Part I, Section 3, A, 1 (a-e)
Contractor's performance under this Exhibit A, Attachment I, Part I, shall be monitored by DHCS during the term of this Contract. Monitoring criteria shall include, but not be limited to: a) Whether the quantity of work or services being performed conforms to Exhibit B.
b) Whether the Contractor has established and is monitoring appropriate quality standards.
c) Whether the Contractor is abiding by all the terms and requirements of this Contract.
d) Whether the Contractor is abiding by the terms of the Perinatal Services Network Practice Guidelines (Document 1G).
e) Whether the Contractor conducted annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of its monitoring and audit reports to DHCS within two weeks of issuance. Reports shall be sent by secure, encrypted email to:

SUDCountyReports@dhcs.ca.gov or Substance Use Disorder-Program, Policy, and Fiscal Division
Performance Management Branch
Department of Health Care Services
PO Box 997413, MS-2627
Sacramento, CA 95899-7413

Finding: The County indicated a total of 67 monitoring reports were completed for FY 17-18. The County did submit 20 monitoring reports to DHCS within two weeks of report issuance The County submitted 28 SABG monitoring reports to DHCS more than two weeks of report issuance. The County did not submit the remaining 19 monitoring reports for FY 17-18 to DHCS at all.

CD 2.16:

SABG State-County Contract Exhibit A, Attachment I A1, Part I, Section 3, A, 1 (a-e)
Contractor's performance under this Exhibit A, Attachment I, Part I, shall be monitored by DHCS during the term of this Contract. Monitoring criteria shall include, but not be limited to: a) Whether the quantity of work or services being performed conforms to Exhibit B.
b) Whether the Contractor has established and is monitoring appropriate quality standards.
c) Whether the Contractor is abiding by all the terms and requirements of this Contract.
d) Whether the Contractor is abiding by the terms of the Perinatal Services Network Practice Guidelines (Document 1G).
e) Whether the Contractor conducted annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of its monitoring and audit reports to DHCS within two weeks of issuance. Reports shall be sent by secure, encrypted email to:

SUDCountyReports@dhcs.ca.gov or Substance Use Disorder-Program, Policy, and Fiscal Division
Performance Management Branch
Department of Health Care Services
PO Box 997413, MS-2627

Sacramento, CA 95899-7413

Finding: The County indicated a total of 67 monitoring reports were completed for FY 17-18. The County did submit 32 SABG monitoring reports encrypted or secure when submitting reports electronically. The County did submit 16 of their SABG monitoring reports not encrypted or secure when submitting reports electronically. The County did not submit the remaining 19 monitoring reports for FY 17-18 to DHCS at all.

7.0 CALIFORNIA OUTCOMES MEASUREMENT SYSTEM TREATMENT (CalOMS Tx) AND DRUG AND ALCOHOL TREATMENT ACCESS REPORT (DATAR)

The following deficiencies in CalOMS and DATAR regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 7.34.a:

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, B, 3, 5, 6

(3) Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.

(5) Contractor shall submit CalOMS-Tx admissions, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider No activity" report records in an electronic format approved by DHCS.

(6) Contractor shall comply with the CalOMsTx Data Compliance Standards established by DHCS identified in Document 3S for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, D, 6

Contractor shall comply with the treatment and prevention data quality standards established by DHCS. Failure to meet these standards on an ongoing basis may result in withholding SABG funds.

Finding: The County's open provider report is not current.

CD 7.34.b:

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, B, 3, 5, 6

(3) Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.

(5) Contractor shall submit CalOMS-Tx admissions, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider No activity" report records in an electronic format approved by DHCS.

(6) Contractor shall comply with the CalOMsTx Data Compliance Standards established by DHCS identified in Document 3S for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.

SABG State-County Contract, Exhibit A, Attachment I A1, Part III, D, 6

Contractor shall comply with the treatment and prevention data quality standards established by DHCS. Failure to meet these standards on an ongoing basis may result in withholding SABG funds.

Finding: The County's open admission report is not current.

8.0 PRIVACY AND INFORMATION SECURITY

The following deficiencies in Privacy and Information Security regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 8.40:

SABG State-County Contract, Exhibit F, F-1, 3, D, 2

… Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR Section 164, subpart C, in compliance with 45 CFR Section 164.316. Contractor shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Contractor will provide the Department with its current and updated policies upon request.

Finding: The County did not provide evidence of policies, procedures, and practices that govern the usage of Electronic Health Records (EHRs).

CD 8.41:

ADP Bulletin 10-01

2. *Counties maintain an Electronic Signature Agreement (Exhibit 1) for the terms of use of an electronic signature signed by both the individual requesting electronic signature authorization and the County Alcohol and Drug Program Administrator or his/her designee.*
3. *County Alcohol and Drug Program Administrators complete a County Alcohol and Drug Program Administrator's Electronic Signature Certification form (Exhibit 2), certifying that electronic systems used by the county's alcohol and drug operations, including contract provider systems, meet the standards..*

Finding: The County does not maintain a signed Electronic Signature Agreement for each electronic signature used and a County Alcohol and Drug Program Administrator's Electronic Signature Certification form.

9.0 TECHNICAL ASSISTANCE

DHCS's County Performance Analyst will make referrals for the training and/or technical assistance identified below.

CalOMS: The County requested TA for CalOMS. SUDCalOMSSupport@dhcs.ca.gov has been contacted and a referral has been made.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

May 24, 2019

Sent via e-mail to: vkelley@dbh.sbcounty.gov

Veronica Kelley, DSW, LCSW, Director
San Bernardino County Department of Behavioral Health
303 E. Vanderbilt Way
San Bernardino, CA 92415-0026

SUBJECT: Annual County Performance Unit Report

Dear Director Kelly:

The Department of Health Care Services (DHCS) is responsible for monitoring compliance to the requirements of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver and the terms of the Intergovernmental Agreement operated by San Bernardino County.

The County Performance Unit (CPU) within the Substance Use Disorder Program, Policy, and Fiscal Division (SUDPPFD) of DHCS conducted a review of the County's compliance with contract requirements based on responses to the monitoring instrument, discussion with county staff, and supporting documentation provided by the County.

Enclosed are the results of San Bernardino County's 2018-19 DMC-ODS compliance review. The report identifies deficiencies, required corrective actions, new requirements, advisory recommendations, and referrals for technical assistance.

San Bernardino County is required to submit a Corrective Action Plan (CAP) addressing each deficiency noted to the CPU Analyst by 6/24/2019. Please follow the enclosed instructions when completing the CAP. Supporting CAP documentation may be e-mailed to the CPU analyst or mailed to the address listed below.

If you have any questions regarding this report or need assistance, please contact me.

Sincerely, Type text here

Jessica Jenkins

Jessica Jenkins
(916) 713-8577
Jessica.jenkins@dhcs.ca.gov

Distribution:

To: Director Kelly

CC: Don Braeger, Substance Use Disorders - Program, Policy and Fiscal Division Chief
Tracie Walker, Performance & Integrity Branch Chief
Sandi Snelgrove, Policy and Prevention Branch Chief
Cynthia Hudgins, Quality Monitoring Section Chief
Janet Rudnick, Utilization Review Section Chief
Susan Jones, County Performance Unit Supervisor
Tianna Hammock, Drug Medi-Cal Monitoring Unit I Supervisor
Stephanie Quok, Drug Medi-Cal Monitoring Unit II Supervisor
Tiffiny Stover, Postservice Postpayment Unit I Supervisor
Eric Painter, Postservice Postpayment Unit II Supervisor
Jessica Fielding, Office of Women, Perinatal and Youth Services Supervisor
Alyce Belford, PhD, Senior Program Manager

Lead CPU Analyst: Jessica Jenkins **Assisting CPU Analyst(s):** Mike Bivians Jamari Robinson	**Date of Review:** 4/9/19 – 4/11/2019 **Date of DMC-ODS Implementation:** 3/1/2018
County: San Bernardino	**County Address:** 303 E. Vanderbilt Way San Bernardino, CA 92415
County Contact Name/Title: Alyce Belford, PhD, Senior Program Manager	**County Phone Number/Email:** (909) 386-9761 Alyce.Belford@dbh.sbcounty.gov
Report Prepared by: Jessica Jenkins	**Report Approved by:** Susan Jones

Purpose of Review

The Department of Health Care Services (DHCS) is required to provide programmatic, administrative, and fiscal oversight of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Substance Use Disorder (SUD) services through annual compliance reviews.

This report summarizes the findings of the compliance review conducted by the County Performance Unit (CPU).

REVIEW SCOPE

I. Regulations:
   a. Special Terms and Conditions (STCs) for California's Medi-Cal 2020 section 1115(a) Medicaid Demonstration STC, Part X: Drug Medi-Cal Organized Delivery System
   b. 42 CFR; Chapter IV, Subchapter C, Part 438; §438.1 through 438.930: Managed Care

II. Program Requirements:
   a. State Fiscal Year (SFY) 2018-19 Intergovernmental Agreement (IA)
   b. Mental Health and Substance Use Disorders Services (MHSUDS) Information Notices

ENTRANCE AND EXIT CONFERENCE SUMMARIES

Entrance Conference:
An entrance conference was conducted at 621 E. Carnegie Dr. San Bernardino, CA 92408 on 4/9/2019. The following individuals were present:

- Representing DHCS:
  Jessica Jenkins, Associate Governmental Program Analyst (AGPA)
  Mike Bivians, AGPA
  Jamari Robinson, AGPA

- Representing San Bernardino County:
  Teresa Frausto, MD, Chief Psychiatric Officer
  Manuel Ted Rodriguez, Interim Business, Applications Manager / Security Officer
  Tan Suphavarodom, Deputy Director, Administrative
  Terri Franklin, Deputy Director
  Alyce Belford, PhD, Senior Program Manager, Substance Use Disorder & Recovery Services
  Jonathan Avalos, Addiction Medicine Physician
  Stephanie Williams, Supervising Social Worker
  Robert LaPatriello, SWII Program Coordinator
  Mark Kennedy, SWII Program Coordinator
  Lois Mergener, Program Specialist II
  Shanice Hightower, Program Specialist I
  Marina Espinosa, Deputy Director
  Terri Franklin, Deputy Director
  Jennifer Alsina, Program Manager I
  Shue Xiong, Compliance Analyst
  Catherine Smith, Clinical Therapist II
  Anthony Saldana, Research Analyst
  Alyce Belford, Senior Porgram Manager
  Erica Watkins, Administrative Supervisor II
  Tamara Weaver, Chief Quality Management Officer

During the Entrance Conference the following topics were discussed:

- DHCS provided an overview of the monitoring purpose and process.
- DHCS went over the site review agenda.

Exit Conference:
An exit conference was conducted at 303 E. Vanderbilt Way San Bernardino, CA 92415 on 4/11/2019. The following individuals were present:

- Representing DHCS:
  Jessica Jenkins, AGPA
  Mike Bivians, AGPA
  Jamari Robinson, AGPA

- Representing San Bernardino County:
  Teresa Frausto, MD, Chief Psychiatric Officer
  Manuel Ted Rodriguez, Interim Business, Applications Manager / Security Officer
  Tan Suphavarodom, Deputy Director, Administrative
  Terri Franklin, Deputy Director
  Alyce Belford, PhD, Senior Program Manager, Substance Use Disorder & Recovery Services
  Jonathan Avalos, Addiction Medicine Physician
  Stephanie Williams, Supervising Social Worker
  Mark Kennedy, SWII Program Coordinator
  Lois Mergener, Program Specialist II
  Shanice Hightower, Program Specialist I
  Marina Espinosa, Deputy Director
  Terri Franklin, Deputy Director
  Jennifer Alsina, Program Manager I
  Shue Xiong, Compliance Analyst
  Catherine Smith, Clinical Therapist II
  Alyce Belford, Senior Porgram Manager
  Erica Watkins, Administrative Supervisor II
  Tamara Weaver, Chief Quality Management Officer
  Christopher Schreur, Psychologist IV
  Veronica Kelley, Director
  Toni Harris, Cultural Compotency

During the Exit Conference the following topics were discussed:

- DHCS reviewed compliance deficiencies with the county.
- DHCS discussed recommendations with the county.

SUMMARY OF SFY 2018-19 COMPLIANCE DEFICIENCIES (CD)

Section:	Number of CD's:
1.0 Administration	0
2.0 Member Services	1
3.0 Service Provisions	0
4.0 Access	0
5.0 Continuity and Coordination of Care	0
6.0 Grievance, Appeal, and Fair Hearing Process	0
7.0 Quality	3
8.0 Program Integrity	1

PREVIOUS CAPs

During the SFY 2018-19 review, the following CAPs with CDs were discussed and are still outstanding.

2015-16:

CD # 10:
Finding: The County did not submit CalOMS Tx discharge data or annual updates as required.

2016-17:

CD 10.57d:
Finding: The County and its providers did not submit CalOMS Tx discharge data or annual updates as required.

2017-18:

CD 7.41b:
Finding: The County and its providers' annual updates or client discharges for beneficiaries in treatment over one year were not submitted. No provider should have open admissions for more than 12 months; all open admissions require an annual update or to be discharged
Reason for non-clearance of CD: County stated staff turnover is one critical reason this issue was not resolved during each of the last 3 years. "DBH has the same challenge many other counties face in that Admissions are not in DBH's database because: Status and required action is inconsistent with status within DBH's database (will require State assistance), Item does not exist within the county's systems" and "Those that can be resolved through the system are being assigned to trained staff."
County plan to remediate: The County has submitted the same plan, word for word, to fix the issue for multiple years. **"**DBH (County) Substance Use Disorder and Recovery Services (SUDRS) and DBH IT will work together to resolve this deficiency. It is estimated that full resolution will take a minimum of 6 months. Monthly updates will be provided to the DHCS CPA regarding status of resolution. DBH will also be requesting technical assistance from DHCS to resolve this deficiency."

The County requested Cal-OMS TA again. The Cal-OMS team has already been notified of the TA request. The Open Admissions report is currently 184 pages long and has multiple examples of issues resulting in non-compliance.
Original expected date of completion: 1-31-19
Updated/revised date of completion: October 3, 2019

In each of the review years cited above, the county's plan to remediate deficiencies regarding CalOMS has been the same as documented in CD 7.41b verbatim. CalOMS deficiencies are cited again this year as well. Accurate data submission from counties is critical for the evaluation of the success of the DMC ODS Demonstration Project. The County must bring these deficiencies into compliance by the above date of October 3, 2019. Please describe in the Corrective Action Plan (CAP) what new efforts will be utilized other than what has been stated in previous CAPs to ensure compliance by the deadline.

CORRECTIVE ACTION PLAN

Pursuant to the Intergovernmental Agreement, Exhibit A, Attachment I, Part II, Section EE, 2 each compliance deficiency (CD) identified must be addressed via a Corrective Action Plan (CAP). The CAP is due within thirty (30) calendar days of the date of this monitoring report. Advisory recommendations are not required to be addressed in the CAP.

Please provide the following within the completed 2018-19 CAP:

a) A statement of the compliance deficiency (CD).
b) A list of action steps to be taken to correct the CD.
c) A date of completion for each CD.
d) Who will be responsible for correction and ongoing compliance.

The CPU analyst will monitor progress of the CAP completion.

2.0 MEMBER SERVICES

The following deficiency in the member services requirements was identified:

COMPLIANCE DEFICIENCY:

CD 2.14

Intergovernmental Agreement Exhibit A, Attachment I, II, B, 2, xv, a-c.

a. The Contractor shall make available in electronic form and, upon request, in paper form, the following information about its network providers:
   i. The provider's name as well as any group affiliation;
   ii. Street address(es);
   iii. Telephone number(s);
   iv. Website URL, as appropriate;
   v. Specialty, as appropriate;
   vi. Whether the provider will accept new beneficiaries;
   vii. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training; and
   viiii. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.
b. The Contractor shall include the following provider types covered under this Agreement in the provider directory:
   i. Physicians, including specialists
   ii. Hospitals
   iii. Pharmacies
   iv. Behavioral health providers
c. Information included in a paper provider directory shall be updated at least monthly and electronic provider directories shall be updated no later than 30 calendar days after the Contractor receives updated provider information.

MHSUDS Information Notice: 18-020

Provider Directory Content Each Plan's provider directory must make available in electronic form, and paper form upon request, the following information for all network providers, including each licensed, waivered, or registered mental health provider and licensed substance use disorder services provider employed by the Plan, each provider organization or individual practitioner contracting with the Plan, and each licensed, waivered, or registered mental health provider and licensed substance use disorder services provider employed by a provider organization to deliver Medi-Cal services:

- The provider's name and group affiliation, if any;
- Provider's business address(es) (e.g., physical location of the clinic or office);
- Telephone number(s);
- Email address(es), as appropriate;
- Website URL, as appropriate;
- Specialty, in terms of training, experience and specialization, including board certification (if any);

- Services / modalities provided, including information about populations served (i.e., perinatal, children/youth, adults);
- Whether the provider accepts new beneficiaries;
- The provider's cultural capabilities (e.g., veterans, older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender);
- The provider's linguistic capabilities including languages offered (e.g., Spanish, Tagalog, American Sign Language) by the provider or a skilled medical interpreter at the provider's office; and,
- Whether the provider's office / facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.
- In addition to the information listed above, the provider directory must also include the following information for each rendering provider:
- Type of practitioner, as appropriate;
- National Provider Identifier number;
- California license number and type of license; and,
- An indication of whether the provider has completed cultural competence training.

The provider directory should also include the following notation (may be included as a footnote); "Services may be delivered by an individual provider, or a team of providers, who is working under the direction of a licensed practitioner operating within their scope of practice. Only licensed, waivered, or registered mental health providers and licensed substance use disorder services providers are listed on the Plan's provider directory."

Plans may choose to delegate the requirement to list individuals employed by provider organizations to its providers. If the Plan delegates this requirement, the Plan's website must link to the provider organization's website and vice versa. Alternately, the Plan may elect to maintain this information at the county level. Ultimately, the Plan maintains responsibility for monitoring the network provider's compliance with these requirements.

Finding: The provider directory is missing the following required element(s):

- Whether the provider will accept new beneficiaries
- The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training
- Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment
- National Provider Identifier number
- California license number and type of license
- An indication of whether the provider has completed cultural competence training
- The following required language: "Services may be delivered by an individual provider, or a team of providers, who is working under the direction of a licensed practitioner operating within their scope of practice. Only licensed, waivered, or registered mental health providers and licensed substance use disorder services providers are listed on the Plan's provider directory."

7.0 QUALITY

The following deficiencies in Quality regulations, standards, or protocol requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 7.43:

Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 9

9. The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.

Finding: The Plan did not provide evidence of mechanisms to monitor the safety and effectiveness of medication practices for narcotic treatment programs and residential services.

CD 7.46:

Intergovernmental Agreement Exhibit A, Attachment I, II, F, 1, v – vi, a – c.

v. Annually, the Contractor shall:
   a. Measure and report to the Department on its performance, using the standard measures required by the Department;
   b. Submit to the Department data, specified by the Department, which enables the Department to calculate Contractor's performance using the standard measures identified by the Department; or
   c. Perform a combination of the activities described above.

vi. Performance improvement projects.
   a. The Contractor shall conduct performance improvement projects, including any performance improvement projects required by CMS that focus on both clinical and nonclinical areas.
   b. Each performance improvement project shall be designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction, and shall include the following elements:
      i. Measurement of performance using required quality indicators.
      ii. Implementation of interventions to achieve improvement in the access to and quality of care.
      iii. Evaluation of the effectiveness of the interventions based on the performance measures.
      iv. Planning and initiation of activities for increasing or sustaining improvement.
   c. The Contractor shall report the status and results of each project conducted to the Department as requested, but not less than once per year

Intergovernmental Agreement Exhibit A, Attachment I, III, LL, 4, i – ix.

4. The monitoring of accessibility of services outlined in the Quality Improvement (QI) Plan will at a minimum include:
   i. Timeliness of first initial contact to face-to-face appointment.
   ii. Frequency of follow-up appointments in accordance with individualized treatment plans.

iii. Timeliness of services of the first dose of NTP services.
iv. Access to after-hours care.
v. Responsiveness of the beneficiary access line.
vi. Strategies to reduce avoidable hospitalizations.
vii. Coordination of physical and mental health services with waiver services at the provider level.
viii. Assessment of the beneficiaries' experiences.
ix. Telephone access line and services in the prevalent non-English languages.

Finding: The Plan's Quality Improvement (QI) Plan does not include the following requirements:

- Timeliness of services of the first dose of NTP services
- Strategies to reduce avoidable hospitalizations
- Assessment of the beneficiaries' experiences

CD 7.50:

Intergovernmental Agreement Exhibit A, Attachment I, III, FF, 3, i, c-f.

i. The CalOMS-Tx business rules and requirements are:
Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.
a. Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J) and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Tx data collection and reporting requirements.
b. Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider no activity" report records in an electronic format approved by DHCS.
d. Contractor shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS identified in (Document 3S) for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.

Finding: The following CalOMS Tx report(s) are non-compliant:

- Open Admissions Report
- Open Providers Report

8.0 PROGRAM INTEGRITY

The following Program Integrity deficiency in regulations, standards, or protocol requirements was identified:

COMPLIANCE DEFICIENCY:

CD 8.62:

Intergovernmental Agreement Exhibit A, Attachment I, II, H, 5, i-ii, a.i-vii

i. The Contractor, and its subcontractors to the extent that the subcontractors are delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.
ii. The arrangements or procedures shall include the following:
    a. A compliance program that includes, at a minimum, all of the following elements:
        i. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.
        ii. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the Chief Executive Officer and the board of directors.
        iii. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Contract.
        iv. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and state standards and requirements under this Contract.
        v. Effective lines of communication between the compliance officer and the organization's employees.
        vi. Enforcement of standards through well-publicized disciplinary guidelines.
        viii. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement.

Finding: The Plan did not provide evidence of procedures for detecting and preventing fraud, waste, and abuse.