Shasta County Mental Health Plan (SCMHP)

Fiscal Year (FY) 19/20 Specialty Mental Health Triennial Review

CHART REVIEW CORRECTIVE ACTION PLAN

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Medical Necessity

FINDING 1A-1a

The medical record associated with the following Line number(s) did not establish that the beneficiary had a mental health diagnosis consistent with those included in the CCR, title 9, chapter 11, section 1830.205(b)(1)(A-R) and in the MHP Contract:

> **Line number 8.** The diagnosis was not linked in time as an addendum to the assessment.
>
> An Assessment was completed 6/3/2019 with no accompanying diagnosis or confirmation of the previous diagnosis available for review. The previous diagnosis was completed on 10/10/2018.

CORRECTIVE ACTION PLAN 1A-1a:

The MHP shall submit a CAP that describes how the MHP will ensure that the diagnosis is linked in time to the assessment and is consistent with the presenting problems, history, mental status examination and/or other clinical data documented in the assessment.

Corrective Action Description

- Update clinical documentation training to include the necessity for a Diagnostic Review Form (DRF) with each Assessment Plan update
- The Utilization Review and Quality Assurance (UR/QA) review procedure will be revised to contain the requirement for a DRF to be completed at the time of the annual treatment plan or assessment plan update
- A training will be created based on the triennial review findings and provided to all clinical staff; UR/QA team and direct care staff

Proposed Evidence/Documentation of Correction

- Updated clinical documentation training
- Updated UR/QA review procedure
- Triennial review findings training
- Sign-in sheets of triennial review findings trainings

Ongoing Monitoring (if included)

- UR/QA team's review of all assessment and treatment plans

Person Responsible (job title)

- UR/QA team will be responsible for updating the clinical documentation training, UR/QA review procedures, as well as creating and administering of the triennial review findings trainings.
- Adult Services and Children's Services Branches will ensure that all direct care staff attend the training.

Implementation Timeline

- Updated clinical documentation training by July 2021
- Updated UR/QA review procedure by July 2021
- Triennial review findings training to be created by July 2021
- All direct care staff trained on triennial review findings trainings by October 2021

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 10.** 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.**

CORRECTIVE ACTION PLAN 1A-3b:

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.

Corrective Action Description

- This was a service provided by the Transition, Admission and Discharge (TAD) team. Because of the difficulty in determining which services provided were billable versus non-billable, the TAD team stopped billing for their services as of June 11, 2019.
- A training will be created based on the triennial review findings and provided to all clinical staff; UR/QA team and direct care staff

Proposed Evidence/Documentation of Correction

- Email from Adult Services Branch regarding discontinuation of billing for TAD team services.
- Triennial review findings training
- Sign-in sheets of triennial review findings trainings

Ongoing Monitoring (if included)

- UR/QA team monitors for the appropriateness and effectiveness of services ongoing through various audits

Person Responsible (job title)

- Adult Services Branch will provide email regarding discontinuation of billing for TAD team services.
- UR/QA team will be responsible for creating and administering of the triennial review findings trainings.

- Adult Services and Children's Services Branches will ensure that all direct care staff attend the training.

Implementation Timeline

- Discontinuation of billing for TAD team services was implemented as of June 2019
- Triennial review findings training to be created by July 2021
- All direct care staff trained on triennial review findings trainings by October 2021

Assessment

FINDING 2A

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

> One or more assessments were not completed within the initial timeliness and update frequency requirements specified in the MHP's written documentation standards.
>
> Per Shasta County's Comprehensive Mental Health Assessment and Medication Evaluation Policy (Policy Number 2013-02, Rev 3), Compressive Assessments are completed within the initial 60-day authorization period, and every three years from the start date of the current Comprehensive Assessment (Triennial Assessment).

The following are specific findings from the chart sample:

Initial:

> **Line number 8.** The Episode Opening Date of 9/26/2018 requires the initial assessment to be due 11/26/2018; however, the initial assessment was completed 6/3/2019.

Updated Assessments:

> **Line number 1:** The previous comprehensive assessment is dated 11/16/2015. The updated assessment was due 11/15/2018. The assessment was submitted 11/14/2018 by a student intern, however, it was not co-signed by the registered provider until 11/26/2018. Shasta County's Policy 2013-02, Rev 3 states "assessments completed by Graduate Students must include a LPHA co- signature."

CORRECTIVE ACTION PLAN 2A:

The MHP shall submit a CAP that:

- 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.
- Planned Specialty Mental Health Services are not claimed in the absence of an assessment that substantiates those services.

Corrective Action Description

- A training will be created based on the triennial review findings and provided to all clinical staff; UR/QA team and direct care staff
- Adult Services and Children's Services Branches' staff currently monitor assessment and treatment plans' due dates through monthly reports

Proposed Evidence/Documentation of Correction

- Triennial review findings training
- Sign-in sheets of triennial review findings trainings
- Redacted sample of monthly assessment and treatment tracking report

Ongoing Monitoring (if included)

- UR/QA team reviews all assessments
- Adult Services and Children's Services Branches' staff currently monitor assessment and treatment plans' due dates through monthly reports

Person Responsible (job title)

- UR/QA team will be responsible for creating and administering of the triennial review findings trainings.
- Adult Services and Children's Services Branches will ensure that all direct care staff attend the training.
- Adult Services and Children's Services Branches' staff ensure monitoring of assessment and treatment plans' due dates

Implementation Timeline

- Triennial review findings training to be created by July 2021
- All direct care staff trained on triennial review findings trainings by October 2021
- Adult Services and Children's Services Branches' staff currently monitor assessment and treatment plans' due dates through monthly reports

FINDING 2B

One or more of the assessments reviewed did not address all of the required elements specified in the MHP Contract. Specifically:

a) Medical History: **Line number 1.**

b) Medications: **Line numbers 4, and 5**

c) Risks: **Line number 7.**

CORRECTIVE ACTION PLAN 2B:

The MHP shall submit a CAP that describes how the MHP will ensure that every assessment contains all of the required elements specified in the MHP Contract with the Department.

Corrective Action Description

- UR/QA team reviews all assessments for required elements and informs staff of any deficiencies.
- A training will be created based on the triennial review findings and provided to all clinical staff; UR/QA team and direct care staff

Proposed Evidence/Documentation of Correction

- UR assessment review procedure
- Triennial review findings training
- Sign-in sheets of triennial review findings trainings

Ongoing Monitoring (if included)

- UR/QA team reviews all assessments

Person Responsible (job title)

- UR/QA team is responsible for the review of all assessments
- UR/QA team will be responsible for creating and administering of the triennial review findings trainings.
- Adult Services and Children's Services Branches will ensure that all direct care staff attend the training.

Implementation Timeline

- UR/QA team currently review all assessments
- Triennial review findings training to be created by July 2021
- All direct care staff trained on triennial review findings trainings by October 2021

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Medication Consent

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:

1) The reason for taking each medication: **Line number 4.**
2) Method of administration (oral or injection): **Line number 3.**
3) Duration of taking each medication: **Line numbers 4, 6, 8, and 9.**
4) Possible side effects if taken longer than 3 months: **Line number 4.**

CORRECTIVE ACTION PLAN 3B:

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

- Train prescribing staff on completing medication consents
- A training will be created based on the triennial review findings and provided to all clinical staff; UR/QA team and direct care staff
- Continued medication monitoring

Proposed Evidence/Documentation of Correction

- Medication consent training
- Medication consent training sign-in sheets
- Medication consent review tool
- Triennial review findings training
- Sign-in sheets of triennial review findings trainings

Ongoing Monitoring (if included)

- Biennial medication monitoring

Person Responsible (job title)

- UR/QA team is responsible for training prescribing staff on completing medication consents and the continued medication monitoring.
- UR/QA team will be responsible for creating and administering of the triennial review findings trainings.
- Adult Services and Children's Services Branches will ensure that all direct care staff attend the training.

Implementation Timeline

- UR/QA team is currently providing training on completing medication consents and is conducting medication monitoring
- Triennial review findings training to be created by July 2021
- All direct care staff trained on triennial review findings trainings by October 2021

FINDING 3C

Medication Consent(s) in the chart sample did not include the signature of the provider of service (or electronic equivalent) that includes the provider's professional degree, licensure, job title, and/or the date the provider completed and entered the document into the medical record. Specifically:

- The type of professional degree, licensure, or job title of person providing the service:
  - **Line number 4:** Signature is illegible.

CORRECTIVE ACTION PLAN 3C:

The MHP shall submit a CAP that describes how the MHP will ensure that all Medication Consents include the:

- Provider's signature (or electronic equivalent) that includes professional degree, licensure or title.

Corrective Action Description

- Medication consents are currently within the electronic health record. The electronic signatures include the professional degree, licensure or title, along with the printed name of the staff person signing the medication consent.

Proposed Evidence/Documentation of Correction

- Redacted medication consent showing the electronic signatures

Ongoing Monitoring (if included)

- N/A

Person Responsible (job title)

- N/A

Implementation Timeline

- Completed

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Client Plans

FINDING 4A-2

The medical record did not include services that were sufficient to adequately "achieve the purpose for which the services are furnished". Specifically:

- **Line number 2**: Although two (2) or more different individuals provided services on behalf of the beneficiary at the same point in time, the medical record, including services proposed on the client plan, lacked evidence of the coordination of care and communication among these separate providers.

  This beneficiary was receiving her psychiatric medications from a non-county provider. There was no documentation of coordination of care during the three-month review period. In addition, the MHP was unable to provide any other documentation outside of the review period that the beneficiary's care was coordinated.

CORRECTIVE ACTION PLAN 4A-2:

The MHP shall submit a CAP that describes how the MHP will ensure that all Client Plans and actual services provided include documentation for the coordination of care when the beneficiary receives services from multiple providers at the same point in time in order to help "achieve the purpose for which the services are furnished".

Corrective Action Description

- Develop a care coordination policy and procedures
- Evaluate for complex needs and systems involvement, and detail care coordination needs in the case management intervention
- Adult Services and Children's Services Branches will train upon hire and annually on how to identify care coordination needs and revising the treatment plan to update case management with the intent to provide coordination between providers
- A training will be created based on the triennial review findings and provided to all clinical staff; UR/QA team and direct care staff
- UR/QA team will review charts, as part of the annual treatment plan review, for assessing and providing care coordination as needed

Proposed Evidence/Documentation of Correction

- Care Coordination Policy and Procedures
- Revised Treatment Plan Review Procedures
- Triennial review findings training
- Sign-in sheets of triennial review findings trainings

Ongoing Monitoring (if included)

- Annual monitoring by UR/QA team when reviewing annual treatment plans

Person Responsible (job title)

- The Compliance and Quality Improvement team, along with the UR/QA team will be responsible for creating a Care Coordination Policy and Procedures
- Adult Services and Children's Services Branches will be responsible for training providers on identifying the need for and providing coordination of care
- UR/QA team will be responsible for creating and administering of the triennial review findings trainings
- Adult Services and Children's Services Branches will ensure that all direct care staff attend the training.

Implementation Timeline

- Care Coordination Policy and Procedures will be created by July 2021
- Identifying the need for and providing coordination of care will be continuous
- Triennial review findings training to be created by July 2021
- All direct care staff trained on triennial review findings trainings by October 2021
- Treatment Plan review procedures will be revised by July 2021

FINDING 4A-2a

Services claimed and documented on the beneficiary's progress notes were not sufficient and consistent in amount, duration or scope with those documented on the beneficiary's current Client Plan. Specifically:

- **Line numbers 2 and 3.**
  - **Line number 2:** The client plan dated 2/26/2019 includes the interventions of case management (weekly), collateral (monthly), individual therapy (weekly), group therapy (weekly), individual rehabilitation (weekly), and group rehabilitation (weekly). During the three month review period, the client did not receive individual rehabilitation, group rehabilitation, nor group therapy.

    The MHP was unable to provide progress notes outside of the review period to demonstrate the client received these services at a different time, or documentation explaining why the client was not receiving these services.

  - **Line number 3:** The client plan dated 7/23/2018 includes the interventions of case management (quarterly), med support (monthly), individual rehabilitation (quarterly), group rehabilitation (monthly), and group therapy (weekly). During the three month review period, the client received case management services 2-3 times per month, and no individual rehabilitation, group rehabilitation, or group therapy.

    The MHP was unable to provide progress notes outside of the review period to demonstrate the client received these services at a different time, or documentation explaining why the client was not receiving these services.

CORRECTIVE ACTION PLAN 4A-2a:

The MHP shall submit a CAP that describes how the MHP will ensure that services are provided in the amount, duration, and scope as specified in the Individualized Client Plan for each beneficiary.

Corrective Action Description

- Developing procedures for periodic review of treatment plans and services to identify any significant discrepancies and updating treatment plans if necessary
- Train staff on the periodic review process once it is implemented
- Update UR/QA annual treatment plan review process to include review of interventions on plan compared to actual services provided
- A training will be created based on the triennial review findings and provided to all clinical staff; UR/QA team and direct care staff

Proposed Evidence/Documentation of Correction

- Procedures for periodic treatment plan review and updating plan when necessary
- Procedure training sign-in sheets
- Revised Treatment Plan Review Procedures
- Triennial review findings training
- Sign-in sheets of triennial review findings trainings

Ongoing Monitoring (if included)

- Annual monitoring by UR/QA team when reviewing annual treatment plans

Person Responsible (job title)

- Adult Services and Children's Services Branches will be responsible for creating the procedures and providing training on periodic treatment plan review and updating the plans when necessary
- UR/QA team will be responsible for revising Treatment Plan Review Procedures
- UR/QA team will be responsible for creating and administering of the triennial review findings trainings.
- Adult Services and Children's Services Branches will ensure that all direct care staff attend the training.

Implementation Timeline

- Procedures for periodic treatment plan review and updating plan when necessary will be created by July 2021
- Training staff on the procedures for periodic treatment plan review by October 2021
- Treatment Plan review procedures will be revised by July 2021
- Triennial review findings training to be created by July 2021
- All direct care staff trained on triennial review findings trainings by October 2021

FINDING 4B-2

One or more client plans was not updated at least annually. Specifically:

- **Line number 3**: There was a **lapse** between the prior and current Client Plans. However, this occurred outside of the audit review period.
  - The prior Client Plan expired on 5/24/2018; the current Client Plan was completed on 7/23/2018.

- **Line number 10:** The initial client plan was not timely. However, this occurred outside of the audit review period.
  - The Episode Opening Date is 11/9/2018. The client plan was due 1/9/2019, however, it was not completed until 1/30/2019. Per Shasta County's Treatment Plan Policy (Policy Number 2015-01.2) the "first Annual Treatment Plan;" regardless of whether the client is opened with an Access Treatment Plan or the Annual Treatment Plan, must be completed and signed by the LPHA by the end of the 60-day initial authorization period."

CORRECTIVE ACTION PLAN 4B-2:

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

1) Client plans are completed prior to the provision of planned services.

2) 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

- Electronic Health Record reports are currently used for monitoring due dates on client's treatment and assessment plans by Adult Services and Children's Services Branches. Reports will incorporate highlights based on due dates.
- UR/QA team currently reviews all in-house treatment plans and voids (or marks as non-billable) all planned services provided prior to the LPHA signature on the treatment plan
- UR/QA team currently reviews all organizational provider treatment plans and enters the plan dates into the billing system. Any planned services provided prior to the valid plan date are denied.

Proposed Evidence/Documentation of Correction

- Electronic Health Record reports for monitoring due dates on client's treatment and assessment plans
- UR/QA Gap Procedure

Ongoing Monitoring (if included)

- UR/QA team review of all treatment plans

Person Responsible (job title)

- Adult Services and Children's Services Branches are responsible for the continuous monitoring of clients' treatment and assessment plan due dates
- UR/QA team is responsible for review of in-house and organizational provider treatment plans compared to provision of services

Implementation Timeline

- Monitoring of clients' treatment and assessment plan due dates is continuous and ongoing
- Review of all treatment plans is continuous and ongoing

FINDING 4C

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

- One or more proposed intervention(s) did not include an expected duration. **Line numbers 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10.**

  All client plans included in the sample had a duration listed for either the goal and/or objective, but were not specific to each intervention. Please note that a duration is required for each intervention, per the MHP Contract and Information Notice 17-040.

CORRECTIVE ACTION PLAN 4C**:**

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

Corrective Action Description

- Add duration for every intervention to the UR/QA treatment plan review procedure. Must have frequency and duration for each intervention.
- A training will be created based on the triennial review findings and provided to all clinical staff; UR/QA team and direct care staff

Proposed Evidence/Documentation of Correction

- Revised Treatment Plan Review Procedures
- Triennial review findings training
- Sign-in sheets of triennial review findings trainings

Ongoing Monitoring (if included)

- UR/QA team review of all treatment plans

Person Responsible (job title)

- UR/QA team will be responsible for revising Treatment Plan Review Procedures
- UR/QA team will be responsible for creating and administering of the triennial review findings trainings.
- Adult Services and Children's Services Branches will ensure that all direct care staff attend the training.

Implementation Timeline

- Treatment Plan review procedures will be revised by July 2021
- Triennial review findings training to be created by July 2021
- All direct care staff trained on triennial review findings trainings by October 2021

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Progress Notes

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, 5, 6, 8, 9, and 10.** One or more progress notes were not completed within the MHP's written timeliness standard of five days after provision of service. Forty-one (41) of 229 progress notes or 18% percent of all progress notes reviewed were completed late.

CORRECTIVE ACTION PLAN 5B:

The MHP shall submit a CAP that describes how the MHP will ensure that the MHP has written documentation standards for progress notes, including timeliness and frequency, as required by the MHP Contract with the Department.

Corrective Action Description

- Adult Services and Children's Services Branches monitor timely service documentation monthly using a timeliness report. The report is reviewed with providers during their monthly supervision meetings.
- UR/QA team monitors for timely service documentation when performing progress note audits and provides feedback on timeliness to supervisors and Clinical Division Chiefs as well as train staff as necessary.
- A training will be created based on the triennial review findings and provided to all clinical staff; UR/QA team and direct care staff

Proposed Evidence/Documentation of Correction

- Copy of Timeliness Report
- Triennial review findings training
- Sign-in sheets of triennial review findings trainings

Ongoing Monitoring (if included)

- Adult Services and Children's Services Branches monitor timeliness on a monthly basis
- UR/QA team monitors timeliness when performing progress note audits

Person Responsible (job title)

- Adult Services and Children's Services Branches monitoring on a monthly basis
- UR/QA team monitoring through progress note audits
- UR/QA team will be responsible for creating and administering of the triennial review findings trainings.

- Adult Services and Children's Services Branches will ensure that all direct care staff attend the training.

Implementation Timeline

- Adult Services and Children's Services Branches monitoring is continuous and ongoing
- UR/QA team monitoring through progress note audits is continuous and ongoing
- Triennial review findings training to be created by July 2021
- All direct care staff trained on triennial review findings trainings by October 2021

FINDING 5C

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. Specifically:

- **Line numbers 1 and 8.** While the MHP was able to provide separate documentation listing the number of participants in each group, one or more group progress notes did not accurately document the number of participants in the group. Specifically:
    - **Line number 1:** Eleven (11) progress notes did not document the number of group participants.
    - **Line number 8:** Three (3) progress notes did not document the number of group participants.

CORRECTIVE ACTION PLAN 5C:

The MHP shall submit a CAP that describes how the MHP will ensure that progress notes contain the actual number of clients participating in a group activity, the number and identification of all group provider/facilitators, the correct type of service (e.g., Group Rehabilitation or Group Psychotherapy), and date of service.

Corrective Action Description

- Within the electronic health record (EHR) system, Cerner, although the number and names of group participants are displayed on the screen, when the individual's group progress note is selected for printing, it defaults to one (1). As stated in the findings, the EHR screenshots reflected the correct information. This system glitch was not present in the past, and the Electronic Health Record team is working on resolving the technical glitch. If it cannot be resolved, SCMHP will direct providers to indicate the number of participants in the progress note narrative.

Proposed Evidence/Documentation of Correction

- Redacted group progress note showing the correct number of participants

Ongoing Monitoring (if included)

- N/A

Person Responsible (job title)

- Electronic Health Record team

Implementation Timeline

- To be determined based on the need to address with Cerner and the potential need for a system update to reflect the changes.

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FINDING 5D

Progress notes were not documented according to the contractual requirements specified in the MHP Contract. Specifically:

- **Line number 1**: 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.**
    - The service provided was claimed as Collateral, but the progress note describes a Targeted Case Management service.

CORRECTIVE ACTION PLAN 5D**:**

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 completed within the timeline and frequency specified in the MHP Contract with the Department, and as specified in the MHP's written documentation standards.

Corrective Action Description

- UR/QA team monitors for correct service code documentation when performing progress note audits and provides feedback to supervisors and Clinical Division Chiefs and training to staff
- UR/QA team voids, or voids/replaces when appropriate, any services found that are billed with an incorrect billing code
- UR/QA team provides training to all new and ongoing staff on correct service code documentation and billing
- A training will be created based on the triennial review findings and provided to all clinical staff; UR/QA team and direct care staff
- Staff member responsible for incorrect billing to be trained individually by supervisor

Proposed Evidence/Documentation of Correction

- Service code training
- Case management and collateral tip sheets
- Triennial review findings training
- Sign-in sheets of triennial review findings trainings
- Documentation of staff trained by supervisor

Ongoing Monitoring (if included)

- UR/QA team monitors for incorrect service code billing

Person Responsible (job title)

- UR/QA team is responsible for monitoring for correct service code documentation, voiding, void/replacing services as needed, and providing training on service code documentation and billing
- UR/QA team will be responsible for creating and administering of the triennial review findings trainings
- Adult Services and Children's Services Branches will ensure that all direct care staff attend the training
- Supervisor will train staff member responsible for incorrect billing

Implementation Timeline

- UR/QA team monitoring for correct service code documentation, voiding, void/replacing services as needed, and providing training on service code documentation and billing is continuous and ongoing
- Triennial review findings training to be created by July 2021
- All direct care staff trained on triennial review findings trainings by October 2021
- Staff member responsible for incorrect billing to be trained by supervisor by May 2021

Provision of ICC Services and IHBS for Children and Youth

FINDING 6A

The medical record associated with the following Line numbers did not contain evidence that the beneficiary received an individualized determination of eligibility and need for ICC services and IHBS, and that if appropriate, such services were included in their Client Plan:

- **Line number 8:** The assessment dated 6/3/2019, completed by provider 4515, documented that the beneficiary is being served by multiple child serving
  systems ((i.e., Legal / Child Protective Services, Individual Education Plan with placement in classroom for emotional behavioral challenges, School based counseling and community counseling, group home placement, etc.), indicating the beneficiary may have met eligibility criteria for ICC services and IHBS; however, these services were not included in the 9/28/2018 client plan, and no documentation was provided to confirm they were assessed for such services.

- **Line number 10:** The assessment dated 12/31/2018, completed by provider 4515, documented the beneficiary is being served by multiple child serving
  systems ((i.e., Legal / Child Protective Services, Individual Education Plan with placement in classroom for emotional behavioral challenges, School based counseling and community counseling, group home placement, etc.), indicating the beneficiary may have met eligibility criteria for ICC services and IHBS; however, these services were not included in the 1/30/2019 client plan, and no documentation was provided to confirm they were assessed for such services.

<u>CORRECTIVE ACTION PLAN 6A:</u>

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

1) Training is provided to all staff and contract providers who have the responsibility for determining eligibility and need for ICC and IBHS.
2) Each beneficiary under age 22 who is authorized to receive Specialty Mental Health Services also receives an individualized determination of eligibility and need for ICC Service and IHBS prior to or during the development of the beneficiary's Initial Client Plan.

Corrective Action Description

- Finalize ICC and IHBS policy
- Disseminate finalized policy to organizational providers

- Coordinate with organizational providers on procedure for assessing all clients for ICC and IHBS and how they will document in the medical record that the assessment was done
- The Child and Adolescent Comprehensive Assessment has been updated to contain section for assessing clients for ICC and IHBS needs, and staff were trained on this element
- Update documentation training with ICC and IHBS assessment requirements
- A training will be created based on the triennial review findings and provided to all clinical staff; UR/QA team and direct care staff

Proposed Evidence/Documentation of Correction

- Finalized ICC and IHBS Policy
- Proof of how org providers will train staff and include the assessment in the medical record
- Updated documentation training
- Triennial review findings training
- Sign-in sheets of triennial review findings trainings

Ongoing Monitoring (if included)

- UR/QA team reviews all assessments for required elements, including assessment for ICC and IHBS.

Person Responsible (job title)

- Children's Services Branch will finalize the ICC and IHBS Policy
- UR/QA team will disseminate policy to organizational providers and coordinate on procedure for assessing all clients for ICC and IHBS and documentation of the assessment
- Update to the Child and Adolescent Comprehensive Assessment has been completed by Children's Services Branch and Electronic Health Record team
- Children's Services Branch provided training to staff on new assessment element
- UR/QA team will update documentation training
- UR/QA team will be responsible for creating and administering of the triennial review findings trainings
- Children's Services Branches will ensure that all direct care staff attend the training

Implementation Timeline

- Finalize ICC and IHBS policy by July 2021
- Disseminate finalized policy to organizational providers by July 2021

- Coordinate with organizational providers on procedure for assessing all clients for ICC and IHBS and how they will document in the medical record that the assessment was done by July 2021
- The Child and Adolescent Comprehensive Assessment has been updated to contain section for assessing clients for ICC and IHBS needs, and staff were trained on this element as of August 2020
- Update documentation training with ICC and IHBS assessment requirements by July 2021
- Triennial review findings training to be created by July 2021
- All direct care staff trained on triennial review findings trainings by October 2021