Sonoma County Behavioral Health

Fiscal Year 19/20 Specialty Mental Health Triennial Review

Corrective Action Plan

Chart Review

This is the Corrective Action Plan (CAP) for the Department of Health Care Services' (DHCS) 2019-20 review of the Sonoma County Mental Health Plan.

Requirement 1A-3a

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

1) The beneficiary meets DSM criteria for an included ICD diagnosis for outpatient SMHS in accordance with the MHP contract. (MHSUDS IN Nos., 15-030, 16-016, 16-051, and 17-004E).
2) The beneficiary must have at least one of the following impairments as a result of the mental disorder or emotional disturbance (listed above in A1):
   a. A significant impairment in an important area of functioning.
   b. A probability of significant deterioration in an important area of life functioning.
   c. A probability that the child will not progress developmentally as individually appropriate.
   d. For full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that SMHS can correct or ameliorate. (CCR, title 9, § 1830.205 (b)(2)(A-C).)
3) The proposed and actual intervention(s) meet the intervention criteria listed below:
   a. The focus of the proposed and actual intervention(s) addresses the condition identified in No. 1b (1-3)above, or for full-scope MC beneficiaries under the age of 21 years, a condition as a result of the mental disorder or emotional disturbance that the SMHS can correct or ameliorate per No. 1 (b)(4). (CCR, title 9, §1830.205(b) (3)(A).)

DHCS Finding 1A-3a

The actual interventions documented in the medical record for the following Line numbers did not meet medical necessity criteria since the focus of the interventions did not address the beneficiary's included mental health condition. Specifically:

- **Line number 11.** For service claimed on 4/27/19 (Service Function 30; Units of Time 77), the provider documents providing services to the client's sister (an assessment) rather than the Medi-Cal beneficiary. **RR5, refer to Recoupment Summary for details.**

- **Line number 20.** Five (5) claims from 5/22/19 through 5/26/19 were determined by MHP staff to have been erroneously claimed to this beneficiary, although the claims should have been claimed to another beneficiary.

When this was identified as part of the claims sample development process, MHP billing staff disallowed these claims and provided verification that they had completed this disallowance process.

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

1) Only beneficiaries with an included mental health diagnose have claims submitted for planned Specialty Mental Health Services.
2) Services are provided to and claimed for the correct beneficiary.

Corrective Action Description

1)
   a. Sonoma County no longer contracts with Petaluma People Services, the agency that billed for that service, for specialty mental health.
   b. For Sonoma County employees, the New Employee Documentation Training, provided to all existing employees during FY18-19 and FY19-20 and required for all new employees billing for specialty mental health, includes training on procedure codes, including Collateral. As of 7/14/2021, we have included instruction that Collateral services must be for the benefit of the client, not the support person.
   c. For contracted agencies, the Utilization Review Manager will provide trainings at least annually in documentation requirements, including procedure codes. Trainings were provided to contracted organizations through FY19-20 and FY20-21.
   d. For Sonoma County employees, our ongoing Pre-Billing Audit monitors for procedure code accuracy, and monthly reports of procedure code error fixes are sent to our Health Program Managers to provide feedback to their staff.
   e. For the "Monitoring Documentation & Quality of Care" audit currently being completed weekly by treatment team Clinical Specialists and monthly by Health Program Managers for teams without Clinical Specialists, the auditor reviews one month of progress notes for two random charts, including whether procedure codes are used correctly.
   f. Sonoma County's Utilization Review Manager will distribute a summary of the DHCS Triennial findings to all contracted specialty mental-health organizations as well as Sonoma County specialty mental-health staff so that they are aware of the requirements, as well as present the findings at a county all-staff meeting. We will follow up with provider trainings for contractors and an all-staff training for staff, and our Utilization Review team is available to answer contractor and staff questions at our BHQA@sonoma-county.org email address.
2) Avatar, our electronic health record, was previously set so that it defaulted in the previous client's name when a form was re-opened, which created these billing errors. This setting has been corrected so that no client name defaults into a form in this manner.

Proposed Evidence/Documentation of Correction

1) New Employee Documentation Training - MN & Procedure Codes 7.14.21.pptx
2) Contractor Training Logs
3) CBO Documentation Training Schedule FY21-22
4) Team Training Logs
5) Monthly Procedure Code_Location Corrections January-March 2021.pdf
6) Sample Monitoring Documentation Quality of Care-Weekly Avatar Reports
7) Staff Email of Triennial Findings
8) Documentation Tip – Triennial 2020 Findings PowerPoint
9) Copy of electronic health record ticketing system showing that setting has been fixed: Change Client Name in EHR.pdf

Ongoing Monitoring (if included)

1) Our Outpatient Utilization Review Clinical Specialist conducts spot-checks one month after the New Employee Documentation Training to ensure that employees are documenting correctly, including using procedure codes correctly and documenting the medical necessity of the services rendered. Employees who do not show 100% compliance will be checked again in one month, when they again must reach 100% compliance. Employees who do not meet 100% compliance with the documentation spot check for three months receive an individual follow-up documentation training, and then another spot-check a month later.
2) Our Pre-billing Audit checks for procedure code mistakes.
3) For the "Monitoring Documentation & Quality of Care" audit currently being completed weekly by treatment team Clinical Specialists and monthly by Health Program Managers for teams without Clinical Specialists, the auditor reviews one month of progress notes for two random charts, including whether procedure codes are used correctly.
4) Our Auditing and Monitoring Team audits contractors triennially.

Person Responsible (job title)

1) New Employee Spot Checks: Utilization Review Manager and Outpatient Utilization Review Clinical Specialist
2) Pre-Billing Audit: Pre-Billing Audit Clinical Specialist
3) Monitoring Documentation and Quality of Care: Clinical Specialists, Health Program Managers
4) Triennial Audits: Auditing & Monitoring Team Manager

Implementation Timeline

1) Ongoing monitoring via post-training spot checks, pre-billing audit, weekly program monitoring, triennial contractor auditing: Implemented
2) Email with Triennial summary to contractors: By August 31, 2021
3) Annual contractor trainings: Through FY21-22 (see schedule in Evidence)

Requirement 2A

The MHP must establish written standards for (1) timeliness and (2) frequency of the Assessment documentation. (MHP Contract, Ex. A, Att. 9)

DHCS Finding 2A

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

1) One or more assessments were not completed within the update frequency requirements specified in the MHP's written documentation standards.

Per the MHP's Policy No. MHP-16, *Clinical Documentation Standards for Specialty Mental Health Services*, "Reassessments for youth clients (0-17 years old) are completed at least every six months or when the client has experienced a significant medical or clinical change. Reassessments for adult clients (18 years and older) are completed at least annually or when the client has experienced a significant medical or clinical change."

The following are specific findings from the chart sample:

- **Line number 3.** Current assessment was completed as signed on 7/25/18 and would have been due on 5/31/18, based on the MHP's annual reassessment policy.
- **Line number 4.** Current assessment was completed as signed on 6/26/19 and would have been due on 6/21/19, based on the annual reassessment policy.
- **Line number 6.** Current assessment was completed as signed on 3/26/19 and would have been due on 3/20/19, based on the annual reassessment policy.
- **Line number 8.** Current assessment was completed as signed on 2/11/19 and would have been due on 1/24/19, based on the annual reassessment policy.
- **Line number 12.** Current assessment was completed as signed on 6/6/19 and would have been due on 5/8/19, based on the MHP's 6-month reassessment policy for youth between 0-17 years of age.
- **Line number 19.** Current assessment was completed after the review period which ended on 6/30/19 and would have been due on 1/6/19, based on the MHP's 6-month reassessment policy for youth between 0-17 years of age.

The MHP shall submit a CAP that describes how the MHP will ensure that assessments are completed in accordance with the update frequency requirements specified in the MHP's written documentation standards.

Corrective Action Description

The MHP shall work to create an "Assessment Due Date" report in the Avatar EHR so that clinicians, Health Program Managers, Clinical Specialists, and QAPI staff can monitor upcoming and overdue assessments.

Proposed Evidence/Documentation of Correction

1) Assessment Due Date report (when complete)

Ongoing Monitoring (if included)

Once the Assessment Due Date report is implemented in the EHR, an item requiring monitoring of late assessments and creating a plan to have them completed in a timely manner shall be added to the "Monitoring Documentation & Quality of Care" audit currently being completed weekly by treatment team Clinical Specialists and monthly by Health Program Managers for teams without Clinical Specialists.

Person Responsible (job title)

1) Avatar EHR Implementation: Adult Services Section Manager
2) Ongoing Monitoring: Clinical Specialists, Health Program Managers

Implementation Timeline

1) Avatar EHR Implementation by March 31, 2022

Requirement 2B

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

1) Presenting Problem. The beneficiary's chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information.
2) Relevant conditions and psychosocial factors affecting the beneficiary's physical health including, as applicable; living situation, daily activities, social support, and cultural and linguistic factors.
3) History of trauma or exposure to trauma.
4) Mental Health History. Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions.
5) Medical History, including:
   a) Relevant physical health conditions reported by the beneficiary or a significant support person.
   b) Name and address of current source of medical treatment.
   c) For children and adolescents, the history must include prenatal and perinatal events and relevant/significant developmental history.
6) Medications, including:
   a) Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration and medical treatment.
   b) Documentation of the absence or presence of allergies or adverse reactions to medications.
   c) Documentation of informed consent for medications.
7) Substance Exposure/Substance Use. Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter drugs, and illicit drugs.
8) Client Strengths. Documentation of the beneficiary's strengths in achieving client plan goals related to their mental health needs and functional impairment(s).
9) Risks. Situations that present a risk to the beneficiary and others, including past or current trauma.
10) Mental Status Examination
11) A Complete Diagnosis. A diagnosis from the current ICD-code that is consistent with the presenting problems, history, mental status exam and/or other clinical data; including any current medical diagnosis.

DHCS Findings 2B

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

a) Medications: **Line number(s) 4, 5, 15, and 19.**

b) A mental status examination: **Line number(s) 1, 3, 4, 5, 6, 8, 10, 14, 15, and 19.**

Per the MHP's "Clinical Documentation Standards for Specialty Mental Health Services" and discussion with MHP staff, the MHP utilizes the CANS or ANSA tools for their Reassessment, including specific sections for a Summary of Treatment and Level of Care. The Summary of Treatment section reviews client progress since the prior Client Plan, and the Level of Care section documents the client's ongoing Medical Necessity for SMHS. The MHP includes an additional diagnosis section associated with the reassessments.

When reviewing the CANS and ANSA tools regarding compliance with Assessment elements, the CANS and ANSA do not address Medication information or document a Mental Status Examination.

For the lines noted above, the MHP was encouraged to provide additional sections or progress notes for DHCS reviewers to determine if additional elements of Medications and Mental Status Examination were addressed. No additional documentation was submitted by the MHP.

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 Plan Description

DHCS has recently approved our Corrective Action Plan for this issue resulting from our 2017 Triennial Review. The MHP is in the midst of adding the Mental Status Examination to the reassessments in our Avatar electronic health record. Avatar does currently track our clients' current medications, and this list can be generated at the time of reassessment.

From that approved CAP:

1) The Utilization Review (UR) Manager has added requirements to the DRAFT MHP-16 Policy, Clinical Documentation Standards for Specialty Mental Health Services (Attachment 1). Once DHCS approves the MHP's CAP, the UR Manager will finalize the policy and require that all clinical staff and managers review and adhere to the policy.
2) The UR Manager will train all clinical staff on the timeline requirements for completing the Mental Status Exam (MSE).
3) The MHP will enable the EHR to require that the Mental Status Exam (MSE) is current for every assessment that is submitted. If an MSE needs to be completed at the time of assessment, the MSE will be launched and will be a required document to complete in order to fully submit the assessment. Only licensed staff will be allowed to complete a MSE.

4) Behavioral Health Clinical Specialists will monitor EHR reports on at least a monthly basis to ensure that MSE's are completed and to track expiration due dates. For programs that do not have a Behavioral Health Clinical Specialist on staff, the team's Health Program Manager will monitor EHR reports on at least a monthly basis.

Proposed Evidence/Documentation of Correction

1) Sample Medication List
2) Sonoma FY2016-17 Mental Health Triennial Review CAP

Ongoing Monitoring (if included)

Behavioral Health Clinical Specialists will monitor EHR reports on at least a monthly basis to ensure that MSE's are completed and to track expiration due dates. For programs that do not have a Behavioral Health Clinical Specialist on staff, the team's Health Program Manager will monitor EHR reports on at least a monthly basis.

Person Responsible (job title)

1) Updating and distributing MHP-16 Policy: Utilization Review Manager
2) Training staff on MSE: Utilization Review Manager
3) Ongoing monitoring: Clinical Specialists, Program Managers

Implementation Timeline

1) Adding MSE to reassessment in EHR: Completed
2) Adding Medication List to EHR: Completed
3) Developing and implementing procedure for completing MSE as part of the reassessment: By November 30, 2021

Requirement 2C

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

1) Date of service.
2) The signature of the person providing the service (or electronic equivalent);
3) The person's type of professional degree, licensure or job title.
4) Relevant identification number (e.g., NPI number), if applicable.
5) The date the documentation was entered in the medical record.

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

DHCS Finding 2C

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

- The type of professional degree, licensure, or job title of person providing the service: **Line numbers 1, 2, and 8**

The MHP shall submit a CAP that describes how the MHP will ensure that all documentation includes the signature (or electronic equivalent) with the professional degree, licensure or title of the person providing the service.

Corrective Action Description

All of the signatures missing credentials identified by DHCS were on Assessments and Client Plans only, which were not yet part of our electronic health record. In our EHR, a provider's electronic signature automatically includes their credentials or title. Assessments were added to our EHR in FY19/20, and Client Plans are in the process of being added. We have sent an agency-wide reminder about signature requirements (with additional follow-up to the Program Managers and Clinical Specialists who oversee the providers identified in this review who are still employees), and we have added information to the New Employee Documentation Training regarding signature requirements. Additionally, our MHP-16 "Clinical Documentation Standards for SMHS" policy includes the signature requirements.

Sonoma County's Utilization Review Manager will also distribute a summary of the DHCS Triennial findings to all contracted specialty mental-health organizations as well as Sonoma County specialty mental-health staff so that they are aware of the requirements. We will follow up with provider trainings for contractors and an all-staff training for staff.

Proposed Evidence/Documentation of Correction

1) Credentials required when you sign clinical paperwork
2) New Employee Documentation Training - Other Assessments & Respectful Language 07.15.21
3) MHP-16 Clinical Documentation Requirements for SMHS
4) Summary of Triennial Findings for Staff and CBOs

Ongoing Monitoring (if included)

Triennial Auditing and Monitoring Team audits

Person Responsible (job title)

1) Avatar EHR Implementation: Adult Services Section Manager
2) Distributing DHCS Triennial Chart Review Findings: Utilization Review Manager
3) Ongoing Monitoring: Auditing and Monitoring Manager

Implementation Timeline

1) Assessments in the EHR, email to staff regarding credentials, and New Employee training update: Complete.
2) Client Plans in the EHR: By September 30, 2021

Requirement 3A

The provider obtains and retains a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication. (MHP Contract, Ex. A, Att. 9)

DHCS Finding 3A

The provider did not obtain and retain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication, and there was no documentation in the medical record of a written explanation regarding the beneficiary's refusal or unavailability to sign the medication consent:

1) **Line number 5**: The written medication consent form in the medical record was not current per the MHP's written documentation standards. The MHP's medication consent forms indicate that, "The Consent to Receive Psychiatric Medication will be updated every two years." The most recent medication consent that included prescribed medication of Olanzapine was completed on 3/9/17, but there was no available medication consent for Olanzapine on or after 3/9/19. Per progress notes, the beneficiary continued to be prescribed Olanzapine after this date, however, current medication consents that MHP provided did not include Olanzapine as one of the noted medications.

2) **Line number 6, 9, and 15**: Although there was a written medication consent form in the medical record, there was no medication consent for each of the medications prescribed. *The MHP was given the opportunity to locate the medication consent(s) in question but was unable to locate it/them in the medical record.*

   Line 6. The medication consent form that applied to the review period (signed and dated on 1/26/18) was missing Seroquel among the list of prescribed medications, although the beneficiary continued to be prescribed this medication. The MHP was able to locate consent forms that included Seroquel for time periods that applied prior to and after the review period.

   Line 9. The medication consent form available for review was missing Ativan among the list of the beneficiary's prescribed medications.

   Line 15. The medication consent form available for review was missing Zyprexa Lithium, Carbamazepine, and Trazadone among the list of the beneficiary's prescribed medications.

The MHP shall submit a CAP to address actions it will implement to ensure the following:

1) A written medication consent form is obtained and retained for each medication prescribed and administered under the direction of the MHP.

2) Written medication consent forms are completed in accordance with the MHP's written documentation standards.

Corrective Action Description

1) The MHP has provided training to our psychiatric providers regarding the requirements for Medication Consents at our Medical Staff Meeting, as well as by email. This training document is also reviewed with all new incoming psychiatrists.
2) The MHP is working with our EHR vendor to determine if Medication Consent due dates should be added to the EHR that would generate a "To Do" item for the providers.
3) Our prescriber annual Peer Reviews and our Auditing and Monitoring Team (AMT) triennial program reviews audit for Medication Consent documentation requirements.

Proposed Evidence/Documentation of Correction

1) "Medication Consents" training handout
2) MHP-13 Medication Monitoring policy
3) MHS-114 Medication Monitoring checklist
4) Comprehensive Audit Tracking Tool

Ongoing Monitoring (if included)

1) MD Peer Reviews (annual)
2) MHP Auditing & Monitoring Team program reviews (triennial)

Person Responsible (job title)

1) Avatar EHR Implementation: Adult Services Section Manager
2) MD Peer Reviews: Medical Director
3) Ongoing Monitoring: Auditing and Monitoring Team Manager

Implementation Timeline

1) Training: Completed for existing providers; ongoing for incoming providers
2) Auditing: Ongoing

Requirement 3C

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

1) Date of service.
2) The signature of the person providing the service (or electronic equivalent);
3) The person's type of professional degree, licensure or job title.
4) Relevant identification number (e.g., NPI number), if applicable.
5) The date the documentation was entered in the medical record.

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

DHCS Finding 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:

- Signature, including type of professional degree, licensure, or job title and signature date of the person providing the service (or electronic equivalent), and the date of the signature:
    - **Line numbers 4, 9, 14, 18, and 19.**
- Date the documentation was completed, signed (or electronic equivalent) and entered into the medical record:
    - **Line number 8.** The Medication Consent provided for the prescription of Buproprion was missing the date the provider completed and entered the medication consent form into the medical record.

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

1) Provider's signature (or electronic equivalent).
2) Provider's signature (or electronic equivalent) that includes professional degree, licensure or title.
3) Date the signature was completed and the document was entered into the medical record.

Corrective Action Description

1) The MHP has provided training to our psychiatric providers regarding the requirements for Medication Consents at our Medical Staff Meeting, as well as by email. This training document is also reviewed with all new incoming psychiatrists.

2) As of FY20/21, the Consent for Psychiatric Medications form has been placed in our EHR, which automatically places the provider's electronic signature, signature date, and submitted date on the form.
3) Our MD annual Peer Reviews and our Auditing and Monitoring Team (AMT) triennial program reviews audit for Medication Consent documentation requirements.
4) Our Provider Manual (to be issued by September 30, 2021) includes a section on Medication Consent requirements for contractors.

Proposed Evidence/Documentation of Correction

1) Evidence: "Medication Consents" training handout
2) MHP-13 Medication Monitoring policy
3) MHS-114 Medication Monitoring checklist
4) Summary of Triennial Findings for Staff and CBOs
5) Comprehensive Audit Tracking Tool
6) Provider Manual Draft

Ongoing Monitoring (if included)

1) MD Peer Reviews (annual)
2) MHP Auditing & Monitoring Team program reviews (triennial)

Person Responsible (job title)

1) Training Medical Staff on Requirements: Utilization Review Manager, Medical Director
2) Ongoing Monitoring: Medical Director, Auditing and Monitoring Team Manager
3) Provider Manual Documentation Content: Utilization Review Manager

Implementation Timeline:

1) Training: Completed for existing county providers; ongoing for incoming county providers
2) Provider Manual for contracted providers: By September 30, 2021
3) Consents in EHR: Complete
4) Auditing: Ongoing

Requirement 4B-1

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

DHCS Finding 4B-1

Client Plans were not completed prior to the delivery of planned services and/or were not updated at least annually or reviewed and updated when there was a significant change in the beneficiary's condition (as required in the MHP Contract with the Department and/or as specified in the MHP's documentation standards). Specifically:

- **Line number 2**: The Initial Client Plan was not completed until after one or more planned service was provided and claimed. **RR4a, refer to Recoupment Summary for details.**
- **Line number 2.** The Client Plan was completed as signed by the authorized LMHP on 4/16/19. The Client plan was previously signed by MHRS staff on 4/12/19, which is insufficient to authorize the Client Plan. Services that required an approved client plan (e.g. therapy services) were provided between 4/12/19 and 4/16/19.

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) Planned services are not claimed when the service provided is not included on a current Client Plan.

Corrective Action Description

1) As of May 15, 2020, the MHP clarified to staff that all required signatures must be on the plan before it becomes effective. This requirement was shared with Section Managers at our Quality Management Policy meeting, added to the Avatar Client Treatment Plan Dates Procedure and to the New Employee Documentation Training.
2) Our EHR automatically flags any services provided by county providers without an effective client plan and these services do not get claimed. As part of our monthly pre-billing audit, we do a 100% audit of all services that may be allowed without a Client Plan (e.g., TCM, ICC, Medication Support) to determine if they are reimbursable. Any services that do not meet standards for reimbursement without a client plan (including all Therapy, Collateral, Rehabilitation services) are not submitted for reimbursement.
3) For contracted agencies, the agency must attest when submitting service claims that all claims were in compliance with documentation requirements. Contracted agencies are audited triennially by our Auditing and Monitoring Team.

Proposed Evidence/Documentation of Correction

1) Avatar Client Treatment Plan Dates Procedure
2) New Employee Documentation Training – Client Plans
3) QMP Meeting Minutes 6/1/20
4) Client Plan Signature & Effective Dates – Training Aid for Managers
5) Avatar Pre-Billing Services Without Client Plan Audit Procedure
6) Billing Requirements for No Treatment Plan

Ongoing Monitoring (if included)

1) Monthly Pre-Billing Audit
2) Triennial Auditing & Monitoring Team audits

Person Responsible (job title)

1) Pre-Billing Audit: Pre-Billing Audit Clinical Specialist
2) Triennial CBO and Program Audits: Auditing and Monitoring Team Manager

Implementation Timeline

Implemented

Requirement 4B-2

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

DHCS Finding 4B-2

One or more client plan(s) was not updated at least annually. Specifically:

- **Line numbers 3 and 7**: There was a **lapse** between the prior and current Client Plans. However, this occurred outside of the audit review period.
- **Line number 3.** The prior Client Plan expired on 6/19/2018; the current Client Plan was signed by licensed staff on 8/14/2018.
- **Line number 7**: There was a **lapse** between the prior and current Client Plans. However, there were no claims during this period.
- **Line number 7.** The prior Client Plan expired on 5/24/19; the current Client Plan was signed by licensed staff on 6/13/19.

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

1) Each Personal Service Coordinator (PSC) has access to a report in the EHR of Client Plan due dates.
2) For the "Monitoring Documentation & Quality of Care" audit currently being completed weekly by treatment team Clinical Specialists and monthly by Health Program Managers for teams without Clinical Specialists, the auditor must report on late or missing Client Plans and document a plan for submitting overdue plans.
3) The Outpatient Utilization Review Clinical Specialist runs a monthly report on missing and extremely late Client Plans and follows up with the Program Managers and Clinical Specialists.
4) For contracted agencies, the agency must attest when submitting service claims that all claims were in compliance with documentation requirements. Contracted agencies are audited triennially by our Auditing and Monitoring Team.
5) We are creating a Provider Manual for contractors that includes documentation requirements, including frequency for Client Plans. We expect to share the final manual with contractors by September 30, 2021.

Proposed Evidence/Documentation of Correction

1) Sample Monitoring Documentation Quality of Care-Weekly Avatar Reports
2) Client Plans Expired by more than 70 days
3) Provider Manual draft
4) Comprehensive Audit Tracking Tool

Ongoing Monitoring (if included)

1) Weekly monitoring reports
2) Monthly late Client Plan monitoring
3) Triennial Auditing and Monitoring Team audits

Person Responsible (job title)

1) Monitoring Documentation & Quality of Care: Clinical Specialists, Health Program Managers
2) Monitoring Extremely Overdue Plans: Outpatient Utilization Review Clinical Specialist
3) Triennial Audits of Contractors: Auditing and Monitoring Team Manager
4) Provider Manual Documentation Requirements: Utilization Review Manager

Implementation Timeline

1) Client Plan Due Date report: Implemented and ongoing
2) Monitoring Documentation & Quality of Care audit: Implemented and ongoing
3) Outpatient Utilization Review Clinical Specialist monthly audit: Implemented and ongoing
4) Triennial Auditing & Monitoring Team audit: Implemented and ongoing
5) Provider Manual: By September 30, 2021

Requirement 4C

The MHP shall ensure that Client Plans:

1) Have specific, observable and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairment as a result of the mental health diagnosis.
2) Identify the proposed type(s) of interventions or modality, including a detailed description of the intervention to be provided.
3) Have a proposed frequency of the intervention(s).
4) Have a proposed duration of intervention(s).
5) Have interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance.
6) Have interventions are consistent with client plan goal(s)/treatment objective(s).
7) Have interventions are consistent with the qualifying diagnoses.

DHCS Finding 4C

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

- One or more proposed intervention did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded.
    - **Line number 11.** TBS was added as an addendum to the original Client Plan, but without specific description of the proposed intervention.
- One or more proposed intervention did not include an expected frequency or frequency range that was specific enough. **Line numbers 6, 11, and 20.**
    - **Line number 6.** The description of expected frequency for psychiatric rehabilitation services and case management were written as, "up to 4 hours", which does not provide a clear and specific frequency.
    - **Line number 11.** Therapeutic Behavioral Services was added to the Client Plan but without an expected frequency.
    - **Line number 20.** The Medication Support services frequency was written as "Psychiatrist will meet with you on a regular basis", without a specific frequency. The Targeted Case Management frequency was written "as needed basis," which is not a specific intervention frequency.
- One or more proposed intervention did not include an expected duration. **Line numbers 7, 11, 12, 13, 14, 15, 18, 19, and 20.**
    - **For Line numbers 7, 12, 13, 14, 15, 18, 19, and 20.** Expected duration was not included in the description of proposed interventions.

- **For Line number 11.** Therapeutic Behavioral Services was added to the Client Plan, but without an expected duration.

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

1) Mental health interventions/modalities proposed on client plans include a detailed description of the interventions to be provided and do not just identify a type or modality of service (e.g. "therapy", "medication", "case management", etc.).
2) Mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.

Corrective Action Description

1) The required New Employee Documentation Training instructs employees that interventions must be specific to the client's clinical needs.
2) The required New Employee Documentation Training includes instructions that proposed interventions on Client Plans indicate both an expected frequency and duration for each intervention.
3) Trainings for contracted agencies are based on the template for the New Employee Documentation Training, and so those trainings also include the above information. Client Plan trainings for contractors were conducted throughout FY19-20 and FY20-21.
4) Existing staff were trained on Client Plan requirements through FY18-19 and FY19-20, and Utilization Review staff continue to train treatment teams on Client Plan requirements regularly.

Proposed Evidence/Documentation of Correction

1) New Employee Documentation Training - Client Plans
2) Team Training Logs
3) Contractor Training Logs
4) Comprehensive Audit Tracking Tool

Ongoing Monitoring (if included)

1) Triennial Auditing and Monitoring Team program and CBO audits

Person Responsible (job title)

1) Documentation Training: Utilization Review Manager, Outpatient Utilization Review Clinical Specialist
2) Triennial Auditing: Auditing & Monitoring Team Manager

Implementation Timeline

Implemented and ongoing

Requirement 4H

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

1) Date of service.
2) The signature of the person providing the service (or electronic equivalent);
3) The person's type of professional degree, licensure or job title.
4) Relevant identification number (e.g., NPI number), if applicable.
5) The date the documentation was entered in the medical record.

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

DHCS Finding 4H

One or more Client Plan did not include signature of the person providing the service (or electronic equivalent) that includes the person's professional degree, licensure, job title, relevant identification number. Specifically:

Line numbers 1, 8, 19, 20: Missing provider's professional degree, licensure, or job title on the Client Plan in effect during the review period.

The MHP shall submit a CAP that describes how the MHP will ensure that all documentation includes provider signature (or electronic equivalent) with the professional degree, licensure, or job title.

Corrective Action Description

All of the signatures missing credentials identified by DHCS were on Assessments and Client Plans, which were not yet part of our electronic health record. In our EHR, a provider's electronic signature automatically includes their credentials or title. Assessments were added to our EHR in FY19/20, and Client Plans are in the process of being added. We have sent an agency-wide reminder about signature requirements (with additional follow-up to the Program Managers and Clinical Specialists who oversee the providers identified in this review who are still employees), and we have added information to the New Employee Documentation Training regarding signature requirements.

For contractors, Sonoma County's Utilization Review Manager will distribute a summary of the DHCS Triennial findings to all contracted specialty mental-health organizations so that they are aware of the requirements. We will follow up at a Provider Training, and our Utilization Review team is available to answer contractor and staff questions at our BHQA@sonoma-county.org email address.

Proposed Evidence/Documentation of Correction

1) Credentials required when you sign clinical paperwork
2) New Employee Documentation Training - Other Assessments & Respectful Language 07.15.21
3) Comprehensive Audit Tracking Tool

Ongoing Monitoring (if included)

1) Auditing and Monitoring Team triennial audits

Person Responsible (job title)

1) Avatar EHR Implementation: Adult Services Section Manager
2) Documentation Training: Utilization Review Manager
3) Triennial Audits: Auditing and Monitoring Team Manager

Implementation Timeline:

1) Email reminders to county staff to include credentials with signatures: Sent 6/17/21
2) Training: Added signature requirement to PowerPoint template for new employee training beginning August 5, 2021
3) EHR Implementation of Client Plans: by September 30, 2021
4) Auditing and Monitoring Team triennial audits: Ongoing

Requirement 5B

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

1) Timely documentation of relevant aspects of client care, including documentation of medical necessity.
2) Documentation of beneficiary encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions.
3) Interventions applied, beneficiary's response to the interventions, and the location of the interventions.
4) The date the services were provided.
5) Documentation of referrals to community resources and other agencies, when appropriate.
6) Documentation of follow-up care or, as appropriate, a discharge summary.
7) The amount of time taken to provide services.
8) The following:
   a) The signature of the person providing the service (or electronic equivalent);
   b) The person's type of professional degree, and,
   c) Licensure or job title.

DHCS Finding 5B

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

- **Line numbers 1, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18, and 19.** One or more progress note was not completed within the MHP's written timeliness standard of 3 business days after provision of service. Sixty-three (63) or 13.5 percent of all progress notes reviewed were completed late.

- **Line numbers 1, 3, 5, 6, 8, 11, and 18.** Progress note **"**Completion Timeliness" could not be determined because the provider signed, but did not date the note. Therefore, the note was considered late. Fifty-eight (58) or 12 percent of all progress notes reviewed did not include provider signature completion date (or electronic equivalent. Specifically:

  - **Line numbers 1, 3, 5, 6, and 8.** Progress notes for services provided by Buckelew did not include the date that the note was entered into the medical record, and only contained the date of service.

  - **Line numbers 11 and 18.** Progress notes for services provided by Petaluma People Services Center did not include the date that the note was entered into the medical record, and only contained the date of service.

- **Line number 12.** One or more progress notes was missing documentation of follow-up care, and/or if appropriate, a discharge summary.
    - Within the available progress notes, the provider noted a plan to follow-up with the beneficiary's mother to further assess if she knew of any history of the beneficiary being victim of past abuse. Within the available documentation, there was no further documentation of this additional assessment being conducted. The MHP was given the opportunity to locate any additional documentation, but no additional documentation could be located.
- **Line numbers 9, 11, and 18.** One or more 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. **RR8b3, refer to Recoupment Summary for details.**
    - **Line number 9.** For Medication Management claims on 4/3/19, 4/4/19, and 5/12/19, the MHP submitted copies of Hospitalization records from Marin General Hospital. The units of time for medication management visits on these dates could not be located on either the associated progress notes or the additional billing documents submitted by the MHP associated with these hospitalization periods; as such, progress notes could not be matched with the claims information.
    - **For Line numbers 11 and 18**, services were provided by Petaluma People Services Center and reviewers noted progress notes with units of time that were less than the time claimed. *MHP staff was given the opportunity to locate progress notes that matched the claims in terms of amount of time to provide services, but was unable to locate it/them in the medical record.* □□
        - **Line number 11**. Progress note dated 4/11/19 was for 92 minutes, though claim on the same date was for 102 Units of Time.
        - **Line number 18**:
            - Progress note dated 5/14/19 was for 81 minutes, though claim on the same date was for 82 Units of Time
            - Progress note dated 5/21/19 was for 60 minutes, though claim on the same date was for 79 Units of Time
            - Progress note dated 5/28/19 was for 60 minutes, though claim on the same date was for 87 Units of Time
            - Progress note dated 6/11/19 was for 77 minutes, though claim on the same date was for 83 Units of Time

- Progress note dated 6/18/19 was for 77 minutes, though claim on the same date was for 89 Units of Time

- **Line number 11.** The service time documented on one or more progress note was <u>greater</u> than the time claimed, which did not result in a recoupment.

  - The progress note dated 4/30/19 was for 142 minutes, though claim on the same date was for 131 Units of Time.

1) The MHP shall submit a CAP that describes how the MHP will ensure that progress notes document**:**
   1. Timely completion and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.
   2. Date the progress note was completed and entered into the medical record in order to determine completion timeliness, as specified in the MHP Contract with the Department.

2) The MHP shall submit a CAP that describes how the MHP will ensure that both service dates and times recorded on progress notes match their corresponding claims.

Corrective Action Description

1)
   a. The New Employee Documentation Training instructs employees to complete notes within three business days of the service and to include relevant aspects of client care. We are also developing, in conjunction with our clinical supervisory staff, a training document providing further clinical guidance about what to include in progress notes and how to consider following up. This document would become a hand-out distributed to existing and new staff. Trainings for contracted organizations are based on the templates for New Employee Documentation Trainings and therefore would include the same information.
   b. On the "Monitoring Documentation & Quality of Care" audit currently being completed weekly by treatment team Clinical Specialists and monthly by Health Program Managers for teams without Clinical Specialists, the auditor reviews a sample of one month's progress notes for two clinicians each review period. In the monthly meeting with the Utilization Review Manager, the Clinical Specialists discuss strategies for ensuring that their teams are providing clinically appropriate care and that their documentation reflects that; this meeting is where the "Progress Note Clinical Guidance" document was drafted.
   c. Health Program Managers continue to complete the "Weekly Report Review & Action Steps Worksheet" and submitting it to their Section Manager and/or Client Care Manager. To complete the worksheet, they must monitor the

"Progress Notes in Late Status" report, enter the number of late notes for their staff, and report that to their manager(s), along with comments about how they are working to address it with staff.

d. For services provided by county employees, the Sonoma County EHR accurately captures the date of service and the date of submission for progress notes.
e. For contractors, the Utilization Review Manager will work with our contracted agencies to determine if their documentation practices meet the requirement for listing both the service date and submission date.
f. The Utilization Review Manager will send out a summary of the Triennial findings to our contractors, and will work to ensure that each contractor documents the date the progress note was completed and entered into the medical record in order to determine completion timeliness.

2) Each contracted agency that submits claims to Sonoma County for reimbursement attests that the claims are accurate. Due to these findings as well as many others with this particular contractor, Sonoma County no longer contracts for specialty mental health services with the agency that submitted those claims.

Proposed Evidence/Documentation of Correction

1) New Employee Documentation Training – Progress Note Content & Format
2) Progress Note Clinical Guidance – DRAFT
3) Example of Monitoring Documentation & Quality of Care worksheet
4) Sample Clinical Specialists & QAPI meeting agenda
5) Example of Weekly Report Review worksheet
6) Example Progress Note with DOS and Submitted Date (the DOS is highlighted on the top of p. 1; the date of signature, which is the date the note is submitted in the EHR, is on the bottom of p. 3)

Ongoing Monitoring (if included)

1) Monthly Pre-Billing Audit of progress notes
2) Auditing & Monitoring Team triennial program and CBO audits
3) Monitoring Documentation & Quality of Care worksheet (weekly/monthly)
4) Weekly Report Review worksheets (monthly)

Person Responsible (job title)

1) Documentation Training: Utilization Review Manager, Outpatient Utilization Review Clinical Specialist
2) Monitoring Documentation & Quality of Care: Clinical Specialists, Health Program Managers
3) Weekly Report Review & Action Steps Worksheet: Health Program Managers

4) Review of Documentation Requirements and Distribution of DHCS Triennial Chart Review Findings to Contracted Agencies: Utilization Review Manager

Implementation Timeline:

1) Ongoing monitoring and Sonoma County staff training: Implemented and ongoing, as stated in Ongoing Monitoring section
2) Email to contractors with Triennial findings: By August 31, 2021

Requirement 5C

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

(CCR, title 9, § 1840.314(c).)

DHCS 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:

5) **Line numbers 2 and 17.** Progress note(s) did not document the amount of time of involvement of each provider claimed, including the clear identification and differentiation of direct service, travel and documentation times, if appropriate. **RR13b, refer to Recoupment Summary for details.**

    - **Line number 2.** For services provided by Community Support Network at Opportunity House, group services were provided by co-facilitators without details on the specific involvement of each provider.

    - **Line number 17.** For services provided by Sunny Hills Services, group services were provided by co-facilitators. Though progress notes document the amount of time claimed by each provider, the progress note only clearly describes the services provided by the primary facilitator / progress note author. There is not clear identification of specific services provided by the secondary staff.

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

1) Document and differentiate the contribution, specific involvement, and units of direct service, travel and documentation times for each provider/facilitator whenever a claim represents services rendered by more than one (1) provider within the same activity or session, including groups, "team meetings" and "case consultations".
2) Contain accurate and complete documentation of claimed service activities, that the documentation is consistent with services claimed, and that services are not claimed when billing criteria are not met.
3) Include a clinical rationale when more than one (1) provider renders services within the same group session or activity

Corrective Action Description

1) For group services provided directly by Sonoma County Behavioral Health staff, a Utilization Review pre-approval process, including documentation training specific to groups, is required. The documentation training includes information regarding proper documentation for multiple providers. Additionally, the Utilization Review Manager provided training to all staff on 11/04/2020 regarding documentation for services with multiple providers.
2) The Utilization Review Manager will send out a summary of the Triennial findings to our contractors by August 31, 2021, and will follow up with trainings regarding group note requirements for those contractors who provide group services by 9/30/2021.

Proposed Evidence/Documentation of Correction

1) 19.02.13 QIS Training – Reinstating Group Notes
2) MHS 166 – Treatment Group Proposal Form
3) MHS 167 – Treatment Group Referral Form
4) PowerPoint presentation "Documentation Tip – Consultations & Multiple Providers"
5) Comprehensive Audit Tracking Tool

Ongoing Monitoring (if included)

1) Pre-billing audit of progress notes
2) Auditing & Monitoring Team triennial program and CBO audits
3) Monitoring Documentation & Quality of Care worksheet (weekly/monthly)

Person Responsible (job title)

1) Documentation Training: Utilization Review Manager, Outpatient Utilization Review Specialist
2) Distribution of DHCS Triennial Chart Review Findings to Staff and Contracted Agencies: Utilization Review Manager
3) Ongoing Monitoring: Pre-Billing Audit Clinical Specialist, Auditing & Monitoring Team Manager, Clinical Specialists, Health Program Managers

Implementation Timeline:

1) Sonoma County staff: Implemented and ongoing
2) CBO: Email guidance by 8/31/21; individual trainings for contractors who provide group services by 9/30/21

Requirement 5D

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

1) Every service contact for:
    1) Mental health services
    2) Medication support services
    3) Crisis intervention
    4) Targeted Case Management
    5) Intensive Care Coordination
    6) Intensive Home Based Services
    7) Therapeutic Behavioral Services
2) Daily for:
    1) Crisis residential
    2) Crisis stabilization (one per 23/hour period)
    3) Day treatment intensive
    4) Therapeutic Foster Care
3) Weekly for:
    1) Day treatment intensive (clinical summary)
    2) Day rehabilitation
    3) Adult residential

(MHP Contract, Ex. A, Att. 9; CCR, title 9, §§ 1840.316(a)-(b); 1840.318 (a-b), 1840.320(a-b).)

DHCS Finding 5D

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

- **Line numbers 11, 13, and 18.** There was no progress note in the medical record for the service(s) claimed. **RR8a, refer to Recoupment Summary for details**. *The MHP was given the opportunity to locate the document(s) in question but did not provide written evidence of the document(s) in the medical record.*
    - **Line number 11.** There was no progress note in the medical record for the following claims:
        - 4/10/19; Service Function 30; 156 Units of Time
        - 4/21/19; Service Function 30, 82 Units of Time
        - 6/27/19; Service Function 1; 120 Units of Time

- **Line number 13.** There was no progress note in the medical record for the following claims:
  - 4/17/19; Service Function 30; 102 Units of Time
  - 4/23/19; Service Function 30; 30 Units of Time
  - 4/30/19; Service Function 30; 32 Units of Time
  - 5/7/19; Service Function 30; 30 Units of Time
  - 5/14/19; Service Function 30; 30 Units of Time
  - 5/21/19; Service Function 30; 3 Units of Time
- **Line number 18.** There was no progress note in the medical record for the following claims:
  - 4/23/19; Service Function 30; 91 Units of Time
  - 5/7/19; Service Function 30; 91 Units of Time

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

1) Ensure that all Specialty Mental Health Services claimed are:
   a) Documented in the medical record.
   b) Actually provided to the beneficiary.
   c) Appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a)(b).
   d) Claimed for the correct service modality billing code, and units of time.
2) Ensure that all progress notes:
   a) Are accurate, complete and legible and meet the documentation requirements described in the MHP Contract with the Department.
   b) Describe the type of service or service activity, the date of service and the amount of time to provide the service, as specified in the MHP Contract with the Department.
   c) 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

Sonoma County no longer contracts with Petaluma People Services, the agency that billed for those services, for specialty mental health,

Proposed Evidence/Documentation of Correction

N/A

Ongoing Monitoring (if included)

N/A

Person Responsible (job title)

N/A

Implementation Timeline:

Implemented

Requirement 6A

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)

DHCS Finding 6A

The MHP did not furnish evidence that it has a standard procedure for providing and documenting individualized determinations of eligibility for ICC services and IHBS on behalf of beneficiaries under age 22 that is based on their strengths and needs.

At the time of the review, the MHP was providing ICC/IHBS services to Katie A. subclass children only. The MHP indicated future intent to provide ICC/IHBS services to all beneficiaries under age 22 that meet criteria for ICC/IHBS based on the *Medi-Cal Manual For Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries (Third Edition, January 2018)*, regardless of Katie A. class or subclass membership. The MHP was also able to provide DRAFT ONLY copies of policies that demonstrate to put in place this future practice.

The MHP shall submit a CAP that describes how it will ensure that:
1) Written documentation is in place describing the process for determining and documenting eligibility and need for ICC Services and IHBS.
2) Training is provided to all staff and contract providers who have the responsibility for determining eligibility and need for ICC and IBHS.
3) 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

1) The Youth and Family Section Manager and the Quality Assurance Manager will revise the ICC/IHBS/TFC screening tool to reflect current eligibility criteria.
2) The Youth and Family Section Manager will ensure that all appropriate clinical staff are trained to use the revised ICC/IHBS/TFC screening tool, including when to administer the screening.
3) To ensure that clients under age 22 who are authorized to receive Specialty Mental Health Services receive individualized determination of eligibility and need for ICC Services and IHBS, the Youth and Family Section Manager will establish a workflow to ensure that the ICC/IHBS/TFC screening tool is being used at the time of assessment and reassessment.

Proposed Evidence/Documentation of Correction

1) Revised ICC/IHBS/TFC Screening tool (when complete)
2) DHS-BHD Staff Training Documents – ICC/IHBS/TFC screening tool use and administration (when complete)
3) Monthly spot checks for appropriate use of screening tool (when complete)

Ongoing Monitoring (if included)

Foster Youth Team Manager will conduct monthly spot checks to monitor appropriate use of ICC/IHBS/TFC screening tool

Person Responsible (job title)

1) Revising ICC/IHBS/TFC Screening Tool: Youth and Family Section Manager, Quality Assurance Manager
2) Training Staff: Youth and Family Section Manager
3) Monthly Spot Checks: Foster Youth Team Manager

Implementation Timeline

1) ICC/IHBS/TFC Screening Tool: Finalized by August 31, 2021
2) Clinical training of staff: by September 30, 2021
3) Monthly spot checks: by October 29, 2021