FISCAL YEAR (FY) 2017/2018 ANNUAL REVIEW OF CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES
FRESNO COUNTY MENTAL HEALTH PLAN REVIEW
May 7, 2018

ITEMS OUT OF COMPLIANCE – PLAN OF CORRECTION

ATTESTATION

DHCS randomly selected five Attestation items to verify compliance with regulatory and/or contractual requirements. All requirements were deemed in compliance. A Plan of Correction is not required.

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SECTION B: ACCESS

PROTOCOL REQUIREMENTS	
B2. B2a	Regarding the provider directory: Does the MHP provide beneficiaries with a current provider directory upon request and when first receiving a SMHS?
B2b.	Does the MHP provider directory contain the following required elements: 1) Names of provider(s), as well as any group affiliation?
	2) Street address(es)?
	3) Telephone number(s)?
	4) Website URL, as appropriate?
	5) Specialty, as appropriate?
	6) Whether the provider will accept new beneficiaries?
	7) The provider's cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled interpreter?
	8) Whether the provider has completed cultural competence training?
	9) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment?
• *CFR, title 42, section 438.10(f)(6)(i)and 438.206(a)* • *CCR, title 9, chapter 11, section 1810.410* • *CMS/DHCS, section 1915(b) Waiver*	• *DMH Information Notice Nos. 10-02 and 10-17* • *MHP Contract*

FINDINGS

The MHP did not furnish evidence it provides beneficiaries with a current provider directory upon request and when first receiving a SMHS and the MHP's provider directory did not contain Website URL, DHCS reviewed the following documentation presented by the MHP as

evidence of compliance: Provider Directory policy, and the Fresno County Mental Health Plan Provider Directory. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the Provider Directory did not include the provider's websites. Protocol question B2b (4) is deemed OOC.

PLAN OF CORRECTION

The MHP provided an updated Provider Directory during the review that included the provider's website. A POC addressing the OOC findings for these requirements is not required.

PROTOCOL REQUIREMENTS	
B5e.	Does the MHP ensure its written materials comply with the following: 1) Use easily understood language and format (i.e., 6th grade reading level)?
	2) Use a font size no small than 12 point?
• *CFR, title 42, section 438.10(d)(i),(ii)* • *CCR, title 9, chapter 11, sections*	• *CFR, title 42, section 438.10(d)(2)* • *MHP Contract, Exhibit A, Attachment I*

FINDINGS

The MHP did not furnish evidence it ensures its written materials comply with easily understood language and format (i.e., 6th grade reading level). The MHP did not provide any evidence of compliance. The MHP stated that currently they have no formal way to verify the reading level of their written materials. Protocol question B5e (1) is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it ensure its written materials comply with easily understood language and format (i.e., 6th grade reading level) and use a font size no small than 12 point.

FRESNO'S RESPONSE:

The MHP has initiated a review and revision process of its written materials utilizing the Flesch-Kincaid readability test in Microsoft Word to ensure its written materials comply with easily understood language and format (i.e. 6th grade reading level), as mandated by 42 CFR 438.10 (d) (6) (i). Fresno County DBH Policy and Procedure Guide 2.1.10G - Beneficiary Informing Materials (Attachment A) reflects this requirement as well as the use of a font size no smaller than 12 point. The MHP expects to complete revisions to its written materials by November 2018. Samples of revised written materials (Flesch-Kincaid Grade Level Readability Statistics report is included for demonstration purposes) are included in Attachments A-1 and A-2.

PROTOCOL REQUIREMENTS		
B9 a.	Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number:	
	1) Does the MHP provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county?	
	2) Does the toll-free telephone number provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met?	
	3) Does the toll-free telephone number provide information to beneficiaries about services needed to treat a beneficiary's urgent condition?	
	4) Does the toll-free telephone number provide information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes?	
• *CCR, title 9, chapter 11, sections 1810.405(d) and 1810.410(e)(1)* • *CFR, title 42, section 438.406 (a)(1)*		• *DMH Information Notice No. 10-02, Enclosure,* • *Page 21, and DMH Information Notice No. 10-17, Enclosure, Page 16* • *MHP Contract, Exhibit A, Attachment I*

The DHCS review team made seven (7) calls to test the MHP's 24/7 toll-free line. The seven (7) test calls are summarized below:

Test Call #1 was placed on March 1, 2018, at 10:22 a.m. The call was answered after six (6) rings via a live operator. The caller requested information about accessing mental health services in the county. The operator started the call with asking, "Is this an emergency". The caller responded that it is not emergency. Then the operator asked the caller to provide his/her name, age and phone number. The caller gave first and last name but declined to give age and phone number. The operator verified the service needs with the caller, then provided phone number, address and type of services available at the urgent care wellness center and crisis services in Fresno. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and the caller was provided information about services needed to treat a beneficiary's urgent condition.

The call is deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #2 was placed on April 12, 2018, at 7:29 a.m. The call was answered after four (4) rings via a live operator. The operator informed the caller that he/she reached the access line and asked if this was an emergency. The caller replied in the negative. The operator asked the caller if he/she needed an interpreter. The caller replied in the negative. The operator

asked the caller for his/her name, telephone number, age, and what insurance the caller had. The caller provided his/her name, age, and insurance information however, declined to provide a telephone number. Upon answering the operator's questions, the caller requested information about how to access services. The operator asked the caller if he/she was in crisis or having any thoughts of hurting him/herself or others. The caller replied in the negative. The operator informed the caller that if not in crisis that the operator would provide information about the walk in clinic for Mental Health Services which include an array of services. The operator provided the caller the clinics hours of operation, address, and telephone number. The caller thanked the operator and ceased the call. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, the caller was provided information about services needed to treat a beneficiary's urgent condition and an interpreter.

The call is deemed in compliance with the regulatory requirements for protocol questions B9a1, B9a2, and B9a3.

Test Call #3 was placed on April 3, 2018, at 7:39 a.m. The call was answered after two (2) rings via a live operator. The operator provided his/her name, offered interpreter services, and questioned whether the call was for an emergency. The caller requested information about filing a grievance in the county. The operator asked the caller to provide his/her name and phone number in case the call was disconnected, but graciously accepted the caller declining to provide that information. The operator provided two methods to file a complaint. First, by providing the phone number for Managed Care; and secondly, by offering to e-mail Managed Care to request they return the call. The first method requires the beneficiary to dial again to gain the information that the 24/7 line should provide, the second method requires a return call from the MHP. Prompts for further information did not encourage more information on the grievance process. The operator offered interpretation services, inquired about the caller's current condition, but did not provide information on how to file a grievance.

The call is deemed in compliance with the regulatory requirements for protocol questions B9a1, and B9a3. The call is deemed out of compliance with regulatory requirements for protocol question B9a4.

Test Call #4 was placed on April 5, 2018 at 12:03 p.m. The call was answered after one (1) ring via a live operator. The operator provided his/her name, asked the caller if it was an emergency. The caller replied in the negative. The operator asked if he/she could get the caller's phone number to call in case the call got disconnected. The caller said he/she would rather not give his/her phone number. The operator asked for the caller's name. The caller provided a name. The operator asked if the caller was having suicidal thoughts of hurting him/herself. The caller replied in the negative. The operator asked how he/she could help. The caller said he/she is feeling depressed, sad, and overwhelmed due to being the sole caretaker for his/her mother. The operator gave the caller the address, phone number, and hours of operation to the 24 hour crisis stabilization center. The caller stated he/she just wanted to talk with a counselor. The operator asked if the caller was linked to mental health services, the caller responded in the negative. The operator asked what type of health insurance the caller had. The caller said Medi- Cal. The operator gave the address, phone number, and hours of operation to the outpatient clinic. The operator explained that the caller could walk in from 9 a.m. to 5 p.m. to be assessed and linked to mental health services. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical

necessity criteria are met, and the caller was provided information about services needed to treat a beneficiary's urgent condition.

The call is deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3

Test Call #5 was placed on April 10, 2018, at 3:55 p.m. The call was answered after one (1) ring via a live operator. The caller requested information about accessing mental health services in the county for depression and not feeling like his/herself. The operator asked for the caller's name. The operator asked if the caller was in crisis, or wanting to hurt him/herself or others. The caller responded in the negative. The operator asked if the caller was a Fresno County resident and the caller replied yes. The operator asked if the caller has ever been seen for mental health services or been on psychotropic medication before. The caller replied in the negative. The operator asked if the caller wanted to be seen for counseling and the caller replied yes. The operator provided two options: 1) Urgent Care Wellness Center, no appointment necessary, walk-in hours are Monday through Friday, 8:00 a.m. to 5:00 p.m. This center is part of Fresno County Behavioral Health. Phone number is 559-600-9171 and located at 4441 East Kings Canyon Road, Fresno, CA 93702. Care Team provides assessment and can refer out to providers. 2) For Crisis situations, if harming self/others, can't groom self, etc., can be seen on walk-in basis at 24-hour stabilization center called Exodus Recovery. Address is 4411 East Kings Canyon Road, Fresno, CA 93702, phone number is 559-453-1008. The operator also explained to call 911 for emergency or go to emergency room if needed. No additional information about SMHS was provided to the caller. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and the caller was provided information about services needed to treat a beneficiary's urgent condition.

The call is deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #6 Test call was placed on April 19, 2018, at 8:04 a.m. The call was answered after one (1) ring via a live operator. The operator answered the phone and introduced him/herself. The operator asked if it was an emergency. The caller replied in the negative. The operator asked for the caller's phone number, and personal info. The caller indicated that he/she was calling regarding his/her son who was having issues at school and at home. The caller indicated he/she was worried about his/her son's behavior and was referred to mental health services by the son's doctor. The operator asked the caller to provide the son's DOB (04/05/2005) and son's name (Darren Gomez). The operator asked if the caller had prior mental health issues or if the caller believed he/she would hurt him/herself or others. The caller indicated that he/she did not believe he/she was a threat to him/herself or others. The operator asked if the son had any drug use, the caller indicated that he/she was not aware of any. The operator indicated that the caller could walk in to the Children's Mental Health center, located at 3133 N. Millbrook, Fresno CA and pick up an application to get the process started. The operator indicated that the caller would need legal guardian documents such as a birth certificate and could go to the center M- F, 7:30 a.m-5 p.m. The operator stated that for the initial application the child does not have to be present. The operator also provided the phone number for the center.

The operator also indicated that if the child was in a crisis the caller could call 911 at any time

and let them know they previously spoke with Fresno county SMHS and they could provide crisis services. Or indicated the caller could take his/her son to the crisis center located at 4411 East Kings Canyon Rd, Fresno CA. The crisis center is open 24/7 for services and the operator provided the phone number. The operator also indicated that he/she could call back on the access line for any additional help. The operator asked if the caller had any additional questions or if he/she needed more info regarding the process. The caller confirmed that the/she would go to the center to get an application and start the process. The operator confirmed that this was the first step in getting the child SMHS. The caller thanked the operator and ended the call. The caller was provided information about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, and the caller was provided information about services needed to treat a beneficiary's urgent condition

Test call was deemed in compliance with the regulatory requirements for protocol questions B9a2 and B9a3.

Test Call #7 Test call was placed on April 19, 2018, at 12:21 p.m. The call was answered after two (2) rings via a live operator. The caller explained that he/she wanted to know what to do to file a complaint. The operator asked for caller's first and last name and if the caller needed an interpreter. The caller provider his/her name and responded in the negative to needing an interpreter. The operator explained that for a grievance, the caller had the right to change the provider and that someone from managed care can help and provided the phone number. Another option is that the information could be mailed to the caller, the operator then requested the callers address. The operator also stated the caller could come and pick up the information in person and provided the address: 4409 East Inyo Avenue, Mode. A, Fresno, CA 93702. In addition, the caller could go to urgent care center to pick up the information. The operator also added that the appeal processing takes 3 working days. The caller thanked the operator and ended the call**.** The caller was offered interpreter services, and provided information about how to use the beneficiary problem resolution process.

Test call was deemed in compliance with the regulatory requirements for protocol questions B9a1 and B9a4.

FINDINGS

Test Call Results Summary

Protocol Question	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
9a-1	N/A	IN	IN	N/A	N/A	N/A	IN	**100%**
9a-2	IN	IN	N/A	IN	IN	IN	N/A	**100%**
9a-3	IN	IN	IN	IN	IN	IN	N/A	**100%**
9a-4	N/A	N/A	OOC	N/A	N/A	N/A	IN	**50%**

In addition to conducting the seven (7) test calls, DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy and Procedure (P&P) Access/Referrals 24 hour toll Free Beneficiary Access Line, test call quarterly update report form, and the Exodus Access Line Script. However, it was determined the

documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Protocol question 9a-4 is deemed in partial compliance.

PLAN OF CORRECTION

The MHP will submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a statewide, toll-free telephone number 24 hours a day, 7 days per week, with language capability in all languages spoken by beneficiaries of the county that will provide information to beneficiaries about how to use the beneficiary problem resolution and fair hearing processes.

FRESNO'S RESPONSE:

1. Description of Corrective Actions, including milestones:

The Fresno County MHP acknowledges the issues and is proactive in improving the MHP Access Line, in Fiscal Year (FY) 2016-17 the MHP provided a Performance Improvement Project (PIP) based on the Access Line not meeting mandated State goals. The completion of FY 2016-17 PIP prompted the request of a new Access Line Database and continuation of Exodus Recovery, Inc. to operate the MHP Access Line. On April 16, 2018, the Fresno County, MHP Leadership Team approved the development and implementation of a new Access Line Database via the MHP's Electronic Health Record Avatar system. In addition to the new Access Line Database, the MHP Access Line Operations unit (Exodus Recovery, Inc.) will utilize a new Desk Guide that will provide the operator resources and processes on how to access services and how to file a grievance.

2. Timeline for Implementation and/or completion of corrective actions:

MHP Database – Development and implementation plan is scheduled through the month of September 2018 with a "Go Live" date of October 1, 2018.

	Month(s)	Action
1.	May/June 2018	Develop Access Line Database
2.	July 2018	Review, Input Feedback from appropriate MHP and Exodus operators
3.	July/August 2018	Test Database and create query reports to be utilized
4.	August 2018	Follow up on changes to database and finalize. Present final product to leadership team for approval.
5.	September 2018	Train appropriate MHP Staff and Exodus Operators on the usage of the new Avatar Access Line Database.
6.	October 1, 2018	Implement the Access Line Database, "Go Live"

Desk Guide – In addition to the new Access Line Database, the MHP is seeking to develop and implement a "Desk Guide" to provide information to beneficiaries calling the access line. The Desk Guide is currently in draft and will incorporate input from both MHP and Exodus Contract Provider. The MHP anticipates releasing the Desk Guide prior to October 1, 2018. The MHP meets frequently with Exodus (monthly contract meeting,

Access Subcommittee and the MHP Quality Improvement Committee meeting) to discuss any issues/concerns and test call results for the month. Exodus received results of the FY 2017-18 DHCS Triennial report and acknowledges the use of new interventions of an access line database and a desk guide.

Training – With the intervention of a new access line database and desk guide, training tech support will be provided to appropriate staff. Fresno County MHP will provide training to appropriate County staff on an annual basis and technical support to those staff that require a refresher course. The MHP will provide training to Exodus Recovery, Inc. Access Line Operating staff utilizing the access line in September 2018.

3. Proposed (or actual) evidence of correction that will be submitted to DHCS:

Database – The Access Line Call log and Script are currently in developmental phase but is available upon request via screen shots if necessary. The Database is not accessible to appropriate staff at this time.

Desk Guide – The MHP along with Exodus is in agreement of providing staff with an additional resource, desk guide. The Desk Guide will be available to all MHP Access Entry points. Currently a beneficiary/consumer entering the mental health system has the right to file a grievance (grievance forms are available for beneficiary/consumers at all entry access points). The MHP is mandated to have brochures and self-addressed stamped envelopes available at all mental health lobbies. As it relates to the access line, for beneficiaries/consumers who wish to proceed with filing a grievance the operator will inform the beneficiary/consumer their rights and options to submit a grievance:

"DESK Guide (being developed) – Grievance Information:

Grievances can be submitted in person, in writing or by telephone as it relates to the Access Line. The Access Line Operator will notify beneficiary/consumer his/her options:

a) *Option I (In Person)*; the operator will inform and encourage the beneficiary/consumer to walk in person and speak with appropriate operations manager to file a grievance directly.
b) *Option II (in Writing)* Operator will direct beneficiary/consumer where the caller can access a grievance forms (self-addressed stamped envelope), these forms are located at all entry access points (consumer lobbies). In addition, the caller will be informed that Grievance Forms can be downloaded via the Fresno County, Managed Care website – consumer forms http://www.co.fresno.ca.us/home and mailed to the address noted below. The downloaded grievance form can also be faxed to Managed Care at (559) 455-4633. The operator will also advise the beneficiary/consumer that they can submit their own grievance in writing and mail it to: Fresno County Mental Health Plan at PO BOX 45003, Fresno, CA 93718-9886.
c) *Option III (By Phone) File the grievance over the phone;* Operator will provide, when available, a warm hand-off from the Access Line to Managed Care and speak directly with a Managed Care

staff team member for assistance. Managed Care hours of operation is Monday through Friday, 8am to 5pm excluding holidays. Managed Care staff will help caller file the grievance over the phone. All callers wishing to file a grievance will be logged within the Access Line Database and will receive a follow up call by Managed Care staff within three business days. The Managed Care direct line will also be provided to callers requesting to file a grievance, (559) 600-4645. The MHP will further look into exploring other alternatives to assist the beneficiary in filing a grievance with the MHP.

Trainings – All training related to the Access Line will be filed, materials used for curriculum, Agenda and Sign-In sheet of attendees will be filed for future reference. Trainings provided by the Access Line Operations team will also be recorded and shared with the MHP.

4. **Mechanism for monitoring the effectiveness of corrective actions over time. If the POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS:**

The MHP currently has a mechanism in place to test the new interventions. On a monthly basis the Quality Improvement Team provides for 15 test calls per month. Each test call is scripted for various scenarios; grievances being one of the nine scripts. Beginning October 2018, monthly test calls will include, at minimum, one grievance call scenario to test the Access Line and provide feedback to the Exodus Recovery, Inc. Access Line team. The test call data will provide Operator, Date of Call, Time of Call, Name of Caller, and Reason for the Call, Written Call Log data, Assessment for Crisis, and Disposition and how to access Specialty Mental Health Services/Grievances, Language Request and Comments from the Test Caller. Information provided by the access line operator will be noted within the comment section of each test call monthly report. This information is presented, reviewed, and analyzed at the Access Subcommittee and the Quality Improvement Committee (QIC). Exodus Recovery, Inc. attends the Access Subcommittee and is a member of the QIC. Aside from the Committee meetings, an e-mail for a plan of correction is mailed to the vendor along with the monthly data. Any issues/concerns are also addressed at the monthly vendor conference meetings between MHP and Exodus Recovery, Inc.

5. **Description of corrective actions required of the MHP's contract providers to address findings:**

The MHP works closely with Access Line Operations Team, Exodus Recovery, Inc. on all issues and concerns to be addressed. Exodus Recovery, Inc. is participating in the development and implementation of the new Access Line Database. On July 24, 2018, Exodus will have an opportunity to review and provide input and feedback on the new database. In addition, the vendor will have an opportunity to add additional reports that may benefit Access Line Operations. In addition, Exodus will participate in the development of the Desk Guide, which will be provide at each Access Line workstation. As of now, Exodus provides a list of training provided to staff and is aware that the MHP

is available for technical support and assistance as it relates to the 24/7 toll free Access Line.

PROTOCOL REQUIREMENTS	
B13a.	Regarding the MHP's plan for annual cultural competence training necessary to ensure the provision of culturally competent services:
	1) Is there a plan for cultural competency training for the administrative and management staff of the MHP?
	2) Is there a plan for cultural competency training for persons providing SMHS employed by or contracting with the MHP?
	3) Is there a process that ensures that interpreters are trained and monitored for language competence (e.g., formal testing)?
B13b.	Does the MHP have evidence of the implementation of training programs to improve the cultural competence skills of staff and contract providers?
• *CCR, title 9, chapter 11, section 1810.410 (a)-(e)* • *DMH Information Notice No. 10-02, Enclosure, Pages 16 & 22*	• *MHP Contract, Exhibit A, Attachment I*

FINDINGS

The MHP did not furnish evidence it has a plan for annual cultural competence training necessary to ensure the provision of culturally competent services. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: MHP provided the following training documentation: Empowering Black Families and Communities through Resiliency, Restoration, and Reconnection, KHMER Cross Cultural Education workshop, Islamic Culture Awareness Training, Cultural Competence Summit XX: Supporting Community defined practices, 5th annual Latino conference, 2017 Asian Pacific Islander Mental Health Empowerment Conference, Hmong Spiritual Healing & Mental Health, Fostering Growth in Cultural and Linguistic Competence, LGBTQ 101 Training including sign in sheets for the attendees, and the County Employees Core Training Participation Rate log. HEMCDT (Health Equity and Multicultural Training): This training started in August of 2017 and is targeted for 100% of Fresno County Department of Behavioral Health (DBH) staff as well as a percentage of each contracted program. The MHP has implemented a variety of cultural competency activities since the hiring of their Ethnic Services manager. The MHP hosts 2-day trainings for 45 people twice per month and this is scheduled to go through September of this year to capture all DBH staff and as many of the contracted provider staff as possible. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP did not have a tracking system that identified cultural competency training for administrative and management staff and/or persons providing SMHS employed by or contracting with the MHP that was implemented during the triennial review period. Protocol questions B13a (1) and B13a (2) is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has a plan for annual cultural competence training necessary to ensure the provision of culturally competent services. Specifically, the MHP must develop a plan for, and provide evidence of implementation of, cultural competency training for administrative and management staff as well as persons providing SMHS employed by or contracting with the MHP. The MHP must develop a process to ensure interpreters are trained and monitored for language competence.

FRESNO'S RESPONSE:

PLAN OF CORRECTION & TIME OF IMPLEMENTATION:

1. The MHP is finalizing Policy and Procedure Guideline (PPG) 1.5.1-Cultural Competency (Attachment B) for County staff and updating Cultural Competency Contract Language (Attachment B-1) for contracted SMHS providers. These changes which will require all County staff and contracted SMHS providers to complete eight (8) hours of annual cultural competency training.
    a. September 28, 2018 is the anticipated finalization date for PPG 1.5.1.
    b. September 3, 2018 is the anticipated finalization date for the Contract Language. For SMHS Agreements due for renewal prior to FY 19/20, the MHP will modify the Agreement during the renewal process. For SMHS Agreements not due for renewal prior to FY 19/20, MHP will issue a Cultural Competency Directive Letter by September 28, 2018.
2. The MHP is securing Relias Learning Management System (LMS) (Attachment B-2) as a training mechanism to ensure all County staff and contracted SMHS providers receive required cultural competency training. The LMS will have the ability to plan, coordinate, schedule, track, and measure training efforts across divisions, programs, units, agencies and the population. The item is scheduled to go before Fresno County's Board of Supervisors on August 7, 2018. If approved, the LMS will be implemented in two phases – County Staff & Contracted SMHS Providers.
    a. Relias will upload County staff into the LMS by September 3, 2018. County staff includes all administrative, management and persons providing SMHS. MHP will automatically upload staff utilizing Human Resource Information System.
    b. Relias will upload contracted SMHS providers into the LMS by September 2, 2019. Going forward, MHP will upload contracted SMHS providers manually using a Monthly Staffing Report (Attachment B-3). The MHP will utilize Microsoft Excel to track trainings for contracted SMHS providers until the LMS is available on September 2, 2019.
    c. The following cultural competency trainings are available through Relias Learning Management System: Cultural Diversity (1.25 hours), Infusion of Culturally Responsive Practices (1.75 hour), A Culture-Centered Approach to Recovery (1 hour), Advocacy & Multicultural Care (1.5 hours), Recovery Promoting Relationships (1 hour), Groundwork of Multicultural Care (1.25 units), The Power of Personal Outcome Measures® (1.75 units), etc.
    d. MHP will host Cultural Awareness Events and the hour(s) of attendance will be applied toward cultural competency required training hours.
3. The MHP is providing foundational cultural competency training (HEMCDT) on a monthly basis through July 2019. The MHP will continue to require County staff to

attend the training within six (6) month of hire date. In addition, the training will be open to all contracted SMHS providers and the hours will be applied toward the provider's cultural competency required training hours. County staff and contracted SMHS providers will have the opportunity to complete the foundational cultural competency training once every five years. The provider directory will indicate which providers completed the foundational training.

4. The MHP is requiring certified bilingual staff and DBH contracted interpreters to complete annual Interpreter Training. The LMS has the ability to provide and track interpreter training.
    a. The following interpreter trainings are available through Relias Learning Management System: Overview of the Behavioral Health Systems for Behavioral Health Interpreters (1 hr), The Role of the Behavioral Health Interpreter (1 hr), and Legal Procedures and Client Rights for Behavioral Health Interpreters (.5 hrs)
    b. MHP will continue to require all certified County staff and contracted interpreters to complete Behavioral Health Interpreter Training (BHIT). BHIT will be required within six (6) months from hire or contract execution.
5. The Cultural Competency Contract Language will require contracted SMHS providers to utilize interpreters who have received annual training and have demonstrated language competence.
6. The MHP will require certified bilingual staff and DBH contracted interpreters to receive annual monitoring by FY 19/20. The MHP will establish a Language Expert Review Panel by June 28, 2019. The panel will monitor language competence for certified bilingual staff and DBH contracted interpreters. The LMS will track monitoring.

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SECTION C: COVERAGE AND AUTHORIZATION

PROTOCOL REQUIREMENTS	
C1.	Regarding the Treatment Authorization Requests (TARs) for hospital services:
C1a.	Are the TARs being approved or denied by licensed mental health or waivered/registered professionals of the beneficiary's MHP in accordance with title 9 regulations?
C1b.	Does the MHP approve or deny TARs within 14 calendar days of the receipt of the TAR and in accordance with title 9 regulations?

C1c.	Are all adverse decisions regarding hospital requests for payment authorization that were based on criteria for medical necessity or emergency admission being reviewed and approved in accordance with title 9 regulations by: 1) a physician, or 2) At the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under the psychologist's scope of practice?
• *CCR, title 9, chapter 11, sections 1810.242, 1820.220(c),(d), 1820.220 (f), 1820.220 (h), and 1820.215.* • *CFR, title 42, section 438.210(d)*	

FINDINGS

DHCS inspected a sample of 100 TARs to verify compliance with regulatory requirements. The TAR sample review findings are detailed below:

PROTOCOL REQUIREMENT		# TARS IN COMPLIANCE	# TARs OOC	COMPLIANCE PERCENTAGE
C1c	Adverse decisions based on criteria for medical necessity or emergency admission approved by a physician	99	1	99%

These TARs did not include evidence that adverse decisions based on criteria for medical necessity or emergency admission were reviewed and approved by a physician (or by a psychologist, per regulations). Protocol question C1c is deemed in partial compliance.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services.

FRESNO'S RESPONSE:

Please note that the "Results Summary: System Review" reflects C1b as a protocol question out-of-compliance or partial compliance, however under "Findings", Protocol Requirement C1c is highlighted. This POC addresses C1c.

On May 15, 2018, Utilization Review Specialists were reminded of the need for a physician's review and signature for adverse decisions based on criteria for medical necessity, in this case, a non-included diagnosis code. See Attachment C for staff meeting minutes and sign-in sheet.

PROTOCOL REQUIREMENTS	
C6.	Regarding Notices of Adverse Benefit Determination (NOABDs):
C6a.	Does the MHP provide a beneficiary with a NOABD under the following circumstances: 1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit?
	2) The reduction, suspension, or termination of a previously authorized service?
	3) The denial, in whole or in part, of a payment for service?
	4) The failure to provide services in a timely manner?
	5) The failure to act within timeframes provided in 42 C.F.R. §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals?
	6) The denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities?
• *CFR, title 42, sections 438.10(c), 438.400(b) and 438.404(c)(2)* • *CCR, title 9, chapter 11, sections 1830.205(a),(b)(1),(2),(3), 1850.210 (a)-(j) and 1850.212*	• *MHP Contract, Exhibit A, Attachment I* • *CFR, title 42, section 438.206(b)(3)* • *CCR, title 9, chapter 11, section 1810.405(e)*

FINDINGS

The MHP did not furnish evidence it provides a written NOABD to the beneficiary when, failure to provide services in a timely manner. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: MHP provided letters to beneficiary when contractor would no longer be providing specialty mental health services. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, during the review MHP discussed the ongoing issues with a specific provider, Mental Health Systems Incorporated and their inability to provide services in a timely manner. Although the MHP developed POC's with this contractor, they failed to ensure that the beneficiary received the required NOABD regarding timeliness. Protocol question(s) C6a (4) is deemed in partial compliance.

# Elements	# of Elements OOC	COMPLIANCE PERCENTAGE
6	**1**	**84%**

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it provides a written NOABD to the beneficiary when there is a failure to provide services in a

timely manner.

FRESNO'S RESPONSE:
Please note that the "Results Summary" listed Protocol Question, C6a3, as the area in which Fresno County was out-of-compliance but highlighted is Protocol Question, C6a4. The subsequent Findings and Plan of Correction sections identified issues which aligned with Protocol Question C6a4, and that is what this response addresses.

The Fresno County MHP does require its contracted providers to provide beneficiaries receiving services in their program with a NOABD, when there is a failure to provide services in a timely manner. In the case of the beneficiaries receiving services from Mental Health Systems (MHS) for their child welfare specialty mental health program, MHS did not have an electronic health record and hard copies of NOABDs were kept in the client's physical chart. At the time of the Triennial Review, the Agreement with MHS had ended and physical charts had transferred to the new agency providing services to active clients. All remaining charts for clients receiving services under this program were transferred to Fresno County Department of Behavioral Health's Medical Records area for archiving. Because a list of names of clients who would have received an NOABD had not been kept, the Fresno County MHP was unable to access the relevant files to produce evidence that NOABDs were provided to clients in the MHS's program.

Moving forward, the MHP will ensure that written NOABDs are provided to applicable beneficiaries by the following:

- Ensure that contracted providers share a copy of the NOABD issued to the beneficiary with the MHP. The assigned analyst will notify the contracted providers regarding the expectation of providing a copy of all issued NOABDs to DBH's Managed Care Division, whenever an NOABD is issued to a beneficiary. Notification will take place either immediately via email or at their next monthly contract meeting. A copy of DBH's PPG 1.2.13, "Notice of Action-E" which addresses notification to the client for lack of timely service, will be included in this notification to the contracted provider. Per this PPG, Managed Care maintains and tracks all NOA-E issued by providers and reports this information to the Quality Improvement Council on a quarterly basis.

- The contracted provider will simultaneously be notified of the expectation to share data on NOABDs issued within the past month, during their monthly contract meetings. This expectation falls under the contracted requirement to provide additional reports and data requested for contract monitoring. The assigned analyst will follow-up with Managed Care to ensure that a copy of the NOABD was submitted by the contracted provider.

- Ensure that contracted providers keep a list of beneficiaries who have received NOABDs. A copy of this list will be provided to the assigned Analyst during monthly contract meetings and will also be shared with DBH's Managed Care division. The assigned analyst will follow-up with Managed Care to ensure that the information provided matches up with the NOABDs received.

- Contracted providers will be highly encouraged to utilize an electronic health record (rather than a physical file system) to allow for easier retrieval of documents. Boilerplate contract language currently allows the contracted provider to utilize DBH's electronic health record, should they choose to do so.

- The assigned analyst will monitor and track the number and frequency of issued NOAs to determine if timeliness is an issue. Once identified as a concern, the assigned analyst will meet with relevant County parties (e.g. other DBH divisions and other departments who share in the contract) to determine the next course of action (e.g. issuance of a letter of concern, request for a POC from the contracted provider). If a POC is required from the contracted vendor, the assigned analyst will reference the list of NOABDs issued, request copies of the NOABDs from Managed Care, and include these copies in the request.

This process for ensuring that NOABDs are issued to applicable clients receiving services from contracted vendors will continue to be monitored for compliance and revised, as necessary. The assigned analyst and Managed Care will monitor and keep in communication about the efficiency of the above process, the frequency of NOABDs received from the contracted provider, and any other issues which may arise. Revisions will be based on this communication, as well as feedback, if any, from the contracted provider.

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SECTION D: BENEFICIARY PROTECTION

PROTOCOL REQUIREMENTS	
D2.	The MHP is required to maintain a grievance, appeal, and expedited appeal log(s) that records the grievances, appeals, and expedited appeals within one working day of the date of receipt of the grievance, appeal, or expedited appeal.
D2a.	The log must include: 1) The name or identifier of the beneficiary.
	2) The date of receipt of the grievance, appeal, and expedited appeal.
	3) A general description of the reason for the appeal or grievance.
	4) The date of each review or, if applicable, review meeting.
	5) The resolution at each level of the appeal or grievance, if applicable.
	6) The date of resolution at each level, if applicable.
• *CCR, title 9, chapter 11, section 1850.205(d)(1)*	• *CCR, title 9, chapter 11, section 1810.375(a)*

FINDINGS

The MHP did not furnish evidence it maintains a grievance, appeal, and expedited appeal log(s) that records the grievances, appeals, and expedited appeals within one working day of the date of receipt. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy and Procedure 1.2.11 Consumer Grievance Resolution Process. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, when a contracted provider receives a grievance it is not stamped and entered into a log the day it is received. The grievance is mailed to the MHP. There is no way to verify how long it could take the MHP to receive the grievance and determine if it is logged timely. Protocol question D2 is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it maintains a grievance, appeal, and expedited appeal log(s) that records the grievances, appeals, and expedited appeals within one working day of the date of receipt.

FRESNO'S RESPONSE:

To ensure grievances, appeals, and expedited appeals are recorded in the MHP's Beneficiary Protection Log within one working day of the date of receipt, the MHP will require all In-House (County) programs and contract providers to forward grievances, appeals, and expedited appeals to the appropriate MHP staff within one working day.

The MHP has revised Policy and Procedure Guidelines (PPG) 1.2.11-Consumer Grievance Resolution Process and & PPG 1.2.18-Consumer Appeal and Expedited Appeal Process to require all In-House (County) programs to forward grievances, appeals, and expedited appeals to the appropriate MHP staff within one working day of the date of receipt. See Attachments D and D-1 for the revised draft PPGs. The MHP expects to publish the revised PPGs no later than February 2019.

The MHP has revised the Individual & Group Provider and Organizational Provider Manuals to require all contract providers to forward grievances, appeals, and expedited appeals to the appropriate MHP staff within one working day of the date of receipt. See Attachments D-2 and D-3 for the revised draft version of the relevant sections within the Individual & Group Provider and Organizational Provider Manuals. The Provider Manuals will be revised and published, no later than September 2018.

The MHP will enter grievances, appeals, and expedited appeals into the MHP's Beneficiary Protection Log no later than one working day of the date of receipt. The Beneficiary Protection Log has been updated to include the date of entry of each grievance, appeal, and expedited appeal, as well as the date received, in order to confirm the timeline is met. See Attachment D-4 for an example Beneficiary Protection Log report with the entry dates highlighted. The MHP will begin using the updated Beneficiary Protection Log no later than September 2018.

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SECTION H: PROGRAM INTEGRITY

PROTOCOL REQUIREMENTS	
H5.	Regarding monitoring and verification of provider eligibility:
H5a.	Does the MHP ensure the following requirements are met: 1) Is there evidence that the MHP has a process in place to verify new and current (prior to contracting/employing and monthly thereafter) providers, including contractors, are not on the Office of Inspector General List of Excluded Individuals/Entities (LEIE)?
	2) Is there evidence that the MHP has a process in place to verify new and current (prior to contracting/employing and monthly thereafter) providers and contractors are not on the DHCS Medi-Cal List of Suspended or Ineligible Providers?
	3) Is there evidence that the MHP has a process in place to verify new and current (prior to contracting/employing) providers and contractors are not in the Social Security Administration's Death Master File?
	4) Is there evidence that the MHP has a process in place to verify the accuracy of new and current (upon enrollment and re-enrollment) providers and contractors in the National Plan and Provider Enumeration System (NPPES)?
	5) Is there evidence the MHP has a process in place to verify new and current (prio to contracting/employing and monthly thereafter) providers and contractors are not in the Excluded Parties List System/System Award Management (EPLS/SAM database?
H5b.	When an excluded provider/contractor is identified by the MHP, does the MHP have a mechanism in place to take appropriate corrective action?
• *CFR, title 42, sections 438.214(d), 438.610, 455.400-455.470, 455.436(b)* • *DMH Letter No. 10-05*	• *MHP Contract, Exhibit A, Attachment I, Program Integrity Requirements*

FINDINGS

The MHP did not furnish evidence that is has a process in place to verify new and current (prior to contracting/employing) providers and contractors are not in the Social Security Administration's Death Master File. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy PPG 1.3.1 - Screening for Ineligible Persons and (SSDMF) Plan for Implementation agenda. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP identified that they have not started the screening process. The projected target date is December 11, 2018. Protocol question H5a3 is deemed OOC.

PLAN OF CORRECTION

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SECTION I: QUALITY IMPROVEMENT

PROTOCOL REQUIREMENTS	
I3.	Regarding monitoring of medication practices:
I3a.	Does the MHP have mechanisms to monitor the safety and effectiveness of medication practices at least annually?
• *MHP Contract, Exhibit A, Attachment I*	

FINDING

The MHP did not furnish evidence it has mechanisms to monitor the safety and effectiveness of medication practices at least annually. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: 10-31-17 Meds monitoring Report, multiple Antipsychotic Prescribing Data Reports, Targeted Medication Review process, and Psychiatric Services Agreement. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP reported that difficulty in due to multiple turn over in the Medical Director position. MHP has identified their new prescriber, Central California Faculty Medical Group Inc. and provided the new contract, which was approved on 5-1-18. The contract will provide stable leadership in the psychiatry department. The MHP has made significant progress in the last year however; there was lack of compliance for the first two years of the triennial review period. Protocol question 13a is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has mechanisms to monitor the safety and effectiveness of medication practices at least annually.

FRESNO'S RESPONSE:

1) Description of corrective actions, including milestones

The MHP has been monitoring the use of various medications since July 2017 indicated in the evidence provided during the on-site triennial review. The review in July 2017 evaluated medical records that contained targeted anti-psychotic medication practices. At the end of 2017, the MHP had implemented the use of an electronic dashboard report to identify prescribing patterns for most individual prescribers as well as patterns program/system level over a period(s) determined by the reviewer. The MHP will plan to review a random sample of clients based on a specific DSM-5 diagnostic categories and review current psychopharmacological treatment practices that corresponds to identify diagnosis (es).

2) Timeline for implementation and/or completion of corrective actions

   Implementation of medication monitoring practices identified above will be occurring on an annual basis for all programs within the MHP for all client populations. Monitoring for July 2017- June 2018 will be implemented by October 31, 2018. Subsequent reporting on the finding of the report will be completed by December 31, 2018.

3) Proposed (or actual) evidence of correction that will be submitted to DHCS.

   The MHP will update the current policies and procedures to define the medication monitoring practices implemented. Policy and Procedure guidelines will be completed by December 2018.

4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS

   The reviewer will report the findings of all reviews directly to the medical director, as well as any corrective actions implemented resulting from the review(s). Furthermore, the medical director, or the designee, will report the findings of the medication review(s) to the QIC at least on an annual basis as indicated in the Quality Improvement Work Plan (QIWP). The QIC will make recommendations as needed to the medication review process.

5) Description of corrective actions required of the MHP's contracted providers to address findings.

   The MHP will include all providers, both county operated and contracted programs, within the MHP for future medication reviews. Implementation of review of contracted providers will occur within the next six months.

PROTOCOL REQUIREMENTS	
I3c.	If a quality of care concern or an outlier is identified related to psychotropic medication use is there evidence that the MHP took appropriate action to address
• *MHP Contract, Exhibit A, Attachment I*	

FINDING

The MHP did not furnish evidence that if a quality of care concern or an outlier is identified related to psychotropic medication use is there evidence that the MHP took appropriate action to address the concern. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Targeted Medication Review. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, MHP reported that the new-targeted medication review process was implemented in July 2017. They did not have a process for the entire triennial review period. Protocol question I3c is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for this requirement. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that if

a quality of care concern or an outlier is identified related to psychotropic medication use is there evidence that the MHP took appropriate action to address the concern.

FRESNO'S RESPONSE:

1) Description of corrective actions, including milestones

   Beginning in July 2017, the MHP began reviewing target medication practices, including determining outliers. Evidence of the review process was presented during the on-site review. Since the initial review in July 2017, the developed dashboard report has allowed the ability to monitor outliers more efficiently. This on-demand report will allow medication reviewer to identify quality of care and safety more readily. Reviewer will follow up with prescriber if quality of care concerns are identified. Follow up may include, but not limited to communication of findings and concern to prescriber, direct education and discussion of prescribing practices, continued targeted monitoring of prescriber if practices are not changed and/or offering further educational opportunities. After each review, identified prescriber will be notified of findings and quality of care concerns within three months.

2) Timeline for implementation and/or completion of corrective actions

   Implementation of medication monitoring and follow up to address quality of care concerns will be occurring an annual basis for all programs within the MHP for all client populations. Monitoring for July 2017- June 2018 will be implemented by October 31, 2018. Subsequent reporting on the finding of the report will be completed by December 31, 2018.

3) Proposed (or actual) evidence of correction that will be submitted to DHCS.

   The MHP will update the current policies and procedure to define the medication monitoring practices being implemented, Policy and Procedure guidelines will be completed by December 2018.

4) Mechanisms for monitoring the effectiveness of corrective actions over time. If POC determined not to be effective, the MHP should propose an alternative corrective action plan to DHCS.

   The reviewer will report the findings of all reviews directly to medical director, as well as any corrective actions implemented resulting from the review(s). Furthermore, the medical director, or the designee, will report the findings of the medication review(s) to the QIC at least on an annual basis as indicated in the Quality Improvement Work Plan (QIWP). The QIC will make recommendations as needed to the medication review process.

5) Description of corrective actions required of the MHP's contracted providers to address findings.

   The MHP will include all providers, county operated and contracted, within the MHP for future medication reviews. Implementation for review of contracted providers will occur within the next six months.

PROTOCOL REQUIREMENTS	
I6.	Regarding the QAPI Work Plan:
I6a.	Does the MHP have a QAPI Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed?
I6b.	Does the QAPI Work Plan include evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review?
I6c.	Does the QAPI Work Plan include evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service?
I6d.	Does the QAPI work plan include a description of completed and in-process QAPI activities, including: 1) Monitoring efforts for previously identified issues, including tracking issues over time?
	2) Objectives, scope, and planned QAPI activities for each year?
	3) Targeted areas of improvement or change in service delivery or program design?
I6e.	Does the QAPI work plan include a description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area, including goals for: 1) Responsiveness for the Contractor's 24-hour toll-free telephone number?
	2) Timeliness for scheduling of routine appointments?
	3) Timeliness of services for urgent conditions?
	4) Access to after-hours care?
I6f.	Does the QAPI work plan include evidence of compliance with the requirements for cultural competence and linguistic competence?
• *CCR, title 9, chapter 11, section 1810.440(a)(5)* • *DMH Information Notice No. 10-17, Enclosures, Pages 18 & 19, and DMH*	• *MHP Contract, Exhibit A, Attachment I* • *CCR, tit. 9, § 1810.410* • *CFR, title 42, Part 438-Managed Care,*

FINDINGS

The MHP did not furnish evidence it has a QM/QI work plan covering the current contract cycle, with documented annual evaluations and necessary revisions, which meets MHP Contract requirements. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Cultural competency QIC Meeting Agenda 10-11-17, Cultural Competency QIC Meeting Minutes, Cultural Competency sign in sheet 10-11-17, 2012 Cultural Competency Plan and FY 2017-18 Updated Annual Cultural Competency Plan Summary Reports. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the QAPI work

plan stated that the Cultural Diversity Committee is responsible to provide updates on the Cultural Competence Plan implementation. MHP verbally explained that the 2012 goals were addressed and now they are working on the updates, but did not provide additional evidence. MHP also reported that the cultural diversity committee has a new coordinator as of January 2018 and they are focusing on making improvements to the plan and consumer engagement. The MHP has made progress since January 2018; however, it lacked evidence of compliance for majority of the triennial review period (2015-2017). Protocol question I6F is deemed OOC.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has a QM/QI work plan covering the current contract cycle, with documented annual evaluations and necessary revisions, which meets MHP Contract requirements.

FRESNO'S RESPONSE:

PLAN OF CORRECTION & TIME OF IMPLEMENTATION:

1. Establishing Policy Procedure Guideline (PPG) 1.5.1 – Cultural Competency. The PPG will identify cultural and linguistic competency requirements specified in California Code of Regulations, Title 9 Section 1810.410. Currently, the PPG is in draft form (Attachment E), but the anticipated completion date is September 30, 2018. The cultural and linguistic competency requirements include the following:

    - Foundation Cultural Competency Training for Current County Staff
    - 8 hours of annual Cultural Competency Training or County Staff
    - CLAS Training For Staff Development & Supervisory/Management Classifications
    - 8 hours of annual Cultural Competency Training for Contracted SMHS Providers
    - Foundational Interpreter Training for Current Certified Bilingual Staff
    - Foundational Interpreter Training for Contracted Interpreters
    - Annual Training & Monitoring for Certified Bilingual Staff
    - Annual Training & Monitoring for Contracted Interpreters

2. PPG 1.5.1 will also require the Cultural Competency Committee (CCC) chairperson to report to the Quality Improvement Committee on the dates identified in the QIC FY 2018-19 Calendar (Attachment E-1), which is a mechanism for reviewing and monitoring the effectiveness of corrective actions over time. The chairperson will report on the status of cultural and linguistic competency requirements using the Cultural Competency Committee Report (Attachment E-2).

    The report will include all goals established by the CCC, but the chairperson will report the second page of the form entitled "FY 18/19 – CULTURAL & LINGUISTIC COMPETENCY REQUIREMENTS". The report has been finalized, and the first reporting date will be September 12, 2018.

    Fresno County DBH is securing a Learning Management System on September 1, 2018 for County Staff and September 1, 2019 for Contracted Staff. Once secured, the system will track cultural and linguistic competency requirements. At the close of each fiscal year, the Cultural Competency Committee Report will include evidence

including sign in sheets and tracking logs.

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SECTION J: MENTAL HEALTH SERVICES (MHSA)

PROTOCOL REQUIREMENTS	
J4. J4a	Regarding the County's Capacity to Implement Mental Health Services Act (MHSA) Programs:
J4b.	Does the assessment include: 1) The strengths and limitations of the County and service providers that impact their ability to meet the needs of racially and ethnically diverse populations?
J4b	2) Bilingual proficiency in threshold languages?
J4b.	3) Percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the percentage of the total population needing services and the total population being served?
• *CCR, title 9, chapter 14, section 3610*	

FINDINGS

The County did not furnish evidence it has percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the percentage of the total population needing services and the total population being served. DHCS reviewed the following documentation presented by the County as evidence of compliance: Pie Charts of MHP employees and clients served based on ethnicity. The penetration rate of clients served for fiscal years 2014-2017. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP did not demonstrate it has percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the percentage of the total population needing services and the total population being served. Protocol question J4b3 is deemed OOC.

PLAN OF CORRECTION

The County must submit a POC addressing the OOC findings for these requirements. The County is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it has percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the percentage of the total population needing services and the total population being served.

FRESNO'S RESPONSE:

PLAN OF CORRECTION & TIME OF IMPLEMENTATION:

The MHP will demonstrate it has percentages of diverse cultural, racial, ethnic and linguistic groups represented among direct services providers as compared to the percentage of the total population needing services and the total population being served. The anticipated completion date is June 28, 2019. The completion includes the following processes:

(1) Contracts Division updated the Monthly Staffing Report (Attachment F) to include gender and ethnicity. Cultural Competency contract language (Attachment F-1) will obligate SMHS contractors to provide the monthly report to Contracts Division to ensure cultural, racial/ethnic and linguistic group of direct service providers in comparison to the population needing services and being served. The contractors will submit the report by the 10th of each month. Contracts Division will forward the report to the Staff Analyst within Administration Division by the 15th of each month.

(2) Staff Analyst within Administration will collect gender and ethnicity for County direct service providers utilizing the Human Resource Information System (HRIS). The Staff Analyst will prepare a Microsoft Access Report by the 15th of each month.

(3) Epidemiologist will provide report of individuals served and Medi-Cal Eligible Individuals to Staff Analyst within Administration Division by the 15th of each month.

(4) Administration will review all collected information by the end of the month and report it during the upcoming Cultural Competency Committee (CCC) meeting. Together Administration Division and CCC will assess diverse, cultural, racial/ethnic and linguistic group of direct service providers. MHP will analyze monthly reports and complete an annual assessment. The first annual assessment will be completed by June 28, 2019, and annually thereafter.

(5) Administration will assess Bilingual Proficiency of County staff. In order for Limited English Proficiency (LEP) individuals to receive equal access, the direct service provider/client ratio for English clients will be the basis for all threshold languages. Administration and CCC will review the information annually. The first annual assessment will be completed by October 31, 2018. Going forward, the assessment will be completed at the end of each FY. If applicable, Administration will submit Bilingual Skill Pay Request for Authorization (Attachment F-2) to the Department of Human Resources.

(6) MHP will promote the need of contracted interpreters on the Staff Development – Cultural Competency webpage. Administration will update the website by December 28, 2018.

Section K, "Chart Review – Non-Hospital Services

Assessment (Findings in this area do not result in disallowances. Plan of Correction only.)

PROTOCOL REQUIREMENTS		
2. 2a.	Regarding the Assessment, are the following conditions met: 1) Has the Assessment been completed in accordance with the MHP's established written documentation standards for timeliness?	
	2) Has the Assessment been completed in accordance with the MHP's established written documentation standards for frequency?	
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*		• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

FINDINGS 2a:
Assessments were not completed in accordance with regulatory and contractual requirements, specifically:

One or more assessments were not completed within the timeliness and/or frequency requirements specified in the MHP's written documentation standards. The following are specific findings from the chart sample:

- **Line number** [1]: There was no initial assessment found in the medical record. *During the review, MHP staff were given the opportunity to locate the missing assessment but could not locate the document in the medical record.*
- **Line number(s)** [2]: The initial assessment was completed late.
- **Line number(s)** [3]: The updated assessment was completed late.

PLAN OF CORRECTION 2a:
The MHP shall submit a POC that describes how the MHP will ensure that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards.

FRESNO'S RESPONSE:
In order to ensure that assessments are completed in accordance with the MHP's written documentation standards for timeliness and frequency, Fresno County has mutually developed corrective steps, including:

- The Department's Managed Care utilization review team discussed findings report (Attachment G) to ensure ongoing monitoring by County reviewers for timeliness and frequency of assessments during regularly scheduled annual reviews of providers. Compliance to timeliness and frequency requirements for completion of assessments is part of the current *FCMHP Chart Review Tool,* Item 4 (Attachment G-1) used during

[1] Line number(s) removed for confidentiality
[2] Line number(s) removed for confidentiality
[3] Line number(s) removed for confidentiality

all regular chart reviews conducted within 90 days of the onset of program services and annually thereafter.

- For contracted providers, each provider of services reviewed was contacted and each provided a collaborative Plan of Correction response to address specific findings that were identified (Attachments H through H-6). Evidence of completion of corrective steps related to each Plan of Correction is due to the Department's Managed Care staff no later than September 14, 2018.

- After the audited period of 4/1/2018 – 6/30/2018 and prior to the FY Triennial Review, the standardized documentation manual was finalized in January 2018, and was subsequently released to all clinical staff, posted on the MHP's Managed Care website, and provided during standardized documentation "New Hire" trainings and annually thereafter. The "New Hire" Compliance/Documentation and Billing Training ensures all clinical employees new to the Fresno County MHP system of care receive documentation training and the documentation manual. The "New Hire" training occurs monthly (Attachment I). They have already occurred:
  1/10/2018 2/7/2018 3/7/2018 4/4/2018 5/2/2018 5/30/2018 6/27/2018 7/25/2018

- Education and training is provided to MHP staff upon hire and annually thereafter. Assessments are required to be completed within 30 days of initial request. Tracking mechanisms are in place in Avatar connected to the Access Line for monitoring and tracking timeliness.

- Intervention to meet timeliness have included a PIP, reallocation of staff to the front door, implementation of triage, offering walk-in assessment, and same day services. Urgent appointments are available without an appointment.

- Timeliness data is being tracked and trended through the outcomes committee.

PROTOCOL REQUIREMENTS	
2b.	Do the Assessments include the areas specified in the MHP Contract with the Department? 1) Presenting Problem. The beneficiary's chief complaint, history of 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 and mental 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. If possible, include information from other sources of clinical data such as previous mental health records and relevant psychological testing or consultation reports;
	5) Medical History. Relevant physical health conditions reported by the beneficiary or a significant support person. Include name and address of current source of medical treatment. For children and adolescents the history must include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports
	6) Medications. Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment must include documentation of the absence or presence of allergies or adverse reactions to medications and documentation of an 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 the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis;
	9) Risks. Situations that present a risk to the beneficiary and/or others, including past or current trauma;
	10) A mental status examination;
	11) A Complete Diagnosis; A diagnosis from the current ICD-code must be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data; including any current medical diagnoses.
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)*	• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

FINDING 2b:
One or more of the assessments reviewed did not include all of the elements specified in the MHP Contract with the Department. The following required elements were incomplete or missing:

1) Medications: **Line number [4].**

[4] Line number(s) removed for confidentiality

2) Client Strengths: **Line number(s) [5].**

3) Risks: **Line number(s) [6].**

4) A mental status examination: **Line number [7].**

5) A full DSM diagnosis or current ICD code: **Line number [8].**

PLAN OF CORRECTION 2b: The MHP shall submit a POC that describes how the MHP will ensure that every assessment contains all of the required elements specified in the MHP Contract with the Department.

FRESNO'S RESPONSE:

- The Department's Managed Care utilization review team discussed findings report (Attachment G) to ensure ongoing monitoring by County reviewers for all assessment elements as specified in the MHP Contract. Elements of assessment requirements is part of the current *FCMHP Chart Review Tool,* Item 5a-j (Attachment G-1) used during all chart reviews by the URS team.

- For contracted providers, each provider of services reviewed was contacted and each provided a collaborative Plan of Correction response to address specific findings that were identified (Attachments H through H-6). Evidence of completion of corrective steps related to each Plan of Correction is due to the Department's Managed Care staff no later than September 14, 2018.

- For County-operated providers, staff will be trained in the initial and annual documentation and billing training. Psychiatric Assessments and the Core Assessment are being combined to ensure that all assessment contain the strength and risks component.

- Additional communication will be provided to the prescribers on the use of the strengths and risks components of the assessments.

Medication Consent (Findings in this area do not result in disallowances. Plan of Correction only.)

PROTOCOL REQUIREMENTS	
3b.	Does the medication consent for psychiatric medications include the following required elements: 1) The reasons for taking such medications?
	2) Reasonable alternative treatments available, if any?

[5] Line number(s) removed for confidentiality
[6] Line number(s) removed for confidentiality
[7] Line number(s) removed for confidentiality
[8] Line number(s) removed for confidentiality

	3) Type of medication?
	4) Range of frequency (of administration)?
	5) Dosage?
	6) Method of administration?
	7) Duration of taking the medication?
	8) Probable side effects?
	9) Possible side effects if taken longer than 3 months?
	10) Consent once given may be withdrawn at any time?

• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*	• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

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) Method of administration (oral or injection): **Line number [9].**
2) Duration of taking each medication: **Line number(s) [10].**
3) Possible side effects if taken longer than 3 months: **Line number [11].**

PLAN OF CORRECTION 3b:
The MHP shall submit a POC 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.

FRESNO'S RESPONSE:

- The Department's Managed Care utilization review team discussed findings report (Attachment G) to ensure ongoing monitoring by County reviewers for all required elements of a written medication consent as specified in the MHP Contract. Monitoring of medication consent requirements is part of the current *FCMHP Chart Review Tool,* Item 84 (Attachment G-1) used during all chart reviews by the URS team.

- For contracted providers, each provider of services reviewed was contacted and each provided a collaborative Plan of Correction response to address specific findings that were identified (Attachments H through H-6). Evidence of completion of corrective steps related to each Plan of Correction is due to the Department's Managed Care staff no later than September 14, 2018.

[9] Line number(s) removed for confidentiality
[10] Line number(s) removed for confidentiality
[11] Line number(s) removed for confidentiality

PROTOCOL REQUIREMENTS		
3c.	Do medication consents include: 1) The date of service?	
	2) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?	
	3) The date the documentation was entered in the medical record?	
• *CCR, title 9, chapter 11, section 1810.204* • *CCR, title 9, chapter 11, section 1840.112(b)(1-4)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)*		• *CCR, title 9, chapter 4, section 851- Lanterman-Petris Act* • *MHP Contract, Exhibit A, Attachment I*

FINDING 3c:
The medication consent(s) did not include:

Signature of the person providing the service (or electronic equivalent).

- **Line number [12].**

PLAN OF CORRECTION 3c:
The MHP shall submit a POC that describes how the MHP will ensure that all documentation includes the signature (or electronic equivalent) of the qualified person providing the service with the professional degree, licensure or title.

FRESNO'S RESPONSE:

- The Department's Managed Care utilization review team discussed findings report (Attachment G) to ensure ongoing monitoring by County reviewers for all required elements of a written medication consent including the signature of the person providing the service. Monitoring of medication consent provider signatures is part of the current *FCMHP Chart Review Tool,* Item 85 (Attachment G-1) used during all chart reviews by the URS team.

- For contracted providers, each provider of services reviewed was contacted and each provided a collaborative Plan of Correction response to address specific findings that were identified (Attachments H through H-6). Evidence of completion of corrective steps related to each Plan of Correction is due to the Department's Managed Care staff no later than September 14, 2018.

[12] Line number(s) removed for confidentiality

Client Plans

PROTOCOL REQUIREMENTS		
4.	Regarding the client plan, are the following conditions met:	
4a.	Has the client plan been updated at least annually and/or when there are significant changes in the beneficiary's condition?	
• *CCR, title 9, chapter 11, section 1810.205.2* • *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)(1)(2)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *DMH Letter 02-01, Enclosure A*		• *WIC, section 5751.2* • *MHP Contract, Exhibit A, Attachment I* • *CCR, title 16, Section 1820.5* • *California Business and Profession Code, Section 4999.20*

Reasons for Recoupment (RR): *Refer to the enclosed Recoupment Summary for additional details concerning disallowances*

RR5. Services that cannot be claimed without a Client Plan in place were claimed either:
a) Prior to the initial Client Plan being in place; or
b) During the period where there was a gap or lapse between client plans; or
c) When there was no client plan in effect.

FINDING 4a:
The Client Plan was not completed prior to planned services being provided and 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):

1) **Line number [13]**: There was a **lapse** between the prior and current client plans. However, this occurred outside of the audit review period.
2) **Line number [14]**: There was a **lapse** between the prior and current client plans. However, no services were claimed.
3) **Line number [15]**: The medical record indicated an acute change in the beneficiary's mental health status (the beneficiary received crisis intervention services and crisis

[13] Line number(s) removed for confidentiality
[14] Line number(s) removed for confidentiality
[15] Line number(s) removed for confidentiality

stabilization between [16] and [17]. However, no evidence was found in the medical record that the client plan was reviewed and/or updated in response to the change.

PLAN OF CORRECTION 4a:

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

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

2) Ensure that client plans are reviewed and updated whenever there is a significant change in the beneficiary's condition.

FRESNO'S RESPONSE:

- The Department's Managed Care utilization review team discussed findings report (Attachment G) to ensure ongoing monitoring by County reviewers for timeliness and frequency of client plans, including whenever there is a significant change in the beneficiary's presentation. Monitoring of these client plan requirements is part of the current *FCMHP Chart Review Tool,* Item 11 (Attachment G-1) used during all chart reviews by the URS team.

- For contracted providers, each provider of services reviewed was contacted and each provided a collaborative Plan of Correction response to address specific findings that were identified (Attachments H through H-6). Evidence of completion of corrective steps related to each Plan of Correction is due to the Department's Managed Care staff no later than September 14, 2018.

- For County-operated programs, clinical supervisors will provide training to staff on when to update the treatment plan including:
    - Review and update treatment Plan when there are significant changes in clients symptoms
    - Review treatment plan after any crisis
    - Review treatment plan after discharge from hospital

- For County-operated programs, the clinical supervisor will audit charts and ensure that the treatment plan is being updated and in accordance to department documentation standards.

- Over the past three years we have put many safeguards in place to ensure that there are no lapses in treatment plans these have included:
    - Avatar reports and alerts
    - Sisence Dashboard data and graph that show upcoming expirations by month and client.
    - Education and training for line staff and clinical supervisors

[16] Date removed for confidentiality
[17] Date removed for confidentiality

- Updated language in the interactive documentation in billing handbook that is posted on line for county operated and contracted MHP programs.
- Monthly Supervisor chart audits and consistency monitoring

- Additionally, in the past three years we have implemented Reaching Recovery in Avatar, a wellness based treatment delivery system with recovery based tools. Tools projecting progress in various life domains are completed quarterly, or as needed, and are used in delivering care. This method and frequency of review would trigger a Treatment Plan update when a significant change in client's condition is identified.

- Regarding the lapse in treatment plans in the County-operated program chart, the gap in treatment planning was found outside of the rating period and the above measures have been put in place over the past three years following this occurrence. As there were no noted gaps for the rating in period itself, this suggests that these efforts to monitor continuity of treatment planning have largely been effective.

PROTOCOL REQUIREMENTS		
4b.	Does the client plan include the items specified in the MHP Contract with the Department? 1) Specific, observable, and/or specific quantifiable goals/treatment objectives related to the beneficiary's mental health needs and functional impairments as a result of the mental health diagnosis.	
	2) The proposed type(s) of intervention/modality including a detailed description of the intervention to be provided.	
	3) The proposed frequency of intervention(s).	
	4) The proposed duration of intervention(s).	
	5) Interventions that focus and address the identified functional impairments as a result of the mental disorder or emotional disturbance.	
	6) Interventions are consistent with client plan goal(s)/treatment objective(s).	
	7) Be consistent with the qualifying diagnoses.	
	• *CCR, title 9, chapter 11, section 1810.205.2* • *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)(1)(2)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *DMH Letter 02-01, Enclosure A*	• *WIC, section 5751.2* • *MHP Contract, Exhibit A, Attachment I* • *CCR, title 16, Section 1820.5* • *California Business and Profession Code, Section 4999.20*

FINDING 4b:
The following Line numbers had client plans that did not include all of the items specified in the MHP Contract with the Department:

4b-1) One or more of the goals/treatment objectives were not specific, observable, and/or quantifiable and related to the beneficiary's mental health needs and identified functional impairments as a result of the mental health diagnosis. **Line number(s) [18].**

4b-2) One or more of the proposed interventions did not include a detailed description. Instead, only a "type" or "category" of intervention was recorded on the client plan (e.g. "Medication Support Services," "Targeted Case Management," "Mental Health Services," etc.). **Line number(s) [19].**

4b-4) One or more of the proposed interventions did not indicate an expected duration. **Line number(s) [20].**

PLAN OF CORRECTION 4b:
The MHP shall submit a POC that describes how the MHP will ensure that:

1) (4b-1.) All client plan goals/treatment objectives are specific, observable and/or quantifiable and relate to the beneficiary's documented mental health needs and functional impairments as a result of the mental health diagnosis.

2) (4b-2.) All 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.).

3) (4b-4.) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.

FRESNO'S RESPONSE:

- The Department's Managed Care utilization review team discussed findings report (Attachment G) to ensure ongoing monitoring by County reviewers for all required elements of a client plan as specified in the MHP Contract. Monitoring of client plan requirements is part of the current *FCMHP Chart Review Tool,* Items 12, 13, and 14 (Attachment G-1) used during all chart reviews by the URS team.

- For contracted providers, each provider of services reviewed was contacted and each provided a collaborative Plan of Correction response to address specific findings that were identified (Attachments H through H-6). Evidence of completion of corrective steps related to each Plan of Correction is due to the Department's Managed Care staff no later than September 14, 2018.

- DBH will implement all staff training by October 31, 2018 to ensure understanding of the inclusion of a complete description of the interventions proposed in the treatment plan. Clinical supervisor will monitor the treatment plan in avatar to ensure that guidelines are being followed.

[18] Line number(s) removed for confidentiality
[19] Line number(s) removed for confidentiality
[20] Line number(s) removed for confidentiality

- Supervisors will continue with monthly chart reviews and consistency monitoring practices and will communicate those findings through 1:1 conversations with staff, and team trainings, when needed to support writing of quality treatment plans.

PROTOCOL REQUIREMENTS		
4e.	Is there documentation that the provider offered a copy of the client plan to the beneficiary?	
• *CCR, title 9, chapter 11, section 1810.205.2* • *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)(1)(2)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-5)* • *CCR, title 9, chapter 11, section 1840.314(d)(e)* • *DMH Letter 02-01, Enclosure A*		• *WIC, section 5751.2* • *MHP Contract, Exhibit A, Attachment I* • *CCR, title 16, Section 1820.5* • *California Business and Profession Code, Section 4999.20*

FINDING 4e:
There was no documentation that the beneficiary or legal guardian was offered a copy of the client plan for the following: **Line number [21].**

PLAN OF CORRECTION 4e:
The MHP shall submit a POC that describes how the MHP will ensure that there is documentation substantiating that the beneficiary was offered a copy of the client plan.

FRESNO'S RESPONSE:

- The Department's Managed Care utilization review team discussed findings report (Attachment G) to ensure ongoing monitoring by County reviewers for documentation that every beneficiary or legal guardian is offered a copy of the client plan. Monitoring of this documentation requirement is part of the current *FCMHP Chart Review Tool,* Item 20 (Attachment G-1) used during all chart reviews by the URS team.

- For the contracted provider identified, the provider of record reviewed was contacted and subsequently provided a collaborative Plan of Correction response to address specific findings that were identified (Attachments H through H-6). Evidence of completion of corrective steps related to each Plan of Correction is due to the Department's Managed Care staff no later than September 14, 2018.

[21] Line number(s) removed for confidentiality

Progress Notes

PROTOCOL REQUIREMENTS		
5a.	Do the progress notes document 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?	
	2) Documentation of referrals to community resources and other agencies, when appropriate?	
	3) Documentation of follow-up care or, as appropriate, a discharge summary?	
	4) The amount of time taken to provide services?	
	5) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, and licensure or job title?	
• *CCR, title 9, chapter 11, section 1810.254* • *CCR, title 9, chapter 11, section 1810.440(c)* • *CCR, title 9, chapter 11, section 1840.112(b)(2-6)* • *CCR, title 9, chapter 11, section 1840.314*		• *CCR, title 9, chapter 11, section 1840.316 – 1840.322* • *CCR, title 22, chapter 3, section 51458.1* • *CCR, title 22, chapter 3, section 51470* • *MHP Contract, Exhibit A, Attachment I*

Reasons for Recoupment (RR): *Refer to the enclosed Recoupment Summary for additional details concerning disallowances*

RR6. No progress note found for service claimed.
- **a)** No progress note found.
- **b)** Progress note provided does not match the claim in terms of
  - **1)** Specialty Mental Health Service and/or Service Activity claimed.
  - **2)** Date of Service, and/or
  - **3)** Units of time.

RR12. The progress note was not signed (or electronic equivalent) by the person(s) providing the service.

RR13. No service was provided:
- **a)** No show/appointment cancelled, and no other eligible service documented
- **b)** Service provided did not meet definition of a specific SMHS.

FINDING 5a:
Progress notes were not completed in accordance with regulatory and contractual requirements and/or with the MHP's written documentation standards**:**

- One or more progress note was not completed within the timeliness and frequency standards in accordance with regulatory and contractual requirements.
- The MHP was not following its own written documentation standards for timeliness of staff signatures on progress notes.
- Progress notes did not document the following**:**

5a-1) **Line number(s)** [22]: Timely documentation of relevant aspects of beneficiary care, as specified by the MHP's documentation standards (i.e., progress notes completed late based on the MHP's written documentation standards in effect during the audit period).

5a-7i) **Line number(s)** [23]: The amount of time taken to provide services. There was a progress note in the medical record for the date of service claimed. However, the amount of time was missing on the progress note. **RR6b3, refer to Recoupment Summary for details.**

PLAN OF CORRECTION 5a:

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

5a-1) Timely completion by the person providing the service and relevant aspects of client care, as specified in the MHP Contract with the Department and by the MHP's written documentation standards.

5a-7) The claim must accurately reflect the amount of time taken to provide services.

FRESNO'S RESPONSE:

- The Department's Managed Care utilization review team discussed findings report (Attachment G) to ensure ongoing monitoring by County reviewers for timely completion of progress notes as specified in the MHP Contract and MHP written documentation standards, and accuracy of time taken to provide services. Monitoring of timeliness standards for completion of progress notes and accuracy of reflected time taken to provide services is part of the current *FCMHP Chart Review Tool,* Items 26a-f (Attachment G-1) used during all chart reviews by the URS team.

- For contracted providers, each provider of services reviewed was contacted and each provided a collaborative Plan of Correction response to address specific findings that were identified (Attachment H through H-6). Evidence of completion of corrective steps related to each Plan of Correction is due to the Department's Managed Care staff no later than September 14, 2018.
- For County-operated programs, the policy on timeliness of documentation has been

[22] Line number(s) removed for confidentiality
[23] Line number(s) removed for confidentiality

distributed to line staff in conjunction with conversation about timeliness in documentation in the Clinical Supervisors meeting.

- Avatar reports will be used to monitor timeliness.
- A Sisence Dashboard has been implemented that allows Clinical Supervisors to review timeliness standards with their staff in individual meetings and provide follow-up trainings to teams as needed.
- Within the past 3 months the Sisence Dashboard has been adjusted to show tighter timelessness standards better aligned with the most recently policy.
- These timeliness standards are being referenced in staff performance evaluations and expectations memos.

To ensure all Psychiatric Inpatient Hospital Professional Service contract providers specify the amount of time taken to provide services within their progress notes, the MHP will notify all appropriate contract providers (in writing) of this requirement. The MHP expects to notify the appropriate contract providers no later than September 2018. During regularly scheduled annual audits, the MHP will monitor contract provider compliance by reviewing contract provider notes against claims submitted to ensure the notes accurately reflect the amount of time taken to provide services.