SAN LUIS OBISPO COUNTY HEALTH AGENCY

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September 28, 2016

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Chief, Compliance Section
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PLAN OF CORRECTION

Dear Ms. Boylan Valerio,

We received the Final Findings Report issued for the January 4-7, 2016 triennial onsite review of our programs. We'd again like to thank the entire DHCS review team for a thorough and careful review and we are submitting the attached Plan of Correction (POC) for approval. We developed the POC as an interactive PDF document so that, once it is approved, we can post it on our website and it will be usable for interested members of the public.

Both the services that were subject to recoupment have been voided, and the POC contains evidence of our action in this regard.

If you have any questions or need any additional information, please do not hesitate to contact us.

Sincerely,

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PLAN OF CORRECTION

Triennial Onsite Review Dates: January 4-7, 2016

Final Report Issue Date: August 12, 2016

Plan of Correction Submission Date: September 28,2016

The tables below detail the out-of-compliance items from the protocol, our corrective actions, our timeline for completed or anticipated completion of the correction, and our evident of completion.

- To view attachments, click on the blue link in the Evidence column.
- To return to the table to view the next item, click on the "Black" button in the upper right corner of each attachment.

SYSTEM REVIEW

Protocol Item:	Corrective Actions	Timeline/Status	Evidence
Access 2c6L Provider List must include alternatives and options for cultural services	We revised our Provider List to include alternatives and options for cultural services. Additionally, we made the Provider List more readable by creating separate English Spanish language versions.	✓ Completed Provider List revision on 9/16/16	Attachment A, Provider List (selected pages)
	Once the new Provider List is approved, we will translate into Spanish and post both language versions on our website.	❑ Will post new provider List when POC is approved by DHCS (Date TBD)	

9a. Toll free Access Line must provide information to beneficiaries about how to access/use: 2. SMHS, including assessment 3. Urgent services 4. Beneficiary problem resolution and FH	We revised our Central Access scripted responses to ensure that callers receive information about how to access routine and urgent services and how to access the problem resolution processes.	✓ Revised script on 9/8/16	Attachment B, Scripted Responses 9-8-16
	We changed the Patient Right's Advocate voicemail script to provide additional information to callers about how to access the problem resolution process.	✓ Updated Patient's Rights advocate voicemail on 6/14/16.	Attachment C, PRA voicemail script 6-14-16
10b: Service Request Log must include: 1. Name 2. Date 3. Initial Disposition	Managed Care Program Supervisor conducted staff training for Central Access staff and SLO Hotline regarding the use of scripts and call logging requirements.	✓ Completed training on 1/13/16, 6/22/16, 8/9/16. 8/24/16, and 9/7/16.	Attachment D, Managed Care Staff Meeting Minutes 6-22-16
	Ongoing refresher training will occur at least quarterly	❑ Ongoing training at least quarterly for CA staff and SLO Hotline staff.	Attachment E, Action Plan for Central Access Line

Beneficiary Protection 2a: Beneficiary Log must include the nature of the problem	We added a column to the Consumer Request Log to allow documentation of the nature of the problem	✓ Completed 1/8/16	Attachment H, Consumer Request Log
Provider Relations 3a: MHP must ensure that network providers comply with timely access requirements 3b: Corrective action if network provider does not have timely availability	Managed Care staff contact Network Providers by phone to discuss each referral and obtain information about availability. On 4/1/16, we began tracking time from referral to Network provider to the next available appointment. We will report this data at quarterly Meeting. If a Network Provider cannot provide timely service (for routine referrals timely is within 14 days of the referral). Managed Care staff will continue searching until a Provider is located who has availability within the standard. Further referrals will be held until the provider has timely openings. While we have not had to use it, the Network Provider contract contains a clause that allows us to terminate the contract for cause if the provider fails to perform duties in a timely manner.	✓ Completed 4/1/16	Attachment I, BH Referral Form NWP timeliness tracking Attachment J, slide from QST Committee meeting 7/22/16
MHSA 5b2: MHSA Issue Resolution Log must contain a brief description of the issues	We added a column to the Consumer Request Log to allow documentation of the nature of the problem and another to indicate that the issue is MHSA related.	✓ Completed 1/8/16	Attachment H, Consumer Request Log

CHART REVIEW

Protocol Item:	Corrective Actions	Timeline	Evidence
Medical Necessity 1c2: Interventions provided must meet criteria (Clients in DOS [1])	The therapist incorrectly coded a group participant's absence from group, resulting in a claim even though no intervention was provided. See the highlighted sections of page one of Attachment A for detail. This error was caught in a routine audit and the therapist corrected the mistake in a progress note dated [2] (Attachment K page 2). Unbeknownst to the DHCS review team or our MHP supporting staff at the review, we voided the claim on 11/6/2015 to pay back the claim (Attachment K page 3). We took the following actions: • Voided the service ([3]) • Provided staff training regarding Medical Necessity and how to code cancellations and no shows. • Expanded the Medical Necessity section of the Documentation Guidelines (March 2016)	✓ Voided the service on [4] ✓ Provided staff training regarding medical necessity, April and May, 2016 ✓ Expanded medical necessity section of the Documentation Guidelines, March, 2016	Attachment K, Void evidence, [5] Attachment L, Spring 2016 Training Calendar Attachment M, Documentation Training handout Attachment N, Medical Necessity section of the Spring 2016 Documentation Guidelines
Assessment 2a1: An assessment must be completed in a timely manner. (The assessment for the client in [6] could not be found at the time of the review)	Note <u>regarding</u>[7]: At the time of the review, the initial comprehensive assessment could not be found in the electronic health record. However, the staff member who helped the reviewers did not reset the EHR's 'filters' to look back farther. The assessment, dated [8], is in the record. However, this assessment was completed 30 days after the request for services, which is outside our target of 14 days, so we instituted corrective actions for this item. Corrective actions related to assessment timeliness: • Process revision: Managed Care Program Supervisor contacts the regional clinic Program Supervisor or uses a Managed Care clinician to outside our 14-day wait standard.	✓ Contacted regional site Program Supervisor for additional assessment appointments when the wait standard is exceeded (ongoing). ❑ Ongoing tracking of wait time of assessment at monthly QST meetings	Attachment O, Wait time data from 2015-2016 QST Work Plan Evaluation

[1] *DOS removed for confidentiality*
[2] *Progress Note date removed for confidentiality*
[3] *Service date removed for confidentiality*
[4] *Service date removed for confidentiality*
[5] *Line number removed for confidentiality*
[6] *Line number removed for confidentiality*
[7] *Line number removed for confidentiality*
[8] *Assessment date removed for confidentiality*

	• We track wait time for assessment monthly at our Quality Support Team Committee meetings. • We are exploring the feasibility of walk in assessments to reduce wait time.	demonstrates continued quality improvement	
2a2: Assessments must be updated at a frequency established by the MHP (annually) (Client in [9] had no updated assessment)	Corrective actions related to assessment updates: • We implemented Adult, Youth (5-17) and Child (0-5) Annual Treatment Summary/Assessment Update forms in Anasazi. • OST Division Manager created written Documentation Tips Newsletter and completed in person training at all clinic and CBO sites regarding use of Assessment Updates. • We are setting a "Client Action Schedule" to provide automated reminders to staff when an Assessment Update is due.	✓ Activated Assessment Updates, 3/16/16 ✓ Provided training for staff, April and May, 2016 ✓ Created a Documentation Tips Newsletter for staff, 1/19/16 ❑ Setting automated reminders to staff when update is due (estimated completion date: 10/15/16) ❑ Will add assessment update to audit tool for ongoing compliance tracking (estimated completion date: 12/1/16)	Attachment P, sample Adult Assessment Update Attachment Q, Documentation Tips Newsletter 1-19-16 Attachment L, Spring 2016 Training Calendar Attachment M, Documentation Training handout
Medication Consent 3b: The medication consent must all include the required elements	We are completely revising our medication consents to include all required elements. Our Medical Director and QST UR Nurse are developing multiple consents based on pharmacologic class. See Attachment Q for an example of our intended revision. We plan to require the use of the new electronic medication consent by every prescriber beginning with the first scheduled face to face visit with each client after 12/1/16. Our goal is to have updated medication consents in each client record by 6/30 /17 .	❑ Revision estimated completion date: 10/15/16 ❑EHR implementation estimated completion date: 11/30/16 ❑ Go Live estimated date: 12/1/16	Attachment R, Informed Consent for Medication (sample)
Client Plans 4b2: The proposed type(s) of interventions must include a detailed description of the intervention to be provided. [10]	Note regarding 4b2: We did not to add this requirement to our Documentation Guidelines until April, 2014, when we first became aware of the requirement. We did not require staff to create new Treatment Plans for all clients, but phased in the change with each new Treatment Plan developed after April, 2014. As a result, several plans in effect during the review period had not yet been updated. We also discovered that some staff did not know what to put for the "Evaluation & Management (E&M)" interventions sometimes used for psychiatry services for Medicare beneficiaries and so put little or no information for these interventions. Corrective actions: • We provided training materials • Made Intervention description required • Provided staff training, April and May, 2016	✓ Provided training material for staff regarding Intervention "Planning tier Narratives", 4/29/14 ✓ Made the description required prior to final approval of the Treatment Plan, 4/14 ✓ Provided refresher training regarding intervention	Attachment S, Intervention Planning Tier Narratives Attachment T, Client TP Attachment L, Spring 2016 Training Calendar Attachment M, Documentation Training handout

[9] *Line number removed for confidentiality*
[10] *Line number removed for confidentiality*

		description, April and May, 2016 ❑ Evaluating use of E&M codes.	
4e: There must be documentation that the MHP offered a copy of the client plan to the beneficiary. [11]	We developed two ways to document that a copy of the Treatment Plan was offered to the beneficiary. First, we consider the ability to help develop a Treatment Plan to be a significant usable strength. We add that strength to the plan (Attachment U, page 1). Second, when the beneficiary signs the plan, we add a line to the signature block that serves as an attestation that a copy was offered (Attachment U, page 2).	✓ Implemented two ways to document that a copy was offered	Attachment U, Client TP Copy offered (new TP for client in[12])
Progress Notes 5a1: Progress Notes must be written in a manner consistent with the MHP's Timeliness requirements. [13]	We received feedback from the DHCS Review Team that our standard for timely documentation was overly strict and not really achievable. As a result, we modified our requirements to match our performance rating system. We provided training for staff to help with implementation	✓Implemented a change practice, published in the March, 2016 Documentation Guidelines ✓ Provided training to support the change	Attachment M, Documentation Training handout Attachment L, Spring 2016 Training Calendar
5a4 [14] documented too much time (Client in[15], DOS:[16])	Note regarding[17]: Attachment V, page 1 shows the "Billing Ribbon" values for this service. The client in [18] arrived late for this Group Rehab service. The staff member who wrote the group notes meant to enter .15 (15 minutes) documentation time, but left out the decimal before the numerals. This data entry error resulted in a claim for fifteen hours of documentation time! We caught this error on a report run by our Fiscal staff to identify services that claim very large amounts of time. We voided the service on[19]. Attachment V, page 2 shows evidence of the void. We did not check with Fiscal to confirm the void during the review or we would have shared this information with the review team.	✓ Voided the service on [20] ✓ Provided staff training regarding Billing Ribbon values, April and May, 2016	Attachment V, Void evidence, client [21] Attachment L, Spring 2016 Training Calendar

[11] *Line number removed for confidentiality*
[12] *Line number removed for confidentiality*
[13] *Line number removed for confidentiality*
[14] *Line number removed for confidentiality*
[15] *Line number removed for confidentiality*
[16] *removed for confidentiality*
[17] *Line number removed for confidentiality*
[18] *Line number removed for confidentiality*
[19] *Service date removed for confidentiality*
[20] *Service date removed for confidentiality*
[21] *Line number removed for confidentiality*