San Mateo County Mental Health Plan Review

Plan of Correction

PLAN OF CORRECTION: B9a2, B9a3, B9a4
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, that will provide information to beneficiaries about how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.

(1) Description of corrective actions, including milestones:

1. BHRS Call Center created and is now utilizing a call script. The call script is required to be utilized by all staff answering the 24/7 call center phone calls. They now ask if the call is an emergency at the beginning of the call (See, file 1_Call Center Script). BHRS Administrative staff was re-trained on 10-19-17 regarding providing information about mental health services, addressing client's urgent condition, using the call script, and providing good customer service. The training consisted of reviewing the new call script. They were instructed to ask each caller if the call is regarding an emergency and discussion about how to call 911 or to direct caller to call 911. All Administrative staff were provided with a copy of the call script and were required to post the call script in their cubicle in eye sight. The call script is utilized in training all new staff.
2. BHRS will assure that OPTUM staff, which is the contractor that provides 24/7 call center services for San Mateo County BHRS after hours and on the weekend, is trained regarding BHRS procedures related to this requirement. BHRS provided OPTUM with written instructions describing how to provide information to beneficiaries about mental health services, how to use the beneficiary problem resolution and fair hearing processes, and addressing urgent conditions. BHRS has posted all relevant information on the smchealth.org website and required that all OPTUM staff utilize the information when answering the 24/7 call center phone calls. Information includes all of the required information regarding services, grievances, state fair hearing, and much additional information about mental health services at BHRS: located at: http://www.smchealth.org/overview/client-family-welcome-information
3. BHRS Call Center created a call script for our contactor OPTUM to utilize and it is now required for all staff answering the phones. They now ask if call is an emergency at the beginning of the call (See, file 2_OPTUM Call Script).

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

1. OPTUM reported conducting call center staff training of staff in October 10, 2017.
2. The call center manager conducted training of all BHRS call center staff answering phones on 10-19-17
3. Both new call center scripts have been implemented as of October 2017.

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

1. The BHRS staff training sign-in sheet (See, file 3_Call Center Training Sign-in Sheet).
2. Attached Call Center phone scripts.
3. BHRS has requested proof of the required documentation / proof of training of all staff and screen shots of information added to OPTUM database by 11-6-17.
4. Submission of test calls quarterly report.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time.

1. BHRS will request proof of inclusion of script in OPTUM database by November 6, 2017.
2. BHRS will request proof of trainings of OPTUM staff to be conducted as follow-up training on 10-31-17 to be submitted by 11-6-17

3. BHRS will conduct after hours test calls to determine that OPTUM staff can correctly provide answers to this question and provide results to Call Center Manager and Supervisor. The call center manager will submit copies of test call logs to Quality Management.
4. Call center manager and supervisor will conduct random monitoring of calls via listening to administrative assistants who answer phones and address any inconsistencies with staff. The call center manager will submit copies of test call logs to Quality Management.
5. Quality Management will continue to conduct quarterly test calls and provide results to Call Center manager and Supervisor.

(5) Description of corrective actions required of the MHP's contracted providers to address finding:

1. BHRS call center manager will assure that OPTUM staff is trained regarding BHRS procedures related to this requirement. BHRS call center manager provided OPTUM with written instructions describing how to provide information to beneficiaries, and how to use the beneficiary problem resolution and fair hearing processes, including a link to further information on the BHRS website. BHRS has required OPTUM to train their staff to be able to provide this information and provide proof of this training.
2. BHRS provided OPTUM with a document describing how to access Specialty Mental Health Services for BHRS including specialty mental health services required to assess whether medical necessity criteria are met. OPTUM contracted services answers calls after hours, weekends and holidays. The OPTUM staff did not provide the caller with information about how to use the beneficiary problem resolution and fair hearing process. BHRS call center manager will assure that OPTUM staff is trained regarding BHRS procedures related to this requirement. BHRS provided OPTUM with a document describing how to access Specialty Mental Health Services for BHRS including specialty mental health services required to assess whether medical necessity criteria are met. (See, file 4_OPTUM POC).

PLAN OF CORRECTION: C1 c

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 TARs for non-hospital SMHS services.

(1) Description of corrective actions, including milestones:

- A new TAR procedure was developed to address the following things: 1) procedure for adding secondary dates on TARs was developed when more info needed, 2) White–out is no longer used on TARs, and 3) New documentation procedure for TARs with second received date in the TAR Access Database.
- For TARs/charts missing information, QM reviewer notes TAR is missing info in lower left field on TAR, and communicates with hospital to request needed information. After receipt, QM reviewer puts 2nd date stamp with new date in comments field below information request (See file, 5_TAR Example).TAR review is completed within 14 days of the 2nd date stamp as mandated.
- If hospital does not send needed info, reviewer denies TAR by 14th day after request for information.
- White-out is never used on TARs. Errors will be lined out with staff initials or new TAR will be requested.
- In TAR Access database, for TARs with 2nd received by date (as above) initial date received is noted in small comments field in lower right (See file, 6_TAR Procedure) and new date is entered in the Date Stamped-Received Field (See file, 7_TAR Screen: in TAR Review Dates Section in middle top half of screen.)

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

All steps were implemented by 7/1/17, which is the start of the FY 16-17 Fiscal Year.

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

TAR procedure write up with new steps above is attached to this POC with relevant fields highlighted, along with a blank example TAR with two date stamps and screenshot of Access database showing related fields. One example TAR is attached with PHI blacked out. If needed, additional TARs can be submitted.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time:

Quarterly, QM staff will review hard copy TARs against Access Database to ensure appropriate logging and data entry for TARs with two received dates. This review will include verifying that TARs were processed within the 14 day mandated timeline.

(5) Description of corrective actions required of the MHP's contracted providers to address finding:

When additional information is requested, QM reviewer will tell provider that if needed information is not received within 14 day their TARs will be denied.

PLAN OF CORRECTION: D6

The MHP addressed the OOC findings for this requirement while DHCS was onsite. The MHP identified that they began notifying those providers cited by the beneficiary of the final disposition of the grievance in 2016 as corrective action. The MHP should include this information as part of their POC.

(1) Description of corrective actions, including milestones:

The Grievances and Appeals Team is making sure to comply with this requirement as follows:

- We have sent a copy of the copy of the grievance determination letter to each provider who was named in a grievance in FY 2016-2017
- Our logs were modified by adding a dedicated column for noting the date providers are notified of the grievance determination. Grievances are not considered finished until that column is completed indicating that a copy of the resolution letter has been sent to the provider involved.
- Additionally, the log has a dedicated check mark column where we track that a hard copy of the tracking form including the “resolution to provider” has been placed in the paper grievance file.
- On our grievance tracking form we now must include a copy of the sent email in which we notify the providers of the grievance determination.

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

- Immediately after Quality Management notified us of this issue, around January 2017, we started the corrective action by notifying all providers who had not been notified before. This process ended about March of 2017 and we have continued notifying providers to ensure compliance with this requirement. (3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

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

- BHRS will submit a copy of the grievances and appeals log showing the items mentioned above
- Paper files including the tracking forms showing compliance are available on request.
- The BHRS policy 03-03 Client Grievance & Appeal System has been updated in October 2017 to include*, “the Grievance and Appeal Team (GAT) will send a letter to acknowledge the receipt of a grievance and again once the grievance investigation is complete and a resolution is identified. The resolution letter will inform the client and the providers involved of the outcome. The provider will be sent a copy of the resolution letter.”*

(4) Mechanisms for monitoring the effectiveness of corrective actions over time:

- Compliance on the issue of notifying providers of the grievance determination has been incorporated alongside the other compliance markers, which are routinely monitored by one staff member as well as by the Grievances and Appeals Team
- Grievances are monitored through the grievance log and are not considered closed until all compliance items have been fulfilled.
- Paper files have a written checklist which is completed at the end of the grievance process and includes all compliance items, such as notifying the providers involved. The files are reviewed during by weekly Grievance & Appeal Team's meetings and the checklists are marked before considering a grievance/appeal closed.

(5) Description of corrective actions required of the MHP's contracted providers to address finding:

The corrective plan is carried out directly by county staff. No contracted staff is involved in conducting grievances and/or appeals.

PLAN OF CORRECTION: 1 c-1 and 1 c-2

The MHP shall submit a POC that indicates how the MHP will ensure that interventions are focused on a significant functional impairment that is directly related to the mental health condition as specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(A).

The MHP shall submit a POC that indicates how the MHP will ensure that the interventions provided meet the intervention criteria specified in CCR, title 9, chapter 11, section 1830.205(b)(3)(B)(1-4}.

(1) Description of corrective actions, including milestones:

- The treatment plan form has been updated to increase compliance. There has been an addition of a medical necessity indicator for each goal/intervention, which requires a primary medical necessity diagnosis.
- The following treatment plans were updated:
  1. Medi-Cal Contractors March 2017
  2. The private provider network June 2017
  3. Avatar County Treatment Plan November 2017 (screen shot below):

San Mateo County Mental Health Plan Review

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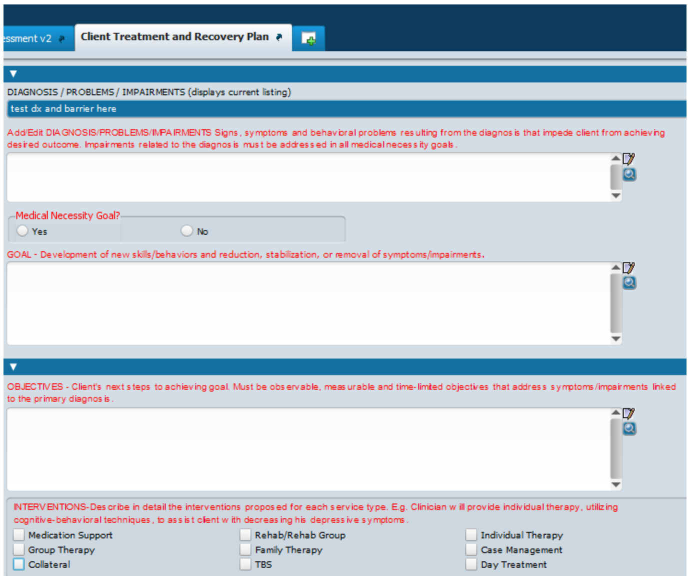

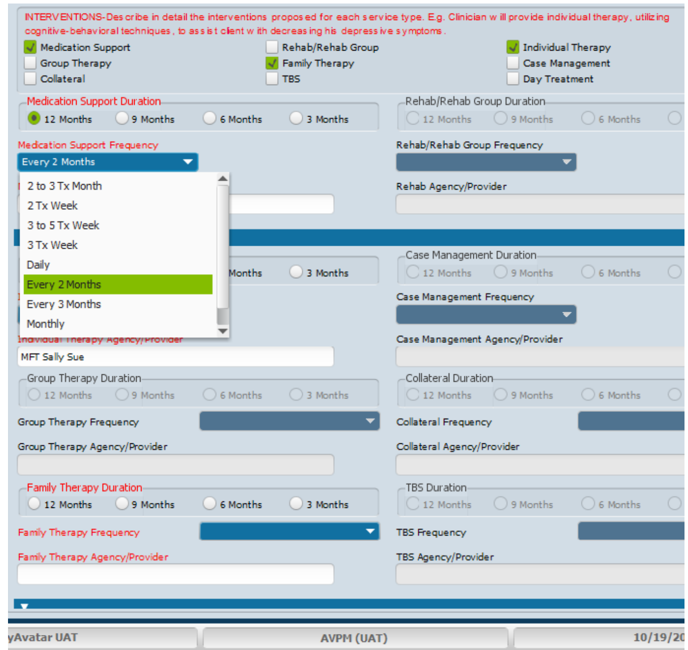

- The documentation manual has been updated with these new standards[: Documentation Manual October 2010.]
- BHRS has implemented an audit program to ensure compliance with treatment plan requirements. The audit program is designed to identify treatment plans that do not meet the minimal requirements. If the treatment plan does not meet the minimum requirement BHRS, voids/self-disallows any service not supported by a qualifying treatment plan.
- BHRS has implemented required treatment plan training: http://www.smchealth.org/bhrs/providers/ontrain

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

- The audit program and training program has been fully implemented.
- Changes to the BHRS Avatar treatment plan have been made and will be implemented in November 2017.
- Changes to the contractor treatment plan have been fully implemented.

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS: See above hyperlinks to undated forms and updated documentation manual with new treatment plan requirements.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time. BHRS implemented an annual audit program of all Medi-Cal programs in June of 2015. Ten percent of all Medi-cal charts will be audited yearly and self-disallowances will occur for any services without a treatment plan that meets the requirements stated in the documentation manual.

See attached audit tool (See file, 8_Audit Tool Sample).

If the answers to these questions are no, the services will be voided/self-disallowed.

35. Is the Primary "Included" Diagnosis addressed in at least 1 barrier/* goal/objective?
39. Are specific behavioral interventions described in detail for each proposed service?

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(5) Description of corrective actions required of the MHP's contracted providers to address finding: BHRS developed a new policy: Delegation Oversight & Audit Program: 17-02, which states the implementation of an audit program of Medi-Cal contractors.
See policy of audit program. http://www.smchealth.org/bhrs-policies/delegation-oversight-audit-program-17-02

PLAN OF CORRECTION: 2a
The MHP shall submit a POC that indicates 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.

(1) Description of corrective actions, including milestones:
BHRS developed several tracking reports to monitor assessment and treatment plan timeliness as specified in the BHRS Documentation Manual.
The reports include:

- The Mental Health Documentation at a Glance- which lists complete date and due dates for assessment and treatment plans.
- The Assessment Coming Due and Overdue Status Report
- The Treatment Plan Coming Due and Overdue Status Report

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

- These reports were implemented in Jan 2016 and are available to all staff having access to the EMR.
- Reports are run every month by quality management and sent to the program supervisor with comments to explain problem areas and needed actions.
- Reports are also run by the BHRS program administration and are reviewed by the executive management team monthly.
- Several meetings were conducted with the contractor to familiarize them with the reports, requirements, and how to run the reports.
- Reports are utilized to determine self-disallowances due to lack of assessment timeliness.

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
The tracking reports were implemented in January 2016.
(4) Mechanisms for monitoring the effectiveness of corrective actions over time.
See attached audit tool (see file, 8_Audit Tool Sample).
. If the answers to these questions are no, the services will be voided/self-disallowed.

20. Is there an Assessment Gap that resulted in Disallowance?
21. Is there a current assessment (<3 years old that covers the audit period)

(5) Description of corrective actions required of the MHP's contracted providers to address finding:
Contractors were trained on how to print and utilize the reports for tracking. BHRS developed a new policy: Delegation Oversight & Audit Program: 17-02, which states the implementation of an audit program of Medi-Cal contractors. See policy of audit program. http://www.smchealth.org/bhrs-policies/delegation-oversight-audit-program-17-02

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

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(1) Description of corrective actions, including milestones:

- Required Training was implemented: All staff that complete assessments were required to complete the assessment online training and all new staff are required to complete the assessment training before being given access to the EMR (where assessments are completed: Implemented in 2015). http://www.smchealth.org/bhrs/providers/ontrain
- Assessment tracking reports were implemented in 2016.
- BHRS implemented an audit program which audits 10% of Medi-Cal Charts utilizing the attached audit tool.
- In addition, for San Mateo County run programs- 75% of newly completed assessment are audited and the assessor is sent specific feedback about assessment lacking any required elements.
- BHRS required all assessments for primary diagnosis- if not an included diagnosis the chart is blocked by the billing department from Medi-Cal billing. Since June 2016 - 106 client charts have been blocked from Medi-Cal Billing due to no included diagnosis.

(2) Timeline for implementation and/or completion of corrective actions:
All elements listed above have been fully implemented.
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
Evidence of internal audit program (See file, 9_Internal Audit Findings).
(4) Mechanisms for monitoring the effectiveness of corrective actions over time.
The following question was added to the BHRS audit tool in June 2015 (see file, 8_Audit Tool Sample).

"If any required assessment elements are missing, the provider will be issued a plan of correction.

> 25. Assessments reviewed were not disallowed but did NOT contain all required elements (rate if any of reviewed assessments did not meet)
> 26. Missing Assessment Content (check all missing elements not addressed in any assessment covering audit period)
> a) Presenting Problem
> b) Relevant conditions and psychosocial factors
> c) Mental Health History
> d) Medical History
> e) Medications
> f) Substance Exposure/Substance Use
> g) Client Strengths
> h) Risks and barriers relevant to achieving Client Plan Goals
> i) A mental status examination
> j) A complete five-axis diagnosis
> k) Additional clarifying formulation information, as needed."

(5) Description of corrective actions required of the MHP's contracted providers to address finding:
The same auditing and training program was implemented and required for all contractors.

PLAN OF CORRECTION 4a-2:
The MHP shall submit a POC that indicates how the MHP will:
1) Ensure that client plans are completed 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.

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2) Provide evidence that all services identified during the audit that were claimed outside of the audit review period for which no client plan was in effect are disallowed.

1) Description of corrective actions, including milestones:
BHRS develop several tracking reports to monitor assessment and treatment plan timeliness as specified in the BHRS Documentation Manual.
The reports include:

- The Mental Health Documentation at a Glance Report- which list completed date and due dates for treatment plans.
- The Treatment Plan Coming Due and Overdue Status Report

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

- These reports were implemented in Jan 2016 and are available to all staff having access to the EMR.
- Reports are run every month by quality management and sent to the program supervisor with comments to explain problem areas and needed actions.
- Reports are also run by BHRS program administration and are reviewed by the executive management team monthly.
- Several meetings were conducted with the contractor to familiarize them with the reports, requirements, and how to run the reports.
- Reports are utilized to determine self-disallowances due to lack of treatment plan timeliness.
- AVATAR/BHRS EMR is set up to automatically block billing if there is not current treatment plan.

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

- The tracking reports were implemented in Jan 2016. Evidence of internal audit program (See file, 9_Internal Audit Findings).

(4) Mechanisms for monitoring the effectiveness of corrective actions over time.

- See attached audit tool. If the answers to the question,"29. Do the Treatment Plan (s) cover ALL billing for the audit period?" is no, the services will be voided/self-disallowed by Quality Management.

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- Below are the services that we did not bill Medi-Cal Short-Doyle due to no treatment plan. These services we blocked from billing. July – Aug 2017 is not complete yet due to billing cycle.

Oct 15 to Sept 2017		
Date Range	**Sum of Amount Not Billed Due to Treatment Plan**	**Number of Services Not Billed Due to Treatment Plan**
Oct-Dec 2015	$ 245,506.98	924
Jan-March 2016	$ 300,550.24	1113
April-June 2016	$ 264,861.40	1024
July-Sept 2016	$ 262,947.75	1066
Nov-Dec 2016	$ 208,734.43	878
Jan-March 2017	$ 173,522.25	661
April-June 2017	$ 211,382.95	822
July-Aug 2017	$ 18,608.36	107
Grand Total	**$ 1,686,114.36**	**6595**

PLAN OF CORRECTION 4 b

The MHP shall submit a POC that indicates how the MHP will ensure that:

1) (4b-l.) 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-3.) All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention.

1) Description of corrective actions, including milestones:
The treatment plan form has been updated to increase compliance. There has been an addition of a medical necessity indicator for each goal/intervention, which requires a primary medical necessity diagnosis.
The following treatment plan were updated:

1. Medi-Cal Contractors March 2017
2. The private provider network June 2017
3. Avatar County Treatment Plan November 2017 (screen shot below):

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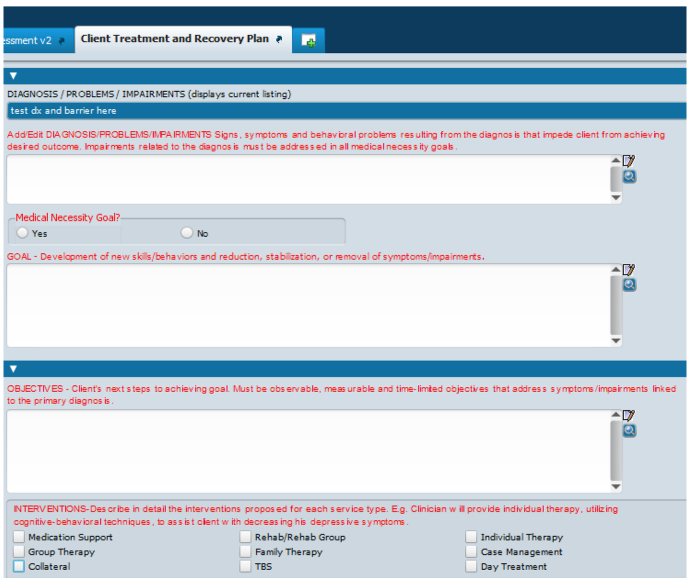
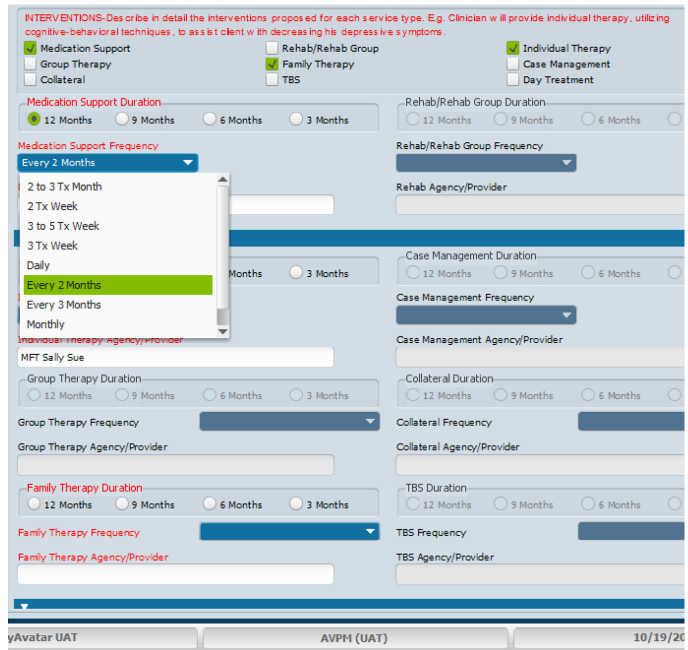
Plan of Correction





The documentation manual has been updated with these new standards: Documentation Manual October 2010.

- BHRS implemented an audit program to ensure compliance with treatment plan requirements. The audit program is designed to identify treatment plans that do not meet the minimal requirements. If the treatment plan does not meet the minimum requirement BHRS, voids/self-disallows any service not supported by a qualifying treatment plan.
- BHRS also implemented required treatment plan training. No new staff gains access to the BHRS EMR without the training competed as of 2016. Current staff that complete treatment plans were required to complete the training http://www.smchealth.org/bhrs/providers/ontrain

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

- The audit program and training program has been fully implemented.
- Changes to the BHRS Avatar treatment plan have been made and will be implemented in November 2017.
- Changes to the contractor treatment plans have been fully implemented.

(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
See above hyperlinks to updated forms and updated documentation manual with new treatment plan requirements.
(4) Mechanisms for monitoring the effectiveness of corrective actions over time.
BHRS implemented an annual audit program of all Medi-Cal programs in June of 2015. Ten percent of all Medi-cal charts with be audited yearly and self-disallowances will occur for any services without a treatment plan that meets the requirements stated in the documentation manual.

See attached audit tool (See file, 8_Audit Tool Sample).

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If the answers to these questions are no, the services will be voided/self-disallowed.

“35. Is the Primary "Included" Diagnosis addressed in at least 1 barrier/* goal/objective?”
“39. Are specific behavioral interventions described in detail for each proposed service?”

(5) Description of corrective actions required of the MHP's contracted providers to address finding: BHRS developed a new policy: Delegation Oversight & Audit Program: 17-02, which states the implementation of an audit program of Medi-Cal contractors.
See policy of audit program. http://www.smchealth.org/bhrs-policies/delegation-oversight-audit-program-17-02

PLAN OF CORRECTION 4d:
The MHP shall submit a POC that indicates how the MHP will:
1) Ensure that the beneficiary's signature is obtained in a timely manner on the client plan as specified in the MHP Contract with the Department and CCR, title 9, chapter 11, section 181 0.440(c)(2)(A)(B).
2) Ensure that services are not claimed when the beneficiary's:

a) Participation in and agreement with the client plan is not obtained or not obtained in a timely manner and the reason for refusal is not documented.
b) Signature is not obtained when required or not obtained in a timely manner and the reason for refusal is not documented.

(1) Description of corrective actions, including milestones:

- San Mateo County provided required training to all clinicians and supervisors in May 2016 concerning the expectation and requirements regarding including clients in their treatment plan development (See files, 10_Documentation Training May 2016.doc and 11_Documentation_updates_may_2016).
- BHRS developed an AVATAR-EMR tracking log and report to track all treatment plans without client signature or family member’s signature.
- BHRS developed a process to verify that each treatment plan has a signature: utilizing the above mentioned tracking report and a signature verification process (See file, 12_Signature Verification Process).
- BHRS developed an internal audit program to review 100% of treatment plans and related progress notes to identify clinicians not including clients in treatment planning. QM reached out to those staff and provided training and guidance related to this requirement.
- BHRS developed a process to alert management and clinics of treatment plans requiring a signature.

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

- All actions have been implemented as of May 2016.
- Ongoing monthly reviews of all treatment plans missing a client/family member signature are conducted by QM. Clinical staff members are notified of treatment plans needing attention. QM tracks these treatment plans utilizing the AVATAR report developed for this purpose.

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

See attached sample email sent out to one program supervisor (See file, 13_Sample Summary Report Sent to Programs).

(4) Mechanisms for monitoring the effectiveness of corrective actions over time.

- Ongoing monthly reviews of all treatment plans missing a client/family member signature are conducted by QM. Clinical staff members are notified of treatment plans need attention. QM tracks these treatment plan utilized the AVATAR report developed for this purpose, monthly (See file, 14_Detailed QM Client Signature Verification Process).

(5) Description of corrective actions required of the MHP's contracted providers to address finding:

The same requirement has been implemented for all contractors as listed above. Treatment plans scanned by BHRS billing staff are verified to be signed by billing staff. Billing staff have been informed not to scan and authorize any treatment plan without the correct signatures. Therefore, if there is no client signature, the plan is not entered into the EMR and all billing is automatically blocked.

PLAN OF CORRECTION: 5a

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

1) Ensure that progress notes meet timeliness, frequency and the staff signature requirements in accordance with regulatory and contractual requirements.

2) The MHP shall submit a POC that indicates how the MHP will ensure that progress notes document:

sa-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 the MHP's written documentation standards.

Sa-4) The date the progress note was completed and entered into the medical record by the person(s) providing the service in order to determine the timeliness of completion, as specified in the MHP Contract with the Department.

Sa-7) The amount of taken to provide services.

3) The documentation is individualized for each service provided.

(1) Description of corrective actions, including milestones:

- Progress notes not meeting these required were for the San Mateo Provider Network. Several procedures and new training has been implemented to ensure that all PPN progress notes meet these minimal requirements including:
- All providers were issued notice of the new progress note and billing requirements in August 2017 (See file, 15_Notice to Provider Network).
- All providers were required to attend training to review this new requirement.
- Providers are now required to meet all progress note requirements to be paid and have been given a new progress note form to utilize (See file, 16_New PPN Progress Note).
- The BHRS billing department has been sending a reminder with any provider invoice without the duration and CPT code listed (See file 17_PPN Notice).

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

Training and requirements have been implemented.

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

- Evidence of internal audit program to be conducted in Dec 2017.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time.

- BHRS QM will conduct a 100% review of all providers which will be billed to Short-Doyle Medi-Cal for the month of October 2017. This audit will be conducted in December. Any provider found to be out of compliance with the minimum requirement will be issued a plan of correction and will be placed on a monthly audit list until in full compliance.
- Any bill found without supportive documentation and progress notes meeting all requirements, will be disallowed and voided from the Short-Doyle Medi-Cal system.

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(5) Description of corrective actions required of the MHP's contracted providers to address finding:

- As stated above providers are required to meet the full list of progress note requirements; they have been trained. QM will audit their progress notes, issue plan of corrections, and void services as needed starting in October 2017.

PLAN OF CORRECTION 5a3:
The MHP shall submit a POC that indicates how the MHP will ensure that:
1) Each progress note is individualized, and describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning, as outlined in the client plan. 2) Services provided and claimed are not solely clerical.
3) All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11, sections 1830.205(a)(b).

(1) Description of corrective actions, including milestones:

- BHRS implemented required training on progress notes and billing as of 2015. http://www.smchealth.org/bhrs/providers/ontrain
- BHRS has implemented an audit program for where medical necessity is reviewed and billing/charts are disallowed if they do not meet medical necessity.

(2) Timeline for implementation and/or completion of corrective actions:
This has already been implemented.
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
Evidence of internal audit program (See file, 9_Internal Audit Finding).

Reviewed Billed Services/Progress Notes since Sept 2015 to July 2017

Rating	Total Number Billed Services/ Progress Notes Reviewed	%
1+Good Progress note met quality requirements.	9,659	67.9%
2+Met only minimal quality requirements (not disallowed given a POC).	1,921	13.5%
These services will voided/self disallowed		
3-No progress note	**47**	0.3%
4-No treatment Plan or LPHA Signature	**203**	1.4%
5-Tx plan-No client sign/ No note	**477**	3.4%
6-No assessment/no qualifying diagnosis or No LPHA signature on assessment	**235**	1.7%
7-Billed non-billable	**458**	3.2%
8-No medical necessity	**934**	6.6%
9-Upcoded	**233**	1.6%
10-Overbilling	**57**	0.4%
Total Number Billed Services/ Progress Notes Reviewed	14,224	
Voided/Disallowed Due to audit	2644	18.6%

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(4) Mechanisms for monitoring the effectiveness of corrective actions over time.
Ongoing audit program of 10% of all Short-Doyle Medi-Cal charts.
(5) Description of corrective actions required of the MHP's contracted providers to address finding:
The audit and training program is also required and implemented for contractors.

PLAN OF CORRECTION 5b:
The MHP shall submit a POC that indicates how the MHP will ensure that:
1) Group progress notes clearly document the contribution, involvement or participation of each staff member as it relates to the identified functional impairment and mental health needs of the beneficiary.
2) There is medical necessity for the use of multiple staff in the group setting.

(1) Description of corrective actions, including milestones:
BHRS required mandatory group billing/progress note training for all providers in 2015.
http://www.smchealth.org/bhrs/providers/ontrain
All new staff must complete the group billing/progress note training before being given access to the BHRS EMR as of 2016.
(2) Timeline for implementation and/or completion of corrective actions:
These changes have been implemented.
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
Evidence of internal audit program tool and training program. See training program at
http://www.smchealth.org/bhrs/providers/ontrain
(4) Mechanisms for monitoring the effectiveness of corrective actions over time
Two questions have been added to the BHRS audit tool to ensure that group progress notes are meeting the requirements see below. Plans of corrections will be issued as needed to ensure that groups billed with co-providers justify the need.

* 50. Did Progress Notes address, as needed.

	Addressed	Not Addressed but Needed	N/A
Interventions, client's response	○	○	○
Services reduced impairment, restored functioning, or prevented deterioration	○	○	○
Address Treatment Plan Goal	○	○	○
Encounters and relevant clinical decisions	○	○	○
Behavior, DX Addressed	○	○	○
Referrals	○	○	○
Follow-up care, a discharge summary	○	○	○
Group progress notes clearly document the contribution, involvement or participation of each staff member as it relates to the identified functional impairment and mental health needs of the beneficiary.	○	○	○

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51. There is medical necessity for the use of multiple staff in the group setting for Group Progress Notes.

- ◯ Yes
- ◯ No
- ◯ N/A

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(5) Description of corrective actions required of the MHP's contracted providers to address finding:
The same training and auditing requirements apply to all BHRS contractors that provide group services. Contractors are subject to regular auditing. Any found to be out of compliance with group progress notes will be issued a plan of correction. The BHRS FY17-18 audit schedule for contractors started in September 2017, audits are underway. Ten percent of all contractor charts will be audited and ensure that they meet this requirement.

PLAN OF CORRECTION 5c:
The MHP shall submit a POC that indicates how the MHP will:
1) Ensure that all SMHS claimed are:
- a) Documented in the medical record.
- b) Actually provided to the beneficiary.
- c) Appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary as delineated in the CCR, title 9, chapter 11 , sections 1830.205(a)(b).
- d) Claimed for the correct service modality and billing code.

2) Ensure that all progress notes are:
- a) Indicate the type of service, the date the service was provided and the amount of time taken to provide the service as specified in the MHP Contract with the Department.
- b) Completed within the timeline and frequency specified in the MHP Contract with the Department.

(1) Description of corrective actions, including milestones:
- Progress notes not meeting these requirements were for the San Mateo Provider Network. Procedures and training have been implemented to ensure that all PPN progress notes meet the minimal requirements including:
- All providers were issued notice of the new progress note and billing requirements in August 2017 (See file, 15_Notice to Provider Network).
- All providers were required to attend training to review this new requirement. Training is held weelk for new providers.
- Providers are now required to meet all progress note requirements to be paid and have been given a new progress note form to utilize (See file, 16_New PPN Progress Note).
- The BHRS billing department has been sending a reminder with any provider invoice without the duration and CPT code listed (See file 17_PPN Notice).

(2) Timeline for implementation and/or completion of corrective actions:
Training and requirements have been implemented.
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:
- Evidence of internal audit program to be conducted in Dec 2017.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time.

- BHRS QM will conduct a 100% review of all providers which will are billing Short-Doyle Medi-Cal for the month of October 2017. This audit will be contacted in December. Any provider found to not be in compliance with the minimum requirement will be issued a plan of correction and will be placed on a month audit list until in full compliance.
- Any bill found to not have supported documentation, progress notes meeting all requirements, will be disallowed and voided. From the Short-Doyle Medi-Cal system.

(5) Description of corrective actions required of the MHP's contracted providers to address finding:

- As stated above providers are required to meet the full list of progress note requirements and have been trained. QM will audit their progress, issue plan of corrections, and void services as needed starting in October 2017.

PLAN OF CORRECTION 5d:
The MHP shall submit a POC that indicates how the MHP will:
1) Ensure that all documentation includes the date the signature was completed and the document was entered into the medical record.
(1) Description of corrective actions, including milestones:

- Progress notes not meeting these requirements were for the San Mateo Provider Network several procedures and training has been implemented to ensure that all PPN progress notes meet these minimal requirements including:
- All providers were issued notice of the new progress note and billing requirements in August 2017 (See file, 15_Notice to Provider Network).
- All providers were required to attend training to review this new requirement.
- Providers are now required to meet all progress note requirements to be paid and have been given a new progress note form to utilize (See file, 16_New PPN Progress Note).
- The BHRS billing department has been sending a reminder to any provider with an invoice without the duration and CPT code listed (See file 17_PPN Notice).

(2) Timeline for implementation and/or completion of corrective actions:
Training and requirements have been implemented.
(3) Proposed (or actual) evidence of correction that will be submitted to DHCS:

- Evidence of internal audit program to be conducted in Dec 2017.

(4) Mechanisms for monitoring the effectiveness of corrective actions over time.

- BHRS QM will conduct a 100% review of all providers which will are billing Short-Dolye Medical for the month of October 2017. This audit will be contacted in December. Any provider found to not be in compliance with the minimum requirement will be issued a plan of correction and will be placed on a month audit list until in full compliance.
- Any bill found to not have supported documentation, progress notes meeting all requirements, will be self-disallowed and voided from the Short-Doyle Medi-Cal system.

(5) Description of corrective actions required of the MHP's contracted providers to address finding:

- As stated above providers are required to meet the full list of progress note requirements, have been trained, QM will audit their progress, issue plan of corrections, and void services as needed starting in October 2017.

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PLAN OF CORRECTION 6a:
The MHP shall submit a POC that indicates how the MHP will ensure that:
1) All beneficiaries and their parents/legal guardians are offered mental health interpreter services, when applicable.
2) There is documentation substantiating that beneficiaries and their parents/legal guardians are offered mental health interpreter services, when applicable.

(1) Description of corrective actions, including milestones:

The Health System has a Client's Right to Language Services Notification Policy (No. HS A-25) which requires clients and their families be notified of the availability of interpreter services at no cost this includes posting the information in points of entry and intake. Furthermore, BHRS Services to Clients in Primary Languages policy (No. MH 99-01) requires BHRS staff to document the primary language of clients and what services were provided to meet the clients' language needs. The following measures have been put in place to ensure adherence to the policy and that beneficiaries are offered interpreter services at no cost:

a. **Staff Trainings:** BHRS staff are required to complete an in-person Working Effectively with Interpreters training every 3 years, which covers our Health System-wide policies requiring that all clients be offered no cost interpreter services and BHRS procedures for requesting in-person and over-the-phone interpreters. An online Refresher Course launched this fall 2017 and will allow staff that have completed in the in-person training to complete an online refresher. Furthermore, BHRS plans to incorporate language access services policies and procedures into future BHRS all-staff orientation.

b. **Notification:** BHRS Policy No. MH 99-01 requires staff to document the primary language of clients and what services were provided to meet the clients' language needs. This policy currently was currently updated, vetted by BHRS Diversity and Equity Council and BHRS Executive Leadership and is scheduled to be finalized at the next Quality Improvement Committee meeting in November 2017. Additionally, clinic sites are required to post Right to an Interpreter signs notifying the public of available interpreter services at no cost. Recently, the Right to an Interpreter poster and information was added to the client and family welcome information on the internet, http://www.smchealth.org/overview/client-family-welcome-information. In early 2015, we conducted site visits of 8 BHRS clinic sites to asses whether or not they had signage, number of posters displayed, where the posters displayed in a visible location and was the signage in good condition. Clinics were not notified in advance about the site visits. BHRS plans to include signage checks into annual site visits moving forward.

c. **Contracted Services:** Contractors are required to develop Cultural Competence Plans that include providing language services, this is an expectation in the contract terms. BHRS provides a rubric to help guide the development of the plan, technical assistance, a budget line item to support provision of interpretation and translation and most recently a pilot project was launched to provide additional fiscal support and technical assistance to BHRS contractors. Attached is the evidence of efforts to support contractors in the provision of language services:

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

a. Staff Trainings:

i. In-person Working Effectively With Interpreters Training – offered twice a year in the Spring and Fall

  ii. On-line Working Effectively With Interpreters Refresher Course – available year-long as of September 2017
  iii. BHRS orientation – once or twice per year, next one is scheduled for early 2018

b. **Notification:**
  i. Signage – ongoing, next site visit scheduled for January 2018
  ii. Website – completed September 2017

c. **Contracted Services:**
  i. Cultural competence plan requirement – submitted annually in September
  ii. Technical assistance – once a year to contractors and as needed
  iii. Budget line item –as contracts are renewed and negotiated
  iv. Pilot project – launched February 2017, ongoing

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

a. **Staff Trainings:**
  - Flyers, sign in sheets, agenda, powerpoint presentations (in-person and refresher)
  - Quick reference guide and wallet cards
  - BHRS staff that have completed the training
  - Emails informing all staff of the mandatory training, presentations at staff meetings

b. **Notification:**
  - Updated language access policy
  - Signage posters, site visit results
  - In-person, over-the-phone requests
  - Client's preferred language and services provided in a language other than English (from EHR)

c. **Contracted Services:**
  - Sample contract with language
  - Results of requirement - # plans submitted, progress,etc.
  - Language Access services memo to contractors
  - Pilot project proposal

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

a. 80% of staff will have attended the in-person "Working Effectively with Interpreters in Behavioral Health" training. Of those staff who took the in-person "Working Effectively with Interpreters in Behavioral Health" training 3 or more years ago, 75% will take the on-line refresher course of "Working Effectively with Interpreters in Behavioral Health Refresher"
b. All staff with direct client contact will accurately report client's "Preferred Language" including American Sign Language or aids like braille or TTY/TDY using the drop down language option in Avatar progress notes. Trends through Avatar and in-person and over-the-phone requests will be determined and identified as "emerging languages"
c. All clinics will maintain signage, notifying clients and families of their right to interpreter services at no cost, in a visible location and in good condition as determined by annual site visits.
d. 80% of BHRS contractors required to submit a cultural competence plan will have one in place with specific goals for providing language services to clients and families.

(5) Description of corrective actions required of the MHP's contracted providers to address finding:
As described above.

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PLAN OF CORRECTION 7a:
The MHP shall submit a POC that indicates how the MHP will ensure that all program requirements for *Day Treatment Intensive* are provided in accordance with regulatory and contractual requirements. For example:

1) Ensure that all the required service components including psychotherapy for Day Treatment Intensive are met.

(1) Description of corrective actions, including milestones:
The day treatment program description was updated and day treatment clinical staff members were trained to ensure that there is either individual and/or group therapy every week.
(2) Timeline for implementation and/or completion of corrective actions:
This change was implemented in March 2017. Staff members were informed of the requirement to provide psychotherapy every week and to document it in both the daily and weekly progress notes. Staff members were sent a follow-up notice in Sept 2017.
That is,
Sent to day treatment team: 9-27-2017“Clinical Team,
“I wanted to make clear to the entire clinical team that it is an expectation that all of the youth have documented in their weekly notes that they have received individual and/ or group therapy each week. Please let me know if you have any questions regarding this expectation. Supervisor of Day Treatment Program.”
(3) Evidenced of correction that will be submitted to DHCS: The change has been implemented to ensure that psychotherapy is provided weekly and documented. See audit results below in question 4.
(4) Mechanisms for monitoring the effectiveness of corrective actions over time.
BHRS Quality management implemented an audit oversight program to ensure that all program components are met. Example, of audit results: Reviewers Leslie Ballan, LMFT and Maia Bora, LMFT reviewed one (1) week in each of four (4 or 12) charts of the Canyon Oaks Youth Center, Day Treatment Intensive Program on August 14-18, 2017 as follows: Daily, weekly, and weekly schedules were audited for compliance with program requirements. All clients/all weeks have at least on therapy session offered. The management team was given a detailed summary report with recommend improvements.
(5) Description of corrective actions required of the MHP's contracted providers to address finding:
BHRS Quality management will conduct a quarterly audit of the day treatment program and will provide a detailed summary.