Santa Barbara County Mental Health Plan Review
Plan of Correction

Attestation

Findings:
The MHP did not furnish evidence that if it is involved in the placement, the MHP must provide the DHCS issued Medi-Cal Services for Children and Young Adults: Early & Periodic Screening, Diagnosis & Treatment (EPSDTI brochure, which includes information about accessing Therapeutic Behavioral Services (TBS) to Medi-Cal (MC) beneficiaries under 21 years of age and their representative in the following circumstances: At the time of admission to a Skilled Nursing Facility (SNF) with a Specialized Treatment Program (STP) for the mentally disordered; at the time of admission to a Mental Health Rehabilitation Center (MHRC) that has been designated as an Institution for Mental Diseases (IMD); at the time of placement in a Rate Classification Level (RCL) 13-14 foster care group home; and at the time of placement in an RCL 12 foster care group home when the MHP is involved in the placement. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy# 4.011 EPSDT Therapeutic Behavioral Services Notification, dated 12/22/2016. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the policy did not specify that the brochure would be provided when a client enters a RCL 12 when the MHP is involved in the placement. This Attestation requirement is deemed OOC.

Plan of Correction
Policy# 4.011 EPSDT Therapeutic Behavioral Services Notification updated to reflect that brochures are to be given to clients when placed in a RCL 12 or higher. **(Attachment A)**

Section B-Access

Findings B6d:
The MHP did not furnish evidence it has policies, procedures, and practices, in compliance with title VI of the Civil Rights Act of 1964, ensuring minor children are not used as interpreters. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy #6 Non- English Speaking Beneficiaries dated 6/9/2010, Patients Rights Brochure, and the Consumer Informing Flyer. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. The Policy, consumer flyer, and Patient Rights brochure did not include language stating that minor children should not be used as interpreters. Protocol question B6d3 is deemed OOC.

Plan of Correction
The Notice of Use of Language Services poster has been modified to clearly state that a minor will not be used for interpreter services **(Attachment B).** This poster is prominently hung at all clinic and provider sites and is available for easy access under "forms" in the Quality Care Management Provider section of the departmental website.

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Section B-Access

Findings B9a2, B9a3 and B9a4:
Test Call Results Summary

Protocol Question	Test Call Findings							Compliance Percentage
	#1	#2	#3	#4	#5	#6	#7	
9a-1	N/A	N/A	N/A	N/A	N/A	IN	IN	**100%**
9a-2	IN	N/A	IN	OOC	N/A	IN*	IN*	**80%**
9a-3	IN	N/A	IN	OOC	N/A	IN	IN	**80%**
9a-4	N/A	OOC	N/A	OOC	IN	N/A	N/A	**33%**

In addition to conducting the seven (7) test calls, DHCS reviewed the following documentation presented bythe MHP as evidence of compliance: Policy #22 Test Call process 24/7 Access Line, Policy #9, Policy #8 Service Triage. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the test calls demonstrated that the MHPs processes do not fully meet regulatory requirements for providing information on how to access SMHS, including SMHS required to assess whether medical necessity criteria are met, informing beneficiaries about services needed to treat a beneficiary's urgent condition, and information about how to use the beneficiary problem resolution and fair hearing processes. Protocol questions B9a2, B9a3, and B9a4 are deemed in partial compliance.

ProtoCall clinicians did not display evidence of understanding how to access specialty mental health services and/or inform beneficiaries on information about services needed to treat the urgent condition of a beneficiary. When following up with ProtoCall on the results of the test calls during the review, we were informed that ProtoCall was undergoing a significant system conversion in their phone computer system which reportedly may have created an impact.

Plan of Correction
Test Call #2 did occur during daytime hours. Access Screeners as well as other QCM clinicians who may assist in answering Access Calls have been re-trained on the beneficiary problem resolution process. All Access Screeners have been provided an online Access Screener guide which allows the information on the beneficiary concern process, policy and forms to be readily available during calls. **(Attachment B2: URL to Access Screener Guide)**

Section B-Access

Findings B10a1, B10a2, B10a3:
The MHP did not furnish evidence its written log(s) of initial requests for SMHS includes requests made by phone, in person, or in writing. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Access Call Logs. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, four of the five test calls were logged accurately, however, call #4 had

been placed on hold for ten minutes and then the call was terminated, leaving call #4 not logged.

Plan of Correction
The Mental Health Plan utilizes an electronic Access Screening Log for logging all required information. All calls taken after hours are emailed daily to the Department for logging. **(Attachment B3: Access Contact Log and sample of ProtoCall log sent to Behavioral Wellness and evidence of this information logged in the Access Contact Log)**

Section B-Access

Findings B12b2:
The MHP did not furnish evidence it has a CCC or other group that provides reports to the Quality Assurance/Quality Improvement program. The MHP did not submit any evidence for this protocol requirement. Protocol question B12b2 is deemed OOC.

Plan of Correction
Ethnic Services and Diversity Manager now has a defined schedule for attendance and participation in the monthly Quality Improvement Committee meeting. **(Attachment B4: QIC meeting minutes)**

Section C-Authorization

Findings C6a1:
The MHP did not furnish evidence it provides a written NOA-C to the beneficiary when the MHP denies payment authorization of a service that has already been delivered to the beneficiary as a result of a retrospective payment determination. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy #4.010 Notices of Action, dated [1]. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP could not provide evidence that a NOA-C was issued for one of two (2) denied TARs from the sample TAR group. Protocol question C6a1 is deemed in partial compliance.

Plan of Correction:
Quality Care Management staff have been cross-trained in order to ensure any QA team member can process a TAR, to prevent delays in meeting regulatory and/or contractual requirements. In the event that the County Board of Supervisors enforces a mandatory "black out" for any length of time, QCM staff will ensure at least one employee, will be on site throughout the closure period to prevent delays in meeting regulatory and/or contractual requirements.

Section C-Authorization

Findings C6d:
The MHP did not furnish evidence it provides a written NOA-E to the beneficiary when the MHP fails to provide a service in a timely manner. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy 4.010 Notices of Action dated [2], Grievance/Appeal logs for FY

[1] Notice of Action Date removed for confidentiality
[2] Notice of Action Date removed for confidentiality

2015/16 and 2016/17, the 2015 AGBAR, and the Access
Database Log. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the Access Database Log identified beneficiaries who had exceeded the 10-day timeliness standard, but the MHP had not issued NOA-Es. Protocol question C6e is deemed out of compliance.

Plan of Correction:
System trainings have occurred covering NOA practices including new NOA guidelines outlined in the CMS Final Rule **(Attachment C: NOA guidelines training power point)**

Section D-Beneficiary Protection

Findings D3a1 and D3a2:
The MHP did not furnish evidence it ensures grievances, appeals, and expedited appeals are resolved within established timeframes and/or required notice(s) of an extension are given to beneficiaries. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy #4.020 Client Problem Resolution Process dated 12/22/2016, Grievance/Appeal logs for FY 2015/16 and 2016/17, 20 sample Grievances, and two (2) sample Appeals. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, two (2) of the twenty sample grievances reviewed were not resolved within 60 days, and one (1) of the two (2) appeals was not resolved within 45 days. The MHP did not request an extension and the beneficiary was not notified of the delay.

Plan of Correction:
Quality Care Management will remain staffed to process grievances received during the mandatory holiday time off for county employees. Beneficiary concerns data is now reviewed in each QIC meeting and noted in each month's QIC meeting minutes. **(Attachment D: QIC meeting minutes)**

Section G-Provider Relations

Findings G4b:
The MHP did not furnish evidence it takes corrective action if providers fail to comply with timely access requirements. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Access Database Log. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHP monitors timeliness via an Access Log. The overall average time to receive services was 4.5 days, however, approximately 4% of consumers on the access log exceeded the 10-day timeliness standard. The MHP can suspend or terminate a provider for failing to meet the requirements, however the MHP stated that they take no action and there is no follow up with the providers. Protocol question G4b is deemed OOC.

Plan of Correction:
Network Provider template created to be sent to Providers who are late in timeliness and requests immediate Plan of Correction. Dedicated QCM staff are identified to monitor timeliness and take action to terminate provider contracts when plans of correction are not adhered to. In addition, the department has developed access to the Access Contact Log for provider use and direct entry of information, which will allow tracking for timeliness. **(Attachment G: Network Provider Template)**

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Section J-Mental Health Services (MHSA)

Findings J6b2:
The County does not maintain an MHSA Issue Resolution Log with all required components. DHCS reviewed the following documentation presented by the County as evidence of compliance: MHSA Issue Resolution Log. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specifically, the MHSA Issue Resolution Log did not contain a column for a description of the issues. Protocol question J6b2 is deemed OOC.

Plan of Correction:
The MHSA Issue Resolution Log has been updated to include the necessary column. **(Attachment J: MHSA Issue Resolution column added to IR log)**

Section K-Chart Review/Non Hospital Services

Findings 1c1:
Focus of the proposed intervention did not address the mental health condition. Plan of Correction will indicate how the MHP will ensure that interventions are focused on a significant impairment directly related to the mental health condition.

Findings 1c2:
There was no expectation that the documented intervention would meet the intervention criteria. Plan of correction will indicate how the MHP will ensure interventions meet the intervention criteria.

Plan of Correction:

- As of March 2016, all clinical staff are required to take an updated mandatory assessment training annually, which covers functional impairments and intervention criteria.
- A documentation manual was developed and distributed to staff in May of 2015, which covers documentation of how interventions must address functional impairments related to the client's mental health condition.
- Documentation training was conducted at each clinic beginning June, 2015 and was offered monthly until June 2017, when it was moved to an online training, which is available at any time and required annually for all staff. This training covers documentation of how interventions must address functional impairments related to the mental health condition.

- Beginning March 2016, a note reviewer training became mandatory for all supervisors, managers, and note reviewers. Note reviewers are required to complete a treatment plan prior to participating in required note reviewer trainings to demonstrate minimum competency, as well as, take a note reviewer test through QCM. This training trains note reviewers to ensure that services are only billed when the interventions provided address functional impairments related to the client's mental health condition.
- By November 2016, all staff were trained on Team Based Care and required to participate in daily meetings. At these meetings, team members are required to complete a checklist tool which documents that the team reviewed treatment plans, discussed interventions, client diagnosis, and task assignment. This ensures that all staff working with a client fully understand how the services, and interventions they provide, will assist the client in reducing functional impairments related to the client's mental health condition, as documented on the treatment plan.

Section K-Chart Review/Non Hospital Services

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

- No initial assessment, no updated assessment, updated assessment was late. Plan of correction will indicate how the MHP will ensure assessments are completed in accordance with the timeliness and frequency requirements.

Findings 2b:
Assessments did not include all the elements specified:

- Medical history, medications, substance use, client strengths, and risks.

Plan of correction will indicate how the MHP will ensure that every assessment contains all of the required elements.

Plan of Correction

- As of March 2016, all clinical staff are required to take an updated mandatory assessment training annually, which covers timelines for completing assessments and how to complete required elements of the assessment.
- Beginning March 2016, a note reviewer training became mandatory for all supervisors, managers, and note reviewers. Note reviewers are required to complete an assessment prior to required note reviewer trainings to

demonstrate minimum competency, as well as, take a note reviewer test through QCM. This training educates note reviewers on how to ensure that staff, under note review, are completing assessments correctly and on time.

Section K-Chart Review/Non Hospital Services

Findings 3a:
The provider did not obtain a current written medication consent form signed by the beneficiary agreeing to the administration of each prescribed psychiatric medication or document reason why the consent was not signed.

Plan of correction will indicate how the MHP will ensure that medication consent is obtained and retained for each medication prescribed and administered and correctly documented.

Plan of Correction:

- Beginning May 2017, a Quality Assurance Psychiatric component was added to the chart review process. The QA psychiatrist reviews the documentation related to medication assessment, prescription, and administration and for correct use of a medication consent. If medication consents are not present or current, the QA Psychiatrist sends a letter of correction to the prescribing doctor, requiring consent completion within five days.
- The medication consent form has been edited to include required information as requested by the Department. **(Attachment K)**

Section K-Chart Review/Non Hospital Services

Findings 4a2:
Client plan was not updated annually or when there was a significant change in the beneficiary's condition. Plan of correction will indicate how the MHP will ensure that client plans are completed at least on an annual basis, all types of interventions/service modalities provided and claimed are recorded on current client plan, non-emergency services are not claimed when a client plan has not been completed or service is not on client plan. 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.

Plan of Correction:

- As of March 2016, all clinical staff are required to take an updated mandatory Treatment Plan training annually, which covers the requirement, that client plans need to be completed annually. The training also covers the necessity

of including all interventions and service modalities on the treatment plan before being provided and/or billed.

- Documentation training was conducted at each clinic beginning June 2015 and was offered monthly until June 2017, when it was moved to an online training, which is available at any time and required annually for all staff. This training covers the necessity of only providing interventions in billable services that are documented on the current treatment plan.
- Client's identified in the February 6-9, 2017 Findings Report as Line [3], Line [4], and Line [5] were found to have invalid treatment plans outside of the audit period. Behavioral Wellness has taken the following steps to address this:
- **Line [6]:** Services between [7] and [8] were blocked from billing, with the exception of assessment services. Santa Barbara County has implemented a system where services that are provided without a current treatment plan are not entered into our billing system, thus not billed to Medi-Cal. **(Attachment L).**
- **Line [9]:** Services between [10] and [11] were originally billed to Medi-Cal due to the fact that
  the MHP defined a valid treatment plan as having a check box indicating that the client signed the plan, without the actual client signature or documentation that the client signed the plan, while it was indicated in February 6-9, 2017 Findings Report that the check box was not sufficient without evidence of the signature or other supporting documentation. These 142 services have been identified and our fiscal department is in the process of having them disallowed. **(Attachment M).**
- **Line [12]:** Services between [13] and [14] were originally billed to Medi-Cal for the same
  reason described above. 129 services have been identified and our fiscal department is in the process of having them disallowed. **(Attachment N).**

[3] Line number(s) removed for confidentiality
[4] Line number(s) removed for confidentiality
[5] Line number(s) removed for confidentiality
[6] Line number(s) removed for confidentiality
[7] Service Date removed for confidentiality
[8] Service Date removed for confidentiality
[9] Line number(s) removed for confidentiality
[10] Service Date removed for confidentiality
[11] Service Date removed for confidentiality
[12] Line number(s) removed for confidentiality
[13] Service Date removed for confidentiality
[14] Service Date removed for confidentiality

Santa Barbara County Mental Health Plan Review
Plan of Correction

Section K-Chart Review/Non Hospital Services

Findings 4b:
Client plans did not include all items required. Specific, measurable objectives focused on mental health needs and functional impairments, detailed interventions, with expected frequency.

Plan of Correction:

- As of March 2016, all clinical staff are required to take an updated mandatory Treatment Plan training annually, which covers the requirement that objectives be specific, measurable, and address mental health needs/ functional impairments caused from the mental health diagnosis.
- Documentation training was conducted at each clinic beginning June, 2015 and was offered monthly until June 2017, when it was moved it an online training which is available at any time and required annually for all staff. This training covers the requirement that objectives be specific, measurable, and address mental health needs/ functional impairments caused from the mental health diagnosis.

Santa Barbara County Mental Health Plan Review
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Section K-Chart Review/Non Hospital Services

Findings 4d1, 4e:
No documentation of participation and agreement with plan and no evidence client was offered a copy of the plan. Plan of correction will ensure that signature is obtained in a timely manner and services are not claimed when participation is not obtained or reason for refusal is not documented. Ensure that there is documentation substantiating that beneficiary was offered a copy of the plan and establish a process to ensure the beneficiary is offered the plan.

Plan of Correction:

- As of March 2016, all clinical staff are required to take an updated mandatory Treatment Plan training annually, which covers the requirement that the client must be offered a copy of the plan and must sign the plan, and this must be documented (or client's refusal to sign must be documented) in order for client plan to be valid and services to be billed.
- Documentation training was conducted at each clinic beginning June, 2015 and was offered monthly until June 2017, when it was moved it an online training which is available at any time and required annually for all staff. This training covers the requirement that the client must be offered a copy of the plan and must sign the plan and this must be documented (or client's refusal to sign must be documented) in order for client plan to be valid and services to be billed.
- Beginning May of 2017, a Plan Development component was added to chart review, where every chart reviewed by QCM is checked to see if there is a Plan Development note which corresponds with every new or revised client plan and documents that the client agreed to and signed the client plan.
- In 2017, a new Treatment plan template has been created and is being piloted as of September 2017. This template requires that the clinician completing the plan enters a service note date, referring to a corresponding plan development note. In the plan development note it will be documented if client agreed to plan, signed the plan, or reasons why client was unable or declined to sign.

Section K-Chart Review/Non Hospital Services

Findings 5a:
Progress notes did not follow policy timelines or cover relevant aspects. Plan of correction will indicate how the MHP will ensure progress notes are completed by policy timelines and cover relevant aspects of client care.

Plan of Correction:

- Documentation training was conducted at each clinic beginning June 2015

and was offered monthly until June 2017, when it was moved it an online training, which is available at any time and required annually for all staff. This training covers the note timeline requirements and the content which all notes are required to contain.

- Policy #8.102 "Mental Health Progress Notes" details the timelines in which notes are to be completed and the content which all notes are required to contain. **(Attachment O)**
- A documentation manual was developed and distributed to staff in May of 2015, which covers the timelines in which notes are to be completed and the content which all notes are required to contain.

Section K-Chart Review/Non Hospital Services

Findings 5b:
Services being provided by two or more persons did not include the contribution of each member as related to functional impairment or mental health need or had time claimed which was greater than time documented. Plan of correction will indicate that group notes clearly document the contribution of each staff member, medical necessity for the use of multiple staff in group setting, and time claimed is consisted with documentation.

Plan of Correction:

- Documentation training was conducted at each clinic beginning June 2015 and was offered monthly until June 2017, when it was moved to an online training, which is available at any time and required annually for all staff. This training covers billable requirements for group notes.
- A documentation manual was developed and distributed to staff in May of 2015, which covers billable requirements for group notes.
- Beginning March 2016, Note Reviewer training became mandatory for all supervisors, managers, and note reviewers. Note reviewers are required to complete a treatment plan prior to note reviewer trainings to demonstrate minimum competency as well as take a note reviewer test through QCM. This training will train note reviewers to ensure that group services are documented and billed appropriately.

Section K-Chart Review/Non Hospital Services

Findings 5c:
No progress note for services billed. Plan of correction will indicate how the MHP will ensure all services claimed are documented in the medical record, claimed for correct code, accurately documented; indicate the type and date of service and amount of time taken to provide the service.

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Plan of Correction:

- The fiscal department has been researching with the program developers how services could be billed without a progress note created, as this is not how the program is designed. There are three ways that billing occurs within our county system: 1. A progress note is created in Clinician's Gateway and bills through Sharecare. 2. Billed services are entered directly into Sharecare. 3. A group of services is entered into Sharecare in a process called "PUP." The four services listed below were found to have progress notes in Clinician's Gateway:

Service date	Consumer Services ID	Service description	Prvdr	DOB	CGNote#
15	16	Group Rehabilitation	17	18	19
20	21	Group Rehabilitation	22	23	24
25	26	Group Rehabilitation	27	28	29
30	31	Group Rehabilitation	32	33	34

These two services were not found to have notes in Clinician's Gateway:

Service date	Consumer Services ID	Service description	Prvdr	DOB	CGNote#
35	36	Group Rehabilitation	37	38	39

[15] Service Date removed for confidentiality
[16] Consumer ID removed for confidentiality
[17] Provider ID removed for confidentiality
[18] DOB removed for confidentiality
[19] CG Note # removed for confidentiality
[20] Service Date removed for confidentiality
[21] Consumer ID removed for confidentiality
[22] Provider ID removed for confidentiality
[23] DOB removed for confidentiality
[24] CG Note # removed for confidentiality
[25] Service Date removed for confidentiality
[26] Consumer ID removed for confidentiality
[27] Provider ID removed for confidentiality
[28] DOB removed for confidentiality
[29] CG Note # removed for confidentiality
[30] Service Date removed for confidentiality
[31] Consumer ID removed for confidentiality
[32] Provider ID removed for confidentiality
[33] DOB removed for confidentiality
[34] CG Note # removed for confidentiality
[35] Service Date removed for confidentiality
[36] Consumer ID removed for confidentiality
[37] Provider ID removed for confidentiality
[38] DOB removed for confidentiality
[39] CG Note # removed for confidentiality

40	41	Group Rehabilitation	42	43	44

Further research will be done to understand the error.

Section K-Chart Review/Non Hospital Services

Findings 6a:
No evidence that interpreter services offered at every occasion. Plan of correction will indicate how the beneficiary plans to ensure all beneficiaries and parents are offered interpreter services and this is documented.

Plan of Correction:

- At admission, beneficiaries and their parents/legal guardians are asked what their preferred/primary language is. This information is recorded within ShareCare and Clinician's Gateway, the Department's electronic health record system. If the beneficiary and/or their parent/legal guardians indicate that their preferred/primary language is a language other than English, they will be informed of interpreter services that are available to them at no cost.
- Information on interpreter services is documented in the Consumer Information Checklist. At completion, this document is signed by the beneficiary or parent/guardian and Department staff and placed in the client record.
- On the Outpatient Progress Note template, the preferred/primary language of the beneficiary and their parents/legal guardians will be indicated at the top left hand corner. Additionally, staff will indicate which language services were provided in from a pre-set drop-down menu. For non-English languages, staff will indicate if language services were provided by bilingual staff or an interpreter.

[40] Service Date removed for confidentiality
[41] Consumer ID removed for confidentiality
[42] Provider ID removed for confidentiality
[43] DOB removed for confidentiality
[44] CG Note # removed for confidentiality